2015-2016
全民健康保險年報
National Health Insurance Annual Report

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健保新紀元—健保以人為本貼心守護全民健康

全民健保秉持初衷，以「無論貧富老幼殘病，人人皆享有並得到同等待遇」的理念，支持全體國民的健康渡過 20 個年頭。目前全民健保納保率已達 99.6%，醫療院所特約率亦高達 93%，民眾就醫非常方便。而對於弱勢族群的照護，除了政府每年提供多達 260 億元之保費補助外，亦提供有欠費協助、醫療保障等多項措施，協助 300 萬人以上的弱勢族群就醫無障礙之外，也提供品質持續提升的醫療服務。

健保制度的用心也獲得民眾高度肯定，透過醫界、民眾及衛生福利部中央健康保險署（以下稱健保署）的通力合作與努力下，無論在醫療服務的內涵、醫療品質的提升，以及健保資訊化等各方面，近年來健保滿意度平均維持在八成以上，締造了納保率高、公平性高、肯定度高及醫療費用低的紀錄，達成「普及、方便、自由、經濟、滿意度高」的目標，成為各國稱讚及學習的對象，也因此每年吸引多國外賓慕名來訪，2014 年 1 月至 2015 年 11 月止，計有 82 國 1,202 位外賓來署參訪。

A New National Health Insurance Era

In the 20 years that Taiwan's national health insurance (NHI) system has safeguarded the health of the country's citizens, it has always been guided by the mission of providing equal treatment to all – rich or poor, young or old, healthy or infirm.

The NHI system now covers 99.6% of Taiwan's population, and 93% of the country's hospitals and clinics are NHI-contracted, making it extremely convenient for people to get care. More than 3 million economically disadvantaged individuals have unobstructed access to medical services because of several forms of assistance, such as insurance premium subsidies of about NT$26 billion a year, overdue premium support, and right-to-care guarantees even if people fall behind on their payments.

Yet even with this extensive support for the underprivileged, the quality of medical services provided is constantly upgraded.

The dedication shown by the NHI system has also earned the program widespread recognition and acclaim. Through the concerted efforts of the medical community, the public and the National Health Insurance Administration (NHIA), it has averaged satisfaction ratings of above 80% in recent years, whether in terms of medical services offered, upgrades in the quality of care or the extensive use of information technology.

歷經二代健保改革後，全民健保更回歸以人為中心的概念，率亞洲之先，積極推動「提升急性後期照護品質試辦計畫」，挑選腦中風疾病優先試辦，於治療黃金期幫助各類急重症個案改善失能程度，在 2015 年 6 月八仙樂園粉塵暴燃事件，健保署面對大量的燙傷患者，自 7 月起著手規劃並於 9 月 9 日公告啓動「全民健康保險燒燙傷急性後期整合照護」，依個別患者需求整合醫療照護服務，期能縮短復健時間，幫助傷者早日回歸社會；積極推動「全民健康保險中醫提升孕產照護品質計畫」、「全民健康保險早期療育門診醫療給付改善方案」及「全民健康保險安寧共同照護試辦方案」等，都是健保署以民眾為中心，提供有尊嚴且適切的醫療協助

The NHI system's consistently high enrollment, commitment to fairness, high level of approval and low costs have helped it attain its goals of being "universal, convenient, easily accessible, affordable and highly satisfactory," and those attributes have drawn global interest. Health representatives from around the world visit the NHIA every year to learn more about the program, with 1,202 dignitaries from 82 countries visiting the agency between January 2014 and November 2015.

After the introduction of second-generation NHI reforms, the NHIA renewed its commitment to a people-oriented approach and pioneered the first "Post-acute Care Pilot Program" in Asia to help stroke patients recover from their incapacitating condition during their golden periods of treatment. The NHI system was tested in late June 2015 when airborne colored powder ignited at an outdoor concert held at the Formosa Fun Coast water park in northern Taiwan, leaving hundreds of people badly burned. To provide integrated care services capable of meeting each patient's specific needs, the NHIA began planning an "Integrated Post-acute Care Program for Burns" in July and launched it on Sept. 9. The program has successfully shortened rehabilitation times and helped burn victims take their places back in society.

The NHIA has also promoted several people-centric initiatives dedicated to providing dignified and appropriate medical care and counseling. These initiatives include programs to upgrade the quality of maternity care and enhance reimbursements for early intervention outpatient care and a trial project to deliver hospice shared-care services. Another program, the Integrated Delivery System (IDS), delivers medical care

與諮詢；「山地離島地區醫療給付效益提昇計畫」，將醫療服務推送到山地離島、偏鄉等醫療資源不足地區，提供民眾在地就醫的服務，未來更規劃將全民健保結合長期照護系統，建構完整的社會安全網，提供全民完整的醫療安全保障。

為保障民眾對於「知」的權利，除了加強重要資訊公開透明，健保署更以人為出發點，運用累積 20 年的全民健保資料庫，於 2014 年 9 月完成建置「健康存摺」（My Health Bank）系統，透過雲端將個人健康及就醫資訊交還民眾，有助自主健康管理，建構醫病資訊對等模式，提高就醫品質；健保署更運用科技，建置「雲端藥歷系統」，供醫師、藥師即時線上查詢病人用藥紀錄，協助整合處方減少過度用藥，避免產生未知的藥害反應，更可以節省不必要的藥費支出，進而增進醫療品質的滿意度。另外民眾可以利用自

to underserved mountainous areas and islands and remote communities, providing residents with localized health care services. In the future, the NHIA plans to incorporate long-term care into the NHI system to build a more comprehensive social security net and provide citizens greater medical security.

The idea of putting people first also motivated the "My Health Bank" system that was launched in September 2014 to strengthen the public's "right-to-know" and the transparency of important information. Built on the NHIA's database that has accumulated 20 years of records, the cloud-based system puts the personal health and medical information of the insured back in their hands, helping them manage their own health and creating a model of information symmetry between doctor and patient to enhance the quality of care.

Another advanced technology system, the NHI PharmaCloud System, enables doctors and pharmacists to search a patient's medication history online in real time – a function that consolidates prescriptions and

然人憑證，在家就可以輕鬆上網查詢事前審查醫療項目審核進度、個人健保資料查詢及保費繳納情形，還可以辦理個人加退保，讓資料更新更迅速，服務更便捷。

甫經成年禮的洗禮，在各界守護下成長茁壯的全民健保，面對下一個 20 年，更將積極回應民眾對高品質醫療服務的期待及世界潮流的驅動，貼近民眾的需求，持續聆聽社會各界的聲音，加強與各界溝通，不斷擷取新知、滾動革新，提供更符合全民期望的健康照護服務，持續為守護全民的健康努力，逐步達成讓國人「活得更久、更好、更健康」的目標，強化我國健康服務全方位的照護網絡。

reduces excessive use of medication, prevents the prescribing of drugs that cause allergic reactions, and saves unnecessary spending on medication, ultimately increasing satisfaction with medical care quality. Individuals, meanwhile, can use their "citizen digital certificate" to perform several functions on the NHIA's online system from the comfort of their homes, such as changing their enrollment status or checking personal health insurance information, premium payment records, or progress in granting authorization for the use of certain medical devices. Through this online system, information is updated more quickly and services are more convenient.

Having grown strong over the past 20 years through the nurturing of society, the NHIA will be just as committed over the next two decades to provide high-quality medical services, be responsive to global trends and people's needs, listen to voices from all walks of life, strengthen communications with NHI stakeholders, acquire new knowledge and promote reforms, all to safeguard the health of Taiwan's people. This dedication to progressively strengthening the country's comprehensive network of health care services will move us closer to achieving our ultimate goal of helping people "live longer, better and healthier lives."

Chapter 1

Administrative Framwork

第一篇
組織革新　再寫新章

臺灣的全民健保採行集中、統籌資源且適用層面廣的單一保險人體制，相較於其他國家健康照護體制，行政成本較低並可達保險費公平性及一致性的優點，也是許多國家取經的優點。

全民健康保險組織

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 年整併當時既有僅 50% 國民可參加之公保、勞保、農保三大醫療保險體系，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。

Taiwan's NHI has adopted a single-payer system that relies on a centralized pooling of resources has resulted in far lower administrative costs than seen in other countries' health care systems and fair and consistent premiums, strengths that several countries have been eager to learn from. In the future, the NHIA will further harness existing strengths, continue to incorporate suggestions from throughout society, and learn from other countries' systems to develop a health insurance system that best suits Taiwan's people.

NHIA Organization

The National Health Insurance Administration was previously known as the "Bureau of National Health Insurance" under the Executive Yuan and defined as a "financial and insurance public enterprise." When founded in 1995, the BNHI merged three existing health insurance programs – government employee insurance, labor insurance and farmers' health insurance – that covered only 50 percent of the population at the time and expanded into a comprehensive social insurance system that offered universal coverage based on the principles of sustainability and caring for the disadvantaged. The BNHI was repositioned in 2010 as an "administrative agency" and renamed as the NHIA in 2013 as part of a government reorganization plan and has ultimately emerged as a state-run national health insurance agency based on a single-payer model.

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

為有效推動全民健保各項服務，健保署除依業務專業性質設置專業組室，規劃各項業務措施之推動，在各地設有 6 個分區業務組（圖 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 21 個聯絡辦公室，服務在地民眾。人員編制至 2015 年 6 月 30 日，共有 2,881 名。

Taiwan's NHI system is a social insurance program organized by the government under the jurisdiction of the Ministry of Health and Welfare. The ministry's NHI Committee helps plan and monitor NHI-related tasks, and its NHI Dispute Mediation Committee deals with NHI-related disputes. The NHIA is responsible for managing health insurance affairs, medical quality, research and development, manpower training and information on the health care system. Its operations are funded out of the central government budget.

In addition to specialized groups and offices that plan and promote various health insurance measures, the NHIA has six regional divisions across Taiwan (Chart 1) that handle insurance enrollments, premium collections, utilization review and reimbursements, and the management of contracted medical institutions. Twenty-one liaison offices have been set up around the country to serve the public. As of June 30, 2015, the NHIA had 2,881 employees.

全民健康保險願景

全民健康保險立基於增進全體國民健康，走過從前、邁向未來，除了運用更先進的科技發展進化雲端藥歷系統，建置「健康存摺」，讓醫療資訊更透明更隨手可得外，因應高齡化社會到來，臺灣是亞洲第一個推動「急性後期照護」的國家，未來希望將全民健保結合長期照護系統，建構成完整的社會安全網，持續朝提升品質、關懷弱勢、健保永續及國際標竿等方向努力。

未來健保署的施政方向：

1. 健全財務穩定，賡續推動多元支付。
2. 精進資源配置，抑制不當耗用。
3. 強化資訊發展，提升執行效率。
4. 關懷弱勢照護及醫療協助，保障就醫權利。
5. 持續健保品質改善，促進國際交流。

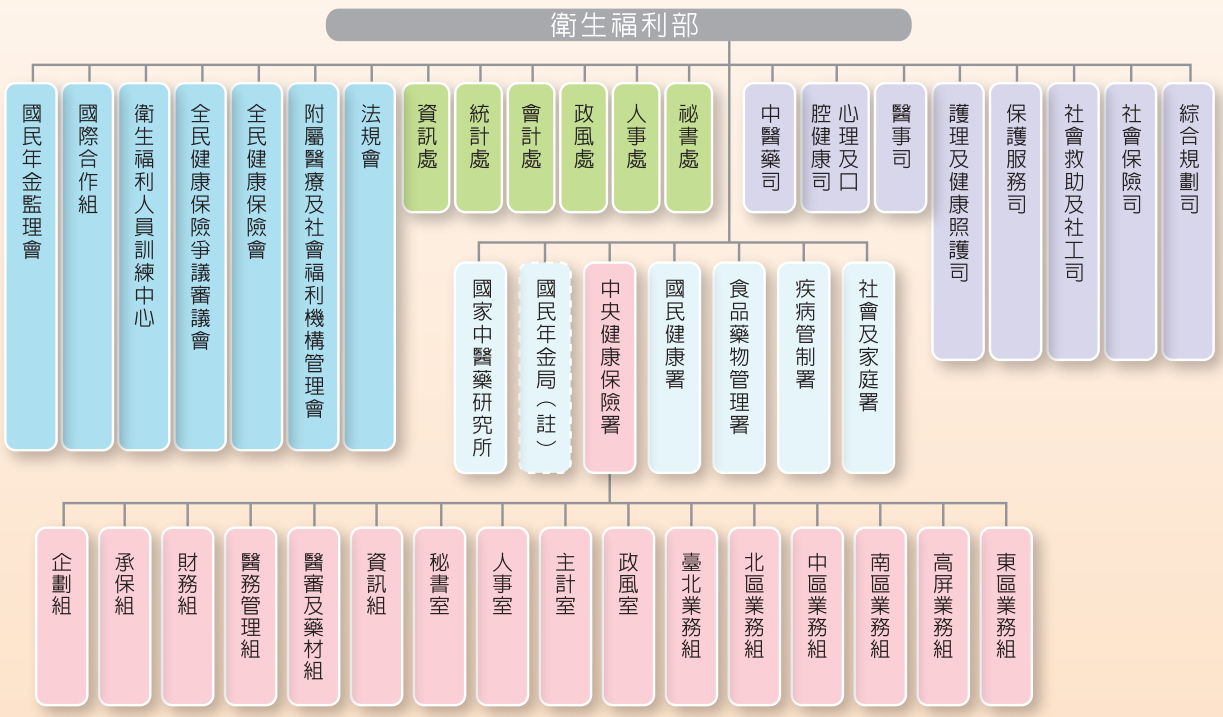
National Health Insurance Program's Vision

The founding mission of the NHIA was to promote and advance the health of all of Taiwan's citizens. As it moves into the future, the agency has taken advantage of technological advances to set up an NHI PharmaCloud System and develop "My Health Bank" to make medical information more transparent and accessible. To cope with the arrival of an aging society, the NHIA initiated a "Post-acute Care" system – the first developed in Asia – and hopes to incorporate a long-term care system in the NHI program in the future and build a more complete social security net. Of course, efforts to upgrade quality, care for the disadvantaged, make the system more sustainable and serve as an international benchmark will continue without compromise.

The NHIA's main policy directions are to:

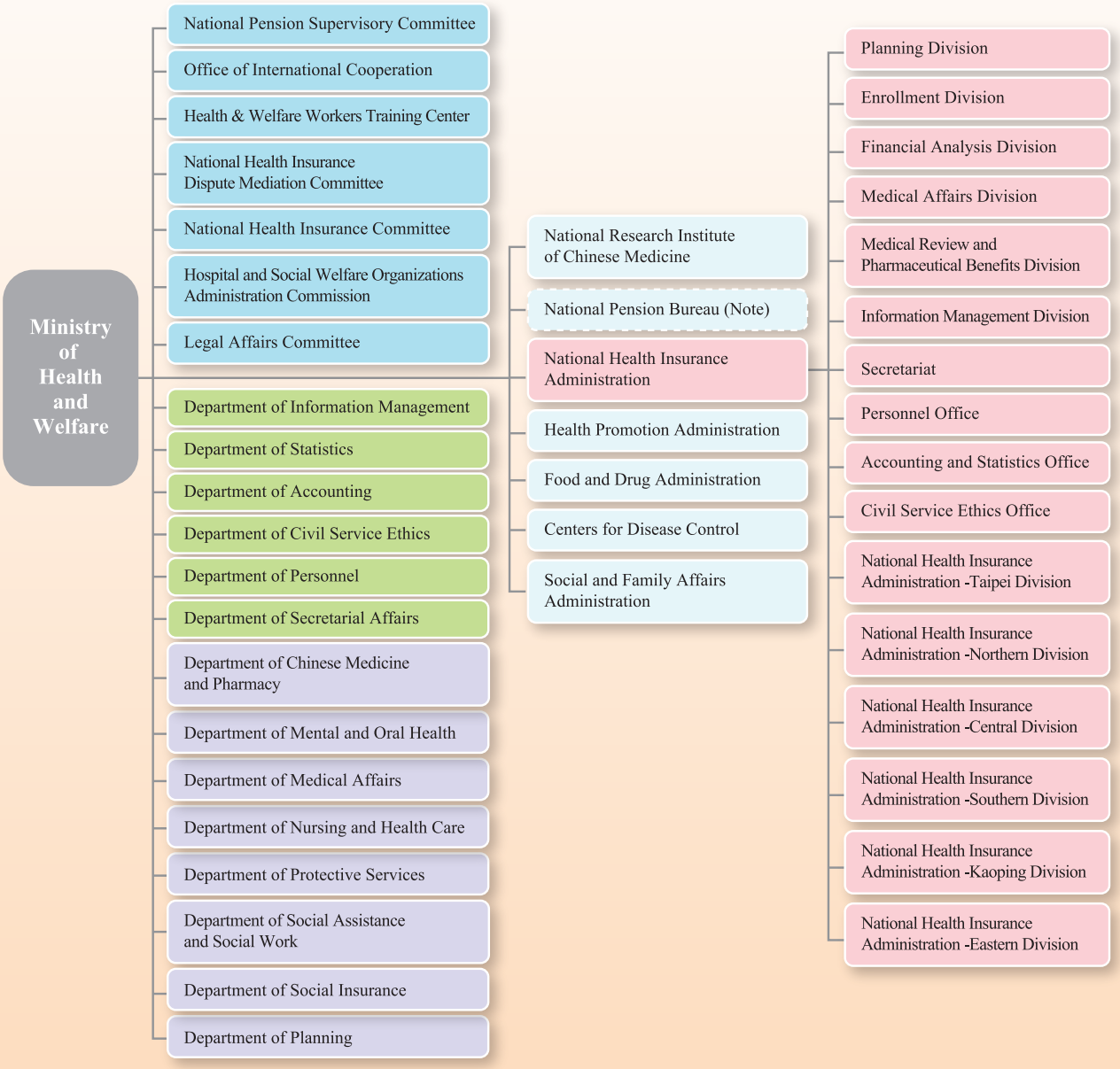
1. Stabilize the system's finances, promote diverse reimbursement plans.
2. Optimize resource allocation, curb inappropriate resource use.
3. Strengthen information development, upgrade execution efficiency.
4. Prioritize disadvantaged care and medical assistance, protect the right to care.
5. Continue to improve health insurance quality, promote international exchanges.

圖 1　全民健康保險組織架構圖



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

Chart 1　NHIA Organizational Chart

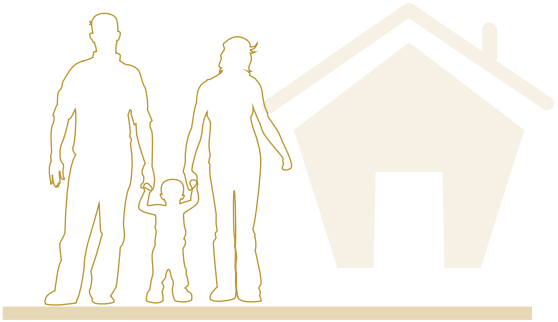


Note: The National Pension Bureau has yet to be established. The Organic Act for Ministry of Health and Welfare stipulates that before the bureau is set up, its responsibilities must be handled by other agencies.

Chapter 2

Enrollment and Financing

第二篇
全民納保　財務平衡



全民有保　就醫平權

強制性社會保險

政府開辦全民健康保險的初衷，即在透過自助、互助制度，將經濟弱勢族群納入健康保障。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已辦妥戶籍登記之新生兒，都必須參加全民健保。保險對象分為 6 類（表 1），以作為保險費計算的基礎。除了本國國民之外，符合全民健康保險法規定及主管機關公告持有居留證明文件之外籍人士（包括港、澳、大陸人士），除了有一定雇主的受僱者自受僱日起參加全民健保外，應自持有居留證明文件滿 6 個月起參加全民健保，以保障自身就醫權利。

Health Care for All and Equal Access to Care

Compulsory Social Insurance

The original concept behind the establishment of the NHI program was to provide health security to the economically disadvantaged through a system of mutual assistance. When the system was conceived, therefore, it was designed to cover segments of the population not classified as workers before the system's inception – dependents, veterans, housewives, students, children and the elderly. The inclusion of these groups in the program meant that all Taiwanese enjoy equal rights to care and have access to medical services when they get sick, are injured in an accident or give birth. Based on that concept, any Republic of China (Taiwan) citizen who has established residency for six months or more or infants born in Taiwan with a household registry must enroll in this compulsory program. Foreign nationals who meet NHI regulations and residency requirements must also be insured under the system. Those hired by local employers are covered from the day their employment contract takes effect, while others must enroll in the system after meeting the six-month residency requirement.

表 1 全民健保保險對象分類及其投保單位

類別	保險對象		投保單位
	本人	眷屬	
第 1 類	公務人員、志願役軍人、公職人員	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滿 20 歲且無職業，或年滿 20 歲無謀生能力或仍在學就讀且無職業者。	所屬機關、學校、公司、團體或個人
	私校教職員		
	公民營事業、機構等有一定雇主的受僱者		
	雇主、自營業主、專門職業及技術人員自行執業者		
第 2 類	職業工會會員、外僱船員	同第 1 類眷屬	所屬的工會、船長公會、海員總工會
第 3 類	農、漁民、水利會會員	同第 1 類眷屬	農會、漁會、水利會
第 4 類	義務役軍人、軍校軍費生、在卹遺眷	無	國防部指定之單位
	替代役役男	無	內政部指定之單位
	矯正機關受刑人	無	法務部及國防部指定之單位
第 5 類	合於社會救助法規定的低收入戶成員	無	戶籍地的鄉（鎮、市、區）公所
第 6 類	榮民、榮民遺眷家戶代表	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滿 20 歲且無職業，或年滿 20 歲無謀生能力或仍在學就讀且無職業者。	戶籍地的鄉（鎮、市、區）公所
	一般家戶戶長或家戶代表	同第 1 類眷屬	

註：1. 各類眷屬及第 6 類被保險人均須為無職業者。

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。

Table 1　Classification of the Insured and the Organizations Enrolling Them

Category	NHI System Participants		Insurance Registration Organization
	The Insured	Dependents	
Category1	Civil servants, volunteer military personnel, public office holders	1. Spouses (not employed) 2. Direct blood relatives (not employed) 3. Direct blood relatives two generations younger under 20 (not employed) or over 20 but still studying or unable to support themselves	Organizations, schools, companies or groups at which individuals are employed, or the individuals themselves
	Private school teachers and employees		
	Employees of public and private enterprises and organizations		
	Employers, the self-employed, and independent professionals and technical specialists		
Category2	Occupation union members, foreign crew members	Same as above	Union that the insured belongs to; the Master Mariners Association; the National Chinese Seamen's Union
Category3	Members of farmers, fishermen and irrigation associations	Same as above	Farmers' associations, fishermen's associations; or irrigation associations
Category4	Conscripted servicemen, students in military schools, dependents of military servicemen on pensions	None	Agencies designated by the Ministry of Defense
	Males performing alternative military service	None	Agencies designated by the Ministry of the Interior
	Inmates at correctional facilities	None	Agencies designated by the Ministry of Justice and Ministry of National Defense
Category5	Members of low-income households as defined by Public Assistance Act	None	Administrative office of the village, township, city or district where the household is registered
Category6	Veterans or dependents of deceased veterans	1. Unemployed spouse 2. Unemployed direct blood relatives 3. Direct blood relatives two generations younger under 20 (not employed) or over 20 but still studying or unable to support themselves	Administrative office of the village, township, city or district where the household is registered
	Heads of households or household representatives	Same as for Category 1	

Note: 1. For people to qualify as dependents or as members of Category 6, they must not be employed.
2. Inmates were included in the NHI system under Category 4 beginning on Jan. 1, 2013.

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，歷經三次修正，逐步擴大加保對象，包括新住民、長期在臺居留的白領外籍人士、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居留滿 6 個月始可加入健保，以符合社會公平正義之期待。至於曾有參加健保紀錄之本國籍保險對象，在二代健保施行前已出國者，如戶籍已遷出國外致有喪失投保資格情況時，只要在二代健保施行後 1 年內（2013 年 12 月 31 日以前）返國重新設籍，免受等待期之限制，自設籍日即可再參加健保。

截至 2015 年 6 月底止，參加全民健保的總人數有 23,644,464 人（表 2），投保單位有 817,902 家。

As the social environment has changed, the NHI system has undergone three revisions out of respect for human rights and fairness that have expanded its scope to cover new immigrants, white collar foreign nationals who are long-term Taiwan residents, overseas Chinese and foreign students, and military personnel. Under the second-generation system, inmates at correctional facilities have also been included in the program to further achieve the vision of equal treatment and access to care for all.

Another change made under the second-generation system in the interest of fairness dealt with Taiwanese nationals who have lived abroad for an extended period of time but want to re-establish their residency and re-enroll in the program. To do so, they must now have either participated in the system at some point during the previous two years or have established residency in Taiwan for at least six months to be eligible. Foreign nationals must also have resided in Taiwan for at least six months before they can enroll in the system.

Taiwanese nationals who were once enrolled in the NHI system but lost their eligibility by establishing their residency abroad prior to the introduction of the second-generation system were given the chance to re-enroll in the system. They were allowed to have their eligibility restored without being subject to a waiting period if they re-established residency in Taiwan within one year from the time the second-generation NHI system took effect, or by December 31, 2013.

As of the end of June 2015, 23,644,464 people (Table 2) were enrolled in the NHI program under 817,902 insurance registration organizations (generally employers).

表 2　全民健保各類保險對象人數

	第 1 類	第 2 類	第 3 類	第 4 類	第 5 類	第 6 類	總計
人數	13,251,210	3,774,460	2,502,974	178,671	334,077	3,603,072	23,644,464
占總納保人數百分比	56.04%	15.96%	10.59%	0.76%	1.41%	15.24%	100%

資料時間：2015 年 6 月。

Table 2　No. of Participants in NHI System by Category

	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	Total
Insured	13,251,210	3,774,460	2,502,974	178,671	334,077	3,603,072	23,644,464
Percent of total insured	56.04%	15.96%	10.59%	0.76%	1.41%	15.24%	100%

Note: Figures as of June 2015

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（pay-as-you-go financing）原則，因屬短期保險性質，財源大部分由保險費支應，除了維持財務平衡目標，全民健保也被賦予自負盈虧且不以累積盈餘的期望。依法全民健保財務須維持 1-3 個月安全準備為原則，目前保險財務收入主要來自於被保險人、雇主及政府共同分擔的保險費，少部分為外部財源挹注，包括保險費滯納金、公益彩券盈餘分配收入、菸品健康福利捐等補充性財源。

Balanced Finances for Sustainable Operations

Since 1995 when it integrated Taiwan's mosaic of social insurance systems, the NHI program has been financially self-sufficient and operated based on the "pay-as-you-go" financing principle, a short-term approach that means the system is primarily funded by premiums. The system is also expected to maintain a fiscal balance and cover any deficits without accumulating surpluses. By law, however, the NHIA must maintain a contingency reserve fund equal to between one and three months of medical expenditures.

At present, the system mainly derives its revenue from the premiums paid collectively by the insured, employers, and the government. Other revenues come from outside sources, such as fines on overdue premiums, public welfare lottery contributions, and the health surcharge on cigarettes.

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快於保費收入成長速度，健保署除積極開源節流外，分別於2002年、2010年及2016年三次調整保險費率，更以量能負擔、擴大費基的精神，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。

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」（側重收入面監督）及「全民健康保險醫療費用協定委員會」（側重支出面協定）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，針對保險費率及保險給付範圍進行審議，並協議訂定及分配年度醫療給付費用總額，期透過上述收支連動機制，確保長期財務穩定。

一般保險費的計算

全民健保保險費由被保險人、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3、表4）。

As Taiwan's overall environment and population structure have changed, however, revenue growth has lagged far behind the rate of increase of medical expenses. The NHIA has responded by actively pursuing new sources of funds and trying to broaden the revenue base while cutting expenditures. Premium rates have been increased three times in 2002, 2010 and 2016, and several other measures have been taken based on the insured's "ability to pay" and the spirit of mutual assistance. The salary brackets on which premiums are calculated have been repeatedly adjusted, as has the premium formula for dependents; military personnel, civil servants and teachers, whose premiums were once calculated based on their base salaries, now pay premiums based on their total compensation; a supplementary premium is now collected on six types of income not previously included in premium calculations; and the minimum government contribution to the program has been clearly stipulated. All of these initiatives have consolidated sources of revenue, helping sustain the system's operations and keeping its finances balanced.

The second-generation insurance reforms established a mechanism to clearly link revenues and expenditures. The "National Health Insurance Supervisory Committee" (responsible for supervising revenues) and "National Health Insurance Medical Expenditure Negotiation Committee" (responsible for setting reimbursements) were merged into the "National Health Insurance Committee." This new panel, composed of representatives of the insured, employers, medical service providers and government agencies, experts and scholars, and impartial observers is responsible for reviewing insurance premium rates, rates of reimbursement of medical services, and the range of items covered. The committee also sets the total medical expenditure budget for the year and decides how it will be allocated. This process keeps revenues and expenditures aligned, ensuring the system's long-term financial stability.

全民健保的保險費率自 1995 年 3 月開辦起到 2002 年 8 月底均維持 4.25%，2002 年 9 月起調整為 4.55%；2010 年 4 月為穩固健保經營，避免健保財務缺口繼續擴大，以 2 年收支平衡為調整基礎，調整保險費率至 5.17%。二代健保實施後，因加收補充保險費，故一般保險費率從 2013 年 1 月 1 日起調整為 4.91%。自 2016 年 1 月後將調整為 4.69%。

How Standard Premiums are Calculated

NHI premiums are shared by the individual, the individual's insurance registration organization, and the government. Insured individuals classified in categories 1, 2, and 3, who are all employed, pay premiums are calculated by the premiums plus the salary registered in their name by their insurance registration organization (usually their employer) with the NHIA. The standard premiums for individuals classified in categories 4, 5, and 6 are based on the average premium paid by those classified in categories 1-3 (Table 2, Table 3).

表 3　全民健保保險費計算公式

薪資所得者	被保險人	投保金額 × 保險費率 × 負擔比率 ×（1 ＋眷屬人數）
	投保單位或政府	第 1 類第 1 目至第 3 目：投保金額 × 保險費率 × 負擔比率 ×（1 ＋平均眷屬人數）
		第 2、3 類：投保金額 × 保險費率 × 負擔比率 × 實際投保人數
地區人口（無薪資所得者）	被保險人	平均保險費 × 負擔比率 ×（1 ＋眷屬人數）
	政府	平均保險費 × 負擔比率 × 實際投保人數

註：1. 負擔比率：請參照表 4 全民健保保險費負擔比率。
2. 保險費率：2010 年 4 月至 2012 年 12 月為 5.17%；2013 年 1 月至 2015 年 12 月為 4.91%；2016 年 1 月起保險費率為 4.69%。
3. 投保金額：請參照表 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 口的以 3 口計算。
5. 平均眷屬人數：自 2016 年 1 月 1 日起公告為 0.61 人。
6. 2016 年 1 月起，第 4 類及第 5 類平均保險費為 1,759 元，由政府全額補助。
7. 2010 年 4 月起，第 6 類地區人口平均保險費為 1,249 元，自付 60%、政府補助 40%，每人每月應繳保險費為 749 元。

Table 3　Current NHI Premium Formulas

Wage Earners	The Insured	Salary Basis x Premium Rate x Contribution Ratio x (1 + Number of Dependents)
	Insurance Registration Organization or the Government	Category 1 (subcategories 1~3 Category 1 in Table 1): Salary Basis x Premium Rate x Contribution Ratio x (1+ Average Number of Dependents)
		Categories 2 and 3: Salary Basis x Premium Rate x Contribution Ratio x Actual Number of People Insured
Non-Wage-Earning Individuals	The Insured	Average Premium x Contribution Ratio x (1+ Average Number of Dependents)
	The Government	Average Premium x Contribution Ratio x Actual Number of People Insured

NOTES:
1. Contribution Ratio: Based on ratios set by the NHIA (Table 4)
2. Insurance Premium Rate: 5.17% from April 2010 to December 2012; 4.91% from January 2013 to December 2015; 4.69% starting from January 2016
3. Salary Basis: The amount on which premiums are calculated based on a payroll bracket table (Table 5). The salary basis reflects the salary registered on behalf of the insured.
4. Number of Dependents: Maximum of three even if the actual number of dependents is higher
5. Average Number of Dependents: Will become 0.61 in January 2016
6. Beginning in January 2016, the average monthly premium for individuals in categories 4 and 5 will go up to NT$1,759 and continue to be entirely subsidized by the government.
7. Since April 2010, the average premium for individuals in Category 6 has been NT$1,249, with 60% paid for by the individual (NT$749) and 40% by the government.

表 4 全民健保保險費負擔比率

保險對象類別			負擔比率（%）		
			被保險人	投保單位	政府
第一類	公務人員	本人及眷屬	30	70	0
	公職人員、志願役軍人	本人及眷屬	30	70	0
	私立學校教職員	本人及眷屬	30	35	35
	公、民營事業、機構等有一定雇主的受僱者	本人及眷屬	30	60	10
	雇主	本人及眷屬	100	0	0
	自營業主	本人及眷屬	100	0	0
	專門職業及技術人員自行執業者	本人及眷屬	100	0	0
第二類	職業工會會員	本人及眷屬	60	0	40
	外僱船員	本人及眷屬	60	0	40
第三類	農民、漁民、水利會會員	本人及眷屬	30	0	70
第四類	義務役軍人	本人	0	0	100
	軍校軍費生、在卹遺眷	本人	0	0	100
	替代役役男	本人	0	0	100
	矯正機關受刑人	本人	0	0	100
第五類	低收入戶	家戶成員	0	0	100
第六類	榮民、榮民遺眷家戶代表	本人	0	0	100
		眷屬	30	0	70
	地區人口	本人及眷屬	60	0	40

Table 4　Premium Contribution Ratios under NHI System

Classification of the Insured			Contribution Ratios (%)		
			Insured	Registration Organization	Government
Category1	Civil servants	Insured and dependents	30	70	0
	Volunteer servicemen, public office holders	Insured and dependents	30	70	0
	Private school teachers	Insured and dependents	30	35	35
	Employees of public or private owned enterprises and organizations	Insured and dependents	30	60	10
	Employers	Insured and dependents	100	0	0
	Self-employed	Insured and dependents	100	0	0
	Independent professionals and technical specialists	Insured and dependents	100	0	0
Category2	Occupation union members	Insured and dependents	60	0	40
	Foreign crew members	Insured and dependents	60	0	40
Category3	Members of farmers, fishermen and irrigation associations	Insured and dependents	30	0	70
Category4	Military conscripts	Insured	0	0	100
	Military school students on scholarships, widows of deceased military personnel on pensions	Insured	0	0	100
	Males performing alternative military service	Insured	0	0	100
	Inmates in correctional facilities	Insured	0	0	100
Category5	Low-income household	Household members	0	0	100
Category6	Veterans and their dependents	Insured	0	0	100
		Dependents	30	0	70
	Other individuals	Insured and dependents	60	0	40

平均眷屬人數亦經過多次的調整：1995 年 3 月開辦起至 1995 年 12 月為 1.36 人，1996 年 1 月為 1.1 人，1996 年 10 月為 0.95 人，1998 年 3 月為 0.88 人，2001 年 1 月為 0.78 人，2007 年 1 月為 0.7 人，2015 年 1 月為 0.62 人，2016 年 1 月為 0.61 人。

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 2015 年 7 月 1 日起共有 52 級（表 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、水利會會員等被保險人的投保金額自 2014 年 7 月 1 日起為 22,800 元。

補充保險費之計收

自全民健保 1995 年開辦起，政府、雇主及民眾間都維持一定的負擔比率，二代健保實施後，提高政府及雇主負擔之健保費。以政府為例，原來大約負擔了整體保費的 34%，二代健保則明確規範政府負擔比率至少須達 36%。

The NHI premium rate was 4.25% from when the system was launched in March 1995 until September 2002, when it was adjusted to 4.55%. To stabilize NHI operations and prevent the system's deficits from widening, the premium rate was further increased to 5.17% in April 2010 with the goal of balancing revenues and expenditures within two years. It was then lowered to 4.91% when the second-generation NHI system took effect on January 1, 2013, which introduced the collection of "Supplementary Premiums". For this reason, the premium rate will become 4.96% in January 1, 2016.

The average number of dependents per insured, a number set by the NHIA, has been adjusted frequently over the years. It has gone from 1.36 people in December 1995, to 1.1 in January 1996 to 0.95 in October 1996 to 0.88 in March 1998. It further declined in the next decade, to 0.78 in January 2001 and 0.7 at the beginning of January 2007. It was again lowered to 0.62 in January 2015 and will become 0.61 in January 2016.

Payroll Brackets on which Premiums are Based

To determine the salary levels on which premiums for individuals classified in categories 1, 2 and 3 are based, the Ministry of Health and Welfare sets a periodically updated payroll bracket table that is then approved by the Cabinet. The most recent table, which took effect on July 1, 2015, consists of 52 brackets (Table 5). The salary basis on which premiums are calculated for individuals in Category 1 is based on where their monthly salaries registered by their insurance registration organizations fit in the table. The lowest salary basis allowed for the insured in Category 2 who do not have steady employment and the salary basis for the insured in Category 3 was set at NT$22,800 on July 1, 2014.

為穩固健保財源，使健保永續經營，二代健保採「量能負擔」原則，也就是所得較高的民眾有能力多繳保險費，故對原有一般保險費計費基礎過度依賴經常性薪資所得的情形予以適度調整。為了擴大保險費基，「二代健保」的保費收入，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）。補充保險費的收取對象以第一類至第四類及第六類保險對象為主，第五類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，投保單位（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，以落實量能負擔的精神，提升保費負擔的公平性。

Calculations of Second-generation NHI Premiums

The NHI system has maintained steady contribution ratios for the government, employers and individuals since its inception in 1995. The government and employers will make greater contributions under the second-generation NHI system. The government, for example, paid 34% of all premiums in the past but is now legally mandated to pay at least 36% of all premiums because of the revisions to the NHI Act.

The second-generation NHI system was adopted to broaden and solidify the NHI revenue base and ensure the program's long-term sustainability. The previous system collected premiums solely on the basis of regular wages, but that put an excessive and unfair burden on wage earners in an age when irregular and unearned income have become increasingly prevalent in Taiwan. Embracing the "ability to pay" principle, which asks higher income earners to pay more in premiums, the second-generation system builds on the existing base of "standard premiums" based on monthly salaries by also collecting "supplementary premiums" on other forms of income not considered under the previous system, such as large bonuses, wages from part-time jobs, fees from professional practices, and interest, dividend and rental income.

The hope is that broadening the system's premium base will narrow the gap in the NHI premiums paid by individuals with similar total incomes and have them more equitably share the premium burden (Chart 2). Everybody is subject to supplemental premiums except for Category 5 low-income households.

（一）一般民眾的補充保險費費率：

計費公式：補充保險費費基 × 費率（2016 年 1 月 1 日起為 1.91%），主要包括 6 個項目：

1. 高額獎金
2. 兼職所得
3. 執行業務收入
4. 股利所得
5. 利息所得
6. 個人租給公司、企業、機關的租金收入

（二）雇主的補充保險費：

計費公式：（每月支付之薪資所得總額－其受僱者當月投保金額總額）× 補充保險費率（2016 年 1 月起為 1.91%）。

Supplementary premiums are also collected on the difference between the total salaries (not including bonuses or subsidies) insurance registration organizations (employers) actually pay their employees in a month and the total "salary basis" (Table 4) for the organization's employees. This also reflects the "ability to pay" principle and promotes a more equitable distribution of the program's financial burden.

A. Supplementary Premium Rate for Individuals

Premium calculation formula: Premium rate (1.91% from January 1, 2016) x supplementary premium base. The supplementary premium base consists of six categories of income:

1. High bonuses (bonuses exceeding four times the insured's monthly salary basis; premiums collected on the amount exceeding four times the monthly salary basis)
2. Wages from second or part-time jobs
3. Fees from professional practices
4. Stock dividends
5. Interest income
6. Individual rental income from rents collected from companies, enterprises and organizations

B. Supplementary Premium Rate for Employers

Premium calculation formula: Premium rate (1.91% from January 2016) x (total monthly salaries paid – total employee "salary basis")

圖 2　二代健保保險費計收示意圖

二代健保保險費＝一般保險費＋補充保險費

保險對象：第 1 類至第 4 類及第 6 類收取補充保險費

一般保險費	第 1 類 ~ 第 3 類：投保金額 × 一般費率 × 負擔比率 × (1 + 依附眷口數) （以第 1 類為例：負擔比率為 30%；眷屬人數最多 3 口） 第 4 類及第 6 類：定額保險費
補充保險費	[高額獎金、執行業務收入、兼職所得、股利所得、利息所得、租金收入] × 補充保險費率

註：1. 補充保險費費率：2013 年 1 月起至 2015 年 12 月為 2%；2016 年 1 月起為 1.91%。
2. 兼職所得：非屬投保單位給付之薪資所得。

Chart 2　Premium Collection under Second-generation NHI System

Second-generation NHI premiums = standard premiums + supplementary premiums

Supplementary premiums can be collected from the insured in NHI categories 1-4 and 6

Standard premiums	Category 1 ~ Category 3: Salary basis × premium rate × contribution ratio × (1 + number of dependents) (If Category 1, individual contribution ratio 30%; Maximum of 3) Category 4 and Category 6: Fixed Premium
Supplementary Premium	[High Bonuses, Professional Fees, Part-time Wages, Stock Dividends, Interest Income, Rental Income] × Supplementary Premiums Rate

NOTES: 1. Supplementary premium rate set at 2% from January 2013 to December 2015; 1.91% Starting from January 2016.
2. Part-time wages: Wages received from employers other than the unit through which the individual is enrolled in the NHI program.

表 5 全民健保投保金額分級表

中華民國 84 年 2 月 7 日衛署健保字第 84000335 號公告訂定（第 1 次公告）
|
中華民國 104 年 4 月 16 日衛部保字第 1040109319 號令修正（第 15 次修正）

組別級距	投保等級	月投保金額（元）	實際薪資月額（元）
第一組級距 900 元	1	20,008	20,008 以下
	2	20,100	20,009-20,100
	3	21,000	20,101-21,000
	4	21,900	21,001-21,900
	5	22,800	21,901-22,800
第二組級距 1200 元	6	24,000	22,801-24,000
	7	25,200	24,001-25,200
	8	26,400	25,201-26,400
	9	27,600	26,401-27,600
	10	28,800	27,601-28,800
第三組級距 1500 元	11	30,300	28,801-30,300
	12	31,800	30,301-31,800
	13	33,300	31,801-33,300
	14	34,800	33,301-34,800
	15	36,300	34,801-36,300
第四組級距 1900 元	16	38,200	36,301-38,200
	17	40,100	38,201-40,100
	16	42,000	40,101-42,000
	19	43,900	42,001-43,900
	20	45,800	43,901-45,800
第五組級距 2400 元	21	48,200	45,801-48,200
	22	50,600	48,201-50,600
	23	53,000	50,601-53,000
	24	55,400	53,001-55,400
	25	57,800	55,401-57,800
第六組級距 3000 元	26	60,800	57,801-60,800
	27	63,800	60,801-63,800
	28	66,800	63,801-66,800
	29	69,800	66,801-69,800
	30	72,800	69,801-72,800
第七組級距 3700 元	31	76,500	72,801-76,500
	32	80,200	76,501-80,200
	33	83,900	80,201-83,900
	34	87,600	83,901-87,600
第八組級距 4500 元	35	92,100	87,601-92,100
	36	96,600	92,101-96,600
	37	101,100	96,601-101,100
	38	105,600	101,101-105,600
	39	110,100	105,601-110,100
第九組級距 5400 元	40	115,500	110,101-115,500
	41	120,900	115,501-120,900
	42	126,300	120,901-126,300
	43	131,700	126,301-131,700
	44	137,100	131,701-137,100
	45	142,500	137,101-142,500
	46	147,900	142,501-147,900
	47	150,000	147,901-150,000
第十組級距 6400 元	48	156,400	150,001-156,400
	49	162,800	156,401-162,800
	50	169,200	162,801-169,200
	51	175,600	169,201-175,600
	52	182,000	175,601 以上

備註：第 47 級（含）以下比照勞工退休金月提繳工資分級表訂定。

Table 5　Salary Brackets on which Premiums are Calculated

First announced and established on February 7, 1995
|
Last revised on April 16, 2015 (15th revision)

Bracket Income Differential	Income Tier	Salary Basis (Amount on which Premiums are Calculated) (NT$)	Actual Registered Monthly Salary (NT$)
Bracket 1 NT$900	1	20,008	Under 20,008
	2	20,100	20,009-20,100
	3	21,000	20,101-21,000
	4	21,900	21,001-21,900
	5	22,800	21,901-22,800
Bracket 2 NT$1,200	6	24,000	22,801-24,000
	7	25,200	24,001-25,200
	8	26,400	25,201-26,400
	9	27,600	26,401-27,600
	10	28,800	27,601-28,800
Bracket 3 NT$1,500	11	30,300	28,801-30,300
	12	31,800	30,301-31,800
	13	33,300	31,801-33,300
	14	34,800	33,301-34,800
	15	36,300	34,801-36,300
Bracket 4 NT$1,900	16	38,200	36,301-38,200
	17	40,100	38,201-40,100
	16	42,000	40,101-42,000
	19	43,900	42,001-43,900
	20	45,800	43,901-45,800
Bracket 5 NT$2,400	21	48,200	45,801-48,200
	22	50,600	48,201-50,600
	23	53,000	50,601-53,000
	24	55,400	53,001-55,400
	25	57,800	55,401-57,800
Bracket 6 NT$3,000	26	60,800	57,801-60,800
	27	63,800	60,801-63,800
	28	66,800	63,801-66,800
	29	69,800	66,801-69,800
	30	72,800	69,801-72,800
Bracket 7 NT$3,700	31	76,500	72,801-76,500
	32	80,200	76,501-80,200
	33	83,900	80,201-83,900
	34	87,600	83,901-87,600
Bracket 8 NT$4,500	35	92,100	87,601-92,100
	36	96,600	92,101-96,600
	37	101,100	96,601-101,100
	38	105,600	101,101-105,600
	39	110,100	105,601-110,100
Bracket 9 NT$5,400	40	115,500	110,101-115,500
	41	120,900	115,501-120,900
	42	126,300	120,901-126,300
	43	131,700	126,301-131,700
	44	137,100	131,701-137,100
	45	142,500	137,101-142,500
	46	147,900	142,501-147,900
	47	150,000	147,901-150,000
Bracket 10 NT$6,400	48	156,400	150,001-156,400
	49	162,800	156,401-162,800
	50	169,200	162,801-169,200
	51	175,600	169,201-175,600
	52	182,000	Over 175,601

Note: Tiers 1-47 follow the wage classification table for monthly contributions into the labor pension fund

健保財務收支情形

歷年保險收入及保險成本均呈上升趨勢，自 1998 年起保險財務開始發生短絀，至 2007 年 3 月底，累計健保財務收支首度呈現短絀，2010 年起，因調整保險費率，歷年保險收支累計短絀已由 2012 年 2 月開始有收支結餘，另受二代健保財務新制影響，增加補充保險費及政府應負擔健保總經費下限提高至 36% 的規定，至 2015 年 6 月累計收支結餘為 1,968 億元（表 6）。

表 6 歷年全民健康保險財務收支狀況（權責基礎）

	保險收入 [1]		保險成本 [2]		保險收支當年餘絀（億元）[1]-[2]	保險收支累計餘絀（億元）
	金額（億元）	成長率 (%)	金額（億元）	成長率 (%)		
1995/3~12 月	1,940	–	1,568	–	371	371
1996	2,413	–	2,229	–	184	555
1997	2,436	0.96	2,376	6.58	60	616
1998	2,605	6.91	2,620	10.28	-16	600
1999	2,649	1.69	2,859	9.10	-210	390
2000	2,852	7.65	2,842	-0.59	10	400
2001	2,861	0.34	3,018	6.19	-156	243
2002	3,076	7.50	3,233	7.12	-157	87
2003	3,368	9.48	3,371	4.29	-4	83
2004	3,522	4.60	3,527	4.61	-4	79
2005	3,611	2.51	3,674	4.18	-63	15
2006	3,819	5.76	3,822	4.02	-3	12
2007	3,874	1.44	4,011	4.96	-138	-126
2008	4,020	3.77	4,159	3.68	-140	-265
2009	4,031	0.28	4,348	4.53	-317	-582
2010	4,608	14.32	4,423	1.73	185	-397
2011	4,924	6.85	4,582	3.59	342	-55
2012	5,072	3.01	4,806	4.90	265	210
2013	5,557	9.57	5,021	4.47	536	746
2014	5,695	2.49	5,181	3.19	514	1,260
2015/1~6 月	3,376	–	2,668	–	708	1,968
合計	76,309	–	74,341	–	–	–
1996~2014 年平均	3,736	4.89	3,690	4.80	–	–

說明：1.1995 年為自開辦月 3 月至 12 月之金額；2015 年為截至 6 月底之金額。

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）＋其他金融保險成本。

NHI Financial Status

NHI revenues and expenditures have increased over the years. The deficit of the system had plagued from 1998, and the cumulative deficit came out in March, 2007 for the first time. In order to alleviate the financial problem, the NHI premium rate was raised in 2010 and the system turned into a surplus beginning in February 2012. In addition to the second-generation NHI reforms, the introduction of the supplementary premium and the 36% of the annual health insurance budget that burdened by the government, led to a surplus of NT$196.8 billion in June, 2015 (Table 6).

Table 6　NHI Financial Revenue and Expenditure from 1995 to 2015 (Accrual Basis)

	NHI Revenues [1]		NHI Expenditures [2]		Insurance Outstanding Balance /a year (a hundred million NT$) [1]-[2]	Cumulative Insurance Outstanding Balance (a hundred million NT$)
	Amount (a hundred million NT$)	Growth rate (%)	Amount (a hundred million NT$)	Growth rate (%)		
1995/March to December	1,940	–	1,568	–	371	371
1996	2,413	–	2,229	–	184	555
1997	2,436	0.96	2,376	6.58	60	616
1998	2,605	6.91	2,620	10.28	-16	600
1999	2,649	1.69	2,859	9.10	-210	390
2000	2,852	7.65	2,842	-0.59	10	400
2001	2,861	0.34	3,018	6.19	-156	243
2002	3,076	7.50	3,233	7.12	-157	87
2003	3,368	9.48	3,371	4.29	-4	83
2004	3,522	4.60	3,527	4.61	-4	79
2005	3,611	2.51	3,674	4.18	-63	15
2006	3,819	5.76	3,822	4.02	-3	12
2007	3,874	1.44	4,011	4.96	-138	-126
2008	4,020	3.77	4,159	3.68	-140	-265
2009	4,031	0.28	4,348	4.53	-317	-582
2010	4,608	14.32	4,423	1.73	185	-397
2011	4,924	6.85	4,582	3.59	342	-55
2012	5,072	3.01	4,806	4.90	265	210
2013	5,557	9.57	5,021	4.47	536	746
2014	5,695	2.49	5,181	3.19	514	1,260
2015/January to June	3,376	–	2,668	–	708	1,968
Total	76,309	–	74,341	–	–	–
Average of 1996 to 2014	3,736	4.89	3,690	4.80	–	–

Note：1. NHI system was launched in March 1996; Figures as of June 30, 2015.
2. NHI Revenues = Premiums Receivable + Delinquency Charges + Investment Income + Lottery Income & Contribution for Tobacco + Others − Bad Debt-Interest.
3. NHI Expenditures = Medical Benefits + Others.

Chapter 3

Benefits and Payments

第三篇
醫療普及　合理給付

醫療給付範圍及改革

參加全民健保的保險對象，經繳交保險費並領取健保卡後，凡發生疾病、傷害事故或生育，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、會診、手術、麻醉、藥劑、材料、處置治療、護理及保險病房等，可說是將所有必要的診療服務都包含在內。

Scope of Benefits Package and Reforms

Founded with the mission to promote good health for all, the program has a clearly defined and broad package of benefits: people who have paid their premiums and have valid health insurance cards who need treatment for illnesses or injuries, are giving birth, or have other medical conditions have access to more than 20,000 contracted medical care facilities (hospitals, clinics, pharmacies and medical laboratories) around the country.

The medical services currently offered by the NHI system include: inpatient and ambulatory care, dental services, traditional Chinese medicine therapies, child delivery services, physical rehabilitation, home care, and chronic mental illness care, among others, and most forms of treatment are covered. They include general diagnoses and treatment, medical consultations and operations, and related expenses such as examinations, laboratory tests, anesthesia, prescription medications, supplies, nursing care, hospital rooms, and certain OTC drugs. Pretty much every type of necessary health care service is covered by the program.

全民有保　就醫便利

為讓民眾獲得完善的醫療服務，容許民眾自由選擇就醫一直是健保的原則。截至 2015 年 6 月底止，全民健保特約醫療院所合計達 20,620 家，占全國所有醫療院所總數 93.20%（表 7）；另有特約藥局 5,837 家、居家護理機構 547 家、精神社區復健機構 198 家、助產所 15 家、醫事檢驗機構 217 家、物理治療所 11 家、醫事放射機構 9 家、職能治療所 2 家及呼吸照護所 1 家。

民眾參加全民健保後，健保署即發給健保卡。目前健保卡為智慧卡型式，民眾的基本資料載於 IC 晶片，遇有疾病、傷害、生育等事故，民眾持健保卡即可就醫。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，接受妥善的醫療照顧服務。即使在國外，民眾因不可預期的緊急傷病接受醫療，回國後也可申請核退國外自墊醫療費用。

Providing Convenient Access to Health Care

Giving patients freedom of choice to ensure that they receive good care has been a fundamental principle of the NHI system since its inception. As of the end of June 2015, 20,620 hospitals and health care providers, or 93.20% of all health care facilities in the country, were contracted by the NHI system (Table 7). Another 5,837 pharmacies, 547 home-nursing care institutions, 198 psychiatric community rehabilitation centers, 15 midwife clinics, 217 medical laboratories, 11 physical therapy clinics, nine medical radiology institutions, two occupational therapy clinics and one respiratory care clinic were also contracted by the NHIA.

Once individuals enroll in the NHI program, they are issued an IC card by the NHIA. These "smart" cards, which contain basic information about the cardholder in an embedded chip, serve as formal NHI ID cards and are used to get treatment for illnesses or injuries, when giving birth, or for other medical conditions. Under the NHI system, the insured can visit any NHI-contracted hospital, clinic, pharmacy, or medical laboratory for access to health care. Even individuals who have emergency procedures when they are abroad can apply to have some of their out-of-pocket medical expenses reimbursed through the NHI system.

表 7　全民健保特約醫療院所數

單位：機構數

	總計	西醫醫院	西醫診所	中醫醫院	中醫診所	牙醫診所
全國醫療院所數	22,124	479	11,319	12	3,664	6,650
特約醫療院所數	20,620	479	10,186	10	3,421	6,524
特約率	93.20%	100%	89.99%	83.33%	93.37%	98.11%

資料時間：2015 年 6 月 30 日。

Table 7　No. of Participants in NHI System by Category

Unit: No. of Institutions

	Total	Hospitals	Clinics	Chinese Medicine Hospitals	Chinese Medicine Clinics	Dental Clinics
Total Health Care Institutions	22,124	479	11,319	12	3,664	6,650
Contracted Health Care Institutions	20,620	479	10,186	10	3,421	6,524
Percent of Institutions Contracted	93.20%	100%	89.99%	83.33%	93.37%	98.11%

Figures as of June 30, 2015

家庭醫師及社區藥局在地照顧

為建立分級醫療制度，使民眾獲得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作為家庭醫師，民眾就可獲得全家健康第一線的健康照護。家庭醫師平日為預防保健的專業顧問，建立完整的家庭醫療資料，提供 24 小時健康諮詢服務專線。若病情需要進一步手術、檢查或住院時，可協助轉診，減少民眾到處找醫師所浪費的時間與金錢。

截至 2015 年 6 月底，已有 426 個社區醫療群在運作，參與之基層診所 3,035 家，參與率為 29.69%，參加醫師數 3,709 位，參與率為 24.87%；透過社區醫療群受益者超過 248 萬人。

Family Practitioners and Community Pharmacies

The NHIA launched a family doctor plan in March 2003 as part of its effort to promote a multi-tiered health care system that integrates primary care with more specialized treatment when needed to ensure health care continuity. Five or more NHI-contracted western medicine clinics in the same neighborhood can join with a community hospital to form a community health care group. The program has enabled families to obtain primary care through local clinics or physicians in their neighborhoods who are networked with contracted hospitals. These family practitioners serve as preventive medicine consultants who maintain complete medical records for every member of the family, and they provide a 24-hour information hotline for patients in their group. If a condition requires further tests, surgery or hospitalization, they can arrange for a referral to a larger hospital, saving patients time and money in searching for specialist care.

As of the end of June 2015, there were 426 family practitioner groups in existence, with 3,035 clinics, or 29.69% of the country's total, and 3,709 physicians, or 24.87% of the total, participating in the program. More than 2.48 million people have benefited from these community health care groups.

在藥局服務方面，截至 2015 年 6 月底，健保特約藥局已達 5,837 家，民眾可持特約醫療院所交付的處方箋，到特約藥局領藥。如有用藥的疑問，可以請藥局的藥師或藥劑生提供用藥及健康諮詢等專業服務。藥局不僅為大家的用藥安全把關，更能就近教導民眾正確的用藥知識。

多元支付制度

全民健保支付制度採第三者付費機制，民眾至醫療院所就醫所花費的醫療費用，由健保署根據支付標準付費給醫療院所，因此，為求一個合理、公平及健全的全民健康制度，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，鼓勵醫療院所申請為健保特約機構，即以論量計酬方式，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。相形之下，在這種支付方式，反而缺乏醫師追求病人健

In addition, there were 5,837 contracted community pharmacies around Taiwan as of the end of June 2015 able to fill prescriptions prescribed by a hospital or clinic. If patients have questions about the drugs prescribed, they can ask their community pharmacists for more information on how they are to be taken and potential side effects. Community pharmacies not only serve as a safeguard against drug hazards, they can also offer residents in their neighborhoods accurate information on the medications patients have been prescribed.

Diversified Reimbursement Plans

Taiwan's NHI program uses a third-party payer mechanism to cover medical expenses. When a patient gets care from a health care provider, the NHIA reimburses the provider for the medical services used to treat the patient based on reimbursement standards. Consequently, the design of these reimbursement plans plays a critical role in shaping a reasonable, fair and sound NHI system.

When the NHI program first got off the ground, one of its main goals was to quickly integrate the government, labor and farmers' insurance systems under the NHI umbrella, and medical institutions were given incentives to apply to become NHI-contracted organizations. Thus a "fee-for-service" payment model was adopted based on fee schedules carried over from the government and labor insurance schemes, and adjustments to the scope of items covered were made with the help of suggestions from medical groups.

That model, however, gave doctors few incentives to put a priority on patient health and elevate the quality of care and resulted in a surge in the "volume" of care provided and a sharp rise in medical expenses.

康及提升醫療品質的誘因，導致醫療費用大幅成長。經自 1998 年起陸續逐年推動的牙醫、中醫、西醫基層、醫院等部門總額支付制度，至 2002 年起，即全面採行總額支付制度，加強特約醫事服務機構的責任，進而提升看診品質。

醫療費用總額預算支付制度為一種前瞻性、宏觀調控醫療費用之方法；健保署根據不同醫療照護的特性，同時透過支付工具等微觀策略，包括擴大支付單位（如總額支付制度、論病例計酬、診斷關聯群 (Tw-DRGs)、論人計酬），增進醫療服務體系整合（如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），以品質與結果支付（如論質計酬支付）等，有效提升醫療品質及效率。

種種配套措施規劃的目標就是，民眾愈健康，需要的醫療服務愈少，醫界所獲得鼓勵與報酬則愈大。其中，自 2010 年 1 月起實施的全民健康保險住院診斷關聯群（Taiwanese Diagnosis Related Groups, Tw-DRGs）支付制度，用意即在於提升醫療服務效率、使民眾獲得更完整的全人照護，依健保署監測情形，實施 Tw-DRGs 制度，確實能提升住院醫療服務效率。2014 年 DRGs 案件平均住院天數下降 0.16 天，提高病床週轉率；平均每件實際醫療費用下降，減少不必要手術、用藥及檢查等，並減少醫療成本。

To constrain the rapid growth in spending, global budget systems were phased in between 1998 and 2002 for dental clinics, traditional Chinese medicine facilities, Western medicine clinics and hospitals. From 2002 on, the entire NHI system has adopted a global budget that has put more responsibility on medical service providers and improved the overall level of care.

The global budget system set broad "macro" limits for total health care spending in different medical sectors, but within this system, payment strategies were still needed at the "micro" level to effectively enhance the quality and efficiency of care. They included: diversifying payment schemes (such as global budget systems, case payment plans, Tw-DRGs, and capitation payment plans); paying for quality and outcomes (such as pay-for-performance plans) and promoting the integration of medical service systems (such as the IDS program).

The goal of these many payment plans was to provide the medical community with incentives and higher returns to foster a healthier society that required fewer medical resources. Among these programs, Taiwan's version of diagnosis related groups (Tw-DRGs) were launched in July 2010 to further increase efficiency and provide patients more holistic care.

The many Tw-DRGs that have been phased in over the past few years have in fact demonstrated more efficient use of medical resources used for inpatient care. In 2014, the average length of hospital stay for patients in diagnosis related groups fell 0.16 days from a year earlier, freeing up hospital beds. Average medical expenditures per case also fell because of the elimination of unnecessary operations, medications and tests, resulting in lower health care costs.

而論人計酬支付制度自 2011 年 7 月起以 3 種模式試辦，打破傳統「醫院看的越多、領的越多」觀念，提供更大誘因促使醫院投入健康促進服務，以民眾健康為導向，只要把病人照顧得越好，醫生和醫院的收益就越多，讓民眾獲得更周全的醫療整合照護。試辦期間 2012-2014 年，計有 8 個試辦團隊，照護對象 20 萬人。

全民健保醫療服務診療項目之支付標準，除論病例計酬及 DRGs 支付制度採包裹支付外，相同之診療服務多訂定相同之支付點數。點數之合理性，除依各界建議不定期協商調整外，有關特定診療項目，於 2004 年 7 月及 2011 年二次全面進行以醫療資源耗用相對值表（Resource-based Relative Value Scale, RBRVS）作業，以全面調整健保支付標準。

此外，針對醫療費用大、罹病人數多、照護模式有改善空間之疾病別，推動醫療給付改善方案，採論質計酬－即論「品質」付費的支付方式。醫院可依治療指引，使病患獲得較佳之治療，並透過個案管理師針對病患提供疾病管理追蹤，使病患得到完整且持續之照護，讓疾病獲得良好控制，改善論服務量計酬無法有誘因提升醫療品質之缺點，且根據不同疾病之醫療照護特性設計支付誘因，兼顧了醫療費用控管，也提升了醫療服務的效率與品質，達成全民健保照顧全民健康的使命。

Beginning in July 2011, three types of capitation payment models were introduced on a trial basis. This approach – which essentially pays doctors a fixed amount per person – is designed to break the traditional mindset that doctors will make more if they see more patients or render more services. It provides incentives for medical institutions to invest in preventive health care and health promotion, because the better patients are cared for, the more the institutions will benefit. During the trial period from 2012 to 2014, there were eight medical teams responsible for 200,000 people in Taiwan working under the capitation payment system.

Aside from care delivered under case payment or DRG plans, standard reimbursements for medical services and treatment are based on an RBRVS (resource-based relative value scale) system first developed in July 2004 and then completely revised in 2011. The system assigns relative values to medical services based on the medical resources used to provide the service.

Meanwhile, for certain diseases that are expensive to treat, relatively prevalent and could benefit from improved care models, the "pay-for-performance" system has been introduced to tie payments to clinical outcomes. Doctors can rely on treatment guidelines to help patients get better care, and the management professional in charge of each case can track a patient's condition and ensure that the patient receives complete and continuous attention and that the disease is under control. Unlike the "fee-for-service" system, which offers no financial incentives to improve quality, the "pay-for-performance" system creates payment incentives for different diseases based on how patients are treated that not only enhance efficiency and quality but also restrain costs, fulfilling a core mission of the NHI system.

部分負擔　使用者付費

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，但是，民眾於就醫時，並非完全由健保署來支付醫療費用，而是必須自行負擔一部分的就醫成本，且一般情況部分負擔金額是隨醫療費用增加而遞增。回溯全民健保開辦前，公、勞、農保等各類相關的保險給付項目中，少有部分負擔的規定，因而造成醫療資源嚴重的浪費，各類保險也因此發生鉅額虧損。有鑑於此，全民健康保險於規劃之初，即設計部分負擔的制度，藉由「以價制量」提升民眾的就醫成本觀念。

至 2005 年 6 月底，門、急診之部分負擔已經調整多次。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，自 2005 年 7 月 15 日起推出若配合轉診則不加重部分負擔之設計，增進全民健保資源的有效運用，門診基本部分負擔亦配合修正（表 8）。其中，西醫門診基本部分負擔按「未轉診」及「轉診」兩種方式計收。民眾若未經轉診直接到醫學中心、區域醫院、地區醫院就醫，就會付比較高的部分負擔。牙醫、中醫不分層級一律計收 50 元。此外，民眾看病時，如藥費超過一定金額，則須加收藥品部分負擔（表 9）。同一療程中接受第 2 次以上的復健物理

Co-payments

Through the NHI program's third-party payer mechanism, the NHIA reimburses NHI-contracted medical institutions for the cost of the medical services they provide to patients. But not all costs are covered by the NHIA; those seeking care must also pay a share of the costs incurred, with these co-payments increasing incrementally the higher the expense. Prior to the NHI program's inception, government, labor and farmers' insurance did not require co-payments for most types of services they covered, resulting in the serious waste of medical resources and massive losses to the various insurance systems. So when the new NHI program was designed, it included a co-payment system to curb demand for medical services and make people more conscious of the cost of the treatment they receive.

The co-payments for outpatient and emergency care were adjusted multiple times during the system's first 10 years. But in July 2005, the NHIA inaugurated a new co-payment fee schedule and referral system to encourage patients to seek treatment for basic ailments at local clinics and then get referrals to regional hospitals or medical centers if more advanced treatment or tests are necessary. The system, which keeps co-payments lower for people with referrals, has led to the more efficient use of medical resources by leaving regional hospitals and medical centers free to focus on patients with more pressing needs.

Under the new co-payment schedule shown in Table 8, the basic co-payment fee for a visit to a western medicine facility is based on whether a patient was

治療（中度 - 複雜、複雜項目除外）或中醫傷科治療，每次須自行繳交 50 元的部分負擔費用。

2013 年二代健保實施後，於醫療資源缺乏地區就醫的民眾，部分負擔費均可減免 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。

住院部分負擔設有上限

民眾若罹患急性、慢性病需要住院時，一般情況住院 30 日之內之部分負擔比率為 5%（慢性病房）或 10%（急性病房）（表 10）；為減輕民眾負擔，對於急性病房住院 30 日之內、慢性病房住院 180 日之內，訂定負擔金額上限，由衛生福利部每年依法公告，2015 年以同一疾病每次住院 33,000 元、全年累計住院 56,000 元為上限。

referred to the hospital or not. Patients who go directly to medical centers and regional and district hospitals without a referral from a clinic or hospital will pay a higher co-payment than if they have a referral. The co-payment for visits to dentists or traditional Chinese medicine clinics is uniformly NT$50. If drugs prescribed to a patient exceed a certain cost, a co-payment for the medication is also charged (Table 9). Follow-up rehabilitation or traditional Chinese medicine treatments for the same course of therapy also carry co-payments of NT$50.

With the introduction of the second-generation NHI system in 2013, individuals who get care in regions lacking medical resources can get a 20% discount on their co-payments and have co-payments for home care reduced to 5% from the normal 10% – policies intended to benefit residents of areas where medical resources are limited and seeking help elsewhere is difficult.

Caps on Co-payments for Inpatient Care

The co-payments for hospitalized patients are between 5% and 10% for more typical stays of under 30 days but can go as high as 30% of their bills for longer stays (Table 10). To minimize inpatients' financial burden, co-payments on acute ward stays of fewer than 30 days and chronic ward stays of fewer than 180 days are capped by the Ministry of Health and Welfare, with the ceilings adjusted annually. For 2015, caps on hospital stay co-payments were set at NT$33,000 for a single hospital stay for a particular condition and at a cumulative NT$56,000 for the entire calendar year.

表 8 全民健保門診基本部分負擔

單位：新臺幣元

類型	基本部分負擔				
醫院層級	西醫門診		急診	牙醫	中醫
	經轉診	未經轉診			
醫學中心	210	360	450	50	50
區域醫院	140	240	300	50	50
地區醫院	50	80	150	50	50
診所	50	50	150	50	50

註：

1. 凡領有《身心障礙證明》者，門診就醫時不論醫院層級，基本部分負擔費用均按診所層級收取 50 元。
2. 門診手術後、急診手術後、生產後 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. 自 2005 年 7 月 15 日起公告實施。

Table 8 Basic Co-payments for Outpatient Visits under NHI System

Unit: NT$

Institution Class	Basic Co-payments				
Type of Institution	Western Medicine Outpatient Care		Emergency Care	Dental Care	Traditional Chinese Medicine
	With Referral	Without Referral			
Medical Centers	210	360	450	50	50
Regional Hospitals	140	240	300	50	50
District Hospitals	50	80	150	50	50
Clinics	50	50	150	50	50

NOTES:

1. Individuals classified as disabled pay co-payments of NT$50 for any medical visit, regardless of the type of medical institution they go to.
2. Patients who return for their first checkup after an outpatient or emergency procedure, or within 42 days after giving birth, or within 30 days after being discharged from the hospital, pay the same co-payment as if they were given a referral as long as they have a hospital certificate confirming the need for a follow-up visit.
3. This co-payment schedule took effect on July 15, 2005.

表 9　全民健保門診藥品部分負擔

單位：新臺幣元

每次藥費	每次部分負擔費用
100 以下	0
101~200	20
201~300	40
301~400	60
401~500	80
501~600	100

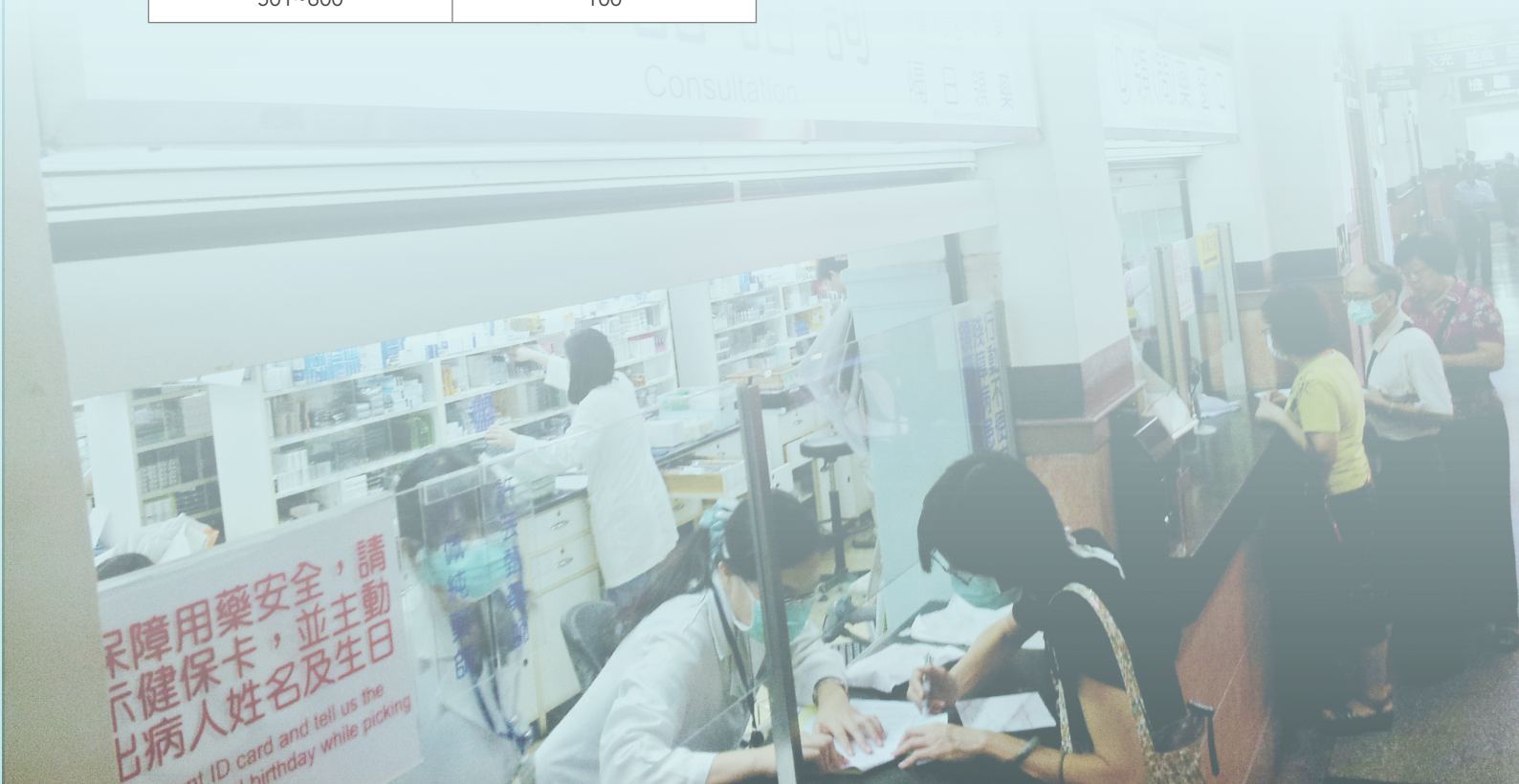
每次藥費	每次部分負擔費用
601~700	120
701~800	140
801~900	160
901~1000	180
1001 以上	200

Table 9　Medication Co-payments under NHI System

Unit: NT$

Drug cost per prescription	Co-payment per prescription
Under 100	0
101~200	20
201~300	40
301~400	60
401~500	80
501~600	100

Drug cost per prescription	Co-payment per prescription
601~700	120
701~800	140
801~900	160
901~1000	180
1001 and above	200



特殊情況得免除部分負擔

為了不讓部分負擔影響民眾的正常就醫，符合全民健康保險法第 48 條各款情形之一者，如重大傷病（表 11）、分娩、山地離島地區就醫者均免收部分負擔，另健保卡上註記「榮」字的榮民、榮民遺眷之家戶代表、低收入戶、3 歲以下兒童、登記列管結核病患至指定特約醫院就醫、勞保被保險人因職業傷病就醫、多氯聯苯中毒的油症患者、替代役役男等，係由相關單位支付部分負擔，就醫時亦免收部分負擔。另外，針對特定項目如接受門診論病例計酬項目服務、持慢性病連續處方箋（可連續調劑 2 次以上，且每次在 28 天以上者，包括中醫）的民眾及接受牙醫診療服務者，可免除門診藥品部分負擔。

Co-payment Exemptions

The National Health Insurance system exempts certain groups of patients from co-payments to ensure that the payments do not discourage them from seeking necessary medical attention. Based on Article 48 and others of the National Health Insurance Act, co-payments are not required for people suffering from catastrophic illnesses (Table 11) or living in remote and mountain areas or on outlying islands, or for women giving birth. Others exempt from co-payments include veterans and their dependents, members of low-income households, children under the age of three, males performing alternative military service and registered tuberculosis patients who receive treatment at specified contracted hospitals.

Patients being treated for occupational ailments who are covered by labor insurance or those suffering from PCB (polychlorinated biphenyl) poisoning are also not subject to co-payments.

Outpatient medication co-payments are waved for special cases, including services covered under the "case payment" reimbursement method, refillable prescriptions for chronic illnesses (prescriptions can be refilled twice, each time for 28 days, including for traditional Chinese medicine) or those receiving dental care.

表 10　全民健保住院部分負擔

病房別	部分負擔比率			
	5%	10%	20%	30%
急性病房	-	30 日內	31 ～ 60 日	61 日以上
慢性病房	30 日內	31 ～ 90 日	91 ～ 180 日	181 日以上

Table 10　Co-payment Rates for Inpatient Care

Ward	Co-payment Rates			
	5%	10%	20%	30%
Acute	-	30 days or less	31-60 days	61 days or more
Chronic	30 days or less	31-90 days	91-180 days	181 days or more

為方便慢性病患者例行取藥，健保署提供慢性病連續處方箋的措施。慢性病連續處方箋是醫師開給慢性病患者的長期用藥處方箋，當醫師診斷後認為屬於衛生福利部公告之慢性病且病情穩定，可在 3 個月內使用同一種處方用藥者，就能開給至多 90 天用藥量之慢性病連續處方箋。這種處方箋須分次領藥，有效期間依處方箋給藥日數計，每次最多領取 1 個月份藥量，但如預定出國、返回離島地區、遠洋漁船與國際航線船舶船員出海作業或罕見疾病病人，可在領藥時出具切結文件，一次領取處方箋的總給藥量。

The NHIA's refillable prescription option was adopted to make it more convenient for patients with chronic illnesses to get the medication they need by allowing doctors to write long-term prescriptions for them. When doctors certify that a patient has a chronic but stable illness, as recognized by the Ministry of Health and Welfare, they can write a prescription valid for three months covering 90 days of medication. The prescription must be filled in installments, with up to one month of medicine allowed to be dispensed at a time. Those with proof that they will be traveling abroad, returning to an outlying island, or working on a deep-sea fishing boat or ship sailing international routes for an extended period of time, or those with a rare disease, can collect the entire prescription at once if they present a waiver.

表 11 全民健康保險重大傷病項目

	疾病名稱
1	需積極或長期治療之癌症 惡性腫瘤
2	先天性凝血因子異常
3	嚴重溶血性及再生不良性貧血〔血紅素未經治療，成人經常低於 8gm/dl 以下，新生兒經常低於 12gm/dl 以下者〕
4	慢性腎衰竭〔尿毒症〕，必須接受定期透析治療者。
5	需終身治療之全身性自體免疫症候群。
6	慢性精神病。
7	先天性新陳代謝異常疾病〔G6PD 代謝異常除外〕。
8	心、肺、胃腸、腎臟、神經、骨骼系統等之先天性畸形及染色體異常。
9	燒燙傷面積達全身 20%以上；或顏面燒燙傷合併五官功能障礙者。
10	接受腎臟、心臟、肺臟、肝臟、骨髓、胰臟及小腸移植後之追蹤治療。
11	小兒麻痺、腦性麻痺所引起之神經、肌肉、骨骼、肺臟等之併發症者（其身心障礙等級在中度以上者）。
12	重大創傷且其嚴重程度到達創傷嚴重程度分數 16 分以上者（INJURYSEVERITYSCORE ≧ 16）（※ 植物人狀態不可以 ISS 計算）。
13	因呼吸衰竭需長期使用呼吸器符合下列任一項者： (一)使用侵襲性呼吸輔助器二十一天以上者。 (二)使用侵襲性呼吸輔助器改善後，改用非侵襲性陽壓呼吸治療總計二十一天以上者。 (三)使用侵襲性呼吸輔助器後改用負壓呼吸輔助器總計二十一天以上者。 (四)特殊疾病 (末期心衰竭、慢性呼吸道疾病、原發性神經原肌肉病變、慢性換氣不足症候群) 而須使用非侵襲性陽壓呼吸治療總計二十一天以上者。 以上天數計算須符合連續使用定義原則。
14	(一)因腸道大量切除或失去功能引起之嚴重營養不良者，給予全靜脈營養已超過 30 天，且病情已達穩定狀態，口攝飲食仍無法提供足量營養者。 (二)其他慢性疾病之嚴重營養不良者，給予全靜脈營養已超過 30 天，且病情已達穩定狀態，口攝飲食仍無法提供足量營養者。

Table 11　Catastrophic Illnesses Recognized by NHI System

	Illness Name/Description
1	Cancer requiring aggressive or long-term care; malignant neoplasm
2	Congenital coagulation disorders (Hemophilia)
3	Severe hemolytic and hypoplastic anemia (a heme count routinely below 8gm/dl in adults and routine below 12 gm/dl in newborns before treatment)
4	Chronic renal failure (uremia) requiring regular dialysis
5	Generalized autoimmune syndrome requiring lifelong treatment
6	Chronic mental illness or chronic psychiatric disorder
7	Congenital metabolic disorders (not including G6PD deficiency)
8	Congenital cardiac, pulmonary, gastrointestinal, renal, neurological, and skeletal malformations and chromosomal abnormalities
9	Burns covering more than 20% of the body, or facial burns with concurrent eye, ear, nose, or throat dysfunction
10	Follow-up treatment after kidney, heart, lung, liver, bone marrow, pancrease or intestine transplant
11	Neurological, muscular, skeletal, or pulmonary complications from poliomyelitis or cerebral palsy (where the degree of impairment is moderate or higher)
12	Major trauma rated 16 or above on the injury severity scale (Note: The ISS cannot be applied to the condition of people in a vegetative state.)
13	Long-term mechanical ventilation, defined as one of the following: (1) Invasive mechanical ventilation for 21 or more days; (2) Invasive mechanical ventilation followed by non-invasive ventilation as the patient's condition improves, for a total of 21 or more days; (3) Invasive mechanical ventilation followed by negative pressure ventilation for a total of 21 or more days; or (4) Non-invasive ventilation for 21 or more days required to deal with specific diseases, such as end stage heart failure, chronic pulmonary diseases, primary neuromuscular diseases, and chronic hypoventilation syndrome. The duration periods above must meet the standard for "continuous use."
14	(1) Patients suffering from severe malnutrition due to major enterectomy or intestinal failure, who have been on a fully intravenous diet for more than 30 days but are still unable to obtain sufficient nutrition through an oral diet. (2) Patients suffering from severe malnutrition due to other chronic diseases, who have been on a fully intravenous diet for more than 30 days but are still unable to obtain sufficient nutrition through an oral diet.

	疾病名稱
15	因潛水、或減壓不當引起之嚴重型減壓病或空氣栓塞症，伴有呼吸、循環或神經系統之併發症且需長期治療者。
16	重症肌無力症。
17	先天性免疫不全症。
18	脊髓損傷或病變所引起之神經、肌肉、皮膚、骨骼、心肺、泌尿及腸胃等之併發症者（其身心障礙等級在中度以上者）。
19	職業病
20	急性腦血管疾病（限急性發作後 1 個月內）
21	多發性硬化症
22	先天性肌肉萎縮症
23	外皮之先天畸形
24	漢生病
25	肝硬化症，併有下列情形之一者： （一）腹水無法控制。 （二）食道或胃靜脈曲張出血。 （三）肝昏迷或肝代償不全。
26	早產兒所引起之神經、肌肉、骨骼、心臟、肺臟等之併發症。
27	砷及其化合物之毒性作用（烏腳病）。
28	運動神經元疾病其身心障礙等級在中度以上或須使用呼吸器者。
29	庫賈氏病。
30	經衛生福利部公告之罕見疾病，但已列屬前 29 類者除外。

	Illness Name/Description
15	Severe decompression sickness or air embolism caused by scuba diving or improper decompression and accompanied by respiratory, circulatory, or neurological complications, and requiring long-term treatment
16	Myasthenia gravis
17	Congenital immunodeficiency disorders
18	Neurological, muscular, cutaneous, skeletal, cardiopulmonary, urological, or gastrointestinal complications due to spinal cord injuries or other spinal cord diseases (where the degree of impairment is moderate or higher)
19	Occupational disease
20	Acute cerebrovascular disease (within 1 month after acute attack)
21	Multiple sclerosis
22	Congenital muscular dystrophy
23	Congenital anomalies of the integument
24	Leprosy (Hansen's disease)
25	Cirrhosis of the liver, accompanied by one of the following complications: (1) Uncontrollable ascites (2) Esophageal or gastric variceal bleeding (3) Hepatic coma or hepatic decompensation
26	Neurological, muscular, skeletal, cardiac, or pulmonary complications in preterm children
27	Toxic effect of arsenic and its compounds (black foot disease)
28	Motor neuron disease (moderate impairment or above or needed mechanical ventilation)
29	Creutzfeldt-Jakob Disease
30	Other rare diseases listed by the Ministry of Health and Welfare that are not included in the other 29 categories.

Chapter 4

Quality Control

第四篇
品質管理　嚴謹把關

醫療審查　合理管控

健保制度仰賴全民共同的付出，健保署一向致力於為醫療品質及健保資源合理使用把關，自開辦之初，為避免醫療浪費，保障醫療品質，即設有醫療服務審查制度。然而醫療服務並無標準且極為專業，健保署即設計一連串查處機制及多元化審查、監控個別醫療機構醫療服務，以維護保險對象民眾就醫安全與品質。

全民健保醫療服務案件之審查，在於審查特約醫療院所提供之醫療服務項目、數量、適當性及品質。平均一年門診申報量約 3.84 億件，平均每日約 105 萬件，一年住院約 324 萬件，平均每日約 8.8 千件。基於人力及行政成本考量，有關醫療服務審查大體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。

Claims Review System Based on Reasonable Controls

The NHI system depends on the concerted efforts of all of society to function well, and the NHIA does its part through its unwavering commitment to controlling health care quality and using NHI resources reasonably. Soon after the NHIA was founded, it established a system to review the delivery of medical services to prevent waste and safeguard quality, but there remained a lack of applicable standards for evaluating highly specialized medical services. Consequently, the NHIA developed a series of examination mechanisms and diverse reviews and controls to monitor health care services provided by medical institutions and ensure that the public had access to safe and quality care.

The review of reimbursement claims filed by contracted health care organizations involves examining the type, volume, quality and appropriateness of medical services provided under the insurance program. Every year, 384 million reimbursement claims on average (or 1.05 million per day) are filed for outpatient visits and about 3.24 million claims (or about 8,800 per day) are filed for inpatient care. Because of the massive volume of claims, the review process follows two tracks: a procedural review track that is fully automated and a professional review track that involves peer reviews. Computer technology is used in conducting both types of reviews, but especially the procedural review, which relies on profile analysis based on specific medical criteria to conduct automated audits, improving the efficiency of claims reviews.

程序審查之內容包括：

1. 保險對象資格。
2. 保險給付範圍。
3. 醫療服務給付項目及支付標準、藥物給付項目及支付標準正確性之核對。
4. 申報資料填載之完整性及正確性。
5. 檢附資料之齊全性。
6. 論病例計酬案件之基本診療項目。
7. 事前審查項目。
8. 其他醫療費用申報程序審查事項。

特約醫療院所申報之醫療服務案件，依前述程序審查發現有違反全民健保相關法令規定者，應不予支付該項費用，並註明不予支付內容及理由。

另外，由於申報案件量甚鉅，健保署於專業審查時採隨機抽樣審查，即以抽樣方式調閱部分病歷送請審查醫藥專家審查，透過以樣本的核減率按比例回推至全部母體案件進行核減的作業方式，是醫療費用事後專業審查的最主要作業。自 2007 年起，隨機抽樣方式除原有以案件比率的作業方式外，另新增以病人數比例計算的論人隨機抽樣審查作業方式，主要目的是為了能讓審查醫藥專家看到病人完整的就醫內容，更能掌握審查重點，提升審查的適切性。

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，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，提升審查效率。

The procedural/automated checks focus on the following criteria:

1. The eligibility of those treated
2. The scope of reimbursements
3. Verification that the medical services or drugs claimed were appropriate and their respective reimbursement standards were correct
4. Whether the submitted forms were properly and fully filled out
5. The completeness of appended documents
6. A preliminary check of the basic treatment services on the case payment system
7. Pre-authorization review of special surgeries or treatments.
8. Other procedural items related to medical expenditures

If any health care providers submit medical services claims that are found to have violated insurance regulations, they will not be reimbursed for the claims, with the reason noted on the file.

The huge volume of claims makes it impossible to screen each and every one of them manually. Instead, claims are randomly selected and sent to medical experts for closer inspection. If the amounts claimed by a medical institution are reduced by a certain percentage across the sampling after peer reviews, the institution's total claims will be reduced automatically by the same percentage. This is the most important function of the professional reviews of medical expense claims.

Since 2007, random checks have been conducted based not only on reviewing a fixed percentage of reimbursement claims but also on profiling a certain percentage of patients treated, primarily to enable the experts conducting the reviews to see complete patient information and help them better identify the main points of emphasis of the reviews, making the process more relevant.

總額支付制度自 2002 年全面實施後，健保署配套進行專業自主事務的勞務委託，另訂定審查醫藥專家之遴聘管理方式，並逐步與受託單位建立了各分區專業審查共同管理的機制。

有關專業審查的醫療專業審查規範及注意事項之訂定，均係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立。為有效提升專業審查一致性，健保署對審查醫師，除辦理業務說明外，亦舉辦各科審查醫藥專家會議，尋求對醫療專業見解之共識。此外，於 2012 年 2 月建置「專業審查知識庫查詢系統」，提供全署各單位行政人員及審查醫藥專家方便線上查詢審查相關規定，增進審查效率；後續亦將配合智慧型專業審查雛型系統之建置，於 2011 年至 2013 年，分年完成各類審查相關規定醫令別查詢資料之整編建置及整合運用作業。

Beginning in September 2014, a "Central Intelligence System" (CIS) was installed to further screen claimed costs. The system automatically targets important items and picks out anomalies that are then listed for peer review or specially marked, and it also provides information on the anomalies, enhancing the efficiency of the reviews.

Since the global budget system's phase-in from 2002, the NHIA has also commissioned medical associations to handle some of the professional reviews and established management guidelines on recruiting experts to conduct the reviews. In addition, the NHIA and the independent agencies have developed a mechanism capable of jointly managing the professional reviews in every region.

The practices and guidelines for these professional reviews are established through consultations by advisory panels for different medical specialties consisting of medical experts with clinical or review experience. To ensure the consistency of the professional reviews, the NHIA trains and orients panel members on the workings of the insurance system and related applicable standards, and tries to develop a consensus on review standards. In February 2012, the NHIA created a "professional review databank inquiry system" to give NHI staff and medical experts on the review panels a convenient way to check or look up related regulations, improving review efficiency. To follow-up on the initiative and support the development of a prototype "smart professional review system," the NHIA took steps from 2011 to 2013 to computerize the order-specific regulations for all medical services, enabling professional reviewers to call up every review regulation and standard for any item on the NHI fee schedule with a single click as they conduct their reviews, saving them considerable amounts of time.

多元支付　提升品質

增修支付標準

為平衡醫療發展，自全民健保開辦起，即積極改善醫界普遍認為支付偏低而較不願投入或發展的項目，例如住院、急診、重症醫療、婦產科、小兒外科、一般外科等，並配合新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 2015 年 6 月，支付標準共計 4,395 項診療項目，經統計 2004 年至 2015 年 6 月，共計 76 次公告調整支付標準，共修訂 1,597 項診療項目的支付標準點數。

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

Diversified Payment Systems for Better Outcomes

Adjusting Reimbursement Fee Schedules

Since the inception of Taiwan's NHI system, the NHIA has steadily increased the number of services and procedures covered to keep up with technological advances and clinical needs and provide the insured with access to new technologies. As of June 2015, there were 4,395 items covered in the fee schedule. At the same time, the NHIA has worked to change the medical community's perception that a number of medical fields, such as emergency and inpatient care, critical care/intensive care, obstetrics/gynecology, pediatrics surgery and general surgery, were not worth pursuing because their reimbursement rates were too low. Between 2004 and June 2015, the NHIA adjusted reimbursement rates 76 times, with the biggest overhauls of the fee schedule coming in June 2004 and December 2005, when the relative point values of 1,597 items and services were revised.

The NHIA has also given hospitals incentives to focus more closely on their clinical care manpower and strengthen their nursing staffs. A program to improve the quality of nursing care was initiated in 2009, and more than NT$9.17 billion had been poured into it as of 2014. The funding has been directed at hiring more nurses, increasing pay for overnight shifts, and subsidizing extra overtime, making nurses more willing to stay on the job. Another NT$2 billion was invested in 2015 to adjust the reimbursement rates for nursing services. The measure not only increased the point values for the nurses' services, but also reduced the nurses' burdens through reimbursement systems that linked payments with nurse-patient ratios.

可選擇使用新醫療特材

部分新醫療材料係改善現有品項之某些功能，惟價格較原全民健保給付類似產品之價格昂貴。為減輕保險對象的負擔及增加民眾使用新醫療材料的選擇權，自 2006 年 12 月 1 日起陸續將塗藥及特殊塗層血管支架、特殊材質人工髖關節（陶瓷及金屬對金屬介面）、特殊功能人工水晶體、耐久性生物組織心臟瓣膜及調控式腦室腹腔引流系統等 5 類（共 6 項）列入自付差額項目（表 12）。凡符合健保現行類似品項之使用規範，而自願選用較為昂貴品項，全民健保按現行類似品項之支付標準給付，超過費用由民眾自行負擔。

為保障民眾權益，醫療院所應於手術或處置前讓民眾充分獲得資訊，健保署規定告知程序應為二階段程序：

一、第一階段

（一）應於手術或處置前 2 日（緊急情況除外），由醫師交付說明書予保險對象或家屬，同時充分向保險對象或家屬解說，並由醫師及保險對象或家屬共同簽名一式二份，一份交由保險對象或家屬保留，另一份則保留於病歷中。

Providing More Medical Device Choices

Many new, technologically advanced medical devices that provide better health benefits are far more expensive than the devices they have been designed to replace. To ease the financial burden of patients who stand to benefit from such advanced devices and give them greater choice, the NHIA has phased in coverage of drug-eluting and bio-active coronary stents, artificial hip joints (ceramic and metal-on-metal), artificial intraocular lenses, bioprosthetic heart valves and programmable ventriculoperitoneal shunts since December 1, 2006 (Table 12). For patients who choose these and other more expensive devices and materials, the NHI system covers the standard amount it would reimburse for similar more conventional devices and has patients cover the additional cost.

To safeguard the rights of the insured, hospitals must provide complete information on device options to people prior to operations or procedures. The NHIA requires that the information be provided in two stages:

I. First Stage

A. Two days before an operation or treatment (except in the case of emergencies), the physician must give a patient or a member of his or her family a written description and a verbal explanation of the special device being proposed, and the physician and the insured or a family member must sign two copies of the description sheet, one for the patient or his or her family and one for the hospital to keep with the patient's medical records.

表 12 民眾關心之自付差額特材一覽表

項目	開始實施時間
塗藥及特殊塗層血管支架	2006 年 12 月 1 日
陶瓷人工髖關節	2007 年 1 月 1 日
特殊功能人工水晶體	2007 年 10 月 1 日
金屬對金屬介面人工髖關節	2008 年 5 月 1 日
耐久性生物組織心臟瓣膜	2014 年 6 月 1 日
調控式腦室腹腔引流系統	2015 年 6 月 1 日

Table 12 Special Devices Covered by Health Insurance System

Item	Date Coverage Began
Drug-eluting and Bio-active Coronary Stents	December 1, 2006
Artifical Ceramic Hip Joints	January 1, 2007
Artificial Intraocular Lenses	October 1, 2007
Metal-on-metal Artificial Hip Joints	May 1, 2008
Bioprosthetic Heart Valves	June 1, 2014
Programmable Ventriculoperitoneal Shunt	June 1, 2015

（二）說明書內容包括：自付差額特材品項之費用及產品特性使用原因、應注意事項、副作用與健保給付品項之療效比較。

二、第二階段

（一）保險對象或其家屬於獲得相關醫療資訊後，醫事服務機構應另行向其說明收費情形並給予充分考慮時間，再請其簽署同意書一式二份，一份交由保險對象保留，另一份則保留於病歷中。

（二）同意書載明事項：

1. 自付差額品項名稱及品項代碼 。
2. 醫療器材許可證字號 。
3. 單價、數量及自費金額。

B. The contents of the description sheet should include: the added cost of a special device, the reason the special device is being used, issues to be considered, potential side effects, and a comparison with the standard device fully covered under the NHI system.

II. Second Stage

A. Once the patient or his or her family members have received the detailed information, the medical services provider must then explain to them the fees that would be charged and give them time to fully consider their options. Once a decision is made, the patient or a family member must sign a consent form in duplicate, with one copy for the patient and the other for the hospital to put with the patient's medical records.

B. The consent form must include:

1. The name and item number of the special device for which the patient will have to pay extra.
2. The special device's permit number.
3. The unit price, quantity and amount to be paid by the patient.

此外，醫療院所應將病患使用自付差額特材之品項名稱、品項代碼、收費標準（包括醫院自費價、健保支付價及保險對象負擔費用）、產品特性、副作用、與本保險已給付品項之療效比較等相關資訊置於醫療院所之網際網路或明顯之處所。另健保署亦會將自付差額特材之相關資訊置於健保署全球資訊網站，民眾並可至健保署全球資訊網「自費醫材比價網」搜尋各醫院價格。

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作為支付費用的依據。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。除子宮頸癌方案自 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。近年各方案之照護率如表 13。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。糖尿病方案因執行成效良好，於 2012 年 10 月導入支付標準全面實施；高血壓方案收案對象常合併有糖尿病、慢性腎臟病等疾病，為整併照護方式，自 2013 年起不再列為單獨項目，而併入其他論質方案推行。

Medical institutions, meanwhile, are also required to provide detailed information on special devices for which patients have to pay extra on their official websites or in easily noticeable spots on their premises. The information should detail the item's name, product number, price (including the cost to patients if they pay for the device on their own, the amount covered by health insurance, and the insured's co-payment), special characteristics, potential side effects, and a comparison with the therapeutic effects of similar devices fully covered by national health insurance.

The NHIA also posts information on its Chinese-language website (http://www.nhi.gov.tw) on these special devices and materials for which patients have to pay extra. The public can also find a comparison of different hospitals' prices for these devices on the NHIA website.

Reimbursement Plans that Improve Health Care Quality

The NHIA has developed a series of plans that are structured to improve the quality of care while keeping costs under control. The plans offer health care providers incentives to care for patients' overall well-being by reimbursing them based on clinical outcomes. The NHIA phased in this pay-for-performance system in phases beginning in October 2001 to cover payment for the treatment of cervical cancer, breast cancer, tuberculosis, diabetes and asthma based on well-defined clinical criteria. The management of the cervical cancer program was handed over to the Health Promotion Administration at the start of 2006, but that same year hypertension treated at western medicine clinics was added to the ailments included under this pay-

表 13 全民健保醫療給付改善方案照護率

方案別	2005 年	2006 年	2007 年	2008 年	2009 年	2010 年	2011 年	2012 年	2013 年	2014 年 1-6 月
氣喘	32.50%	34.78%	35.17%	31.29%	31.61%	47.02%	45.45%	39.30%	37.49%	41.94%
糖尿病	23.52%	23.16%	24.67%	26.34%	27.56%	29.26%	31.36%	33.94%	35.06%	41.90%
結核病	68.78%	78.99%	91.81%	導入支付標準	-	-	-	-	-	
乳癌	12.09%	12.98%	13.60%	14.64%	14.50%	14.62%	13.67%	13.43%	13.09%	10.88%
高血壓	未實施	基層試辦 9.31%	6.54%	3.93%	2.65%	2.55%	2.94%	1.36%	註	註
思覺失調症	未實施					40.65%	46.94%	51.20%	52.22%	59.11%
B 型 C 型肝炎帶原者	未實施					9.83%	19.37%	26.14%	30.58%	37.18%
初期慢性腎臟病	未實施						20.15%	26.40%	32.1%	26.71%

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及醫院，呈現照護率下降情形，又因病患常合併多重疾病，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。

Table 13 Percentage of Patients Treated Outcome-based Payment Plan

Disease	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014 Jan. to June
Asthma	32.50%	34.78%	35.17%	31.29%	31.61%	47.02%	45.45%	39.30%	37.49%	41.94%
Diabetes	23.52%	23.16%	24.67%	26.34%	27.56%	29.26%	31.36%	33.94%	35.06%	41.90%
Tuberculosis	68.78%	78.99%	91.81%	Standard fee schedule	Standard fee schedule	Standard fee schedule	Standard fee schedule	Standard fee schedule	Standard fee schedule	Standard fee schedule
Breast Cancer	12.09%	12.98%	13.60%	14.64%	14.50%	14.62%	13.67%	13.43%	13.09%	10.88%
Hypertension	N/A	9.31% (Trial basis)	6.54% (Note)	3.93% (note)	2.65%	2.55%	2.94%	1.36%	(Note)	(Note)
Schizophrenia	N/A					40.65%	46.94%	51.20%	52.22%	59.11%
Hepatitis B and C carriers	N/A					9.83%	19.37%	26.14%	30.58%	37.18%
Early chronic kidney disease	N/A						20.15%	26.40%	32.10%	26.71%

Note: Hypertension was added to the pay-for-performance plan in 2006 on a trial basis at clinics. It was introduced at hospitals in 2007. The figure for that year and after covers the percentage of patients at both hospitals and clinics, which partially explains the declining rate. Also, because hypertension sufferers also often have other conditions, such as diabetes and chronic kidney disease, hypertension stopped being tracked on its own, and the pay-for-performance plan for hypertension alone was ended in 2013.

總額支付制度

採用醫療費用總額支付制度，同時避免在論量計酬支付制度下，引發醫療費用快速成長，也是可以落實提供醫療服務者的財務責任設計。醫療費用總額支付制度實施之程序，是在每一年度開始前，由醫界與付費者就醫療服務內容，先協商次年適當的健保醫療費用總額。在此協定的額度下，若服務量過多，就可能導致每點點值降低；反之，若醫界間同儕合作，減少不必要醫療、加強預防保健措施有成，則因服務量可以有效控制，有可能提高每點點值。

醫療費用總額預算支付制度自 1998 年 7 月起由牙醫門診先開始實施，其後分別於 2000 年 7 月陸續推動實施中醫門診總額預算支付制度，2001 年 7 月實施西醫基層總額預算支付制度，至 2002 年 7 月實施醫院總額預算支付制度，完成全面實施醫療費用總額預算支付制度。總額預算支付制度全面實施後，有效將每年醫療費用成長率控制在 5% 以下。自 2006 年起之醫療費用成長率如圖 3。為確保民眾就醫權益不因總額支付制度實施而有所變更，健保署與醫療團體共同執行醫療品質確保方案，以監督醫療院所，提供更高品質的健康服務。醫療費用總額研擬程序如圖 4。2006 年起各總額部門醫療費用協定成長率如（表 14）。

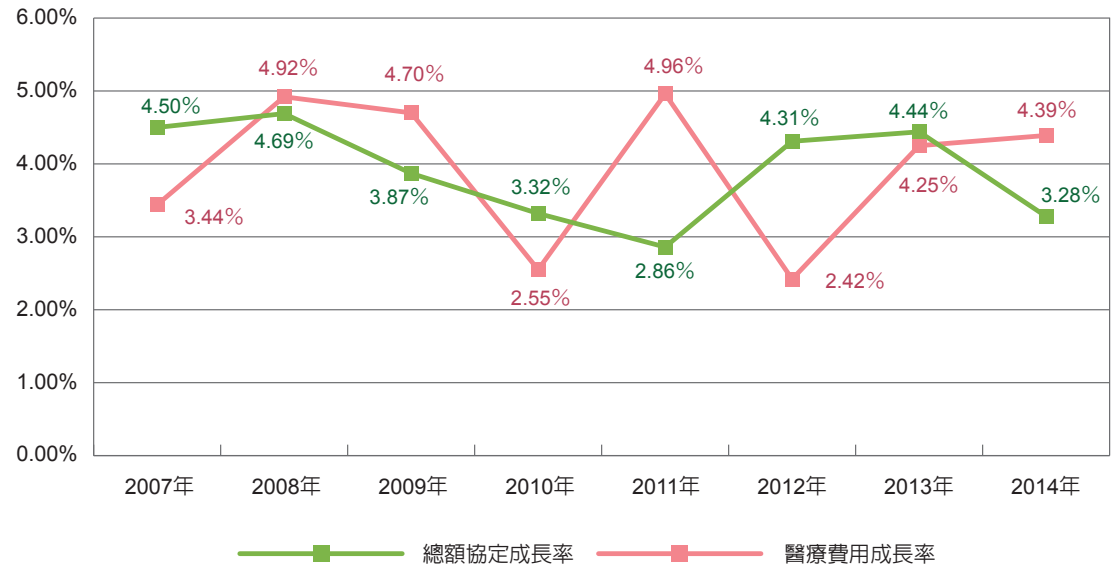
for-performance structure. In 2007, hospitals became eligible to treat hypertension under the plan, and in 2008, the pay-for-performance tuberculosis plan became the standard for treatment of the disease. The percentage of patients being treated under outcome-based plans in recent years is shown in Table 13.

Two more pay-for-performance plans were added in January 2010 for schizophrenia and for hepatitis B carriers and hepatitis C patients, and another was introduced in January 2011 for early chronic kidney disease. Because of the positive impact of the pay-for-performance plan in treating diabetes, it was instituted as the standard for all diabetes cases in October 2012. Hypertension sufferers on outcome-based plans were often found to suffer from other comorbidities such as diabetes and chronic kidney disease, and to better integrate care, the outcome-based program for the treatment of hypertension was incorporated into the pay-for-performance plans for these other illnesses beginning in 2013.

Global Budget Payment System

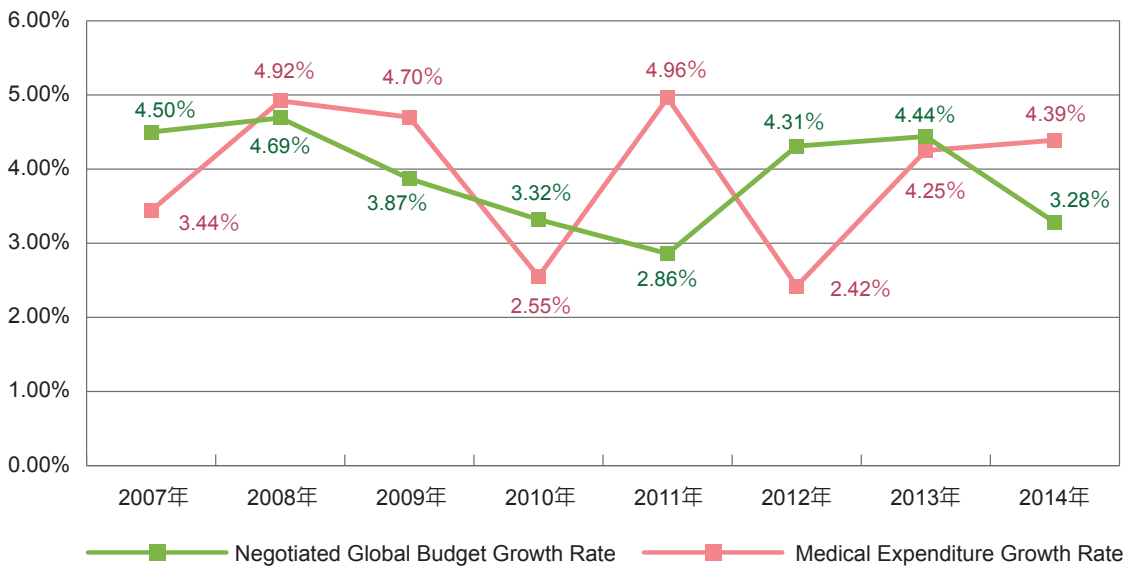
The global budget payment system was adopted to constrain the rapid growth in costs under the fee-for-service model and institute a system of financial accountability. Under the system, medical providers and payers negotiate overcall caps on total medical payments with the NHI system prior to the beginning of a fiscal year based on a fixed volume and range of medical services. The process is illustrated in Chart 4. The negotiated growth rates for each medical sector's total expenditures since 2006 are shown in Table 14.

圖 3 歷年全民健保醫療費用成長率



資料來源 : 衛生福利部全民健康保險會第 1 次委員會議 2015 年 6 月份全民健康保險業務執行報告。

Chart 3 Annual Growth Rate of NHI Medical Expenditures



Source: Report presented at the NHI Committee meeting in June 2015 on the NHI system's operations.

圖 4　全民健保醫療費用總額預算研擬程序及方向

Chart 4　Procedure for Establishing Global Budget

表 14 全民健保歷年各總額部門醫療費用協定成長率

總額部門	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015 年
整體	4.536%	4.501%	4.687%	3.874%	3.317%	2.855%	4.314%	4.436%	3.275%	3.430%
牙醫門診	2.930%	2.610%	2.650%	2.571%	1.941%	1.607%	2.190%	1.409%	1.580%	1.916%
中醫門診	2.780%	2.478%	2.506%	2.486%	1.490%	2.370%	2.776%	2.177%	2.104%	1.897%
西醫基層	4.684%	4.181%	4.129%	3.346%	2.236%	1.716%	2.915%	2.809%	2.116%	2.991%
醫院	4.900%	4.914%	4.900%	4.461%	2.734%	3.007%	4.609%	5.578%	2.990%	3.453%

註：2006 年起為總醫療費用成長率。

Table 14 Annual Negotiated Growth Rates of Global Budgets by Sector

Sector	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Total	4.536%	4.501%	4.687%	3.874%	3.317%	2.855%	4.314%	4.436%	3.275%	3.430%
Dental	2.930%	2.610%	2.650%	2.571%	1.941%	1.607%	2.190%	1.409%	1.580%	1.916%
Traditional Chinese Medicine	2.780%	2.478%	2.506%	2.486%	1.490%	2.370%	2.776%	2.177%	2.104%	1.897%
Clinics	4.684%	4.181%	4.129%	3.346%	2.236%	1.716%	2.915%	2.809%	2.116%	2.991%
Hospitals	4.900%	4.914%	4.900%	4.461%	2.734%	3.007%	4.609%	5.578%	2.990%	3.453%

Note: Figures are for overall growth rates in medical spending starting from 2006

品質確保措施

在協定醫療費用總額時，同時訂定品質確保方案，以確保醫事服務機構提供的照護品質及範圍，不致因總額支付制度的實施，而衍生負面的影響。

各總額部門所訂定之「品質確保方案」內容包括：

一、 保險對象就醫權益的確保：含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。

二、 專業醫療服務品質的確保

（一）訂定臨床診療指引、專業審查、病歷紀錄等專業規範。

（二）建立持續性醫療服務品質改善方案：

1. 監測診療型態及服務品質
2. 建立醫療院所輔導系統
3. 建立醫療服務品質指標，並將品質資訊透明化，公開於健保署全球資訊網，作為醫療院所持續提升醫療品質的參考。

If the total amount claimed for reimbursement by a sector exceeds the pre-set ceiling, point values for that sector's services may drop. If, on the other hand, a particular sector works together to reduce unnecessary treatment and strengthen preventive care measures, effectively controlling the volume of services provided, point values for its services may increase.

The global budget system was phased in between 1998 and 2002, capping overall expenditures in Taiwan's four broad medical sectors — dental (implemented in July 1998), traditional Chinese medicine (July 2000), western medicine clinics (July 2001) and hospitals (July 2002). Since the system was fully implemented in 2002, it has successfully controlled the growth of medical expenditures at below 5% a year. Chart 3 shows medical expenditure growth since 2006.

To ensure that patients' rights to care are not affected by the constraints of the global budget payment system, the NHIA and medical associations have adopted measures to jointly supervise hospitals and clinics that operate under the system and ensure that they are providing high quality care.

Ensuring Quality under the Global Budget System

As global budgets are being negotiated and approved, other measures are taken to ensure that the global budget payment system will not force medical sectors or institutions to cut back the quality or scope of care because of budget constraints.

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，此制度設計有利於導引藥價下降。由於醫事機構有議價誘因，透過市場競爭機制，以較健保支付價為低之價格購買藥品，健保署再透過定期藥價調查，取得實際交易價格，據以調整藥品價格。若健保署依照醫療院所購買價格支付藥品，醫療院所因此缺乏議價的誘因，藥品購買價格無從下降，反而不利於健保財務。

The quality assurance programs agreed to with Taiwan's medical sectors contain the following provisions:

I. Safeguarding the insured's right to health care

The right to care is guaranteed through satisfaction surveys on health care quality, mechanisms to handle appeals and complaints, and the monitoring of accessibility to health care.

II. Ensuring quality of specialized health care services

A. Professional guidelines established for clinical practices, peer reviews and medical records

B. Ongoing programs developed to improve health care quality by:

1. Monitoring clinical profiles and service quality;
2. Establishing a guidance system for medical institutions
3. Establishing health care quality indicators and posting quality information on the NHIA website as a reference for medical institutions to help them continue improving the quality of their care.

Reasonable Drug Price Adjustments

Under the current system for reimbursing drug expenses, medical institutions file claims for reimbursement from the NHIA according to designated prices for each medication covered by the NHI program. The system gives medical institutions the incentive to negotiate drug

健保署為了掌握市場上藥品的實際交易價格，自 1999 年起，依據調查的結果，將醫療院所壓低的藥價，反映至調降藥品的支付價格，目前已累計調降約 500 多億元的藥費。歷次藥價調降，除了縮小藥價差距，亦減緩藥費支出成長，每次藥價調降所節省的費用，用於加速新藥收載及給付、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，主要是預設每年藥費支出「目標值」，並與實際藥費支出做連結，當超過目標值時，自動啓動每年一次之藥價調整，讓藥費維持於穩定及合理範圍。

prices with pharmaceutical companies that are lower than the amount they are reimbursed by the NHIA. The NHIA regularly surveys market prices for drugs, and once it verifies actual transaction prices, it adjusts the amount it reimburses for that drug accordingly. If the NHIA were to simply reimburse health care providers based on the actual prices they pay for drugs, the providers would have no incentive to bargain with pharmaceutical companies. Prices would be less likely to fall, and the NHI system's finances would suffer.

The process of surveying market prices for drugs and adjusting reimbursed amounts according to the surveyed prices began in 1999. The lower prices obtained by hospitals from suppliers have been reflected in several downward adjustments of reimbursement prices for medications, saving the NHI system more than NT$50 billion over that time. These periodic adjustments have helped narrow the gap between actual market prices and NHI-listed prices and slowed the growth of the system's drug expenditures. The money saved through the process has been used to extend coverage to new drugs and increase listed drug prices that were found to be too low, ensuring that patients have access to drugs in step with developed countries around the world and that the quality of care improves.

To further control overall spending on drugs, the NHIA initiated an "NHI Drug Expenditure Target Allocation System" on a trial basis starting on January 1, 2013. The program, which is still ongoing, sets a yearly target for drug expenditures, and if actual spending exceeds the target, it automatically triggers a once-a-year downward adjustment in drug reimbursement prices, keeping the NHI system's overall spending on drugs stable and within a reasonable scope.

Chapter 5

Care for the Disadvantaged

第五篇
照顧弱勢　減輕負擔

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 15。

In a compulsory health insurance program, there will inevitably be an economically marginalized segment of the population that will not be able to afford NHI premiums. To ensure that all of Taiwan's citizens have access to care, a safety net encompassing subsidies and other measures has been created that reinforces the system's spirit of mutual assistance. Several preferential aid programs have been created to help the economically disadvantaged or patients with catastrophic diseases – such as cancer, renal failure requiring dialysis, hemophilia or mental health problems – retain their right to health care.

In addition, the NHI system provides medical and financial assistance to those living in remote areas or those coping with a rare disease or critical illness. The assistance programs available for the poor or seriously ill include premium subsidies, relief loans and installment payment plans (Table 15).

表 15 2014 年 1 月 ~2015 年 6 月繳納健保費之協助措施成效

項目	對象	期間	人 (件) 數	金額
保費補助	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	2014.1~12	304 萬人	239 億元
		2015.1~6	318 萬人	129 億元
紓困貸款	符合衛生福利部所訂經濟困難資格者	2014.1~12	3,045 件	1.90 億元
		2015.1~6	1,373 件	0.95 億元
分期繳納	欠繳保險費無力一次償還者	2014.1~12	11.7 萬件	31.66 億元
		2015.1~6	5.7 萬件	16.03 億元

資料時間：2014 年 1 月 1 日 ~2015 年 6 月 30 日。

Table 15 Assistance Provided to Help the Disadvantaged Afford Premiums from January 2014 to end of June 2015

Item	Assisted Groups	Period Covered	No. of People Affected	Amount
Premium Subsidies	Government subsidies to the disadvantaged, including to low-income households, the near poor, unemployed veterans, unemployed workers and their dependents, people with physical or mental disabilities, and unemployed indigenous people younger than 20 or older than 55. workers and their dependents, people with physical or mental disabilities, and unemployed indigenous people younger than 20 or older than 55.	January to December 2014	3.04 million people	NT$23.9 billion
		January to June 2015	3.18 million people	NT$12.9 billion
Relief Loans	Those who qualify as economic hardship cases based on Ministry of Health and Welfare criteria	January to December 2014	3,045 cases	NT$190 million
		January to June 2015	1,373 cases	NT$95 million
Installment Plans	Those unable to pay overdue premiums in one lump sum	January to December 2014	117,000 people	NT$3.17 billion
		January to June 2015	57,000 people	NT$1.60 billion

Note: Figures cover from Jan. 1, 2014 to June 30, 2015

健保政策　照顧弱勢

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，2014 年全年補助金額約 239 億元，補助人數約 304 萬人。另，2015 年截至 6 月 30 日止，補助金額約 129 億元，補助人數約 318 萬人。

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。2014 年全年共核貸 3,045 件，金額 1.90 億元。2015 年截至 6 月 30 日止，共核貸 1,373 件，金額 0.95 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，2014 年全年辦理分期繳納共 11.7 萬件，合計 31.66 億元。另，2015 年截至 6 月 30 日止，辦理分期繳納共 5.7 萬件，合計 16.03 億元。

Programs for the Disadvantaged

Premium Subsidies

The government routinely subsidizes premiums for several impoverished and socially disadvantaged groups, such as low-income households, the near poor, unemployed veterans, unemployed workers and their dependents, people with disabilities, and unemployed indigenous people younger than 20 or over 55. A total of NT$23.9 billion in premium subsidies was disbursed to 3.04 million people in 2014, and in the first half of 2015, NT$12.9 billion in premium subsidies was distributed to around 3.18 million people.

Relief Loans

Interest-free loans are provided to people facing economic hardship to make it possible for them to pay their premiums or unpaid out-of-pocket medical expenses and safeguard their right to care. In 2014, NT$190 million in loans was disbursed to 3,045 people. Another NT$95 million in loans was disbursed to 1,373 people in the first six months of 2015.

Installment Plans

Individuals who do not qualify for relief loans and cannot not clear overdue premiums of NT$2,000 or more in one lump sum payment are eligible to repay the overdue amount in installments. In 2014, some 117,000 people were granted permission to repay NT$3.17 billion in installments, and another 57,000 people received permission to repay NT$1.60 billion in installments in the first half of 2015.

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。

2014 年全年轉介成功個案計 10,377 件，補助金額共 2,475 萬餘元。2015 年截至 6 月 30 日止，轉介成功個案計 4,600 件，補助金額共 950 萬餘元。

急重症醫療協助

因經濟困難欠繳健保費之弱勢民眾，經醫院醫師診斷需住院、急診或急重症須門診醫療者，只要持有村里長或由醫療院所出具清寒證明，即可以健保身分先行就醫。獲得以健保身分就醫之個案，嗣後再依其個案狀況，協助其辦理投保、健保費紓困、轉介、分期繳納等，2014 年全年獲得醫療保障者計 2,124 件，金額 0.55 億元。2015 年截至 6 月 30 日止，獲得醫療保障者計 948 件，金額 0.28 億元。

爭取公益彩券回饋金協助弱勢族群

健保署為落實照顧弱勢族群，保障其就醫權益，除已有分期繳納、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辦理「協助弱勢族群減輕就醫負擔計畫」，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 2015 年 6 月底，累計補助金額已達 33 億元，累計補助人數達 178,854 人（表 16）。

Sponsorship Referrals

The NHIA may also refer people who cannot afford their premiums to charitable organizations or philanthropic corporations or individuals for assistance. In 2014, 10,377 people were successfully referred to charitable groups, which subsidized NT$24.75 million in premiums. In the first half of 2015, another 4,600 people were referred to philanthropic groups, which provided NT$9.50 million in premium subsidies.

Critical Care Assistance

Individuals with overdue premiums because of economic difficulties can still receive medical care. If a hospital physician determines that a patient needs to be hospitalized, or given emergency treatment or critical care, the patient only needs to provide a certificate of low-income status from the hospital or borough chief to receive care as an insured patient. Based on the specific circumstances of each case, the NHIA then helps people by re-enrolling them in the NHI program (if their eligibility was suspended because of overdue premiums), deferring their premiums, referring them to a charitable organization or allowing bills to be paid in installments. A total of 2,124 patients with outstanding bills totaling NT$55 million received help in this way in 2014, and another 948 patients with overdue bills of NT$28 million received such help in the first half of 2015.

Contributions from Lotteries

In addition to the installment plans, relief loans and referral plans used to safeguard the right of the economically disadvantaged to care, the NHIA has also vied for public welfare lottery funds since 2008 to provide financial assistance to individuals in need. Eligible patients are notified through the program that they will receive help in paying what they owe. As of the end of June 2015, a total of NT$3.30 billion in subsidies had been paid for 178,854 people through the program (Table 16).

表 16　歷年公益彩券回饋金補助成果表

年度	計畫名稱	人數	金額
2008	協助弱勢民眾繳納全民健康保險保險費計畫	26,446 人	4 億元
2009	協助弱勢族群減輕就醫負擔計畫	19,308 人	3.95 億元
2009	協助風災災民及災區民眾繳納健保欠費計畫	19,841 人	3.78 億元
2010	協助弱勢族群減輕就醫負擔計畫	7,888 人	3.79 億元
2011	協助弱勢族群減輕就醫負擔計畫	18,222 人	3.81 億元
2012	協助弱勢族群減輕就醫負擔計畫	13,882 人	3.24 億元
	協助 18 歲以下自始未加保或長期斷保之兒少加保及繳清無力負擔欠費試辦計畫	111 人	0.03 億元
2013	協助弱勢族群減輕就醫負擔計畫	19,185 人	4.01 億元
	協助未成年人繳納健保欠費及紓困未還款計畫	1,717 人	0.21 億元
2014	協助弱勢族群減輕就醫負擔計畫	32,025 人	4.00 億元
	協助未成年人繳納健保欠費及紓困未還款計畫	249 人	0.02 億元
2015	協助弱勢族群減輕就醫負擔計畫	19,924 人	2.15 億元
	花東兩縣新住民健保弱勢保險欠費協助計畫	56 人	0.01 億元
總計		178,854 人	33.00 億元

註：資料時間截至 2015 年 6 月底。

Table 16　Contributions from Public Welfare Lotteries to NHI Patients

Year	Program Description	No. of Beneficiaries	Amount
2008	Help the disadvantaged pay NHI premiums	26,446	NT$400 million
2009	Help the disadvantaged defray their medical expenses	19,308	NT$395 million
2009	Help people in natural disaster-affected regions pay premiums owed	19,841	NT$378 million
2010	Help the disadvantaged defray their medical expenses	7,888	NT$379 million
2011	Help the disadvantaged defray their medical expenses	18,222	NT$381 million
2012	Help the disadvantaged defray their medical expenses	13,882	NT$324 million
	Pilot program to help people 18 and under not enrolled in the NHI system or who have had their coverage cut for an extended period of time enroll in the system and pay expenses they cannot afford	111	NT$3 million
2013	Help the disadvantaged defray their medical expenses	19,185	NT$401 million
	Program to help minors pay premiums owed or offer relaxed payment terms	1,717	NT$21 million
2014	Help the disadvantaged defray their medical expenses	32,025	NT$400 million
	Program to help minors pay premiums owed or offer relaxed payment terms	249	NT$2 million
2015	Help the disadvantaged defray their medical expenses	19,924	NT$1 million
	Program to assist disadvantaged new immigrants in Hualien and Taitung counties pay premiums owed	56	NT$215 million
Total		178,854	NT$3.3 billion

Note: Figures as end June 2015

減輕特定病患就醫部分負擔費用

（一）對於領有「身心障礙證明」者，門診就醫時不論醫院層級，門診基本部分負擔費用均按診所層級收取 50 元，較一般民眾（80-360 元）為低。

（二）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。

Easing the Financial Burden of Co-payments

A. People certified as having disabilities pay an outpatient co-payment of NT$50 regardless of where they receive care, lower than the NT$80-NT$360 they would otherwise pay.

B. People with catastrophic illnesses, such as cancer, chronic mental disorders, rare diseases, and congenital diseases or who require kidney dialysis, are exempt from paying co-payments for treatment of those conditions. To safeguard the rights of rare disease patients to receive proper medical care, the cost of any medication listed by the Ministry of Health and Welfare as necessary to treat the affliction is paid for based on specific earmarks for the purpose, easing the economic burden of such patients as much as possible.

醫療保障　減輕負擔

對疾病弱勢族群照護

（一）身心障礙者：

1. 健保署自 2002 年起施行「牙醫特殊服務項目醫療服務試辦計畫」，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。目前障別包括腦性麻痺、植物人、智能障礙、自閉症、染色體異常、中度以上精神障礙、失智症、多重障礙、重度以上視覺障礙、頑固性（難治型）癲癇、發展遲緩兒童及失能老人等牙醫服務。

2. 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有特殊需求的啓智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，提供入住身心障礙機構之長期臥床者牙醫服務。

Service Guarantee and Burden Reduction

Care for Medically Vulnerable Populations

A. People with disabilities:

1. The NHIA launched a pilot program in 2002 offering dental services to people with disabilities that remains in effect to this day. The program offers higher reimbursements to encourage dentists to provide dental care to patients with congenital cleft lip and palate and other groups with specified disabilities, including people in a vegetative state, those afflicted with cerebral palsy, intellectual disabilities, autism, chromosomal abnormalities, moderate or severe mental disorders, dementia, multiple impairments, severe visual impairments, and intractable epilepsy, developmentally delayed children or incapacitated seniors.

2. The NHIA eased regulations in 2006 to allow local dentist associations or dentist groups to form dental teams that visit organizations or facilities devoted to caring for people with disabilities. The teams provide dentists on a rotating basis to help psychiatric hospitals without dental departments or special education schools with special needs. Since July 1, 2011, dentists from the teams have provided in-home dental services for people with specified disabilities who also require home care. On January 1, 2013, the teams began providing dental services to bedridden patients at centers caring for the disabled.

（二）重大傷病患者：

1. 現行衛生福利部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。

2. 截至2014年12月底，重大傷病證明有效領證數約有97萬餘張（人數為91萬餘人，約占總保險對象的3.87%），而2014年全年重大傷病醫療費用約1,679億餘元（占全年總醫療支出的27.30%），健保藥品費用中，每年約有4百億元（近3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。

（三）罕病患者：

1. 罕見疾病屬重大傷病範圍項目，就醫時可免除部分負擔，衛生福利部公告的罕見疾病種類有207項，截至2014年12月底止，領證卡數共9,666張。經統計2014年罕見疾病之醫療費用約33.35億元，其中藥品費用約為30.56億元。為保障罕見疾病患者的權益，凡是經衛生福利部公告的罕見疾病必用藥品，全民健保均予全額支付。

B. People with catastrophic illnesses:

1. The 30 catastrophic illnesses recognized by the Ministry of Health and Welfare, including cancer, chronic mental disorders, chronic renal failure requiring kidney dialysis and congenital conditions, are all very costly to treat. Insured individuals with a catastrophic disease card are exempt from co-payments for treatment of their disease.

2. As of the end of December 2014, just over 910,000 people (or about 3.87% of all those insured) were holding 970,000 valid catastrophic illness cards. The treatment they received in 2014 cost NT$167.9 billion, or 27.30% of all NHI expenditures. Roughly NT$40 billion a year is spent on medication for patients with catastrophic illnesses, nearly 30% of the total amount the NHI system spends on drugs. These spending levels are an indication of the system's commitment to helping those with major ailments.

C. People with rare diseases:

1. Individuals with rare diseases, which are uniformly categorized as "catastrophic illnesses," are exempt from making co-payments for treatment of their condition. The Ministry of Health and Welfare now officially recognizes 207 different rare diseases, and 9,666 rare disease cards were in use as of the end of December 2014. A total of NT$3.34 billion was spent to treat rare diseases in 2014, of which NT$3.06 billion was for medication. To safeguard patients' rights, any drugs listed by the Ministry of Health and Welfare as necessary for the treatment of a specific rare disease will be fully covered by the NHI system.

2. 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。

（四）多重慢性病患者：

1. 多重慢性病患乃是我國醫療照護系統中最重要的資源使用者，隨著我國人口結構的逐年老化，多重慢性病的盛行率逐年升高，其醫療照護課題也將愈趨重要。為使多重慢性病的民眾可以獲得整合性照護服務，避免重複及不當用藥、檢驗檢查與治療等，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」，參與的病人，可減少部分負擔及掛號費支出、看診及往返交通時間，並提升就醫安全及品質。

2. 本計畫執行多年，每年收案照護對象每人每月平均就醫次數均較上年同期呈現減少，施行成效良好。2015 年 6 月參與整合照護之醫院計 187 家，照護對象中屬失智、三高疾病及高齡多重慢性疾病等重點照護對象約 9 萬餘人，醫院自行收案照護多重慢性病患者約 17 萬餘人，合計有 27 萬餘人接受者整合照護。健保署將定期檢討及修訂計畫，以鼓勵醫療體系提供以病人為中心之全人照護。

2. Any drugs approved for treatment of rare diseases and their reimbursement standard must be listed expeditiously in the package of benefits covered by the NHI system. This policy ensures that rare disease sufferers get the care they are entitled to in a timely manner and keeps the financial burden of the care they receive to a minimum.

D. People with multiple chronic conditions:

1. Patients with multiple chronic conditions are the biggest users of resources in Taiwan's health care system. As the country's population ages, the prevalence of people with multiple chronic diseases will inevitably climb higher, giving the issue ever greater importance. The NHIA decided to take action to address the trend, instituting a "Hospital Integrated Care Program" on December 1, 2009 to ensure that people with more than one medical condition have access to integrated health care services and are not prescribed inappropriate drugs or given redundant prescriptions, tests or treatment. Those participating in the program spend less on co-payments and registration fees and spend less time going to hospitals and getting treatment. Most importantly, they get safer and higher quality care.

2. In the years that the program has been in place, participants have consistently made fewer doctor visits per month on average than they did the previous year, an indication of the program's effectiveness. As of June 2015, 187 hospitals were participating in the program, providing integrated care to about 270,000 patients. Of those, there were more than 90,000 core target patients (who have been treated by the same hospital for more than a year) suffering from dementia, hypertension, hyperglycemia and

對山地離島、偏鄉及醫療資源缺乏地區族群的照護

（一）全民健康保險山地離島地區醫療效益提昇計畫：

1. 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。

2. 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，支援當地醫療服務。

（二）醫療資源不足地區改善方案：

健保署對醫療資源較不足鄉鎮，每年約額外投入 5.8 億元，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。

hyperlipidemia, or multiple chronic conditions (seniors). Another 170,000 were multiple chronic condition sufferers (either new patients or patients who had been treated at other hospitals) directly accepted into the program by hospitals. The NHIA regularly reviews and adjusts the program to encourage medical institutions to provide patient-centered holistic care.

Providing Care in Remote Areas Lacking Medical Resources

A. IDS: Bringing care to Remote Mountain Areas and Islands

1. Taiwan has a number of sparsely populated mountainous areas and islands that lack medical resources because of their locations and relative inaccessibility. To address the gap in care, the NHIA devised a plan to have willing and capable hospitals send health care workers into those underserved areas. Initiated in November 1999, the Integrated Delivery System (IDS) encourages major hospitals to offer outpatient care, emergency services, and overnight care either on-site or on a rotating basis.

2. The IDS program covers 50 mountainous and island townships in the country. They are served by 26 contracted hospitals running 30 separate projects to supplement local medical services.

B. Getting Resources to Other Regions in Need:

The NHIA invests an additional NT$580 million annually on a specific "Improvement Plan for Medically Underserved Areas." The initiative centers around a preferential medical reimbursement plan emphasizing "localized services" that encourages

（三）醫療資源不足地區之醫療服務提昇計畫：

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，2015年計有70家醫院參與。

dentists and traditional Chinese medicine and western medicine physicians to work in resource-deprived areas or provide health care services in such areas on a rotating basis.

C. Upgrading Medical Services in Resource-deprived Regions

In 2012, the NHIA launched a separate program to upgrade and improve accessibility to medical services and preventive care at the community level in remote and mountainous and island regions and other areas lacking health care resources. The plan, which has a specific budget and guaranteed point value, encourages hospitals in these or neighboring areas to provide 24-hour emergency services, inpatient services and internal, surgical, gynecological/obstetric and pediatric department outpatient services. Seventy hospitals were participating in the plan in 2015, helping deliver care at a more local level.

Chapter 6

Value-added Services

第六篇
智慧 e 化　服務加值

全民健保在籌備之初，為了加強資訊處理效率與服務競爭力，訂定了全面電子化作業目標，然而在無前例可循，及當時資訊設備及傳輸速度限制下，健保署逐步推動醫療申報電子化，累積至今，已成為全球獨一無二的全民健保資料庫。透過電子 e 化，健保署可快速有效率的審查醫療院所申報資料及擷取異常狀態，並從大量的倉儲資料中，輔助分析未來政策方向，啓動相關措施，達避免醫療資源浪費，珍惜健保資源的目標。全民健保系統從醫療紀錄、醫院管理，逐步推展至學術研究用途，未來更將彙整成個人的終生病歷，提供全面性的整合醫療服務，加值國民健康。

As the National Health Insurance system was being planned, one of the goals was to digitize its operations to handle information more efficiently and make its services more competitive. Without any precedent to rely on and limited by the equipment and transmission speeds available at the time, the NHIA still promoting in digitizing medical claims submission resulting in a national database of health insurance information unparalleled anywhere around the globe.

Because of this digitization process, the NHIA can quickly and efficiently review the claims for reimbursement of medical services submitted by health care providers and detect irregularities and anomalies. The information collected in our vast database is also used to analyze future policy directions, shape related measures, and prevent the waste of medical resources. Now focused on compiling medical records, managing hospitals and supporting academic research, the NHI information system will in the future aggregate its data into personal lifetime medical histories and provide fully integrated medical services to contribute further to the nation's health.

醫療資訊　透明公開

醫療紀錄雲端隨行

全民健保累積 20 年的健保申報資料，堪稱是全國最大的個人資料庫，近年來大數據（Big Data）觀念興起，健保署在資安確保下，開始逐步彙整各域資料，透過雲端技術將資料回饋給民眾。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」（圖 5），透過健保的 VPN 系統，提供特約醫事服務機構即時查詢病人過去 3 個月的用藥紀錄，提供醫師處方開立或藥師用藥諮詢參考，以提升民眾就醫品質，減少不必要之醫療資源重複使用。

至 2015 年 6 月 30 日健保雲端藥歷系統查詢使用情形，總計有 13,884 家院所查詢使用，包括全部醫院（醫學中心 26 家、區域醫院 84 家、地區醫院 382 家）、約 51%的基層診所共計 10,367 家、52%的藥局計 3,014 家、2%的居家照護計 12 家；總查詢病人數計約 1,389 萬人，查詢次數約 8,061 萬人次，查詢醫事人員數 44,130 人。從 2015 年第 1 季資

Fully Transparent Medical Information

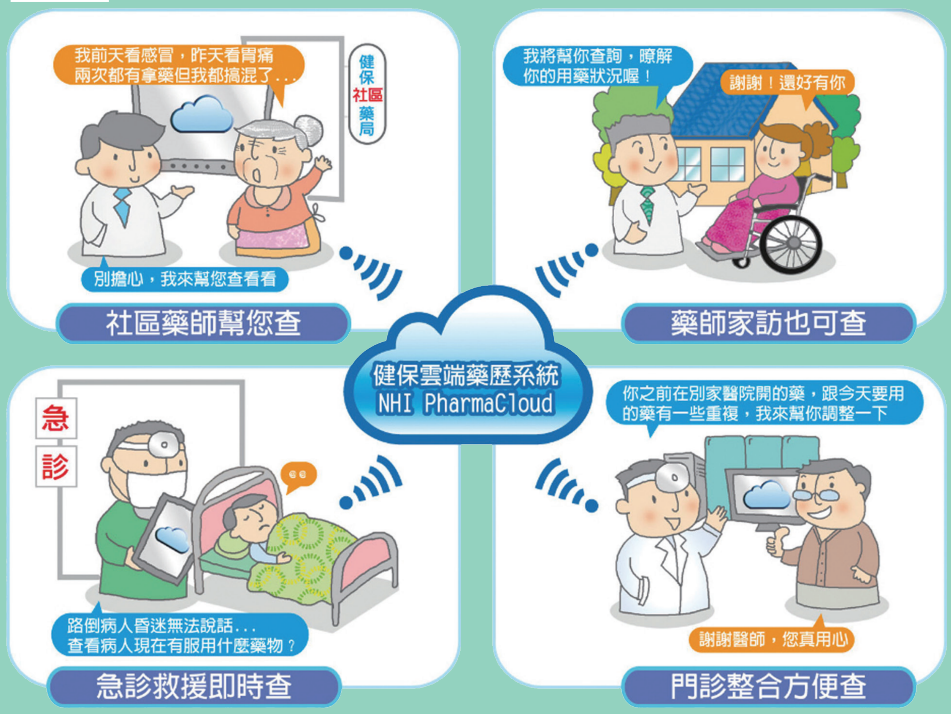
Cloud-based Medical Records

Having accumulated national health insurance data over the past 20 years, the NHIA's database is the country's biggest repository of personal information. With the rise of Big Data concepts in recent years, the NHIA has begun to aggregate information from different fields and give it back to the insured with the help of cloud technology without compromising information security. In July 2013, the NHIA completed the first phase of the patient-centered NHI PharmaCloud System (Chart 5). The system enables doctors and pharmacists at NHI-contracted medical institutions to check a patient's medication records for the previous three months through the NHI virtual private network, in effect improving the quality of care and preventing duplicated prescriptions.

Chart 5: NHI PharmaCloud System Functions

As of the end of June 2015, a total of 44,130 medical professionals had used the NHI Pharma Cloud System through 15,108 health care-related providers, including all hospitals (26 medical centers, 84 regional hospitals and 382 area hospitals) about 51% (or 10,367) of all clinics, about 52% (3,014) of all pharmacies, and about 2% (12) of all home-nursing care institutions. In addition, 13.89 million patients had made use of the system 80.61 million times.

圖 5　雲端藥歷系統即時查詢



料分析，整體門診病人與去年同期比較，有使用雲端藥歷查詢之病患用藥日數重疊率均已明顯降低；而慢性病患如高血壓、糖尿病和高血脂之病患，有使用雲端藥歷查詢之用藥重疊率下降幅度均較整體為多。

Based on data from the first quarter of 2015, the rate of medication duplication (number of days prescriptions overlapped) among patients who used the cloud-based system fell significantly from the same period a year earlier, and the trend was even more evident among people suffering from high blood pressure, diabetes and high levels of blood fat.

另外，健保署於 2014 年 9 月 25 日推出另一項個人化雲端服務—「健康存摺」系統，將健保資料庫中的個人資料送還民眾，只要透過網際網路可簡易且安全地使用「自然人憑證」或「已註冊密碼之健保卡」，即時取得個人最近的醫療資料及保險狀態。藉由提供民眾最近的就醫、住診紀錄及預防保健資料，讓民眾更直接掌握本身的健康狀況，進行自我健康管理，民眾也可以列印個人健康存摺資料或透過行動裝置下載，將個人就醫資料隨身攜帶，就醫時提供醫師參考，預期可縮短醫病間醫療資訊的不對等，提升醫療安全與效益和服務品質。

The NHIA launched another personalized cloud-based service on September 25, 2014 – the "My Health Bank" system – to "return" personal information in the database back to the insured. People can go online and use their "citizen digital certificate" or "password-registered NHI card" to safely and conveniently obtain their latest medical information and insurance status (including whether premium payments are up to date) in real time.

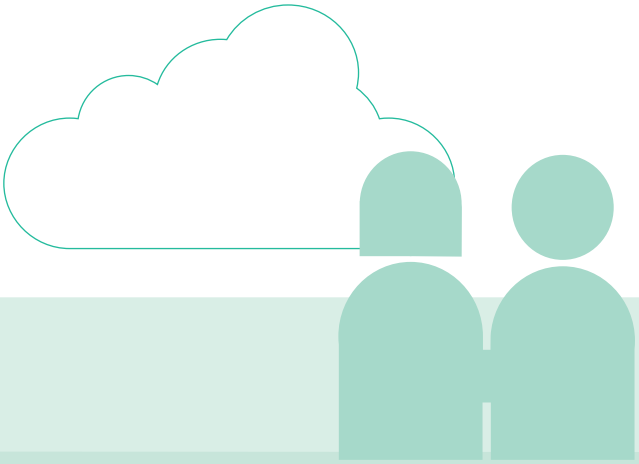
By providing the insured access to their latest treatment records and preventive health information, the system empowers people to more directly control and manage their health. They can print out "My Health Bank" data or download it on mobile devices and have it with them when they go to a clinic or hospital as a reference for the doctor. The service narrows the information asymmetry between doctor and patient and ultimately makes medical care safer, better and more effective.

自推出以來，健康存摺使用人數不斷上升，健保署也不斷提升系統的便利性及資料完整性。截至 2015 年 11 月 30 日止，健康存摺下載人次已達 23 萬 4,100 人次。在使用者滿意度方面，77.1% 的使用者對健康存摺系統網頁操作介面感到滿意，81% 對於健康存摺提供的資料內容感到滿意，約 9 成使用者認同透過健康存摺可瞭解個人就醫情形，有助於掌握自我健康情形，顯示健康存摺對於促進民眾自我健康照護有正向幫助。

醫療品質資訊公開

健保署自 2005 年起建置醫療品質資訊公開平台，以藉品質資訊公開，激勵醫界更努力提升個別院所之醫療服務品質，及增進民眾對本保險醫療品質及醫療利用之瞭解，以做為民眾就醫選擇之參考。

為提供民眾可讀性高之醫療品質資訊，除適度說明資訊之來源、定義、意義及使用限制外，並依資訊公開之目的、屬性及特質作分類，內容包括：



Since the "My Health Bank" system was introduced, the number of people using it has steadily grown, and the NHIA has repeatedly upgraded the system's convenience and range of information. As of the end of November 2015, there had been 234,100 downloads from the system, with 77.1% of those completing downloads having a positive impression of the way the system operates. Some 82.7% expressed satisfaction with the information provided and 90.8% agreed that "My Health Bank" helped them better understand their medical situation and overall health. The response indicates that the system has a positive influence in helping healthy people stay healthy.

Transparent Information on Health Care Quality

The NHIA launched a platform in 2005 to provide transparent information on health care quality, hoping that it would motivate the medical community to improve the quality of medical services offered by every hospital and clinic in Taiwan. The platform was also intended to enhance people's understanding of the NHI system's quality and treatment options and serve as a reference to help the insured make informed decisions when choosing providers and types of care.

To make the information easily understandable, its source, definition, significance and limitations are explained, and it is classified by purpose and characteristics, as follows:

（一）整體性醫療品質資訊：公開各醫療服務類別之「專業醫療服務品質報告」，讓大眾瞭解國內之醫療品質概況。

（二）機構別醫療品質資訊：公開各特約院所之醫療品質指標，包括服務類指標、及特定疾病類指標等多元性品質資訊。

特約醫事服務機構資訊公開

（一）醫事機構基本資料：包括服務項目、診療科別、固定看診時段等。

（二）保險病床比率：民眾住院時免自付病房費差額之病床數比率。

（三）違規醫事機構資訊：公開醫療院所查處統計表及查處名冊。

（四）掛號費查詢：門診掛號費及急診掛號費。

多憑證網路承保作業

為落實電子化政府，健保署於 2006 年 1 月更新網路作業系統，建置多憑證網路承保作業平台，另為提供投保單位線上申報作業便利性，又於 2014 年 10 月份建置承保網路服

A. General information on health care quality: Reports on the quality of specialized health care services, giving the public a good overview of health care quality around the country

B. Information on health care quality at specific types of institutions (i.e. medical centers, regional hospitals, clinics): Quality indicators for types of institutions and specific institutions within each grouping. They include indicators for services and selected illnesses.

Information on NHI-contracted Institutions

A. Basic information: Medical departments and services available, outpatient schedule

B. NHI-insured bed ratio: The proportion of beds in an institution that are fully covered by the NHI system and do not require any extra out-of-pocket expense

C. Rules violations: List of medical institutions found to have violated regulations and related statistics

D. Registration fees: Outpatient clinic and emergency ward registration fees

Multifunctional Online Platform for Employers

In January 2006, the NHIA updated its Internet services system by creating a "multiple authentication Internet platform." A special online insurance services section was then set up in October 2014 to make online tasks even more convenient for insurance registration organizations (mostly employers) and further diversify the online services available. The NHIA also continually adds new functions to serve the public and create a better service environment. As of the end of June 2015,

務專區，讓服務更多元化。為提供更優質作業環境，健保署陸續新增多項功能，服務民眾。截至 2015 年 6 月底，使用之投保單位已有 18.5 萬家，每個月透過網路申報之異動資料約 120 萬筆，占全部異動量之 7 成以上。

投保單位或民眾個人，利用網路申報或查詢異動資料、應繳保費情形等，不但便利迅速，又節省書面填報及遞送成本，同時因為使用者必須先經過電子認證確定身分，更具安全性。

more than 185,000 insurance registration organizations had used the system, and they were reporting 1.2 million changes in information on average per month, or more than 70% of all changes filed, through the online system.

The platform makes it easy for insurance registration organizations and individuals to handle a multitude of functions, including filing or changing information and checking on the status of their premium payments. Convenient and fast, the online system saves users the costs of filling out and sending forms and is very safe because it requires users to first log in through an electronic authentication system.

Chart 6: The multiple authentication Internet platform (down) .

圖 6　多憑證網路承保作業平台

運用科技　提升效率

健保卡與資訊安全

為提升民眾就醫便利性，自 2004 年 1 月 1 日起，健保卡全面正式上線，整合原有的健保紙卡、兒童健康手冊、孕婦健康手冊和重大傷病證明卡 4 種卡冊的就醫紀錄，並將原本卡冊上明示之登記事項，以隱性及代碼方式，登記於晶片內，除具便利性，同時保障就醫隱私。

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 (Virtual Private Network, VPN) 封閉性專屬網路，設有多道防火牆，可大幅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。

Enhanced Efficiency through Technology

NHI Cards and Information Security

Another step to make the health care experience more convenient came on January 1, 2004, when health insurance IC cards were introduced to replace the previously used paper cards and three other medical records – child health care handbooks, maternity health care handbooks and catastrophic illness certification cards. The information that had been previously recorded on the four documents was hidden and encoded in the new card's embedded chip, offering greater convenience and privacy.

The health insurance card also facilitates the improved flow of information through Taiwan's medical online information platform. It has received international recognition on several occasions for its security management. To safeguard information security, the card possesses several anti-forgery characteristics, and the embedded microchip employs a number of verification mechanisms to protect the information it contains.

The online transmission of information is conducted within the NHIA's own closed network, the Virtual Private Network, which is reinforced by a multi-tiered firewall that greatly reduces the risk of hackers breaking into the system or stealing information. Card records are encoded when entered and garbled when transmitted, effectively safeguarding cardholders' privacy.

In August 2003, the NHIA created an "information security task force" to build the security management framework for the soon-to-be introduced NHI IC cards

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，歷經 9 個多月的努力，於 2004 年 6 月及 8 月，健保署健保卡金鑰管理系統（Key Management System, KMS）和健保卡資料管理中心（IC Card Data Center, IDC），通過世界公認的資通安全及認證標準，分別取得英國標準協會（The British Standards Institution, BSI） 之 BS7799 及 CNS17800 之安全認證。健保署是國內首家取得英國標準協會授權全國認證基金會（Taiwan Accreditation Foundation, TAF）發出 CNS17800 證照的政府機構。

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紮根。健保署資訊單位於 2006 年 3 月及 2008 年 5 月均通過國際資安標準 ISO27001 驗證，獲得國內外 UKAS &TAF 資安證照，並於 2010 年配合健保署改制，推動 ISMS 制度及證照整併作業，並通過資安驗證，之後配合 ISO/IEC27001 版本更新，於 2015 年完成 ISO27001:2013 轉版驗證，嗣後並依循 PDCA 持續改善之精神，推動資訊安全工作，以確保民眾資訊安全。

健保署為強化整體資安監控，於 2010 年 9 月納入政府機關資安監控（Government Security Operation, GSOC）體系，進行全年無休之網路及電子郵件安全監控作業。

and health insurance information. The task force was made responsible for managing security-related tasks and obtaining independent certifications of the system. After more than nine months of effort by the panel, the IC card's key management system (KMS) and IC Card Data Center (IDC) were found to comply with internationally recognized information security and recognition standards. The KMS received British Standards Institution BS7799 certification in June 2004, and the IDC received CNS17800 certification in August 2004.

The NHIA was also the first government agency in Taiwan to obtain CNS17800 certification through the Taiwan Accreditation Foundation.

An "information security management system" (ISMS) was also installed to keep medical information secure. The NHIA's information division received certification based on ISMS standard ISO27001 from the Taiwan Accreditation Foundation and the United Kingdom Accreditation Service in both March 2006 and May 2008. In 2010, in conjunction with an organizational restructuring initiative, the NHIA consolidated the ISMS system and certification and passed information security verification. After the ISO/IEC27001 standard was updated in 2013, the ISMS completed certification under the new ISO27001: 2013 standard in 2015. Since then, the NHIA has followed the spirit of the PDCA (Plan-Do-Check-Act) cycle in continuing to improve information security, giving people confidence that their personal information will remain confidential.

In September 2010, the NHIA joined the Government Security Operation network, which monitors Internet and e-mail security around the clock.

登錄藥品處方及重要檢查

健保卡除有重大傷病證明的註記，也登錄藥品及檢驗 (查) 項目，讓醫師在診療時參考，如此可提升就醫安全性，間接避免浪費健保醫療資源。

此外，健保卡啓用後，每次就醫紀錄應於健保卡登錄並於 24 小時內傳送至健保署，每天的門診與住院人次即可及時統計，針對某些異常就診的行為，健保署可及早發現而加以追蹤輔導。而且，衛生福利部轉送保險對象器官捐贈或安寧緩和醫療意願之檔案，會載入健保卡資料庫，保險對象只要持健保卡至設有讀卡機之地點更新內容，就可將意願註記載入健保卡，這樣在保險對象意識不清，無法清楚表達意願時，家屬即可以了解其意願。

Prescription and Test Records Stored on NHI Cards

The NHIA enters drug prescriptions and medical examinations and tests on patients' NHI cards as a reference for physicians treating the cardholder. Access to this information can enhance medical safety and indirectly prevent the waste of NHI medical resources.

The adoption of the NHI card has made it possible for a record of every patient visit to be transmitted within 24 hours to the NHIA, enabling the agency to tabulate outpatient and inpatient visits on a daily basis and spot and pursue irregularities or anomalies as they happen.

Another feature of the NHI card is that it can store information on the patient's willingness to donate organs or desire not to be resuscitated or given hospice care if they lose consciousness. For people who register their preferences on these issues with the Ministry of Health and Welfare, that information can be downloaded to the NHI's IDC system, and the patient can transfer the information onto their cards wherever a card reading machine is installed. This will give family members and physicians a clear understanding of how cardholders who have lost consciousness feel about end-of-life issues.

電子申報系統提升整體效率

自全民健保開辦以來，健保署即鼓勵特約醫事服務機構採用網際網路、媒體、VPN 等方式申報費用，有效節省書面申報之人工及郵遞成本，提升申報作業效率，且可縮短費用暫、核付時程。統計資料顯示，特約醫事服務機構採醫療費用電子申報之比率已近 100%。

2004 年 1 月 1 日健保卡全面上線後，健保署建置健保資訊網 (VPN) 作為與特約醫事服務機構雙向溝通之專用網路，特約醫事服務機構除了可透過 VPN 進行健保卡連線、認證、更新、上傳作業以外，更可進行費用申報、試辦計畫等網路申報服務，提供更有效率之連線服務管道。2015 年 6 月份平均每日健保卡就醫上傳檢核成功之清單明細約 172 萬筆、醫令約 565 萬筆資料。另為因應近年來醫療院所 e 化的腳步逐漸加速，健保署於 2006 年 9 月建置完成並啓用「電子化專業審查系統（Picture-Archiving and Communication System, PACS)」，建立了醫療費用專業審查（含文字及影像資料）作業 e 化環境，以期協助醫療院所進行醫療專業審查電子化申請或申報；同時串接健保署內部之醫療給付相關系統，使整個審核流程更加自動化，並提升原有人工審查作業的效率，降低行政作業成本。

Enhanching Efficiency with Electronic Claims System

Since the inception of the NHI program, the NHIA has encouraged contracted medical institutions to file their reimbursement claims electronically via the Internet, electronic media or the Virtual Private Network, which has improved claims efficiency and lowered the administrative costs of processes that were once handled manually. The system also shortens the time it takes to approve or deny reimbursement claims. Nearly all contracted medical institutions now file their claims electronically.

The Virtual Private Network in particular was set up to provide a dedicated two-way communication channel with medical institutions. It is used to verify and update NHI cards during patient visits, file their expense claims and claim costs for pilot plans. In June 2015, an average of 1.72 million patient visit summaries containing 5.65 million medical service orders (physician orders) were uploaded and verified daily through the system.

The NHIA has set up other online systems to accommodate the growing efforts of medical institutions to digitize their operations and strengthen the overall e-government environment. In September 2006, a picture-archiving and communication system (PACS) to audit expense claims (including text and imaging information) was launched to help medical institutions report their expenses electronically. At the same time, the system was linked to the NHIA's internal payment systems, automating the auditing system even further. Ultimately, the increased reliance on electronic systems has improved efficiency and cut administrative costs.

為鼓勵更多醫療院所採用網路方式申報醫療費用，所有特約醫事服務機構申報作業以健保署健保卡資料管理中心（IDC）為單一入口，集中由全民健保資訊網路連線申報，健保署也配合作業需求，持續提供特約醫事服務機構更多更便捷的電子申報服務。於 2012 年 1 月推動以電子憑證登入健保資訊網，提供醫事機構整合式權限管理，並提升網路服務之資訊安全；原使用「帳號＋密碼」登入作業方式自 2014 年 4 月起停止服務，全面改用電子憑證登入。同時亦期望透過推動跨院所間的醫療影像檔傳輸與交換作業，減少不必要的重複檢驗與檢查，促進跨醫院間的資訊流通，減少全民健保財務支出，進而帶動醫療產業 e 化及醫療影像標準化。

資訊科技提高審查效率

利用電腦資訊科技，發展電腦醫令自動化審查系統，針對全民健康保險醫療服務給付項目及支付標準、全民健康保險藥物給付項目及支付標準、全民健康保險醫療費用審查注意事項等給付規定，明確規範不給付之規定（例如年齡限制、性別限制、加成限制、申報次數限制、專科醫師限制、試辦計畫限制、不可併同申報項目、不得實施部位等），建立醫令自動化審查邏輯，透過醫療院所申報資料，進行電腦邏輯程式檢核，直接核減不給付醫令項目，以減少醫療院所不當申報之情形，並逐步導正醫療院所申報之正確性，以提升審查效率。

The NHIA has made it even easier for medical institutions to file reimbursement claims electronically by enabling all providers to file their expense claims through a single electronic window – the IC Card Data Center (IDC). Other convenient e-reporting services have and will continue to be provided in the future. In January 2012, for example, a health insurance information network requiring specific digital verification to log in was introduced to give medical institutions a more integrated authorization management system and enhance the security of electronic network services. The digital verification system emerged as the only log-in system in use in April 2014 when the previous system, under which institutions would log in with an account name and password, was discontinued.

At some point in the future, medical institutions will also be able to share image and document files of patients among themselves online, which will help prevent repeat tests and checkups, reduce the NHI system's expenditures and further encourage the digitization of the medical sector and the standardization of medical imaging.

Highly Efficient Automated Auditing System

The NHIA has developed an automated auditing system with its own internal logic that can screen payment claims submitted by medical institutions against such criteria as NHI benefits and reimbursement schedules for medical services and drugs, NHI medical expenditure review guidelines, and other empirical standards that rule out reimbursement (such as age, gender, mark-up or frequency parameters, specialist physician requirements, pilot program restrictions, or services that cannot be combined). By weeding out expense claims that do not

總額支付制度全面實施後，健保署積極建立以檔案分析為主軸之審查制度，進行醫院醫療利用異常之審查管理，目前已採行之措施，舉例如下：

（一）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。

（二）邀請醫界代表討論，共同發展檔案分析審查異常不予支付指標，利用申報資料對醫療院所診療型態進行審核，並針對各指標值設定閾值，就異常部分，以程序審查方式進行核減（統扣），以節省人工審查成本。

（三）健保署各分區業務組依轄區特性，就高利用及高費用醫療項目，如電腦斷層掃描攝影（CT）、核磁共振掃描攝影（MRI）、體外震波碎石術（ESWL）等，利用檔案分析建立監測指標，以篩選異常院所或醫師，加強審查管理及輔導。

（四）2014 年 9 月建置「全民健康保險中央智慧系統」(CIS)，將重要項目納入統一管控，並結合醫療資訊系統，自動化勾稽抽樣審查，提供異常警示功能，提升管控效率，並產製監控管理報表及審查結果統計，供全面監控管理成效。

conform to regulations, the system reduces the number of improper claims and prods health care providers into improving the accuracy of their claims, further enhancing audit efficiency.

After the global budget payment system was implemented, the NHIA developed an auditing system built around profile analysis that looks for potential anomalies in how hospitals treat patients and use resources. The features of this profiling system to date include:

1. Detecting through statistical analysis abnormalities in patient visits and medical institutions' diagnosis and treatment practices and reimbursement claims, and turning over the results to the experts handling professional reviews. The focus of the professional review then shifts from individual claims to the health care provider's practices and operating patterns.

2. Inviting medical representatives to participate in identifying indicators that can detect abnormalities and make use of claims data to review medical institutions' diagnosis and treatment practices. These indicators, which all have specific thresholds that signal abnormalities, are used in automated procedural reviews and help save on the manpower used in professional reviews.

3. Having branches of the NHIA use profile analysis to develop region-specific indicators that work best in monitoring the use of high-utilization, high-cost devices, such as CT-scans, MRIs and ESWL, in their jurisdictions and detecting abnormal usage patterns among individual medical institutions or physicians.

4. In September 2014, a "Central Intelligence System" was installed to further screen medical claims. It

門診高利用輔導展現成效

自 2001 年起實施「全民健康保險門診高利用保險對象輔導專案計畫」，掌握門診高利用保險對象醫療資源利用情形，輔導正確就醫，杜絕醫療浪費。2010 年起，門診高利用保險對象定義為全年門診申報就醫次數超過 100 次者，自 2013 年起更擴大輔導範圍，將 2012 年度門診就醫次數超過 90 次（不含重大傷病患者）之保險對象納入輔導。

輔導方式包括郵寄關懷函、電訪或親訪、結合多元社會資源、審查醫師及家庭醫師進行實地輔導等。經輔導未見改善且由專業認定有指定院所就醫必要之保險對象，將依其病情及意願指定至特定醫療院所就醫，惟緊急就醫者不在此限。

截至 2014 年 12 月底止，42,984 名於 2013 年門診就醫次數超過 90 次的保險對象，經 2014 年輔導後，其醫療費用較 2013 年同期約減少 5.32 億元，平均就醫次數下降 20%，平均醫療費用下降 15%。藥事照護計畫總輔導人數為 8,198 人，與前一年同期比較，平均門診醫療費用下降 14%，就醫次數下降 17%。

automatically monitors claims for the most common medical items through the integration of the medical information system and automated random checks, and automatically warns of anomalies. The system enhances the efficiency of the claims monitoring process and generates monitoring management reports and statistical data on checks conducted, making overall claims monitoring as effective as possible.

Counseling Effective in Reducing Excessive Utilization

Since 2001, the NHIA has operated a program to track and counsel individuals who make an excessive number of outpatient visits. The program prevents the abuse of medical resources by guiding these heavy users of medical resources on how to seek proper treatment. Beginning in 2010, a "heavy user" subject to counseling was defined as an individual who made more than 100 outpatient visits a year. The definition was broadened in 2013 to those who made more than 90 outpatient visits in 2012 (not including those with catastrophic illnesses).

Counseling methods include sending letters to patients, calling them up or visiting them, mobilizing other social resources to provide help, or having a patient's family doctor and the doctor reviewing the case provide on-site counseling. If counseling does not improve the situation and a review of the case indicates the need for the patient to be treated at a specific health care facility, the patient is sent to that facility contingent on the individual's medical condition and willingness. Those requiring emergency care are not subject to those constraints.

A total of 42,984 patients who sought outpatient care 90 times or more in 2013 were given counseling in 2014, with positive results. Total medical spending on this group of patients fell by NT$532 million in 2014, representing a per-patient decline of 15%, and they averaged 20% fewer doctor visits per patient. Under a pharmaceutical care plan (designed to help patients rationalize their use of medications), 8,198 patients who were counseled at home by pharmacists averaged 17% fewer visits to the doctor, and average spending on their outpatient visits fell by 14%.

健保費繳納管道多元

健保署為因應時代的潮流，體貼服務民眾，健保費之繳納管道，包括郵局、銀行、便利商店及健保署各業務組臨櫃繳納或選擇更便捷之約定銀行轉帳扣款、自動櫃員機、網路等多元繳費方式，讓民眾可選擇距離最近、最方便的地點或方式繳納健保費。

健保署自 2007 年 1 月 1 日起實施多元繳納健保費管道，依 2015 年 6 月 30 日之繳納資料顯示，已使用多元管道繳納之民眾，金融機構臨櫃繳納（占 44%）、金融機構轉帳代繳（占 26%）及便利超商繳費（占 30%），另有部分民眾選擇自動櫃員機繳費及網路繳費，讓民眾有更多元、更便利的繳費方式，並達到簡政便民的政策目標。

Diversified Premium Payment Channels

In a world driven by convenience, the NHIA wants to make it as easy as possible for people to pay their premiums and offers several payment channels. Premiums can be paid at post offices, banks, convenience stores or NHIA branches, through ATMs, via the Internet or by automatically deducting them from a bank account every month. With so many options, the insured are sure to find a convenient payment method and location.

This program to diversify payment channels has proved effective. Based on payments made from January 1, 2007 (when the program began) to June 30, 2015, 44% of the insured have paid their premiums at banks, 26% have had payments automatically deducted from designated accounts, and 30% have made payments at convenience stores. Some have also used ATMs and the Internet. Whatever the option chosen, the program has achieved the goal of simplifying government services and making life easier for the insured.

Chapter 7

International Recognition and Public Satisfaction

第七篇
國際肯定　民眾滿意

健保經驗　蜚聲國際

全民健保開辦以來，在醫界的配合以及全民的支持下，已逐漸達到減輕民眾就醫負擔的目標，特別是保險費負擔輕、行政經費低及全民納保等，更在國際上贏得好評。

美國公共電視網（Public Broadcasting Service, PBS）製作群製作了 "Sick Around the World" 專輯，深入報導英國、臺灣、德國、瑞士和日本 5 個國家的醫療保險制度，以作為美國討論健保議題之參考。其中有關臺灣健康照護服務的內容，除了讚揚我國提供西醫、牙醫、中醫及精神疾病照護服務外、健保卡（smartcard）的使用、醫療照護費用不及美國一半等優勢，都成為探討的重點。

Internationally Acclaimed Experience

In the two decades of Taiwan's National Health Insurance program, the NHIA, with the cooperation of the medical community and the support of the public, has been able to gradually reduce the financial burden of health care, and its many achievements, such as affordable premiums, low administrative costs and universal coverage, have earned the acclaim of the international community and international media.

In 2008, the U.S. Public Broadcasting Service (PBS) produced a Frontline series called "Sick Around the World" that focused on the health insurance systems of Taiwan, Britain, Germany Switzerland and Japan as a reference for U.S. policy makers when debating the issue. The report on Taiwan's health care system explored and praised the range of western medicine, dental, traditional Chinese medicine and mental illness services offered, as well as the adoption of the NHI card, and a cost of care less than half that in the United States.

The series gave Taiwan a chance to be compared with other advanced countries and brought considerable attention to the country's health insurance system.

這次的報導不僅使臺灣的健保受到國際的肯定，對臺灣國際形象的提升亦極有助益。2012 年美國有線電視新聞網（CNN）專題報導我國、英國及瑞士之健保醫療制度，該報導內容探討及比較各國健保制度優缺點，以各國相關經驗討論如何作為美國健保制度改革的參考。而有關臺灣的健保制度部分，則說明我國在 1995 年起全力推動全民健保，以全民投保模式，由政府擔任單一保險人，創造了高水準及成本控制成功的醫療系統，讓全民受到完善之醫療照護。

In 2012, American cable news network CNN presented a special report comparing the strengths and weaknesses of the health insurance systems of Taiwan, Britain, and Switzerland and discussing how the experiences of the three countries could be applied to reform the health insurance system in the U.S. The report explained that the NHI program, launched in 1995, is a universal health insurance program in which the government acts as the sole insurer. It concluded that Taiwan's NHI program has been a success over the years by delivering high standards of care, keeping costs down, and enabling the insured to receive comprehensive health care.

國際評論佳
Attracting Worldwide Attention

2015	"Reflections on the 20th Anniversary of Taiwan's Single-Payer National Health Insurance System" Health Affairs, March Issue 健康經濟雜誌	Health Affairs
2014	United States Senate Subcommittee Hearing – Access and Cost: What the US Health Care System Can Learn from Other Countries 美國參議院聽證會	
2012	"Taiwan's Progress on Health Care" by Uwe E. Reinhardt/New York Times blog 紐約時報	The Washington Post
	National Geographic Channel documentary "Taiwan's Medical Miracle" premieres 國家地理頻道	NATIONAL GEOGRAPHIC CHANNEL
	"Health Insurance Is for Everyone" by Fareed Zakaria/Time Magazine 時代雜誌	TIME
	GPS Special: Global Lessons-The GPS Road Map for Saving Health Care 美國有線電視新聞網	CNN
2009	"Five Myths about Health Care around the World" by T.R. Reid/Washington Post 華盛頓郵報	The Washington Post
2008	Taiwan featured in one episode of "Sick around the World," a Frontline series by the U.S. Public Broadcasting Service (PBS) 美國公共電視	PBS
2005	"Pride, Prejudice, Insurance" by Paul Krugman/New York Times 紐約時報	The Washington Post

除國際媒體報導外，其他國際期刊也時常以臺灣經驗作為借鏡，相繼報導我國的健保成就，在肯定我國努力的同時，更企盼能作為各國學習的楷模。例如：2008 年美國內科學年鑑 Annuals of Internal Medicine 刊載了由國家衛生研究院溫啓邦研究員發表的 "Learning from Taiwan: Experience with Universal Health Insurance"，其內容評估全民健保實施十年的經驗，並肯定我國全民健保政策有助於提升弱勢人口的健康，更使因病致貧的問題相對減少；在英國醫學期刊 "BMJ 12 January2008 vol. 336" 的「觀測站專欄」中，美國知名健康經濟學者 Uwe Reinhardt 教授在 "Humbled in Taiwan" 一文裡，也曾強調臺灣健保行政效率高，建議美國可從臺灣經驗中得到啓發；2008 年美國政治期刊「異議」"Dissent" 在 "Health Care in Taiwan-Why Can't the United States Learn Some Lessons?" 一文中，介紹臺灣全民健保，強調美國人民所疑懼的單一保險人設計導致政府濫權，在臺灣健保中並不存在；遠在非洲發行的利比亞群衆醫學期刊 "Jamahiriya Medical Journal, Summer 2009 v9 n2" 季刊中之社論專欄也刊登我國全民健保制度之報導，作者介紹臺灣健保制度特色，並總結各國應和臺灣一樣，由不同

Several international journals have also taken a close look at Taiwan's NHI system, reporting on the program's achievements in the hope that it could serve as a model for other countries to learn from. Among them: An editorial in the U.S.-based Annuals of International Medicine in early 2008, titled "Learning from Taiwan: Experience with Universal Health Insurance," summarized a paper by Wen Chi-pang, an investigator with the National Health Research Institutes' Center for Health Policy Research and Development, and others that evaluated the NHI program's first 10 years. The paper concluded that Taiwan's health care policies had helped improve the life expectancies of socially disadvantaged groups and narrowed the disparity in care between the wealthy and the poor.

At around the same time, in a column in the British Medical Journal (BMJ) in January 2008 titled "Humbled in Taiwan," noted health economist Uwe Reinhardt stressed the high administrative efficiency of Taiwan's health insurance system and suggested that the United States should be humbled and inspired by Taiwan's experience. Later the same year, an article in the winter 2008 edition of U.S. political magazine Dissent titled "Health Care in Taiwan: Why Can't the United States Learn Some Lessons?" introduced Taiwan's health care system and stressed that the government abuses that Americans fear would result from a single-payer scheme have yet to materialize in Taiwan.

國家的經驗學習到，自由市場的運作除了無法提供公平的醫療保障，並會產生逆選擇現象，而難以達到風險分攤的目標。2015年美國健康經濟雜誌 Health Affairs 刊載了普林斯頓大學 Tsung-Mei Cheng 教授發表的 "Reflections On The 20th Anniversary Of Taiwan's Single-Payer National Health Insurance System"，闡述了臺灣全民健保的單一保險人制度、全民強制納保及人人可負擔的費率、完整的資料庫技術值得美國健保改革借鏡參考。

榮獲 2008 年諾貝爾經濟學獎的普林斯頓大學保羅克魯曼（Paul Krugman）教授，更曾在 2005 年 11 月 7 日紐約時報（New York Times） 中， 以 "Pride, Prejudice, Insurance" 一文，公開讚許臺灣的健保，

Then there was a column published in 2009 in the quarterly Jamahiriya Medical Journal in Libya that introduced the special characteristics of Taiwan's health insurance system and suggested that countries around the world should be like Taiwan and learn from the experience of others. It argued that free market health care systems have not been able to safeguard medical equality and had resulted in "adverse selection," making it impossible to pool and share risk.

Most recently, American health policy journal Health Affairs published an analysis titled "Reflections On The 20th Anniversary Of Taiwan's Single-Payer National Health Insurance System" by Tsung-Mei Cheng, a health policy research analyst at Princeton's Woodrow Wilson School of Public and International Affairs. Cheng described the NHI program's single-payer system, compulsory enrollment, affordable premium rates and sound database technology and said they all offered lessons that America could learn from as it reforms its health insurance system.

Meanwhile, Nobel Laureate and New York Times columnist Paul Krugman praised Taiwan's health care system in a November 7, 2005 column called "Pride, Prejudice, Insurance," writing that Taiwan had reached nearly universal coverage without much of an increase in health expenditures.

在沒有大幅增加醫療費用的情況下，卻達成了全民納保的目標。2009 年 10 月美國的 Global Post 對臺灣的健康照護做特別報導，讚揚臺灣健保費用低、就醫方便、公平性高，為亞洲最受讚譽的制度，並認為美國應向臺灣學習。2012 年更有四大國際媒體，包括紐約時報、國家地理頻道、時代雜誌及 CNN 電視台報導臺灣的全民健康保險制度，全民健保已成為國家最珍貴的資產。

臺灣以公平就醫、全民納保、等候時間短、民眾不會因病致貧及行政經費最有節制的成就，獲得各方高度的肯定。臺灣的全民健保不僅保障全體國人的健康，也成為世界各國學習的對象，每年均吸引大量國外專家學者或官方代表前來我國考察健保制度。2014 年至 2015 年 11 月健保署共接待全球 82 國，計 1,202 位外賓參訪。

另外，為提高我國健保制度於國際舞台的能見度，型塑全民健保的國際形象，健保署積極參與各項國際會議並提交報告或演講，藉學術交流，宣揚我國健保制度成就。

An October 2009 special report on "Health Care in Taiwan" on the U.S. online news site GlobalPost praised Taiwan's health insurance system for its low costs, easy access to care and high level of equality and concluded that perhaps it was time for the United States to listen to Taiwan. Three years later, in 2012, four major international media organizations – the New York Times, the National Geographic Channel, Time Magazine and CNN – all reported on Taiwan's health insurance system, an indication of how much the NHI system stands out as a precious national asset.

Universal coverage, equal access to care, short or negligible waiting times, low administrative costs, and affordable care that will not drive families into poverty all stand out as hallmarks of the NHI-system and have been widely recognized. Because of these achievements, Taiwan's NHI-program has been held up as model to learn from, and experts, scholars and officials from many countries visit Taiwan every year to get a first-hand look at how it works. From 2014 to the end of November 2015, 1,202 guests from 82 countries visited the NHIA.

為促進亞洲國家健保體系相互學習及交流，健保署於 2013 年 7 月 1 日邀請與臺灣醫療體系相近之日本及韓國等健保機構代表，舉辦「2013 臺日韓全民健保研討會」，計有國內外健保相關機關、團體、學者專家、醫療院所、藥界、民間代表等 200 餘人齊聚一堂，分享健保施行的難得經驗。更於 2014 年 10 月 13、14 日舉辦「2014 年亞洲全民健保國際研討會」，以「健保醫療服務、藥品與未來挑戰」為主題，邀請亞洲地區包含泰國、馬來西亞、印尼、越南、菲律賓、韓國、日本等國家專家學者與會，透過國際間分享在全民健保上的不同經驗與努力，增廣宏觀視野，讓亞洲各國相關單位互相交流與借鏡。

The NHIA also regularly participates in international conferences to increase the NHI-system's visibility and build its image internationally and often has the chance to present papers or deliver speeches that help promote the achievements of the NHI program.

To promote exchanges between health insurance bodies in Asian countries, the NHIA invited health insurance officials from Japan and South Korea, which have health care systems similar to Taiwan's, to join Taiwanese health officials at the "2013 Taiwan-Japan-Korea National Health Insurance Conference" on July 1, 2013. More than 200 people, including scholars and representatives of health insurance agencies, civic groups, medical institutions and pharmaceutical associations, were in attendance and shared their NHI practices.

A year later, in 2014, the NHIA held the "2014 NHI International Conference" in Taiwan in mid-October, featuring the theme "Medical Services, Drug Benefits and Future Challenges." It was attended by top health experts from several Asian countries, including Thailand, Malaysia, Indonesia, Vietnam, the Philippines, South Korea and Japan. The sharing of different experiences and practices in the health insurance field helped expand the horizons of the participants and gave insurance agencies from around Asia the chance to learn from each other.

2014 年 11 月 17 日健保署進一步與韓國健康保險審查評價院簽訂「健康保險合作瞭解備忘錄」，正式建立長久的合作模式，以精進兩國全民健保制度的服務內涵。本次合作瞭解備忘錄的重點，目的在於推廣並增進臺、韓雙方與健康保險及健康服務購買有關之經驗交流，包括醫療服務審查、藥品與特材之給付及訂價、支付制度設計及改革、醫療品質及健保資訊系統。

而臺灣全民健保政策雖備受國際社會極度稱許，但仍有醫療體系的整合、人口老化、健保財務永續等挑戰，為因應民眾對高品質

The NHIA went a step further on Nov. 17, 2014, signing a "Memorandum of Understanding on Health Insurance Cooperation" with South Korea's Health Insurance Review & Assessment Service to formally establish a long-term cooperation model and strengthen the services of the two countries' NHI systems. The focus of the MOU was to promote and expand the sharing of experience related to procuring health insurance and health services, including reviewing claims for medical services; setting prices and reimbursing claims for medications, materials and devices; designing and reforming payment systems; enhancing health care quality; and developing health insurance information systems.

Though Taiwan's NHI program has earned the international community's praise, many challenges remain, including medical system integration, an aging population and the sustainability of the program's finances. To better address the public's expectations of high-quality medical services and gain greater awareness of global health care trends, the NHIA held a conference on the achievements, challenges and reforms of health systems in major advanced countries on March 16-17, 2015. The seminar invited 20 health experts from Taiwan and abroad who gave presentations, including 11 from the U.S., Canada, Britain, Germany and Japan.

醫療服務的期待及世界潮流的驅動，2015年3月16至17日健保署邀請美國、加拿大、英國、德國、日本等國家11位專家學者，共計約20名國內、外講員以「先進國家健康照護系統之成就、挑戰與改革」主題齊聚交流。馬總統親臨開幕典禮致詞，讚許全民健保讓民眾無論貧富均能安心就醫；此外，韓國國民健康保險公團理事長Sang Cheol Seong、菲律賓健康保險局局長Alexander A. Padilla及泰國國家健康安全局局長Winai Sawasdivorn等重要貴賓皆肯定臺灣健保20年來的成就為各國學習模範，也期許共同為民眾健康照護而努力。為期2日的國際研討會約有1,100人次參與，會議規模盛大。會中研討最適合臺灣實施的健保政策。各國代表並分享健康照顧體制及

President Ma Ying-jeou delivered the conference's opening remarks, in which he praised the country's NHI system for providing access to care regardless of an individual or family's financial situation. In addition, several dignitaries, including Sang-Cheol Seong, president of South Korea's National Health Insurance Service, Alexander A. Padilla, president of the Philippine Health Insurance Corporation, and Winai Sawasdivorn, secretary-general of Thailand's National Health Security Office, all praised the achievements of Taiwan's NHI program over the past 20 years as examples to learn from. They also expressed the hope of working together to care for the health of people in the region.

The conference, attended by about 1,100 people over the two days, explored health insurance policies that would be most appropriate for Taiwan. Representatives from other countries discussed their health care systems and future reforms and offered insight on reforming payment systems, sustaining the finances of health insurance systems, improving the effectiveness and efficiency of health care and enhancing the quality of care. The insights introduced new concepts and ideas that will contribute to the review and ongoing reform of Taiwan's NHI program.

Beyond the conference itself, the NHIA arranged an in-depth seminar for visitors from Ghana, South Africa and Malaysia on such issues as medical review practices, medical information system development and payment systems. Visits to local hospitals were also arranged for the forum's keynote speakers and other foreign delegations to encourage the sharing of experience.

未來改革目標，並以深入支付制度改革、健保財務永續、健康照護之效率及效果及醫療照護品質等議題聚焦對談，為我國健保制度後續的檢討改革帶來嶄新的觀點。除了 2 日研討會外，健保署為迦納、南非、馬來西亞來訪外賓團體，就醫療審查實務、醫療資訊系統建置、支付制度研擬等重要議題規劃 2 日深入交流座談，並視行程安排國外講員及外賓團體至院所參訪，促進經驗傳承交流，相互學習並擴大視野。

In May 2015, Taiwan sent a delegation to Geneva to participate in the World Health Assembly for the seventh year in a row. In conjunction with the meeting's theme of "building resilient health systems," the delegation shared Taiwan's experiences in dealing with different epidemics and disasters, detailing how the country's NHI system mobilizes the resources of public and private hospitals when facing the outbreak of an emerging infectious disease or responding to emergencies to provide timely critical medical services. This insight served as a reference to countries concerned about controlling the Ebola outbreak in West Africa or dealing with the challenge of preventing epidemics in the future.

2015 年 5 月我國代表團第 7 度參與第 68 屆 WHA 期間，針對大會主題「Building resilient health systems」與各國分享我國醫療體系如何因應各種疾病和災難，臺灣擁有的全民健保體系統籌並整合了公私立醫療院所資源，面對新興傳染病爆發時及各種緊急災害應變，提供適切的及重症醫療服務，可供與會各國關注的西非伊波拉疫情控制，及後續防疫挑戰的借鏡。如 2003 年 SARS 疫情失控，透過健保署與各大醫學中心合作成立抗煞指揮中心運作機制，甚至今年 6 月臺灣醫療史上受傷人數最多的粉塵暴燃事件，全臺醫療體系的動員，加上全民健保制度的支撐，給予傷者適當的醫療與照護規劃，再再顯示全民健保是民眾強有力的後盾及保障。

Among the examples offered was the 2003 SARS crisis, in which the NHIA and medical centers cooperated to set up a SARS Coordination Center. Taiwan's emergency response capabilities were again severely tested in June 2015 by dust explosions at an outdoor concert that resulted in the biggest group of injured people in a single incident in Taiwan's medical history. Medical systems around Taiwan mobilized personnel and provided the many burn victims appropriate medical and care regimens with the support of the NHI system, demonstrating once again the strong backing and protection the NHI program provides to the public.

全民健保　民眾滿意

全民健保實施曾面臨諸多困難，從一開始的滿意度不到 4 成 , 到目前持續成長至 8 成以上，顯見民眾十分肯定健保。其中雖曾因 2002 年度保險費率及部分負擔調整，導致民眾對全民健保的滿意度稍有下降，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，實施上半年，滿意度一度下滑，下半年起，即回穩至 8 成左右（圖 7）。1995 年健保開辦之前，國人平均餘命為 74.5 歲，自全民健保實施後，2013 年國人平均餘命女性 83.3 歲，男性 76.7 歲，顯著的提升了國人的平均餘命，並降低了死亡率（圖 8），成果深受民眾肯定。

醫療費用　控制得宜

我國實施全民健保，提供國人優質且方便的醫療服務，且醫療費用低於世界其他主要國家。以購買力平價指數計算，臺灣每人每年花費 2,546 美元，約僅為美國的三分之一。以醫療費用占國內生產毛額計算，我國只有 6.6%，低於絕大多數國家。（圖 9）

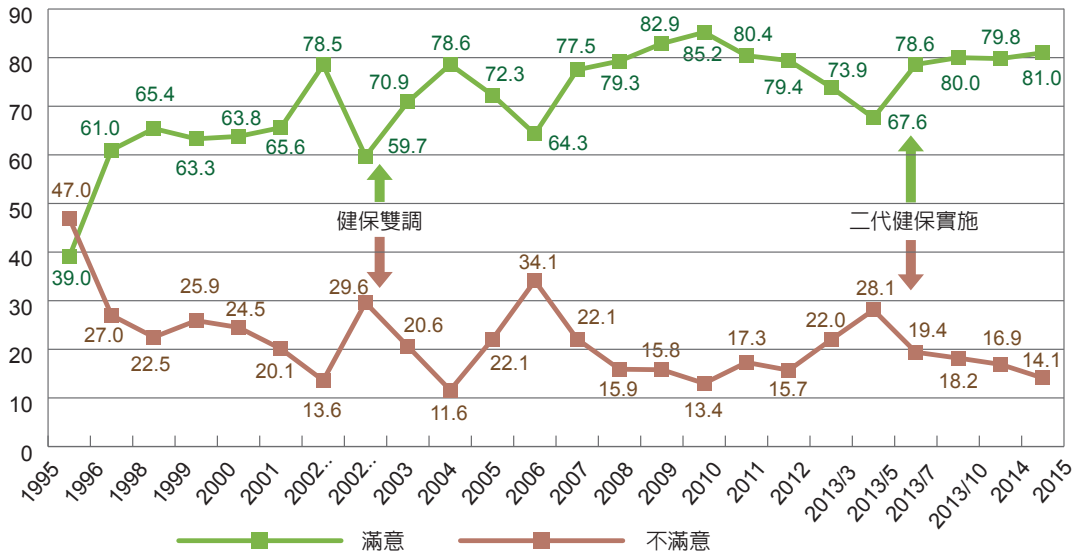
Delivering Satisfaction

The NHI system faced considerable challenges and resistance when it was first put in place, and public satisfaction with the program at its inception was below 40%. Today, the satisfaction rating is over 80%, reflecting the public's high degree of approval of the system. The NHI-program's satisfaction rating did take a plunge in 2002 when premiums and co-payments were increased, but it quickly recovered to above 70% in the following years and eventually climbed to above 80%. The second-generation health insurance program, which collects supplemental premiums from individuals with higher incomes, was introduced on January 1, 2013. In the six months following the launch, public satisfaction with the NHI system plunged to below 70% but rebounded to around 80% in the second half of the year (Chart 7). Life expectancy in Taiwan has risen from 74.5 years in 1995, the year the program was introduced, to 76.7 years for men and 83.3 years for women in 2013, and the standardized mortality rate has fallen considerably (Chart 8), gains that have been widely recognized by the public.

Controlling Health Care Costs

Taiwan's NHI system has been able to deliver convenient and good quality medical services while spending less on health care than other major countries. Adjusted for purchasing power parity, Taiwan's annual health expenditures per capita are US$2,546, about one-third the amount spent by the United States. Health care spending as a percentage of the total economy is also lower than for most countries, totaling just 6.6% of Taiwan's GDP (Chart 9).

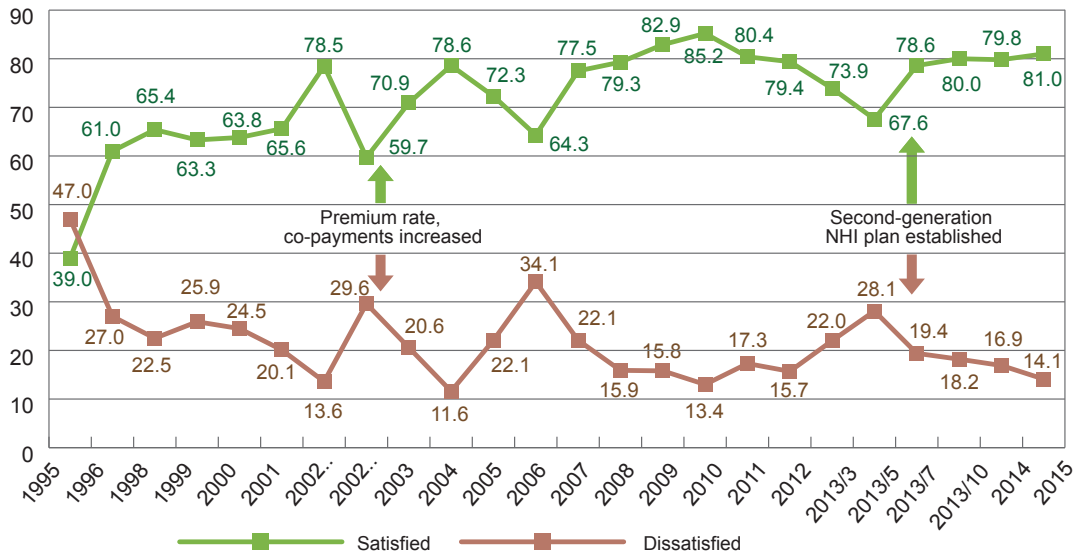
圖 7 全民健保歷年滿意度調查結果



註 1：2002 年，保險費率及部分負擔調整。

註 2：2013 年，二代健保實施。

Chart 7 NHI Public Satisfaction Ratings 1995-2014



Note 1: NHI premium rate and co-payments were increased in 2002.

Note 2: Second-generation health insurance program implemented in 2013

圖 8　健保開辦後死亡率降低

健保實施後民眾更長壽

開辦之前 15 年（1980-1995 年）	開辦之後 15 年（1995-2010 年）
標準化死亡率 ↓ 20.1%	標準化死亡率 ↓ 29.7%
平均餘命 男↑ 2.3 歲 / 女↑ 2.3 歲	平均餘命 男 4.3 ↑歲 / 女 4.8 ↑歲

註：1. 標準化死亡率：指依性別、年齡別等校正後肢死亡率
2. 平均餘命，指零歲以後平均尚可期待生存之年數
3. 2011 年國人平均餘命：男性 76 歲、女性 82.7 歲

資料來源：行政院衛生福利部、內政部

Chart 8　Standardized Mortality Rate Down Since Start of NHI Program

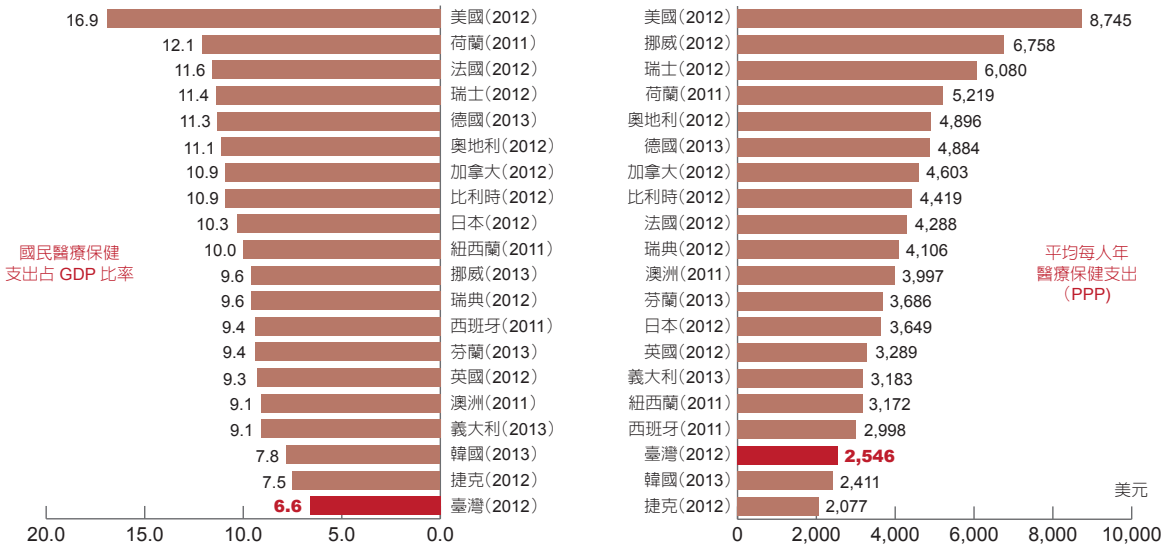
People living longer since NHI program's inception

15 years before NHI began (1980-1995)	15 years after NHI began (1995-2010)
Standardized mortality rate ↓ 20.1%	Standardized mortality rate ↓ 29.7%
Average life expectancy Men up ↑ 2.3 years/Women up ↑ 2.3 years	Average life expectancy Men 4.3 ↑ years/women up4.8 ↑ years

Notes: 1. Standardized mortality rate: Mortality rate of a population adjusted to a standard age and gender distribution.
2. Average life expectancy: Refers to the average number of years of life a person can expect to live from birth
3. Average life expectancy in Taiwan in 2011: men 76 years; women 82.7 years

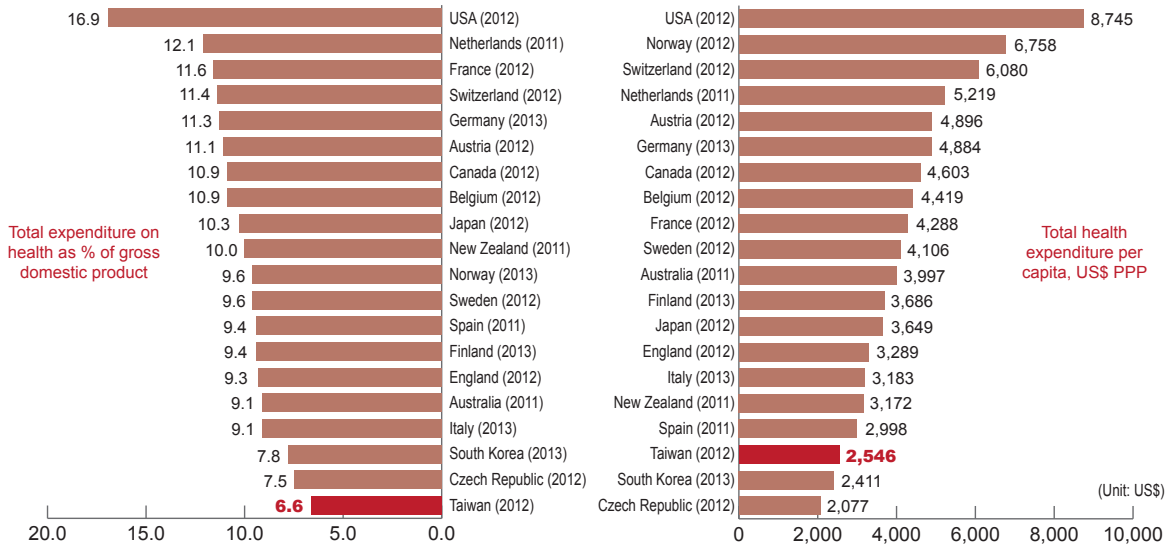
Source: MOHW, Ministry of the Interior

圖 9 我國醫療費用與世界主要國家之比較



資料來源：OECD Health Statistics 2014、衛生福利部 2014

Chart 9 Comparison of Health Care Spending in Taiwan and the World's Major Countries



Sources: OECD Health Statistics 2014
Ministry of Health and Welfare, 2014

充分發揮　互助功能

全民健保的核心價值在於透過社會互助，以「社會保險」的形式，來分擔保險對象罹病時的財務風險。重大傷病人口占全體保險對象人數的 3.87%，醫療費用卻高達健保總醫療支出的 27.30%。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 5.1 倍到 125.9 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 17）。

Harnessing the Power of Social Insurance

The core value underpinning Taiwan's NHI system is having all of society share the financial burden of caring for those who get sick through a social insurance mechanism. Patients with catastrophic illnesses account for 3.87% of those enrolled in the system but 27.30% of all NHI spending. The amount spend on patients with some of those illnesses, such as those with cancer or hemophilia or who regularly undergo renal dialysis, is 5.1 times to 125.9 times the amount spent on the average individual, an example of how the system's social insurance concept is fully harnessed. Because of that, patients with catastrophic illnesses are not driven into poverty by medical bills. (Table 17)

表 17　健保醫療資源利用情形

類別	醫療費用 (點)	平均值倍數
全國每人平均	26,380	1.0
每一重大傷病患者	181,276	6.9
每一癌症患者	135,595	5.1
每一罕病患者	468,161	17.7
每一洗腎患者	587,944	22.3
每一呼吸器患者	739,052	28.0
每一血友病患者	3,320,589	125.9

註：以 2014 年重大傷病年度統計資料為例。

Table 17　How NHI Resources are Used

Category	Medical Expense (Pts.)	Average Value Multiple
Average Individual	26,380	1.0
Average catastrophic illness patient	181,276	6.9
Average cancer patient	135,595	5.1
Average rare disease patient	468,161	17.7
Average kidney dialysis patient	587,944	22.3
Average patient on mechanical ventilation	739,052	28.0
Average hemophilia patient	3,320,589	125.9

Note: Above figures based on 2014 catastrophic illness statistics

Conclusion

Future Challenges and Responses

結語

跨步精進　展望未來

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

一、躍升雲端健康隨行

在這個醫療照護由疾病治療，導向自我照護及預防的時代，健保署將朝向以人為中心的全人照護發展，並配合衛生福利部臺灣健康雲計畫，以電子化為基礎，結合行動（Mobility）、雲端運算（Cloud Computing）、巨量資料（Big Data）及穿戴式裝置（Wearable Device）應用，持續推動以病人為中心的「健保雲端藥歷系統」及個人化的「健康存摺」系統，透過雲端服務將健保資料庫中的個人資料送還民眾，便捷與透明化的服務，將是促成未來醫療照護品質大幅提升的關鍵。

The NHI program has built an excellent reputation around the world through its many major accomplishments achieved through years of hard work, not only earning the praise of several countries but also serving as a reference for those developing or reforming health insurance systems. In looking to the future, changes in Taiwan's overall environment and social structure will likely pose new challenges to the NHI system as it faces medical resource constraints, but the NHIA will remain committed to reviewing and improving the system and promoting reforms in the following areas:

I. Cloud-based Health Advances

In an era where the general concept of health care is gradually evolving from a focus on the treatment of disease to an emphasis on self-care and prevention, the NHIA is putting a greater priority on developing people-oriented holistic care, in part by aligning digital programs with the Ministry of Health and Welfare's "Taiwan Health Cloud" project. Key steps in that direction are the patient-oriented "NHI PharmaCloud System" and personalized "My Health Bank" platform, which make use of mobile and wearable devices, cloud computing and Big Data to provide convenient and transparent cloud services that put people's personal information back in their hands. These services will be critical to dramatically improving the quality of care in the future.

為提升電子化資料的可近性，健保署於2015年3月率先於各分區業務組及聯絡辦公室設置健康存摺查詢服務據點，提供協助申請「健康存摺」服務，讓民眾在等待辦理其他健保業務時，可先註冊健保卡密碼，再至設置的公用電腦申請及下載「健康存摺」，並與各醫療院所合作及設置服務據點，協助家中沒有電腦、網路或讀卡機的民眾，以及不熟稔網路之族群，如老年族群，提供臨櫃服務，方便使用隨身碟存取或電子郵件儲存。未來也會有更多元的登入方式，透過手機或平板電腦的「健保快易通」APP程式，即可下載個人健康存摺資料，貫徹健康隨行的概念。

To improve accessibility to digital information, the NHIA set up "My Health Bank" service stations at branches and liaison offices in March 2015. People can use the stations to register their NHI Card passwords in the system and then use the computer provided to apply for and download "My Health Bank" data. The NHIA is also collaborating with medical institutions to set up service stations on their premises that offer assistance in accessing "My Health Bank" to people or families without computers, Internet access or IC card readers or those lacking Internet skills, such as the elderly. In October 2015, more log-in options were introduced, including an "NHI Fast Connection" app for smartphones and tablet computers that allows people to download their "My Health Bank" information at any time – making the concept of "health at your side" a reality.

健康存摺網頁

健保快易通

Download for Android

Download for iOS

未來健保署將以打造「個人健康 profile」為目標，積極推展整合跨機關健康資料，提供單一窗口即時服務，幫助民眾提升自我健康管理能力，甚至著眼於與產業應用合作，驅動照護、健康產業及商業創意的結合，並規劃擴展為從出生到終老的「終身照護資料庫」，強化珍惜醫療資源觀念，加值健保服務滿意度。

The NHIA ultimately hopes to create a "Personal Health Profile" that integrates health information across many organizations and agencies to provide single-window real-time services. It will further empower people to manage their own health. There is even the hope of extending the system into a "Lifetime Care Database" that will strengthen appreciation for medical resources. The NHIA also hopes to collaborate with the medical sector to come up with creative commercial applications for the database.

二、急性後期貼心照護

健保署自 2014 年 3 月起率亞洲之先，推動「提升急性後期照護品質試辦計畫 (Post-Acute Care, PAC)」，以合併症及併發症較多、且病人也多的腦中風疾病優先試辦；共挑選 39 個團隊 129 家醫院參加，涵蓋全國包含澎湖、金門、連江等各縣市。急性後期照護模式是建構急性照護與長期照護之垂直整合轉銜系統，對治療黃金期之病人給予積極性之整合性照護，使其恢復功能健康返家，減少後續再住院醫療支出，提升照護連續性及品質。

截至 2015 年 6 月底，有 157 家承作醫院結合 23 家上游醫院共 180 家醫院參加 PAC 計畫。收案 3,150 人，87% 結案病人整體功能有進步，84% 回歸社區居家或門診復健。巴氏量表由平均不到 40 分 (顯著依賴等級) 進步到 63 分以上 (功能獨立等級)，接受 PAC 者計畫者較功能相當且未參加者的再住院率、急診率、死亡率低，試辦成效良好。

II. Promoting Post-acute Care

In March 2014, the NHIA introduced a pilot program to improve post-acute care – the first of its kind in Asia – targeted mainly at stroke patients with complications and comorbidities. A total of 39 medical teams from 129 hospitals are participating in the program, which covers every county and city in Taiwan, including the outlying counties of Penghu, Kinmen and Lienchiang.

The post-acute care services model is founded on a vertically integrated transfer system that integrates acute care, post-acute care and long-term care and delivers integrated care to patients during their golden treatment period. That enables them to recover quickly and return home, resulting in lower spending on follow-up re-hospitalization and enhancing the continuity and quality of care.

As of the end of June 2015, there were 180 hospitals participating in the post-acute care program that had treated or were still treating 3,150 paitients. A total of 87% of the patients who had completed their care regimen had improved, and 84% were able to get by with rehabilitation therapy at home or on an outpatient basis. Their Barthel Index scores, which averaged below 40 when they began the trial (indicating severe dependency), had risen to 63 (indicating only moderate dependency). Also, compared with other stroke patients in similar condition, the re-hospitalization rate, the emergency room visit rate and the mortality rate of the trial patients was lower, indicating that the pilot post-acute care program has been beneficial.

因應八仙樂園粉塵暴燃事件發生，大量燒傷病人之復健需求，健保署於 2015 年 9 月 9 日公告實施高強度復健整合之「全民健康保險燒燙傷急性後期整合照護計畫（BPAC）」，期能提供該患者整合醫療，縮短復健時間，早日回歸社會。

為讓更多失能病人能接受更好之整合照護，健保署召開專家會議研議下階段急性後期照護將以功能別為導向，納入更多及需復健且有復健潛能的失能病人，期使病人恢復功能返家，也減少後續家庭照顧、醫療支出及社會成本，達成多贏局面。

In response to the major rehabilitation needs of the hundreds of burn victims in the Formosa Fun Coast water park dust explosions, the NHIA announced on Sept. 9 an "Integrated Post-acute Care Program for Burns" to provide the victims integrated care, shorten their rehabilitation times and help them resume their lives in society as quickly as possible.

Another initiative is being developed to help incapacitated patients receive better integrated care. The NHIA has convened meetings with experts to chart the next phase of the post-acute care project and make it more function-oriented by including more incapacitated people who need rehabilitation therapy and stand to benefit from it. The goal is to help them better function on their own so they can return home, lessen the need for follow-up home care and reduce medical expenses and social costs.

三、便民服務貼近需求

健保署致力提升改善健保服務，提供更加便民的措施，目前健保署設有 6 個分區業務組，每個分區業務組於人口密集、交通便利處設有 21 個聯絡辦公室作為對外服務據點，以便民眾申請納保、欠費處理等臨櫃服務。自 2008 年健保署更打破距離限制，實施「行動辦公室」服務，直接深入偏鄉山地離島地區，積極協助當地居民得到貼心的健保服務，保障健康及就醫權利。只要一張 3.5G 的行動網卡就能在廟口的大樹下成為健保署的服務據點，展開上山下海為民服務的旅程。行動辦公室專案小組出發前會先行篩選需要服務的地區及對象，透過當地里長協助週知聯繫，確保提供適當的服務，貼近民眾的需求。

III. Convenient Services that Meet Needs

Committed to upgrading and improving the country's health insurance services, the NHIA wants to make life as convenient as possible for the public. It has six regional divisions, and those divisions have set up 21 liaison offices in densely populated, easily accessible parts of the country to provide greater convenience to people who want to enroll in the program, pay premiums they owe or handle other matters. In 2008, the NHIA further improved access to services by setting up "mobile office services" that extended NHI services into previously underserved areas. With a 3.5G mobile broadband card, even the shaded area under a tree outside a temple can become an NHIA service outlet. Before launching the function, the mobile office task force first identified areas and target segments that needed the services and then asked ward chiefs in those areas to spread the word to ensure that the appropriate services were being offered and meeting the public's needs.

此外，從 2015 年 7 月開始，全民健保結合戶政系統，民眾到戶政事務所申請補發、換發身分證時，可以同時申辦健保卡，且新生兒申報出生登記時，也可以直接辦理投保及申請製發無照片的健保卡，省去往返多機關臨櫃申辦的不便。民眾也可以透過網路查詢欠費、申請電子繳款單及中英文投保證明，屬第 6 類保險對象者（無職業地區人口）亦可在網路上申請加退保、停保及復保等。隨著網路行動裝置的普及，自 2015 年 5 月起新增透過行動網路利用全國繳費網設定活期帳戶，供讓民眾自由選擇最方便的方式繳納健保費。

未來健保署將持續改善便民服務，包括透過行動裝置 APP 下載健康存摺、行動櫃檯服務、醫療院所線上查詢等功能，以拉近距離、一次到位的目標，不斷將貼心的健保服務帶到民眾身邊。未來健保卡更規劃提升加值功能，結合其他憑證或電子支付、行動化服務等功能，提升為新一代的保險憑證，讓民眾一卡在手，隨心應用。

Beginning in July 2015, the NHIA begin collaborating with household registration systems across the country to save people time running around to get different certificates. The plan enables people to apply for an NHI card when applying for a replacement or new ID card at a household registration office. The same goes for a newly born child; when parents apply for the child's birth certificate, they can also directly register their child in the NHI program and apply for an NHI card without a photo.

People can also go online to see if they owe premiums and apply for e-bills or proof of insurance registration in Chinese and English. Those insured under Category 6 (the unemployed) can even apply to enroll in or withdraw from the insurance program or suspend or resume their coverage. In recognition of the growing popularity of mobile devices, people were able to use mobile devices beginning in May 2015 to set up an account online through a mobile device on the national "e-bill" payment network to pay their health insurance premiums with the greatest convenience.

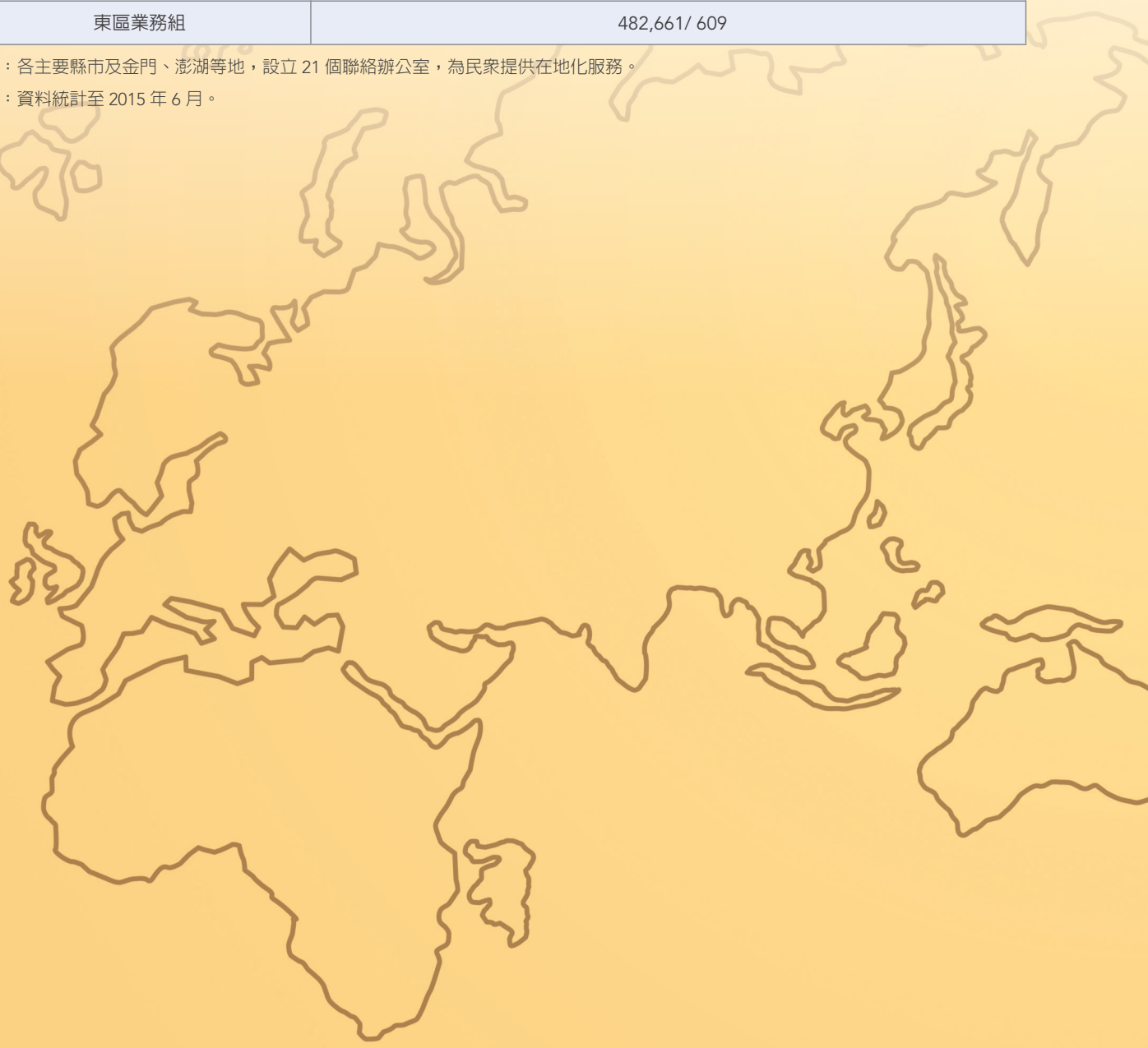
The NHIA will remain fully committed in the future to make its services even more convenient, including the creation of a mobile app through which users can download "My Health Bank" information, access mobile counter services and search the online systems of hospitals and clinics, all so that people can handle their health insurance needs at one time. Plans are also being made to improve the value-added services of the NHI card by incorporating other types of electronic payment or mobile service functions and converting it into a versatile new-generation "insurance certificate" that can be used as needed.

附　錄　中央健康保險署各分區業務組

業務組別	保險對象人數 / 特約醫事服務機構
總 計	23,644,464/ 27,457
臺北業務組	8,774,310/ 8,835
北區業務組	3,719,084/ 3,580
中區業務組	4,275,475/ 5,898
南區業務組	3,094,450/ 4,069
高屏業務組	3,298,484/ 4,466
東區業務組	482,661/ 609

註 1：各主要縣市及金門、澎湖等地，設立 21 個聯絡辦公室，為民眾提供在地化服務。

註 2：資料統計至 2015 年 6 月。



APPENDIX NHIA Divisions

Division	No. of Insured/Contracted Medical Institutions
Total	23,644,464/ 27,457
Taipei Division	8,774,310/ 8,835
Northern Division	3,719,084/ 3,580
Central Division	4,275,475/ 5,898
Southern Division	3,094,450/ 4,069
KaoPing Division	3,298,484/ 4,466
Eastern Division	482,661/ 609

Note 1: A total of 21 liaison offices have been set up in major cities and counties around the country, including in Kinmen and Penghu, to provide local services.

Note 2: The figures above are as of June 2015.

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