2017-2018
National Health Insurance Annual Report

全民健康保險年報

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全民健康保險
NATIONAL HEALTH INSURANCE
SAVE

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前言 署長的話

Preface Message from the Director General

全民健康保險立基於增進全體國民健康，經過多年的耕耘，納保率已達99.6%，醫療院所特約率亦接近93%，近年來滿意度平均維持在八成以上。而台灣全民健保制度「普及、方便、經濟、滿意度高」的成就，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。因此每年吸引多國外賓慕名來訪，每年均有約700位的外賓參訪瞭解全民健保的成就。

回顧過去一年，為落實全民健保照顧弱勢族群的核心價值，自2016年6月起，健保署啓動健保全面解卡政策，實踐醫療人權普世價值，徹底排除弱勢民眾就醫障礙，同時也透過相關計畫，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，此外，健保署更陸續和鄉鎮市公所合作，提供偏遠地區民眾在地製卡服務，現場申領健保卡的即時健保服務，免去申請換補發的等待期與不便，實現「就醫平權」的理念，提供全民完整的醫療保障。

在支出面，因健保資源有限，為使醫療資源能被更妥善使用，健保署配合衛福部自2016年6月起即研議規劃加強推動分級醫療，擬定六大策略及相關配套逐步實施，以鼓勵民眾至基層院所就醫，如醫師專業認定有醫療上之需求，將協助轉診至適當科別院所，以強化大醫院專注於治療重症及醫學研究的功能，基層院所則成為民眾健康第一線守門員，並於2017年4月15日起調整門診、急診就醫應自行負擔之部分醫療費用（通稱部分負擔）、修正轉診辦法，引導民眾改變就醫習慣，以落實雙向轉診。

健保署也運用資訊科技建置「健保醫療資訊雲端查詢系統」提供醫師及藥事人員病患處方及診斷紀錄，保障民眾就醫用藥安全，以及供民眾使用的「健康存摺」系統，提供民眾查詢最近3年的個人就醫資料，使民眾透過簡潔易懂的圖像及分類篩選功能，方便民眾瞭解個人醫療利用情形、疾病就醫歷程及醫師處置方式、用藥等，甚至運用系統內建功能，預估個人罹患肝癌的機率，還能評估腎臟功能狀態，成為個人自我健康管理的好幫手。

感謝各界的支持與守護，全民健保渡過第23年，健保署將更積極回應民眾對高品質醫療服務的期待，加強與各界協商溝通，並利用大數據分析，提供更符合民眾期待的健康照護服務、創造更優質的醫療工作環境及維持我國全民健保制度的永續經營。

衛生福利部中央健康保險署　署長

李伯璋

The National Health Insurance (NHI) was implemented to promote the health of all citizens. After years of intensive effort, the NHI system now covers 99.6% of Taiwan's residents, has service contracts with 93% of the country's hospitals and clinics, and has maintained an average satisfaction level of over 80% in recent years. By achieving its goals of being "universal, accessible, affordable, and highly satisfactory," the NHI system has attained global prestige, not only earning worldwide acclaim, but also serving as a model for other countries wishing to establish or reform health insurance systems. Taiwan has attracted numerous foreign guests from around the world for this reason, and approximately 700 foreign visitors come to Taiwan each year to learn about the NHI's achievements.

Looking back on the past year, in order to fulfill its core value of care for disadvantaged groups, the National Health Insurance Administration （NHIA）initiated a policy to reactivate all health insurance cards previously suspended for failure to pay premiums in June 2016, honoring the universal human right to healthcare and eliminating obstacles to care faced by the disadvantaged. The NHIA has also launched several projects to bring local medical services to underserved areas, including remote mountainous regions and offshore islands. The NHIA has also been collaborating with city, town, and township administrative offices to produce NHI cards on site, enabling residents of isolated areas to obtain a new NHI card immediately when applying for card replacement or renewal. This action epitomizes the NHIA's commitment to the equal right to care and provision of medical protection to all citizens.

With regard to expenditures, to ensure that the country's limited health insurance resources are used more effectively, starting in June 2016, the NHIA has worked with the Ministry of Health and Welfare to draft and gradually implement six major strategies and accompanying measures intended to strengthen the promotion of a hierarchically integrated healthcare system. These strategies encourage members of the public to first seek care at primary-level hospitals and clinics; then if needed, the primary care doctor would refer them to an appropriate specialist hospital department or clinic for further care. This approach allows large hospitals to strengthen their focus on medical research and the treatment of major illnesses, while making primary-level hospitals and clinics the front-line sentries of the healthcare system. Furthermore, on April 15, 2017, the NHIA adjusted the co-payments for outpatient and emergency care, and revised referral regulations in an effort to change the public's habitual approach to seeking medical care and thus realize a two-way referral system.

The NHIA has used information technology to establish the "NHI MediCloud" database, which provides doctors and pharmacy personnel patient prescriptions and diagnostic records, while maintaining the public's medication safety. At the same time, the NHIA has made the "My Health Bank" system available to the public wishing to query their personal medical records from the most recent three years; this system allows users to use graphics and categorized functions to understand their personal medical utilization, disease treatment processes and doctors' treatment methods, and medication use. Users can even employ the system's built-in functions to estimate their chances of contracting liver cancer or assess the state of their kidney function, making this a useful personal health management assistant.

Thanks to everyone's support, the NHI has came through the 23rd year. To meet the public's expectation of high-quality healthcare, the NHIA plans to strengthen communication with relevant stakeholders, and to employ big data analysis to provide healthcare services better satisfying the public's expectations, improve the healthcare working environment, and maintain the sustainability of Taiwan's NHI system.

Po-Chang Lee
Director General
National Health Insurance Administration
Ministry of Health and Welfare

Chapter 1

組織沿革　承先啓後

Organization and History


健保22週年
與護升級再向前
推動分級醫療
落實雙向轉診
NATIONAL HEALTH INSURANCE
ADMINISTRATION, MINISTRY OF
HEALTH AND WELFARE
衛生福利部
中央健康保險署

組織沿革　承先啓後
Organization and History

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

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

為有效推動全民健保各項服務，健保署除依業務專業性質設置專業組室，規劃各項業務

陳時中部長視察健保重要業務會議
Minister Chih-Chung Chen visited the NHIA to inspect important issues of the NHI.

中央健康保險署 107 年度重大政策共識營
Executives Meeting for Discussing NHI Major Policies for 2018

The National Health Insurance Administration was previously known as the "Bureau of National Health Insurance, Department of Health, Executive Yuan." When the Bureau was launched in 1995, only roughly 59% of citizens were eligible to participate in the three major occupational medical insurance systems: Labor Insurance, Farmers' Insurance, and Government Employee Health Insurance. In line with the principles of sustainability and concern for the disadvantaged, these insurance systems were merged and enlarged to become a social insurance system covering all citizens. The BNHI was repositioned in 2010 as an "administrative agency" and renamed as the National Health Insurance Administration in 2013 as part of a government reorganization plan.

The National Health Insurance is a government-implemented social insurance, and has the Ministry of Health and Welfare as its competent authority. The Ministry of Health and Welfare has established the National Health Insurance Committee to assist with the planning of NHI policies and to supervise the implementation of insurance matters. It also established the National Health Insurance Mediation Committee to handle disputes concerning health insurance. As the insurer, the NHIA bears responsibility for the implementation of health insurance matters, healthcare quality and information management, research and development, and human resource training. Administrative funding needed by NHIA is provided by the central government through a budgetary process.

In order to effectively promote various NHI services, apart from establishing specialized departments and offices（Chart 1-1）in accordance with the nature of specific services and planning the promotion of service measures, the NHIA has established six regional divisions throughout Taiwan（Table 1-1）. These directly handle underwriting, insurance premium collection, medical expense review and approval, and the management of contracted medical service organizations. At the same time, the NHIA has established 21 contact offices to serve local residents. As of June 30, 2017, the NHIA had 2,831 employees.

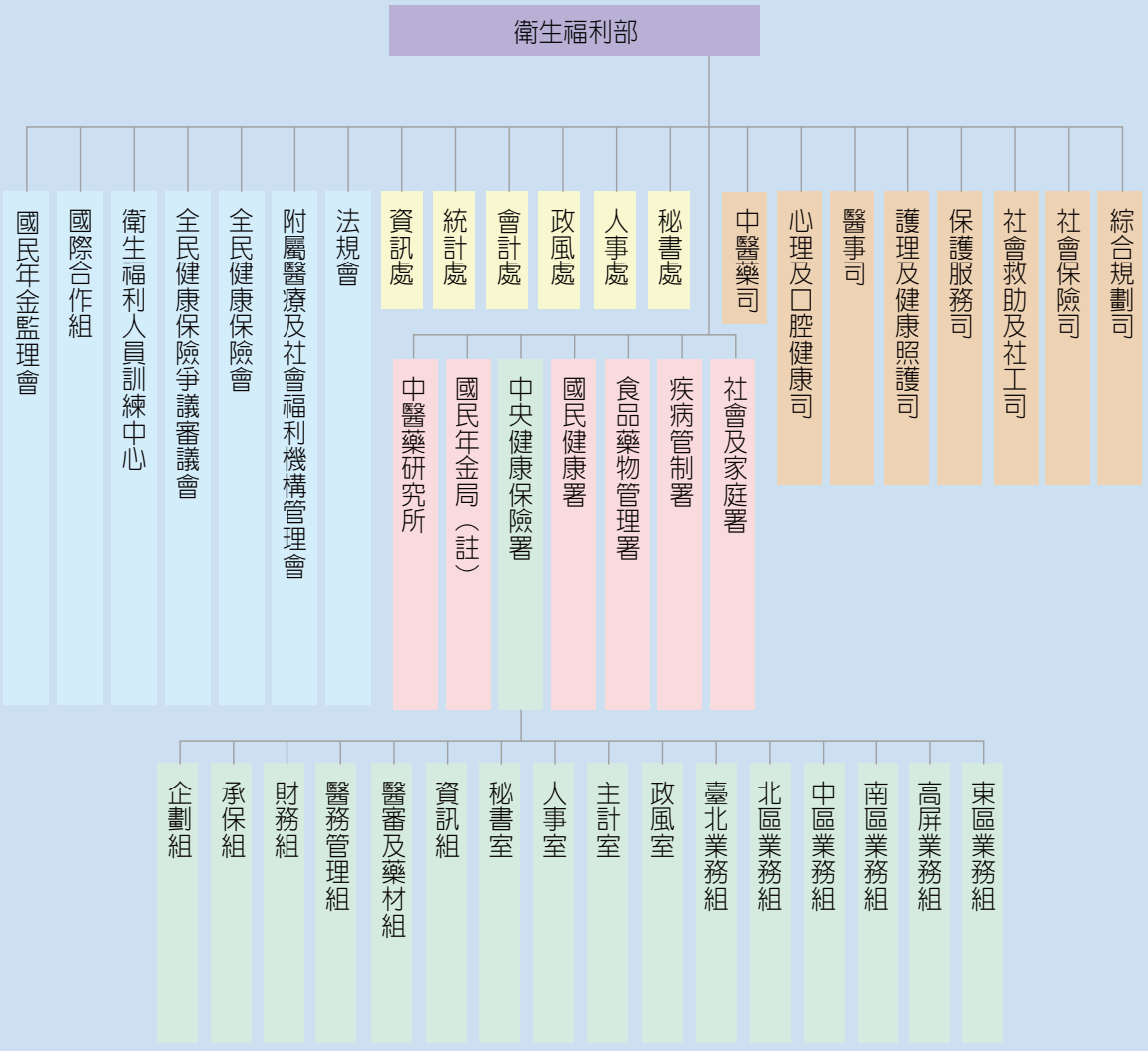
表 1-1　中央健康保險署各分區業務組
Table 1-1　The National Health Insurance Administration's Regional Divisions

業務組別 Division	保險對象人數/特約醫事服務機構 Number of insured/Contracted medical service organizations
總計 Total	23,832,551 / 28,113
臺北業務組 Taipei Division	8,876,864 / 9,021
北區業務組 Northern Division	3,791,951 / 3,679
中區業務組 Central Division	4,310,694 / 6,035
南區業務組 Southern Division	3,086,266 / 4,157
高屏業務組 Kaoping Division	3,290,618 / 4,593
東區業務組 Eastern Division	476,158 / 628

註1：各主要縣市及金門、澎湖等地，設立7個聯合服務中心及21個聯絡辦公室，為民衆提供在地化服務。
註2：資料統計至2017年6月。
Note 1: Seven united services centers and 21 lisaison offices in major cities and counties, and on Kinmen and Penghu, have been established to provide local services to the public.
Note 2: Updated to June 2017.

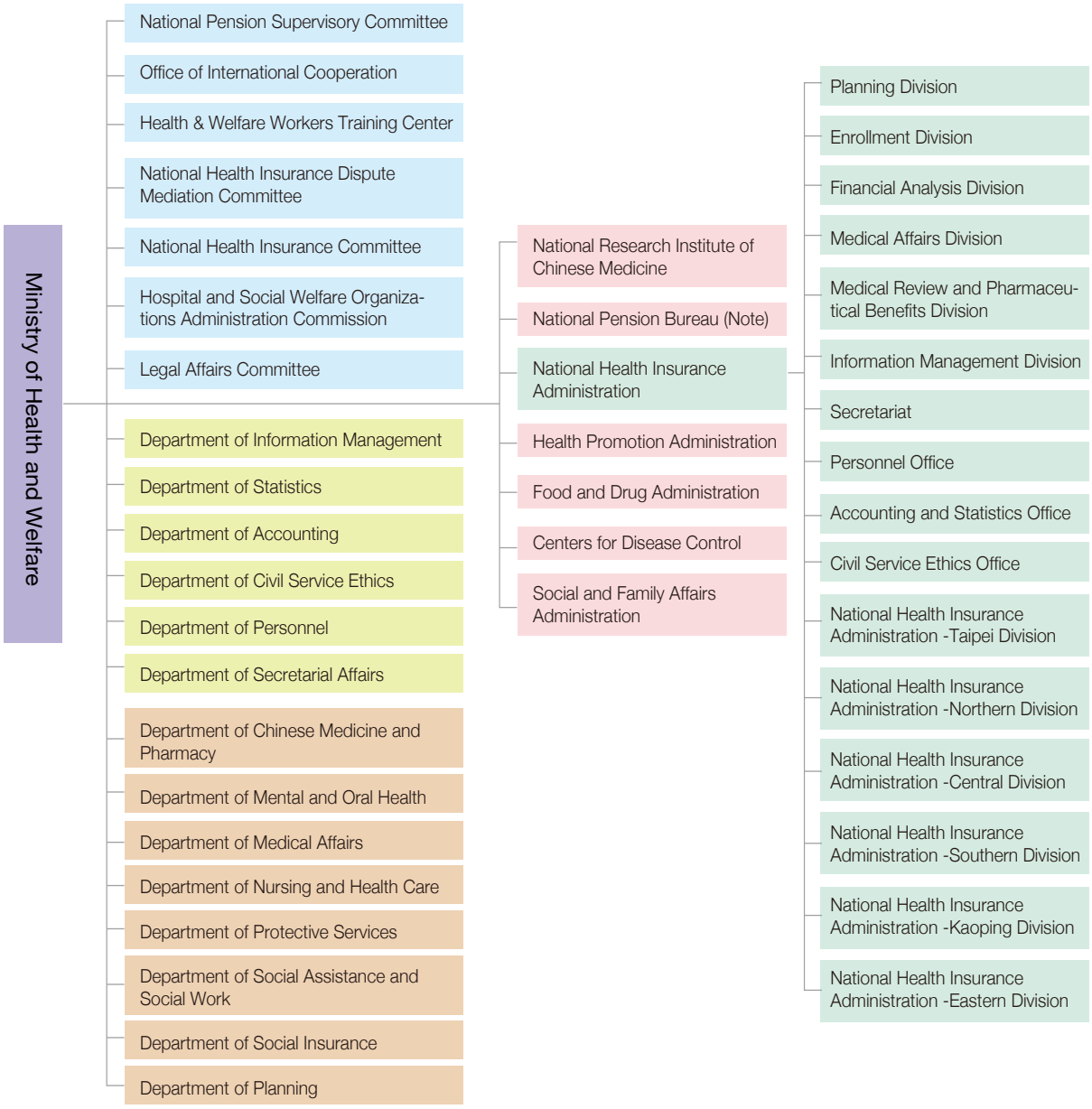
措施之推動，在各地設有6個分區業務組（表1-1），直接辦理承保作業、保險費收繳、醫療費用審查核付及特約醫事服務機構管理等服務，同時設置21個聯絡辦公室，服務在地民眾。至2017年6月30日，人員編制共有2,831名。

圖1-1　全民健康保險組織架構圖



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

Chart 1 -1 NHIA Organization Chart



Note: The National Pension Bureau has yet to be established. The Organization Act of Ministry of Health and Welfare stipulates that before the Bureau is set up, its responsibilities may be commissioned to other agencies.

Chapter 2

全民有保　財務永續

Universal Coverage and Financial Sustainability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全民有保　財務永續
Universal Coverage and Financial Sustainability

全民有保　就醫平權

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

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

表2-1 全民健保保險對象分類及其投保單位
Table 2-1 Classification of the Insured and Their Insured Units

類別 Category	保險對象 NHI Enrolles		投保單位 Insured Units
	本人 The Insured	眷屬 Dependents	
第1類 Category 1	公務人員、志願役軍人、公職人員 Civil servants, volunteer military personnel, public office holders	1.被保險人之無職業配偶。 2.被保險人之無職業直系血親尊親屬。 3.被保險人之2親等內直系血親卑親屬未滿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。 1.Unemployed spouse. 2.Unemployed lineal blood ascendants. 3.Unemployed lineal blood descendants within 2nd degree of relationship under 20, or above 20 but incapable of making a living,including those in school.	所屬機關、學校、公司、團體或個人 Organizations, schools, companies, groups, or individuals
	私校教職員 Private school teachers and employees		
	公民營事業、機構等有一定雇主的受僱者 Employees of public and private enterprises and organizations		
	雇主、自營業主、專門職業及技術人員自行執業者 Employers, the self-employed, and independent professionals and technical specialists		
第2類 Category 2	職業工會會員、外僱船員 Occupational union members, foreign crew members	同第1類眷屬 Same as category 1	所屬的工會、船長公會、海員總工會 Unions, the Master Mariners Associations, the National Chinese Seamen's Unions

Health Care for All with Equal Right to Healthcare

The government's original intention in providing the National Health Insurance program was to provide health security to all citizens via a mutually assisted system. The system was designed to ensure that everyone enjoyed equal rights to healthcare, including groups outside the working population prior to the system's inception, such as dependents, veterans, and the unemployed, including women, students, children, and the elderly. The inclusion of these groups in the program meant that all citizens have equal rights to access medical services when they get sick, are injured, or give birth. Based on this framework, all persons who are citizens of the Republic of China（Taiwan）and have had a registered domicile in the Taiwan area for six months or more, and all infants born in the Taiwan area, must participate in the NHI program. There are six categories of insureds（Table 2-1）, which provide the basis for the calculation of insurance premiums.

In line with recent societal changes and in consideration of human rights and the principle of fairness, the NHI system has been revised several times over the years. Coverage has gradually expanded to include new immigrant residents, foreign white collar workers stationed in Taiwan long-term, overseas Chinese and foreign students, and military personnel within Taiwan's NHI system.

To further achieve the vision of equal access to treatment and right to medical care, following the implementation of second-generation health insurance, inmates at correctional facilities have also been included in the system. ROC nationals who have lived abroad for an extended period of time and wish to re-enroll in the program 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. Foreigners must also have resided in Taiwan for at least six months before they can participate in the system. These changes reflect society's expectation of fairness and justice.

類別 Category	保險對象 NHI Enrollees		投保單位 Insured Units
	本人 Insured	眷屬 Dependents	
第3類 Category 3	農、漁民、水利會會員 Members of farmers, fishermen and irrigation associations	同第1類眷屬 Same as categorg 1	農會、漁會、水利會 Farmers' associations, fishermen's associations; or irrigation associations
第4類 Category 4	義務役軍人、軍校軍費生、在卹遺眷 Conscripted servicemen, students in military schools, dependents of military servicemen on pensions	無 None	國防部指定之單位 Agencies designated by the Ministry of Defense
	替代役役男 Males performing alternative military service	無 None	內政部指定之單位 Agencies designated by the Ministry of the Interior
	矯正機關受刑人 Inmates at correctional facilities	無 None	法務部及國防部指定之單位 Agencies designated by the Ministry of Justice
第5類 Category 5	合於社會救助法規定的低收入戶成員 Members of low-income households as defined by Public Assistance Act	無 None	戶籍地的鄉（鎮、市、區）公所 Administrative office of the village, township, city or district where the household is registered
第6類 Category6	榮民、榮民遺眷家戶代表 Veterans or dependents of deceased veterans	1.榮民之無職業配偶。 2.榮民之無職業直系血親尊親屬。 3.榮民之2親等內直系血親卑親屬未滿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。 1.Unemployed spouse. 2.Unemployed lineal blood ascendants. 3.Unemployed lineal blood descendants within 2nd degree of relationship under 20, or above 20 but incapable of making a living,including those in school.	戶籍地的鄉（鎮、市、區）公所 Administrative office of the village, township, city or district where the household is registered
	一般家戶戶長或家戶代表 Heads of households or household representatives	同第1類眷屬 Same as Category 1	

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。

Notes: 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.

As of the end of June 2017, a total of 23,832,551 people were participating in NHI（Table 2-2）, and there were 868,866 insured units.

Balanced Finances and Sustainable Operations

Since it integrated Taiwan's various social insurance systems in 1995, the NHI system has been operated under financial self-sufficiency, and pay-as-you-go principles. At present, the system derives its income chiefly from premiums paid by the insured, employers, and the government, and the system also receives supplementary funds in the form of premium overdue charges, public welfare lottery earnings distributions, and tobacco health and welfare surcharges.

As Taiwan's overall environment and demographic structure have changed, medical expenses have increased at a faster rate than premium income. Apart from acting vigorously to conserve funds and develop new sources of income, NHIA raised the premium rate in 2002 and again in 2010. Bearing in mind the insured's ability to pay, it has also made gradual adjustments to the upper and lower limits, and intervals of the payroll bracket table used to calculate insurance premiums, and the cap on the number of dependents for whom premiums are collected. Military personnel, civil servants and teachers, whose premiums were once calculated on their base salaries, now pay premiums based on their total compensation. A supplemental premium is now collected on six types of income not previously included in premium calculations, and the lower limit of the government's contribution is now clearly specified. All of these measures have served to stabilize NHI's finances and maintain the NHI system's operation and balance.

Following the implementation of the 2nd-generation NHI in 2013, an income/expenditure linkage mechanism was established, and the NHI Supervisory Committee（responsible for management of income）and the NHI Medical Expenditure Negotiation Committee（responsible for negotiating expenditures）were merged as the National Health Insurance Committee. This committee, which comprises the insured, employers, medical service providers, experts and scholars, impartial public figures, and the representatives of relevant agencies, is responsible for reviewing the premium rates and the scope of insurance payments. It is responsible for negotiating, determining, and allocating total annual medical payment expenses. It is hoped that the income/expenditure linkage mechanism will ensure long-term financial stability.

The NHI system's financial situation improved significantly following implementation

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。

截至2017年6月底止，參加全民健保的總人數有23,832,551人（表2-2），投保單位有868,866家。

財務平衡 永續經營

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

然而，隨著整體環境與社會人口結構等影響，醫療支出增加速度遠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年及2010年兩次調高保險費率，更以量能負擔的精神，陸續調整投保金額分級表上下限與級距及最高付費眷屬人數、逐年將軍公教人員由本薪改以全薪投保、將未列入投保金額的六項所得計收補充保費、明確規範政府負擔比率下限等，積極穩固財務，維持全民健保系統運作及平衡。

2013年二代健保實施後建立收支連動的機制，將「全民健康保險監理委員會」（收入面監督）及「全民健康保險醫療費用協定委員會」（支出面協定）整併為「全民健康保險會」，並由被保險人、雇主、保險醫事服務提供者、專家學者、公正人士及有關機關代表組成，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，期透過收支連動機制，確保長期財務穩定。

二代健保實施後，因擴大費基收繳補充保險費及政府總負擔比率提高等財源挹注，保費收取更符合量能負擔的公平原則，財務亦明顯改善（圖2-1）。故依據「全民健保財務平衡及收支連動機制」，自2016年1月1日起，一般保

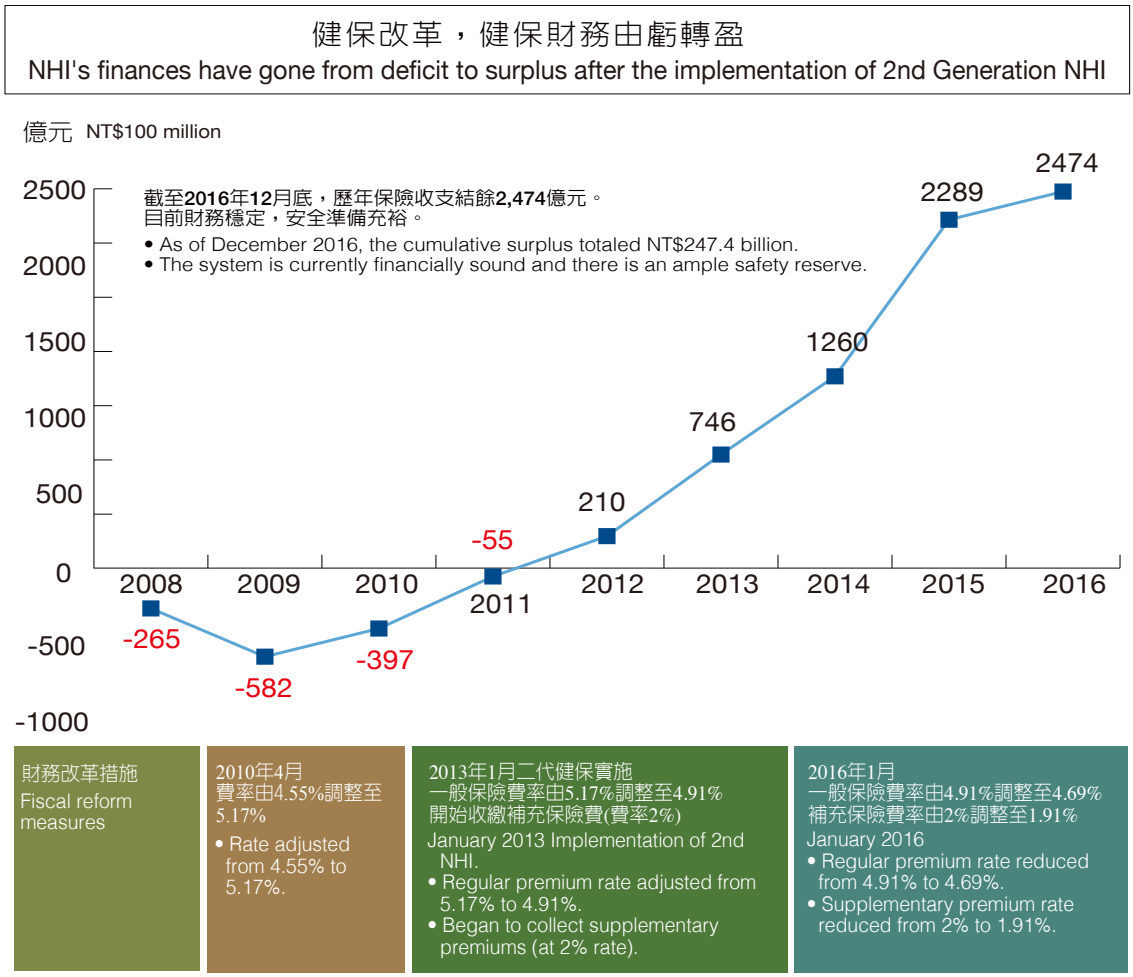
表2-2 全民健保各類保險對象人數
Table 2-2 Number of Insured in NHI System

	第1類 Category 1	第2類 Category 2	第3類 Category 3	第4類 Category 4	第5類 Category 5	第6類 Category 6	總計 Total
人數 Insured	13,704,234	3,701,771	2,338,085	140,590	308,537	3,639,334	23,832,551
占總納保人數百分比 Percentage of the Insured	57.51%	15.53%	9.81%	0.59%	1.29%	15.27%	100%

資料時間：2017年6月30日。
Dated: June 30, 2017.

of the 2nd-generation NHI, due to the collection of supplemental premiums on an expanded revenue base and the increase in the government's overall contribution rate. The NHI's greater sources of funding allowed collection of premiums to comply more closely with the ability to pay, and the insurance system's financial situation improved significantly（Chart 2-1）. As a consequence, in accordance with the "NHI financial balance and revenue-expenditure linkage mechanism," starting on January 1, 2016, the regular insurance premium rate was reduced from 4.91% to 4.69%, and the supplementary premium rate was lowered from 2% to 1.91%. In addition, in accordance with public sentiment, starting in 2016, the threshold for collecting supplementary premium for one-time professional service income, stock dividend income, interest income, and rental income payments, was adjusted upwards from NT$5,000 to NT$20,000. Furthermore, the NHIA has strengthened the auditing and monitoring of supplementary premiums on capital gains. As of the end of June 2017, the cumulative balance was NT$246.3 billion.

圖2-1 Chart 2-1　二代健保實施前後財務收支累計餘絀情形
Cumulative Balance before and after the 2nd Generation NHI



險費費率由4.91%調降為4.69%，補充保險費費率連動由2%調降為1.91%。此外，為回應民情，自2016年起執行業務收入、股利所得、利息所得及租金收入單次給付金額扣取下限由5,000元調整為2萬元；另加強資本利得補充保險費查核及監控；截至2017年6月底保險收支累計結餘為2,463億元。

目前財務狀況穩定，惟因人口老化及醫療科技進步等因素，長期仍將面臨財務壓力，健保署將持續進行制度檢討並研議更穩健之財務制度，以確保長期財務健全，負擔更加公平合理。

一般保險費的計算

全民健保的一般保險費費率自開辦起到2002年8月底均維持4.25%，2002年9月起調整為4.55%；2010年4月為穩固健保財務，調整至5.17%。二代健保實施後，因加收補充保險費（當時費率為2%），一般保險費費率從2013年1月1日起調整為4.91%；2016年1月起一般保險費費率調整為4.69%，補充保險費費率連動調整為1.91%。平均眷屬人數亦經過多次的調整，由開辦時的1.36人調整至現今的0.61人。

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

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2017年1月1日起共有50級（表2-5）。第1類被保險人的投保金額，由投保單位（雇主）依被保險人每月的薪資所得，對照該表所屬的等級申報；第2類無一定雇主勞工被保險人的最低投保金額及第3類農民、漁民、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

二代健保實施後，除了以經常性薪資對照投保金額所計算出的「一般保險費」之外，再加上「補充保險費」，把以往沒有列入投保金額計算的高額獎金、兼職所得、執行業務收入、股利所得、利息所得或租金收入等項目，

Although NHI's financial status is currently stable, Taiwan's aging population and advances in medical technology will inevitably put financial pressure on the system in the long term. In an effort to ensure long-term financial soundness and an even fairer and more reasonable financial burden, the NHIA will continue to perform systematic reviews and take steps to ensure an even more stable financial system.

Calculation of Regular Premiums

The NHI regular insurance premium rate was kept at 4.25% from the start of NHI implementation until the end of August 2002, and was adjusted to 4.55% in September 2002. In order to stabilize NHI's finances, the rate was raised to 5.17% in April 2010. However, since the implementation of the 2nd Generation NHI system, supplementary premium was introduced（initially at a rate of 2%）, and the regular insurance premium rate was lowered to 4.91% on January 1, 2013. In January 2016, the regular insurance premium rate was adjusted to 4.69%, and the supplementary premium rate was also lowered to 1.91%. Moreover, the average number of dependents per insured also experienced several rounds of adjustment over the years, it has changed from the original 1.36 persons to the current 0.61.

Insurance premiums are jointly paid by insureds, insured units（employers）, and the government. For insured classified in categories 1, 2, and 3, premiums are based on their salary basis × the regular premium rate. Regular premium for insured classified in categories 4, 5, and 6 are calculated as the average premium paid by those classified in categories 1 to 3（Table 2-3 and Table 2-4）.

Setting Payroll Brackets on Which Premiums are Based

With regard to the payroll brackets of insureds in categories 1 through 3, the Ministry of Health and Welfare drafts a periodically-updated payroll bracket table that is submitted to the Executive Yuan for approval. The payroll bracket table in effect since January 1, 2017 has 50 brackets（Table 2-5）. The payroll basis of category 1 insureds are reported by their insured units（employers）, based as the brackets in the table corresponding to the insureds' monthly wage income. Starting from July 1, 2014, the minimum payroll basis of insureds in category 2 with no fixed employer and the payroll basis of insured in category 3（farmers, fishermen, and irrigation association members） have been set as NT$22, 800.

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2-2），低收入戶之保險對象則不列為補充保險費之收取對象。另外，雇主每月所支付薪資總額與其受僱者當月投保金額總額間之差額，亦增列為計費基礎，收取補充保險費，並明確規範政府負擔比率至少須達36%；2016年全年補充保險費計收約439億元，占同年保險費收入約7.48%。

健保財務收支情形

健保歷年保險收支自1998年起開始發生短絀，至2007年3月底，累計健保財務收支首度呈現短絀，自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2017年6月累計收支結餘為2,463億元（表2-6）。

圖2-2 二代健保保險費示意圖

二代健保保險費＝一般保險費＋補充保險費

保險對象：第1類至第4類及第6類收取補充保險費

一般保險費

以第1類為例：負擔比率為30%

第1類～第3類：投保金額 × 一般費率 × 負擔比率 ×（1 + 依附眷口數）

眷屬人數如超過3口，以3口計算

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. 目前一般保險費費率為 4.69%；補充保險費費率為 1.91%。
2. 兼職所得：非屬投保單位給付之薪資所得。

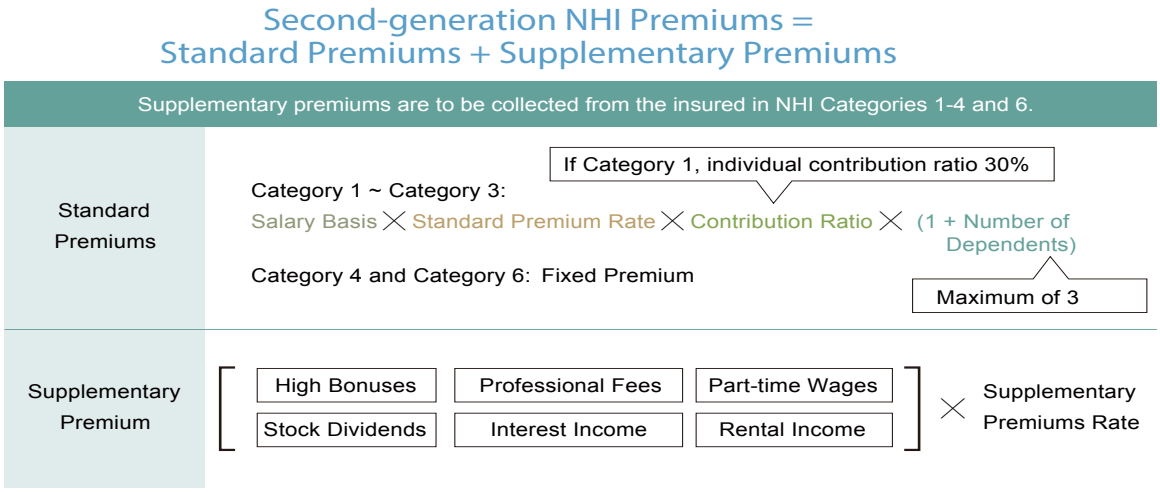
Calculation of Supplementary Premiums

Following the implementation of 2nd Generation NHI, apart from computing regular premiums based on the payroll bracket corresponding to an individual's regular wages, NHIA also assesses supplementary premiums. The basis for the calculation of supplementary premiums includes large bonuses, part-time income, professional service income, dividend income, interest income, and rental income, which were not included in payroll bracket calculations in the past. It is expected that by expanding the NHI's premium base, it can ensure that persons with equivalent incomes will pay similar premiums, and thereby achieve a fair burden（Chart 2-2）. In addition, insureds in low-income households are exempt from contributing supplementary premiums. Furthermore, supplementary premiums are also collected on the difference between the total monthly salaries that employers actually pay their employees each month and the total "payroll basis" of the employees. The government's contribution has also been clearly set at not less than 36%. In 2016, supplementary premium income totaled approximately NT$43.9 billion and accounted for roughly 7.48% of all premium income for the year.

Balancing NHI Revenues and Expenditures

The NHI system first began encountering shortfalls since 1998, and the cumulative budget had its first shortfall at the end of March 2007. An increase in the premium rate in 2010 helped the cumulative budget shortfall shifted to a surplus in February 2012. The launch of the new 2nd Generation NHI system introduced supplementary premiums and increased the government's minimum contribution to premiums to at least 36%. This resulted in an accumulated surplus of NT$246.3 billion as of June 2017（Table 2-6）.

Chart 2-2　2nd Generation NHI Premiums Overview



Notes: 1. At present, the standard premium rate is 4.69% and the supplementary premium rate is 1.91%.
2. Part-time wages: Wage income not paid by the insured's insurance registration organization.

表2-3 全民健保一般保險費計算公式
Table 2-3 Current Formulas for Standard NHI Premiums

薪資所得者 Wage Earners	被保險人 The Insured	投保金額×一般保險費費率×負擔比率×（1＋眷屬人數） Salary Basis x Standard Premium Rate x Contribution Ratio x（1 + Number of Dependents）
	投保單位或政府 Insurance Registration Organization or the Government	第1類第1目至第3目：投保金額×一般保險費費率×負擔比率×（1＋平均眷屬人數） Category 1（subcategories 1-3 Category 1 in Table 1）：Salary Basis x Standard Premium Rate x Contribution Ratio x（1 + Average Number of Dependents）
		第2、3類：投保金額×一般保險費費率×負擔比率×實際投保人數 Categories 2 and 3: Salary Basis x Standard Premium Rate x Contribution Ratio x Actual Number of People Insured
地區人口（無薪資所得者） Non-Wage-Earning Individuals	被保險人 The Insured	平均保險費×負擔比率×（1＋眷屬人數） Average Premium x Contribution Ratio x（1 + Average Number of Dependents）
	政府 The Government	平均保險費×負擔比率×實際投保人數 Average Premium x Contribution Ratio x Actual Number of People Insured

註：1.負擔比率：請參照表2-4全民健保保險費負擔比率。
2.一般保險費費率：2016年1月起為4.69%。
3.投保金額：請參照表2-5全民健保投保金額分級表。
4.眷屬人數：依附投保的眷屬人數，超過3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。

Notes: 1. Contribution Ratio: Based on Table 2-4.
2. Standard Premium Rate: 4.69% starting from January 2016.
3. Salary Basis: Please refer to Table 2-5.
4. Number of Dependents the: maximum is three even if the actual number of dependents is higher.
5. Average Number of Dependents: 0.61 starting from January 2016.
6. Beginning in January 2016, the average monthly premium for individuals in categories 4 and 5 went up to NT$1,759 and continues 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 by the individual（NT$749）and 40% by the government.

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

保險對象類別 Classification of the Insured			負擔比率（%） Contribution Ratios（%）		
			被保險人 Insured	投保單位 Insured	政府 Government
第一類 Category 1	公務人員 Civil Servants	本人及眷屬 Insured and Dependents	30	70	0
	公職人員、志願役軍人 Volunteer Servicemen, Public Office Holders	本人及眷屬 Insured and Dependents	30	70	0
	私立學校教職員 Private School Teachers	本人及眷屬 Insured and Dependents	30	35	35
	公、民營事業、機構等有一定雇主的受僱者 Employees of Public or Private Owned Enterprises and Organizations	本人及眷屬 Insured and Dependents	30	60	10
	雇主 Employers	本人及眷屬 Insured and Dependents	100	0	0
	自營業主 Self-employed	本人及眷屬 Insured and Dependents	100	0	0
	專門職業及技術人員自行執業者 Independent Professionals and Technical Specialists	本人及眷屬 Insured and Dependents	100	0	0
第二類 Category 2	職業工會會員 Occupation Union Members	本人及眷屬 Insured and Dependents	60	0	40
	外僱船員 Foreign Crew Members	本人及眷屬 Insured and Dependents	60	0	40
第三類 Category 3	農民、漁民、水利會會員 Members of Farmers, Fishermen and Irrigation Associations	本人及眷屬 Insured and Dependents	30	0	70
第四類 Category 4	義務役軍人 Military Conscripts	本人 Insured	0	0	100
	軍校軍費生、在卹遺眷 Military School Students on Scholarships,Widows of Deceased Military Personnel on Pensions	本人 Insured	0	0	100
	替代役役男 Males Performing Alternative Military Service	本人 Insured	0	0	100
	矯正機關收容人 Inmates in Correctional Facilities	本人 Insured	0	0	100
第五類 Category 5	低收入戶 Low-income Household	家戶成員 Household Members	0	0	100
第六類 Category 6	榮民、榮民遺眷家戶代表 Veterans and Their Dependents	本人 Insured	0	0	100
		眷屬 Dependents	30	0	70
	地區人口 Other Individuals	本人及眷屬 Insured and Dependents	60	0	40

表2-5 全民健保投保金額分級表
Table 2-5 Salary Brackets on which Premiums Are Calculated

組別 Bracket 級距 Income Differential	投保等級 Income Tier	月投保金額（元） Salary Basis（Amount on which Premiums are Calculated）（NT$）	實際薪資月額（元） Actual Registered Monthly Salary（NT$）
第一組 級距900 元 Bracket 1 NT$900	1	22,000	22,000 以下
	2	22,800	22,001-22,800
第二組 級距1,200 元 Bracket 2 NT$1,200	3	24,000	22,801-24,000
	4	25,200	24,001-25,200
	5	26,400	25,201-26,400
	6	27,600	26,401-27,600
	7	28,800	27,601-28,800
第三組 級距1,500 元 Bracket 3 NT$1,500	8	30,300	28,801-30,300
	9	31,800	30,301-31,800
	10	33,300	31,801-33,300
	11	34,800	33,301-34,800
	12	36,300	34,801-36,300
第四組 級距1,900 元 Bracket 4 NT$1,900	13	38,200	36,301-38,200
	14	40,100	38,201-40,100
	15	42,000	40,101-42,000
	16	43,900	42,001-43,900
	17	45,800	43,901-45,800
第五組 級距2,400 元 Bracket 5 NT$2,400	18	48,200	45,801-48,200
	19	50,600	48,201-50,600
	20	53,000	50,601-53,000
	21	55,400	53,001-55,400
	22	57,800	55,401-57,800
第六組 級距3,000 元 Bracket 6 NT$3,000	23	60,800	57,801-60,800
	24	63,800	60,801-63,800
	25	66,800	63,801-66,800
	26	69,800	66,801-69,800
	27	72,800	69,801-72,800
第七組 級距3,700 元 Bracket 7 NT$3,700	28	76,500	72,801-76,500
	29	80,200	76,501-80,200
	30	83,900	80,201-83,900
	31	87,600	83,901-87,600
第八組 級距4,500 元 Bracket 8 NT$4,500	32	92,100	87,601-92,100
	33	96,600	92,101-96,600
	34	101,100	96,601-101,100
	35	105,600	101,101-105,600
	36	110,100	105,601-110,100

組別 Bracket 級距 Income Differential	投保等級 Income Tier	月投保金額（元） Salary Basis（on which Premiums are Calculated）（NT$）	實際薪資月額（元） Actual Registered Monthly Salary（NT$）
第九組 級距5,400 元 Bracket 9 NT$5,400	37	115,500	110,101-115,500
	38	120,900	115,501-120,900
	39	126,300	120,901-126,300
	40	131,700	126,301-131,700
	41	137,100	131,701-137,100
	42	142,500	137,101-142,500
	43	147,900	142,501-147,900
	44	150,000	147,901-150,000
第十組 級距6,400 元 Bracket 10 NT$6,400	45	156,400	150,001-156,400
	46	162,800	156,401-162,800
	47	169,200	162,801-169,200
	48	175,600	169,201-175,600
	49	182,000	175,601 以上

註：2018 年1 月1 日起生效。
Note: Effective from Jan. 1, 2018.

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

	保險收入[1] NHI Revenues [1]		保險成本[2] NHI Expenditures [2]		保險收支當年餘絀（億元）[1]-[2] NHI Annual Balance（Unit: NT$100 million）[1]-[2]	保險收支累計餘絀（億元）Accumulated Balance（Unit: NT$100 million）
	金額（億元）Amount（Unit: NT$100 million）	成長率（%）Growth rate（%）	金額（億元）Amount（Unit: NT$100 million）	成長率（%）Growth rate（%）		
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	6,410	12.54	5,381	3.85	1,029	2,289
2016	5,869	-8.43	5,684	5.63	186	2,474
2017/1~6	2,913	–	2,924	–	-11	2,463
1995/3~2017/6	88,125	–	85,662	–	–	–

說明：1. 2017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。保險成本＝保險給付（醫療費用）＋其他保險成本

Notes: 1. Dated at the end of June 2017.
2. NHI Revenues = Premiums + Fines for Overdue Payments + Investment Income + Contributions from Public Welfare Lottery Surplus and a Health and Welfare Surcharge on Tobacco Products + Other Net Revenue – Unpaid Debts – Interest Expenses; NHI Expenditures = Medical Reimbursements（Medical Costs）+ Other Insurance Costs

Chapter 3

給付完整　就醫便利

Comprehensive Benefits and Convenient Access

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醫療給付範圍

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。

就醫便利

在全民健保制度之下，民眾可以自由選擇特約醫院、診所、藥局、醫事檢驗機構，接受妥善的醫療照顧服務。即使在國外，民眾因不可預期的緊急傷病或緊急分娩，須在當地醫事服務機構立即就醫，回國後也可於急診、門診治療當日或出院之日起6個月內申請核退國外自墊醫療費用。

截至2017年6月底止，全民健保特約醫療院所合計達20,934家，占全國所有醫療院所總數92.74%（表3-1）；另有特約藥局6,129家、居家護理機構586家、精神社區復健機構204家、助產所18家、醫事檢驗機構212家、物理治療所15家、醫事放射機構10家、職能治療所4家及呼吸照護所1家，保險對象可自由選擇醫療院所，接受醫療照護服務。

2016年，平均每人每年門診就醫次數15.4次（含西醫、中醫及牙醫門診），平均每百人住院次數14次，全國每人每年平均住院日數1.3日。

表3-1　全民健保特約醫療院所數
Table 3-1　Number of NHI-Contracted Hospitals and Clinics

單位：機構數　Unit: No. of Institutions

	總計 Total	西醫醫院 Hospitals	西醫診所 Clinics	中醫醫院 Chinese Medicine Hospitals	中醫診所 Chinese Medicine Clinics	牙醫診所 Dental Clinics
全國醫療院所數 Total Medical Institutions	22,573	477	11,521	7	3,800	6,768
特約醫療院所數 Contracted Medical Institutions	20,934	477	10,304	5	3,532	6,616
特約率 Percentage of Contracted Institutions	92.74%	100%	89.44%	71.43%	92.95%	97.75%

資料時間：2017年6月30日。　Dated: June 30, 2017

Scope of Medical Coverage

When insureds, who have paid their NHI premiums and have received their health insurance cards, get sick, injured in an accident, or give birth, they can receive medical services at medical service organizations such as hospitals, clinics, pharmacies, and medical examination organizations upon presentation of their health insurance card.

The medical services currently provided by the NHI include outpatient care, inpatient care, traditional Chinese medicine（TCM）, dentistal care, child delivery, physiotherapy and rehabilitation, home health care, chronic mental illness rehabilitation, and etc. The scope of medical payments includes diagnosis, examination, lab tests, consultation, surgery, anesthesia, medication, materials, treatment, nursing, and insurance hospital rooms; essentially all necessary health care services are covered by the system.

Convenient Access to Healthcare

Under the NHI system, the public can freely choose to receive medical care services at any NHI contracted hospital, clinic, pharmacy, or medical laboratory. Even when overseas, the insured can immediately obtain medical care at a local medical service organization if they have an unforeseen illness or injury, or have an emergency delivery. Upon return to Taiwan, such individuals may apply for reimbursement of medical expenses paid overseas within six months after receiving emergency treatment, outpatient treatment, or their hospital discharge.

As of the end of June 2017, NHI contracted hospitals and clinics totaled 20,934, and accounted for 92.74% of all hospitals and clinics in Taiwan（Table 3-1）. There were also 6,129 contracted pharmacies, 586 home nursing care institutions, 204 psychiatric community rehabilitation centers, 18 midwife clinics, 212 medical examination institutions, 15 physical therapy clinics, 10 medical radiation institutions, 4 occupational therapy clinics, and 1 respiratory care clinic. Insureds may freely choose at which hospital or clinic they will receive medical services.

In 2016, the average per capita outpatient visit reached an average of 15.4 times（including Western medicine, Chinese medicine, and outpatient dental care）; the average hospital admission rate was 14 times per hundred persons; and the average length of hospital stay per person was 1.3 days.

落實分級醫療與轉診制度公聽會
Public hearing on implementation of a hierarchical medical and referral system

推動分級醫療·落實雙向轉診記者會
Press conference of hierarchically integrated healthcare system and enhancing two-way referrals.

調整部分負擔　落實雙向轉診

全民健康保險部分負擔的設計是為避免醫療浪費，同時不致影響真正有需要的人就醫，自開辦後，門、急診之部分負擔已經調整多次，同時也藉以導正醫療資源利用，使不同層級院所各司其職。

為鼓勵民眾小病到當地診所就醫，需要進一步檢查或治療時再轉診到區域醫院、醫學中心等大醫院，健保署自2005年7月15日起推出若配合轉診則不加重部分負擔之設計，門診基本部分負擔亦配合修正。其中，西醫門診基本部分負擔按「未轉診」及「轉診」兩種方式計收。民眾若未經轉診直接到醫學中心、區域醫院、地區醫院就醫，就會付比較高的部分負擔。牙醫、中醫不分層級一律計收50元。此外，民眾看病時，如藥費超過一定金額，則須加收藥品部分負擔（上限200元）。同一療程中接受第2次以上的復健物理治療（中度—複雜、複雜項目除外）或中醫傷科治療，每次須自行繳交50元的部分負擔費用，但凡因重大傷病、分娩、山地離島地區就醫者及其他符合健保署規定者均免收部分負擔。

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

表3-2 Table 3-2　全民健保門診基本部分負擔 NHI Copayments for Outpatient Visits

單位：新臺幣元　Unit: NT$

類型 Institution Class	基本部分負擔 Basic Copayments					
醫院層級 Type of Institution	西醫門診 Western Medicine Outpatient Care		急診 Emergency Care		牙醫 Dental Care	中醫 Traditional Chinese Medicine
	經轉診 With Referral	未經轉診 Direct Visit	檢傷分類 Triage Classification			
			第1、2級 Grades 1 & 2	第3、4、5級 Grades 3, 4 & 5		
醫學中心 Medical Centers	170	420	450	550	50	50
區域醫院 Regional Hospitals	100	240	300	300	50	50
地區醫院 District Hospitals	50	80	150	150	50	50
診所 Clinics	50	50	150	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新台幣50元。
2.門診手術後、急診手術後、生產後6周內或住院患者出院後30日內第一次回診視同轉診，得由醫院開立證明供病患使用。
3.自2017年4月15日起公告實施。

Notes:1. The copayment for mentally or physically disabled is fixed at NT$50 for each 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 copayment 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 copayment schedule took effect on April 15, 2017.

Adjusting Copayments and Realizing Two-way Referrals

The NHI copayment system was designed to avoid waste, without affecting access to medical care for those truly in need. Since the NHI's inception, the copayments for outpatient and emergency care have been adjusted multiple times. The NHIA has used copayments as a means to guide medical resource utilization to ensure that hospitals and clinics at different levels focus on their respective duties.

To encourage persons with minor illnesses to seek care at local clinics, and obtain referral to regional hospitals, medical centers, and other larger hospitals only when further examination or more advanced treatment is needed. On July 15, 2005, the NHIA modified the copayment and referral system whereby basic outpatient copayments were revised and copayments will not increased if patients conform with referrals. Under these measures, the basic copayment for attending a Western medicine outpatient clinic at a hospital depends on whether or not an individual has a referral. If people seek care directly at a medical center, regional hospital, or local hospital without a referral, they will be subject to relatively high copayments. The copayment for dental and Chinese medicine care is uniformly NT$50 without regard to level of care. In addition, if a prescription costs more than a certain amount, a copayment for the medication is also charged（up to NT$200）. Patients receiving follow-up rehabilitation physical therapy（apart from moderate-complex, complex items）or Chinese medicine trauma treatment for the same course of treatment must pay copayments of NT$50 each time, but such copayments are waived in cases of major illness and injury, child delivery, those who seek care in mountain and offshore island areas, and other cases complying with NHIA regulations.

Starting in June 2016, the NHIA has stepped up the planning and implementation of hierarchically integrated healthcare system in an effort to encourage the public to first seek care at primary care level hospitals and clinics, and if needed they would be referred to an appropriate specialist hospital department or clinic for further care. This approach will enable large hospitals to devote their full attention to treatment of serious illnesses and medical research, while making primary-level hospitals and clinics the frontline of primary care. The revised basic copayment schedule for Western

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

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

註: 依衛生福利部公告，2018年以同一疾病每次住院上限為38,000元、全年累計住院上限為64,000元。
Note: The Ministry of Health and Welfare has announced that the upper limit of inpatient copayments for the same disease is NT$38,000 in 2018, and the upper limit of cumulative inpatient copayments is NT$64,000.

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

此外，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。

家庭醫師及社區藥局在地照顧

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

截至2017年6月底，已有526個社區醫療群在運作，參與之基層診所4,063家，參與率為36.61%，參加醫師數5,182位，參與率為33.73%；透過社區醫療群受益者超過413萬人。

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

多元支付制度

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

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

爰此，健保署參考其他先進國家制度，再根據不同醫療照護的特性，設計以不同支付方式，例如自2002年7月起，全面實施醫療費用總額預算支付制度（Global Budget Payment System）；同時透過支付制度策略，如論病例計酬（Case Payment）、論質計酬（Pay-for-Performance,DP4P）改革方案，改變診療行為；此外，推動山地離島地區醫療給付效益提昇計畫（IDS、家庭醫師整合照護計畫，以增進醫療服務體系整合；並以品質與結果支付，例如論質計酬支付等。另為提升醫療服務效率，更自2010年1月1日起實施全民健保住院診斷關聯群支付制度（Taiwan Diagnosis Related Groups, Tw-DRGs），並於2014年7月1日起實施第2階段Tw-DRGs。

總額支付制度

健保署自1998年起陸續推動牙醫、中醫、

medicine outpatient care announced by the NHIA on April 15, 2017 reduced copayments for referrals to medical centers and regional hospitals by NT$40, and increased copayments for medical care at a medical center without a referral by NT$60. Furthermore, copayments for emergency care are now charged depending on triage grade. These measures ensure the realization of two-way referrals. Outpatient and inpatient copayments are shown in tables 3-2 and 3-3.

Following the implementation of the 2nd Generation NHI, in order to benefit areas with limited medical resources, where it may be difficult to seek care outside, people living in such areas enjoy a uniform 20% reduction in copayments, and the copayment rate for home health care has been reduced to 5% from the original 10%.

Family Doctors and Community Pharmacies

To ensure that the public can obtain comprehensive and continuing medical care near their homes, the NHIA introduced the "NHI Family Doctor Plan" in March 2003. Under this plan, five or more NHI-contracted western medicine clinics in the same area can join with a community hospital to form a community health care group. As long as they take a doctor at a primary-level clinic near their home as their family doctor, people can obtain front-line healthcare. Family doctors should ordinarily serve as preventive healthcare consultants, and should bear responsibility for gathering medical data and providing 24-hour health consulting service hotlines. If patients' conditions warrant surgery, further examination, or hospitalization, their family doctors can provide referrals. The family doctor system is intended to reduce wasted time and money when people must find a doctor.

As of the end of June 2017, 526 community healthcare groups were operating, 4,063 primary-level clinics were participating, which represented a participation rate of 36.6%, 5,182 doctors were participating, for a participation rate of 33.7%, and more than 4.13 million persons benefited from community healthcare groups.

With regard to pharmacy services, individuals can obtain medication from a contracted pharmacy upon presentation of a prescription from a contracted hospital or clinic. If patients have any questions about their prescription, they can ask their pharmacist or assistant pharmacist at a pharmacy to provide usage and health consulting services. Pharmacies not only keep tabs on the public's medication safety, but also provide the public with correct medication usage knowledge.

Diversified Payment Systems

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

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

西醫基層、醫院等部門總額支付制度，至2002年起全面採行總額預算支付制度，有效將醫療費用成長率控制在5%以下。自2009年起之醫療費用成長率如圖3-1。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。醫療費用總額預算研擬程序及方向如圖3-2，2006年起各總額部門醫療費用協定成長率如表3-4。

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

增修支付標準

為平衡醫療發展，自全民健保開辦起，配合醫療科技發展及實際臨床需要，持續新增診療項目，以提供民眾與時並進之醫療技術。截至2017年6月，支付標準共計有4,436項診療項目，經統計2004年至2017年6月，共計85次公告調整支付標準，共修訂1,989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。

醫療給付改善方案

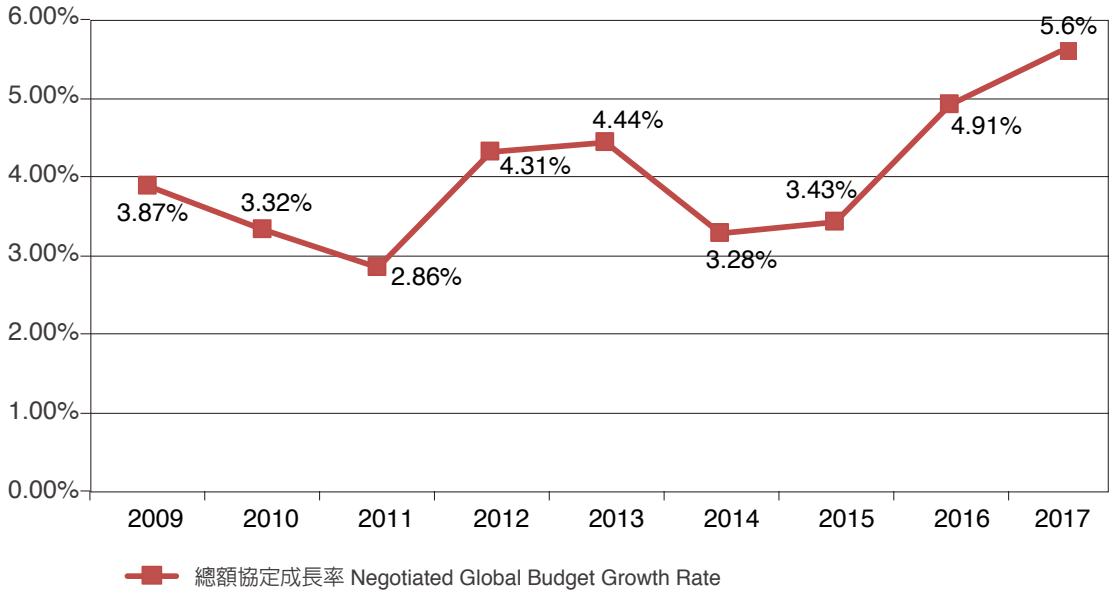
全民健保醫療給付改善方案，係透過調整支付醫療院所醫療費用的方式，提供適當誘因，引導醫療服務提供者朝向提供整體性醫療照護發展，並以醫療品質及效果作為支付費用的依據。自2001年10月起，分階段實施子宮頸癌、乳癌、結核病、糖尿病及氣喘等5項醫療給付改善方案。

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。2010年1月新增思覺失調症、慢性B型肝炎帶原者與C型肝炎感染者等2項論質方案，2011年1月再新增初期慢性腎臟病論質方案，該方案自2016年4月起導入支付標準全面實施辦理。

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

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

圖3-1 歷年全民健保醫療費用成長率
Chart 3-1 Annual Growth Rate of NHI Medical Expenditures



資料來源：衛生福利部全民健康保險會委員會議全民健康保險業務執行報告。
Source: National Health Insurance Service Implementation Report preasented in National Health Insurance Committee meetings under the Ministry of Health and Welfare

increase in medical expenses, and has affected the quality of care.

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

Global Budget Payment System

The NHIA has phased in global budget payment for dental care, traditional Chinese medicine, primary-level Western medicine, and hospital care since 1998, and implemented a full-scale global budget payment system in 2002, which effectively curbed the growth rate of medical expenses to within five percent. See Chart 3-1 for the NHI medical expenditure growth rates since 2009. To ensure that the public's rights and interests are not affected

圖3-2 Chart 3-2 全民健保醫療費用總額預算研擬程序及方向 NHI Global Budget Drafting Procedures and Strategies

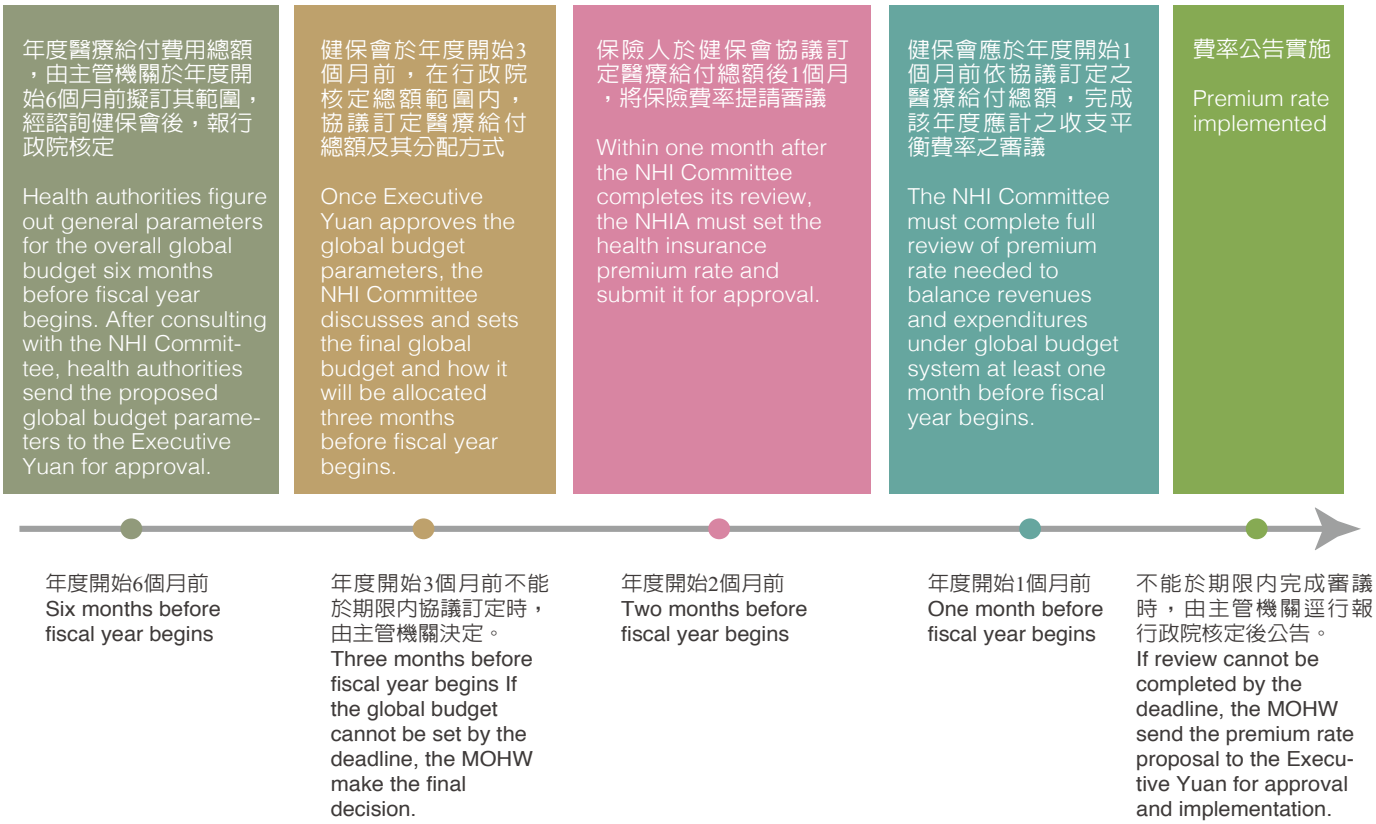


表3-4 Table 3-4 全民健保歷年各總額部門醫療費用協定成長率 Annual Negotiated Growth Rate of Global Budget

總額部門 Sector	2009	2010	2011	2012	2013	2014	2015	2016	2017
整體 Total	3.874%	3.317%	2.855%	4.314%	4.436%	3.275%	3.430%	4.912%	5.642%
牙醫門診 Dental	3.033%	2.515%	1.783%	2.264%	1.421%	1.888%	2.140%	3.463%	3.246%
中醫門診 Traditional Chinese Medicine	2.950%	2.063%	2.551%	2.856%	2.187%	2.421%	2.124%	3.927%	4.066%
西醫基層 Clinics	3.756%	2.742%	1.874%	2.986%	2.818%	2.391%	3.191%	4.274%	5.157%
醫院 Hospitals	4.887%	3.256%	3.173%	4.683%	5.587%	3.281%	3.659%	5.672%	6.021%

by global budgets, the NHIA has jointly implemented a medical quality assurance program in conjunction with medical groups. This program oversees hospitals and clinics' efforts to improve the quality of their healthcare services. Chart 3-2 presents the NHI's global budget drafting procedures and strategies, and Table 3-4 shows the annual negotiated medical expenditure growth rates of each global budget sector since 2006.

To ensure that the quality and scope of the care provided by medical service organizations is not affected by the implementation of a global budget payment system, while negotiating global medical expense budgets, NHIA also drafts quality assurance programs. These quality assurance programs for global budget sectors include medical services quality satisfaction surveys, complaints and reported case handling mechanisms, insured care accessibility monitoring. NHIA has also determined clinical services guidelines for professional treatment quality, drafted standards for professional review and case histories, established a hospital and clinic assistance system and medical services quality indicators, and maintained the transparency of quality information by posting relevant information on the NHIA website as a reference helping hospitals and clinics to continue to improve their medical quality.

Revision of the Fee-Schedule

To ensure balanced medical development and provide the public with up-to-date medical technologies, the NHIA has continued to add new treatment items reflecting technological progress and real clinical needs. As of June 2017, the fee schedule covered a total of 4,436 treatment items. The adjustment of the fee schedule was announced 85 times between 2004 and June 2017, and revisions were made to payment points for 1,989 treatment items.

To encourage hospitals to place greater emphasis on clinical nursing manpower, a program to improve the quality of nursing care was initiated in 2009, and more than NT$9.17 billion had been allocated to it as of 2014. This funding was used to encourage hospitals to hire more nursing staff, increase pay for night shifts, and subsidize extra overtime, making nurses more willing to stay on the job. Another NT$2 billion was invested in 2015 to adjust the reimbursement rates for nursing services. This measure has not only increased the payment point values for the nurses' services, but also reduced nurses' burdens through the linkage of payments to the nurse-patient ratio.

Pay-for-Performance Plans

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

The management of the cervical cancer program was transferred to the Health Promotion Administration in early 2006, but that same year, and a pay-for-performance plan for hypertension treated at Western medicine clinics was added. In 2007, hospitals became eligible to treat hypertension under the plan, and in 2008, pay-for-performance for the treatment of tuberculosis was included in the NHI fee schedule. Two additional pay-for-performance plans were added in January 2010: for schizophrenia and for hepatitis B carriers and hepatitis C patients, and another plan was introduced in January

表3-5 全民健保醫療給付改善方案照護率
Table 3-5 Percentage of Patients Treated Under NHI's Pay-for-Performance Plan

方案別 Plan	2005	2006	2007	2008	2009
氣喘 Asthma	32.50%	34.78%	35.17%	31.29%	31.61%
糖尿病 Diabetes	23.52%	23.16%	24.67%	26.34%	27.56%
結核病 Tuberculosis	68.78%	78.99%	91.81%	導入支付標準 Incorporated in the Fee Schedule	-
乳癌 Breast cancer	12.09%	12.98%	13.60%	14.64%	14.50%
高血壓 Hypertension	未實施 N/A	基層試辦 9.31% Trial-basis 9.31%	6.54%	3.93%	2.65%
思覺失調症 Schizophrenia	未實施 N/A				
B型C型肝炎帶原者 Hepatitis B and C carriers	未實施 N/A				
初期慢性腎臟病 Early stage chronic kidney diseases	未實施 N/A				
孕產婦全程照護 Full-course maternity care	未實施 N/A				
早期療育 Early treatment for development retardation	未實施 N/A				
慢性阻塞性肺病 Chronic obstructive pulmonary lung disease	未實施 N/A				

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。

早期療育門診醫療給付改善方案自2015年10月實施、慢性阻塞性肺病自2017年4月實施。

Note: The hypertension plan was first implemented on a trial basis at Western medicine clinics starting in 2006, and was expanded to hospitals in 2007. Because the care rate for this plan encompasses both primary-level clinics and hospitals, the care rate for this plan decreases. Furthermore, because hypertension patients commonly also have such comorbidities as diabetes and chronic kidney disease, these conditions were no longer tracked under other independent plans, and trial implementation of the plan was ended in 2013.

An early intervention outpatient medicine pay-for-performance plan was implemented in October 2015, and a chronic congestive lung disease plan was introduced in April 2017.

	2010	2011	2012	2013	2014	2015	2016
	47.02%	45.45%	39.30%	37.49%	41.94%	36.00%	28.2%
	29.26%	31.36%	33.94%	35.06%	41.90%	41.07%	43.4%
	-	-	-	-		-	-
	14.62%	13.67%	13.43%	13.09%	10.88%	10.60%	9.7%
	2.55%	2.94%	1.36%	註 See Note	註 See Note	註 See Note	註 See Note
	40.65%	46.94%	51.20%	52.22%	59.11%	61.97%	63.9%
	9.83%	19.37%	26.14%	30.58%	37.18%	32.6%	35.3%
		20.15%	26.40%	32.1%	26.71%	38.54%	42.1%
	由衛生福利部醫療發展基金支應 Sponsored by the MOHW's Medical Development Fund					29.3%	29.5%
							15.3%

2011 for early chronic kidney disease. Pay-for-performance plan for chronic kidney disease was included in the NHI fee schedule in April 2016.

In 2015, the NHIA took back management of the pay-for-performance program covering full-course maternity care for pregnant women, which had previously been managed by the Ministry of Health and Welfare's Medical Development Fund. A pay-for-performance plan for early intervention outpatient therapy was added in October of the same year, and a pay-for-performance plan for chronic congestive lung disease was added in 2017.

Thanks to the positive impact of the diabetes pay-for-performance plan, it was adopted in the fee schedule for all diabetes cases in October 2012. Furthermore, since the patients under the hypertension plan commonly also had such comorbidities as diabetes and chronic kidney disease, etc., to promote holistic care methods, these conditions were no longer listed as independent items starting in 2013, and were included in other pay-for-performance plans. The recent care rates of each plan are shown in Table 3-5.

Chapter 4

專業審查　提升品質

Professional Review and Quality Improvement


MEDICAL
MEDICAL

專業審查　提升品質
Professional Review and Quality Improvement

專業審查 提升效率

為避免醫療浪費，保障醫療品質，醫療服務審查制度為必要機制，以維護保險對象民眾就醫安全與品質。醫療服務案件審查標的為：醫療服務項目、數量、適當性及品質。平均一年門診申報量約3.56億件，平均每日約97萬件，一年住院約328萬件，平均每日約9千件。基於人力及行政成本考量，有關醫療服務審查大體可區分為「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。

健保署自2014年9月起，建置「全民健康保險中央智慧系統」（Central Intelligence System, CIS），對重要項目，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。

自1998年起總額支付制度漸進實施後，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。

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「智慧型專業審查系統IPS」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。

2014~2016年擴大推動數位化審查作業，強化「智慧型專業審查系統IPL」整併IPS資訊功能，自動連結健保給付規定、審查注意事項、病歷電子檔案、審查重點等資訊，並增設提醒機制、個別化設定，協助審查醫藥專家有效率進行精確審查。

運用科技提高審查效率

健保署逐步推動醫療申報電子化，累積至今，已成為全球獨一無二的全民健保資料庫。透過電子ｅ化，健保署可快速有效率的審查醫療院所申報資料及擷取異常狀態，並從大量的倉儲資料中，輔助分析未來政策方向，啓動相

Improving Efficiency through Professional Reviews

The medical service review system is a necessary mechanism to prevent waste, safeguard quality, and maintain the public's healthcare safety and quality. The targets of medical service reviews include medical service items, quantity, appropriateness, and quality. An average of 356 million outpatient reimbursement claims are filed every year, which works out to an average of roughly 970,000 per day, and about 3.28 million inpatient care claims（roughly 9,000 per day）are filed each year. Based on manpower and administrative cost considerations, the review process follows two tracks: a procedural review track and a professional peer review track. Computer technology and data analysis are employed extensively in these reviews, and NHIA is striving to develop "computerized physician's order automated review and profile analysis" computer-aided review systems in an effort to boost review efficiency.

The computerized "NHI Central Intelligence System"（CIS）established by NHIA in September 2014 automatically detects abnormal cases from major items, and outputs sampling proposals or marks these cases, and provides information concerning abnormalities, making overall claims review process as effective as possible.

Following the phased implementation of a global budget payment system starting in 1998, the NHIA has also commissioned medical associations to deal with some professional reviews and established management guidelines for recruiting medical review experts. The NHIA and the independent agencies have also gradually developed mechanisms for jointly managing the various professional reviews in every region.

To effectively enhance the consistency of professional reviews, apart from providing training and orientation on the workings of the insurance system, the NHIA also holds conferences for reviewing experts responsible for different fields for the purpose of achieving consensus among views concerning medical specialties. The NHIA established a "professional review knowledge query system" in February 2012 to give NHIA staff and medical experts a convenient way to look up relevant regulations online, improving review efficiency. Through its "Intelligent Professional Review System," (IPS) the NHIA completed the compilation and integration of various kinds of review-related regulations for different types of query data from 2011 to 2013.

From 2014 to 2016, the NHIA expanded the use of digital reviews using information technology, and strengthened the information integration function of the "Intelligent Peer Review Online System (IPL)". This effort included the establishment of automatic links to health insurance payment regulations, review guidelines, case history e-files, and review focal point information, and the addition of reminder mechanisms and individualized settings helps review experts to perform their work accurately and efficiently.

More Efficient Review through Information Technology

The NHIA has gradually pushed forward the digitization of medical reports, which have been compiled over the years to create the NHI database, which is unique in the world. Thanks to this digitization process, the NHIA can quickly and efficiently review claims submitted by healthcare providers, and detect abnormal situations. The information collected in the NHI's vast database is also used to analyze future policy directions, initiate relevant measures, and prevent the waste of medical resources.

關措施，避免醫療資源浪費。

健保署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、專科醫師限制等），建立醫令自動化審查邏輯，透過電腦邏輯程式檢核，直接核減不給付醫令項目，逐步導正醫療院所申報之正確性，以提升審查效率。

近年健保署也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：

（1）依據各項統計資料分析、偵測病患就醫、醫療院所診療型態與費用申報之異常狀況，供審查參考，使專業審查重點由個案審查轉變為診療型態的審核。

（2）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。

醫療品質資訊公開

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

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

合理調整藥價

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

自1999年起，依據調查的結果，已累計調降約600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、放寬藥品給付範圍、調整支付標準偏低之項目，以提供國內民眾享有與世界先進國家同步的醫療用藥，同時也提升了醫療品質，對於全民的健康保障，具有實質的效益。

The NHIA has developed automated review system for physician's orders, i.e. automated auditing rules and no-payment regulations for NHI covered services, fee schedules, NHI drug list, and NHI medical expense review guidelines（such as age restrictions, gender restrictions, specialist physician requirements, etc.）The system rules out no-payment items directly and helps to improve the accuracy of claims submitted by medical providers and thus boosts review efficiency.

In recent years, the NHIA has also actively established a profile analysis-based review system, which is able to review and manage irregular medical utilization by hospitals; the following specific measures are currently in place:

（1）Use of statistics analysis, detect abnormalities in patient visits, and diagnostic and treatment practices and expense claims irregularities, where the results serve as a reference in professional reviews. This allows the focus of professional reviews to be shifted from individual cases to treatment practices and operating patterns.

（2）Based on their regional characteristics, NHIA's regional divisions can rely on profile analysis to establish monitoring indicators for such high-utilization and high-cost medical items as computerized tomography（CT）, magnetic resonance imaging（MRI）, and extracorporeal shock wave lithotripsy（ESWL）, and strengthen management and assistance by locating abnormal hospitals, clinics, or physicians.

健保醫療資訊雲端查詢系統
Demonstration of NHI MediCloud System

Transparent Medical Quality Information

In 2005, the NHIA launched a platform to provide transparent information on healthcare quality in an effort to encourage the medical community to improve care quality. The platform was also designed to enhance public understanding of medical quality and medical utilization under NHI, and provide guidance to patients making decisions about their healthcare choices. This platform includes professional healthcare service quality reports, medical quality indicators of contracted hospitals and clinics, customer service indicators, and indicators concerning specific diseases, and can help the public gain an understanding of the quality of care in Taiwan.

Furthermore, basic information concerning contracted medical organizations, including service items, examination and treatment departments, scheduled visiting hours, insurance bed ratios, information on medical organizations violating NHI rules, and registration fee queries are made public online.

Reasonable Drug Price Adjustments

Under the current system for reimbursing medication expenses, medical organizations file drug expense claims with the NHIA based on NHI Drug List, and the NHIA will gather actual transaction prices through regular drug price market surveys to adjust drug prices periodically.

Since 1999, drug prices have been reduced based on these market surveys by a cumulative total of more than NT$60 billion. These periodic

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4年，主要是預設每年藥費支出「目標值」，並與實際藥費支出做連結，當超過目標值時，自動啓動每年一次之藥價調整，讓藥費維持於穩定及合理範圍。

差額負擔醫療特材

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、調控式腦室腹腔引流系統及治療淺股動脈狹窄之塗藥裝置等6類（共7項）列入自付差額項目（表4-1）。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。

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。

表4-1 民眾關心之自付差額特材一覽表
Table 4-1 Special Medical Devices With Balance Billing

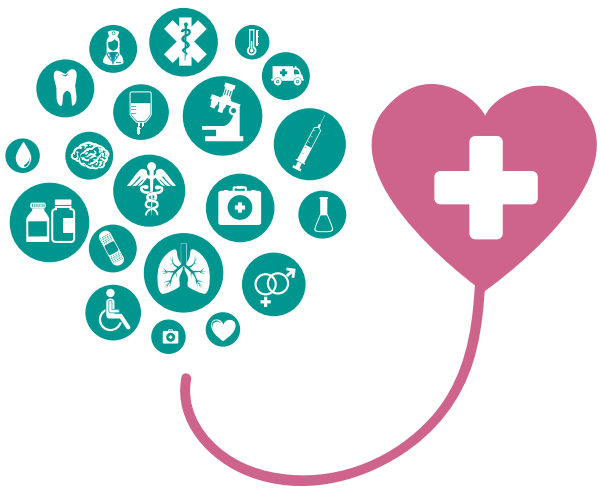
項目 Item	開始實施時間 Effective Date
塗藥及特殊塗層血管支架 Drug-eluting and Bio-active Coronary Stents	2006/12/01
陶瓷人工髖關節 Artifical Ceramic Hip Joints	2007/01/01
特殊功能人工水晶體 Artificial Intraocular Lenses	2007/10/01
金屬對金屬介面人工髖關節 Metal-on-metal Artificial Hip Joints	2008/05/01
耐久性生物組織心臟瓣膜 Bioprosthetic Heart Valves	2014/06/01
調控式腦室腹腔引流系統 Programmable Ventriculoperitoneal Shunt	2015/06/01
治療淺股動脈狹窄之塗藥裝置 Drug-device Combination Products for Superficial Femoral Artery Stenosis	2016/05/01

adjustments in drug prices have not only helped shrinking the gap between actual market prices and NHI reimbursement prices, but also slowed the growth of the system's medication expenditures. The funds saved are being used to accelerate the inclusion of new drugs, widening the scope of drug payments, adjusting the payment standards for items with relatively low prices, the NHIA is ensuring that patient access to drugs is on a par with the world's leading countries while improving the quality of healthcare in Taiwan. This is one way the NHIA used to safeguard people's health.

To further control health insurance medication costs as a whole, the NHIA announced trial implementation of the four-year "NHI Drug Expenditure Allocation Ratio Target System" starting on January 1, 2013. This system sets yearly targets for NHI drug expenditures, which are linked with actual drug expenditures. If actual expenditures exceed targets, a process to lower drug prices is automatically initiated once each year, keeping the NHI system's overall spending on drugs stable and within a reasonable scope.

Special Medical Materials with Balance Billing

Although some new medical devices offer improved functions, they are often far more expensive than similar items in the NHI fee schedule. To ease the financial burden of patients who might benefit from these advanced devices and give them greater choice, since December 1, 2006, the NHIA listed the six categories（seven items）as balance billing items, such as drug-eluting stents and stents with special coatings, artificial hip joints（ceramic and metal-on-metal）, artificial intraocular lenses, bioprosthetic heart valves, programmable ventriculoperitoneal shunts,



and drug-device combination products for superficial femoral artery stenosis（Table 4-1）. Whenever an insured wishes to use the more costly devices and materials, in cases when the NHI has existing payment standards for similar items, NHI will provide reimbursement in accordance with the payment standards for the similar items, and the insured must pay the difference out of his or her own pocket. In order to protect the public's rights and interests, hospitals and clinics must provide the public with adequate information before performing surgery or treatment in such cases.

In addition, hospitals and clinics must post information including the names, item codes, fee standards（including hospital out-of-pocket payment, NHI payment prices, and insured copayments）, product characteristics, side effects, and therapeutic effects comparison with items already covered by the NHI on their websites or premises. In addition, NHIA will also provide information concerning balance billing materials on its website. Thepublic is able to obtain the prices of such materials at individual hospitals in the "Price Comparison Platform of Self-Paid Medical Devices" section of NHIA's website.

Chapter 5

健康科技　服務加值

Health IT and Value-added Services

健康科技　服務加值
Health IT and Value-added Services

雲端加值服務　健康存摺運用

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，透過雲端運算技術提供醫師臨床專業判斷或將健保資料回饋給民眾。2013年7月健保署建置完成以病人為中心的「健保雲端藥歷系統」，透過健保的VPN系統，提供特約醫事服務機構於診療需要時，可即時查詢病人過去3個月的用藥紀錄，作為醫師處方開立或藥事人員用藥諮詢參考，以提升民眾就醫品質，減少不必要之醫療資源重複使用。

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

基於前述推動基礎，健保署參考使用者回饋意見及臨床實務需求，自2015年起擴大發展「健保醫療資訊雲端查詢系統」，除持續精進雲端藥歷系統，並增建中醫用藥紀錄、檢查檢驗紀錄、檢查檢驗結果、手術明細紀錄、牙科處置及手術紀錄、過敏藥物紀錄、特定管制藥品用藥紀錄、特定凝血因子用藥紀錄、復健醫療紀錄及出院病歷摘要等11項查詢系統。各項查詢系統建置於同一查詢平台，並發展提示功

行政院賴清德院長、衛福部陳時中部長共同主持「醫療資訊上傳雲端與調閱分享，無遠弗屆，分級醫療新紀元記者會」
Premier William Lai (賴清德) and Minister of Health and Welfare Chen Shih-chung (陳時中) attended the news conference to introduce the Diagnostic Image Sharing Platform.

Value-added Cloud Services - My Health Bank

Accumulated over the course of 20 years, NHI's claims data constitutes the largest repository of people's health information in Taiwan. With the rise of the Big Data concept in recent years, NHIA has begun to gradually compile data in various fields while maintaining information security. It uses cloud computing technology to provide doctors with clinical professional assessments and offer health insurance data to the public. In July 2013, the NHIA completed the patient-centered NHI PharmaCloud System, which allows contracted medical organizations to query in real-time patients' medication records for the previous three months via the NHI VPN system. By providing reference information to doctors when prescribing prescriptions, and to pharmacy personnel when providing advices on medication use, this system is enhancing care quality and reducing unnecessary duplication of medical resources.

Analysis of usage of the PharmaCloud System has revealed that when doctors use the system to query patients, the overlap in days of drug use is reduced significantly. Furthermore, NHI-contracted medical institutions have incorporated NHI PharmaCloud information into their internal drug management systems to create their own in-house specialized drug management mechanisms. These could include standardized procedures for inpatient and outpatient PharmaCloud System query procedures, setting up counters where the elderly can pick up their prescriptions, developing intelligent PharmaCloud interpretation programs, and tracking inappropriate drug use or prescriptions. The NHI PharmaCloud is also being used to encourage inpatients to use medications that they have brought in themselves（medications prescribed by other hospitals or outpatient departments）. These processes have helped pharmacists to better fulfil their role in enhancing the safe use of medicines and have improved the overall "medication safety" environment, reflecting the profound usefulness of the NHI PharmaCloud System.

Building on this foundation, the NHIA developed the expanded "NHI MediCloud System" in 2015 based on users' feedback and practical clinical needs. The new system encompasses not only the continuously improving PharmaCloud System, but also incorporates information from 11 additional query systems, including: Chinese medicine prescription use records, examination and test records and results, detailed records of surgeries, dental treatment and surgical records, drug allergy records, records of specific controlled drug and specific clotting factor medications usage, rehabilitation records, and hospital discharge summaries. All of this information is brought together on the same single platform. The system also provides a user-friendly search interface and reminders（for instance, reminder windows displaying the most recent date of specific tests and a timeline showing visits to medical practitioners and recent medical care, among other things）. These upgrades to the system make it easier for medical professionals to gain quicker access to vital information by shortening the time needed to read information and use the system. This enables them to make better clinical judgments and provide patients with even better care quality care.

Diagnostic Image Goes on Cloud to Facilitate File-sharing

After analyzing a large pool of big data over the past few years, it is found to be essential to cut down on unnecessary repeated examinations and medication. Therefore, the NHIA launched a cloud-based file-sharing platform for diagnostic images to be shared among hospitals on Jan. 1, 2018. This platform allows large hospitals

能及友善查詢介面（例如特定檢查項目最近一次執行日期提示視窗、就醫用藥時間軸等），以縮短使用及閱讀所需時間，並有助於醫師及藥事人員臨床處置專業判斷，提供病人更好的照護品質。

醫療資訊上雲端　調閱分享無弗屆

從健保大數據分析發現，控制不必要的檢驗檢查及用藥是重要關鍵，因此自107年元旦起，各大醫院為病患所執行的CT及MRI檢查後，健保署鼓勵各醫院即時將檢查的影像及報告上傳，其他的基層院所即可透過健保雲端醫療資訊查詢系統調閱影像及報告內容，對民眾而言，至同層級醫院尋找第二醫療意見或後續照護，只要由雲端資料調閱，就可看到檢驗檢查報告，節省等待醫院作業流程與金錢花費，也降低重複檢查的潛在健康風險。藉此落實分級醫療「社區好醫院，厝邊好醫師」的理念，提升病患就醫品質及方便性，也減少醫學中心壅塞的問題。

另外，健保署於2016年7月將個人化雲端服務的「健康存摺」系統全新改版，提供已註冊健保卡的民眾免插卡即可登入系統查詢的服務，運用一目瞭然的視覺化資訊圖表，搭配篩選及分類功能，讓民眾快速瞭解個人最近的就醫紀錄、檢驗檢查結果及預防保健資料，直接掌握本身的健康狀況，進行自我健康管理。民眾也可以下載個人健康存摺資料加值運用或利用行動裝置登入「全民健保行動快易通APP」之「健康存摺APP版」，隨時查詢個人就醫資料，或於就醫時提供醫師參考，預期可縮短醫病間醫療資訊的不對等，提升醫療安全與效益。

健康存摺自2014年推出以來，使用人數不斷上升，截至2017年6月30日止，健康存摺使用人數約46萬人，使用人次已達326萬人次。約9成使用者認同透過健康存摺可瞭解個人就醫情形，有助於掌握自我健康情形，顯示健康存摺對於促進民眾自我健康照護有正向幫助。

電子申報提升作業效率

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

2004年配合健保卡全面上線後，健保署建置健保資訊網（VPN）作為與特約醫事服務機構雙向溝通之專用網路，特約醫事服務機構除了可透過VPN進行健保卡連線、認證、更新、上傳作業以外，更可進行費用申報等網路申報服務，提供更有效率之連線服務管道。2017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173萬筆、醫令約617萬筆資料。

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；為有效應用資訊資源及善

to upload computed tomography (CT) and magnetic resonance imaging (MRI) scans, which can be retrieved by local hospitals in case of follow-up consultations. It could help hospitals provide better medical services, helping larger medical centers avoid being swamped with patients, which would also improve hospital classification and patient referral systems.

In addition, the NHIA updated the personalized cloud-based service - the "My Health Bank" system in July 2016. This new "My Health Bank 2.0" enables patients with valid NHI cards to log into the system and query their records without the need to insert their cards in a card reader. The system's simple and intuitive graphic interface makes it easy for users to get a clear, accurate picture of their recent doctor visits, examination and test results, and preventive health care information, allowing users to play a more active role in monitoring and managing their own health. Individuals can also download personal My Health Bank value-added applications or use their mobile devices to log onto the My Health Bank app provided via the NHI mobile app. This empowers users to check their medical information at any time and use it as reference information to doctors when users receive care. The NHIA expects that this service will reduce the medical information asymmetry between doctors and patients, and thereby enhance medical safety and effectiveness.

The number of "My Health Bank" users has increased steadily since the system was introduced in 2014. As of June 30, 2017, the system had approximately 460,000 users, and downloads had been made over 3.2 million person-times. Approximately 90% of users agreed that "My Health Bank" helped them to better understand their medical care status and facilitated monitoring of their health condition. These results indicate that the system is making a positive contribution to encouraging people to pay greater attention to their own personal healthcare.

Enhancing Efficiency Through Electronic Claims

Since the inception of the NHI program, the NHIA has encouraged contracted medical organizations to employ the Internet, media, and the NHI VPN to report expenses claims, and statistics indicate that the use of electronic submission of medical expenses claims by contracted medical organizations is approaching 100%.

After NHI cards went fully electronic in 2004, the NHIA set up an NHI virtual private network（VPN）to facilitate two-way communication with contracted medical institutions. Apart from being able to use the VPN to perform uploading and online NHI card verification and updating, contracted medical organizations can also file their expenses claims more efficiently. In June 2017, an average of 1.73 million patient visit summaries containing approximately 6.17 million medical service orders（physician orders）were uploaded and verified daily through the system.

Furthermore, responding to the accelerating adoption of information technology by hospitals and clinics in recent years, the NHIA completed the introduction of the "Picture-Archiving and Communication System"（PACS）in September 2006, which established an online environment（including text and image data）for the professional review of medical expense reimbursement claims. This system is helping hospitals and clinics to perform online applications and reporting in connection with their reimbursement claims. In order to effectively apply information resources and make the best use of manpower, the NHIA instituted the centralized management of medical images and related electronic files in 2017. This initiative has prompted the NHIA to merge similar functions within the integration of operations, strengthened pre-authorization reviews, and added data processing functions for the random review of medical expenses, while also adding professional review of outpatient appeal cases,

用人力資源，於2017年完成醫療影像及相關電子化檔案集中化管理，並進行功能類似作業整併，強化事前審查、醫療費用抽樣審查案件資料處理功能，並將門診申復案件、住院申復案件、住院Tw-DRGs案件、重大傷病案件、牙位更正等之專業審查納入，同時串接健保署內部之醫療給付相關系統，使整個審核流程更加自動化，並提升原有人工審查作業的效率，降低行政作業成本。

為鼓勵更多醫療院所採用網路方式申報醫療費用，所有特約醫事服務機構申報作業以健保署健保卡資料管理中心（IDC）為單一入口，集中由全民健保資訊網路連線申報，健保署也配合作業需求，持續提供特約醫事服務機構更多更便捷的電子申報服務。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。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。

健保卡加速電子化管理

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

因民眾每次就醫紀錄，醫療院所均於健保卡登錄並於24小時內傳送至健保署，每天的門診與住院人次即可及時統計，針對某些異常就診的行為，健保署可及早發現而加以追蹤輔導。此外，保險對象器官捐贈或安寧緩和醫療意願之檔案，亦可註記於健保卡。

多重機制確保資訊安全

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

在網路系統上，則採用健保資訊網（Virtual Private Network, VPN）封閉性專屬

inpatient appeal cases, Tw-DRGs cases, catastrophic disease and injury, and orthodontic cases to the system.

At the same time, NHIA's internal medical payment system ensures even greater automation of review processes, enhancing the efficiency of originally-manual review procedures and reducing administrative costs.

To encourage even more hospitals and clinics to claim medical expenses online, the NHIA has established a single electronic window – the IC Card Data Center（IDC）– on its website where all contracted medical organizations can file expenses online. In conjunction with its operating needs, NHIA is also continuing to provide contracted medical organizations even more convenient electronic reporting services. For example, the introduction of e-certificates use to log onto the health insurance information network in January 2012 has provided medical institutions a more integrated authorization management system and enhanced the security of electronic network services. The NHIA also expects that its promotion of the exchange of medical imaging files between medical facilities will reduce the number of unnecessarily duplicated examinations and tests, while promoting the information exchange between hospitals.

Accelerating Digital Management of NHI Cards

To enhance the public's healthcare convenience, NHIA introduced IC health insurance cards on January 1, 2004 as a replacement for the previously-used paper cards and child healthcare handbooks, maternity healthcare handbooks, and catastrophic illness certification cards. The information that had been previously recorded on these four types of documents has now been encrypted and encoded in the new card's embedded chip. Alongside greater convenience, this shift also protects users' medical privacy, and allows doctors to refer to medication and examination data entered on the chips when performing diagnosis and treatment. The IC NHI cards have enhanced medical safety, and indirectly prevent the waste of health insurance medical resources.

Because hospitals and clinics must enter patients' visit records onto their health insurance cards, and then transmit this information to the NHIA within 24 hours, the NHIA is able to monitor daily outpatient and inpatient use person-times statistics, and is able to quickly discover and track irregular healthcare behavior, and provide prompt assistance. In addition, insureds can also note willingness to donate organs or desire not to be resuscitated or be given hospice care on their NHI cards.

Using Multiple Mechanisms to Ensure Information Security

NHI cards not only ensure privacy, but also facilitate the smooth flow of information through Taiwan's online medical information platform. The NHI card has received international recognition for its security management on several occasions. To safeguard information security, the card provides several anti-forgery features, and the embedded chip employs a number of mutual verification mechanisms intended to maintain data security.

Health insurance information is transmitted via the NHIA's dedicated VPN, which has multiple firewalls in an effort to reduce risk of hackers breaking into the system or stealing data. In addition, NHI cards records are entered in encoded form and encrypted during transmission, which effectively safeguards personal privacy.

To strengthen health insurance card and health insurance data safety management mechanisms, the NHIA established an information security task force in August 2003 responsible for managing security-related tasks and completion of system certification.

網路，設有多道防火牆，可降低駭客入侵系統或盜取資料之風險；健保卡紀錄均以代碼登載及亂碼傳輸，有效保障個人隱私。

為強化健保卡和健保資料的安全管理機制，健保署自2003年8月即成立「資通安全小組」，負責相關工作及推動認證，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），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2014年4月建置全署資安監控機制（Security Operation Center, SOC），進行全年無休之網路及電子郵件安全監控作業。

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務專區，提供更優質作業環境，讓服務更多元化。截至2017年6月底，使用之投保單位已有28.6萬家，每個月透過網路申報之異動資料約169萬筆，占全部異動量之78%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。

健保費繳納管道多元

健保署為體貼服務民眾，健保費之繳納管道因應時代的潮流，包括金融機構、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，及健保快易通APP行動支付等多元繳費方式，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2017年1～6月之繳納資料顯示，已使用多元管道繳納之民眾，金融機構臨櫃繳納（占41%）、金融機構轉帳代繳（占28%）及便利超商繳費（占31%），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。

In June and August of 2004, the NHI card's key management system（KMS）and IC Card Data Center（IDC）received BS7799 and CNS17800 security certification from the British Standards Institution（BSI）. The NHIA was the first government organization in Taiwan to receive CNS17800 certification from the Taiwan Accreditation Foundation（TAF）under authorization from the BSI.

The NHIA has also established a full-scale information security management system（ISMS）to ensure the security of medical information throughout the healthcare system. The NHIA's information unit passed ISO 27001 international information service standard certification in March 2006 and May 2008, and has received domestic and foreign UKAS & TAF information security certification. In 2010, in conjunction with organizational restructuring, the NHIA integrated its ISMS system and certification tasks, and again passed information security certification. After ISO/IEC 27001 certification was updated, the NHIA completed certification under the new ISO 27001: 2013 standard in 2015. Since then, in line with the spirit of the PDCA（Plan-Do-Check-Act）cycle, NHIA has continued to improve information security and protect the public's personal information.

In order to strengthen system-wide monitoring of information security and perform continuous monitoring of e-mail and online security, the NHIA established the Security Operation Center（SOC）in April 2014.

A Multiple Authentication Online Insurance Registration Platform

To realize e-government, the NHIA established a multiple authentication online insurance platform for insurance registration units to file enrolment data online when updating its online operating system in January 2006. Then, in October 2014, the NHIA added an online insurance services section to its website to ensure a better service environment and provide more diversified service. As of the end of June 2017, 286,000 insurance registration units（chiefly employers）had used this section, and had reported approximately 1.69 million data updates online each month, which accounted for more than 78% of all reported updates. The platform makes it easy for employers and individuals to use the Internet to apply or query information, and check on the status of their premium payments. Convenient and fast, this platform saves users the cost of filling out and transmitting forms, and the fact that users must first undergo electronic verification of their identities ensures a high level of security.

Diversified Premium Payment Channels

Responding to the changing times, the NHIA provides the public with a convenient choice of NHI premium payment channels, including payment via financial institution, convenience stores, mobile devices, and service counters at NHIA divisions. Alternatively, members of the public can opt for even more convenient bank account transfers, or ATM, online, or credit card payments. As a result, the public can pay NHI premiums via a variety of nearby or convenient locations and methods.

Premium payment data from the time the NHIA began offering multiple payment channels on January 1, 2007 until June 30, 2017 revealed that service counter payments at financial institutions（41%）, account transfers by financial institutions（28%）, and convenience store payments（31%）are the most popular payment methods. In addition, some individuals choose to make payments via ATMs or online. The NHIA is committed to providing the public with the widest possible variety of convenient premium payment methods, which meets the policy goals of simplifying government services and making life easier for the public.

Chapter 6

照顧弱勢　守護偏鄉

Caring for the Needy and Safeguarding Remote Areas

照顧弱勢　守護偏鄉
Caring for the Needy and Safeguarding Remote Areas

對經濟弱勢民眾的補助措施

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

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

表6-1 繳納健保費之協助措施成效
Table 6-1 Financial Assistance to the Disadvantaged

項目 Item	對象 Assisted Groups	期間 Period	人（件）數 No. of People/ Cases	金額 Amount
保費補助 Premium Subsidies	政府對特定弱勢者補助健保費，包括低收入戶、中低收入戶、無職業榮民、失業勞工及眷屬、身心障礙者、未滿20歲及55歲以上之無職業原住民 Government subsidies to the disadvantaged, including to low-income households, the near poor, unemployed veterans, unemployed workers and their dependents, people with disabilities, and unemployed indigenous people younger than 20 or older than 55.	2016.1~12	327萬人 3.24 million people	261億元 NT$26.1 billion
		2017.1~6	301萬人 3.01 million people	124.8億元 NT$12.48 billion
紓困貸款 Relief Loans	符合衛生福利部所訂經濟困難資格者 Those who qualify as economic difficult cases based on Ministry of Health and Welfare criteria	2016.1~12	2,339件 2,339 cases	1.70億元 NT$170 million
		2017.1~6	1,092件 1092 cases	0.80億元 NT$80 million
分期繳納 Installment Plans	欠繳保險費無力一次償還者 Those unable to pay overdue premiums at one time	2016.1~12	9.1萬件 91,000 cases	26.39億元 NT$2.639 billion
		2017.1~6	3.9萬件 39000 cases	11.12億元 NT$1.112 billion

資料時間：2016年1 月1 日～ 2017年6 月30 日。
Note: Dated from Jan. 1, 2016 to June 30, 2017

Subsidy Programs for the Economically Disadvantaged

Under the NHI's compulsory enrollment system, it is inevitable that some low-income families and economically-disadvantaged groups may not be able to afford health insurance premiums. To ensure that all citizens have access to care, the NHIA provides many assistance measures aimed at maintaining a strong safety net and the spirit of mutual assistance. The NHIA consequently offers numerous premium payment assistance measures aimed at patients with catastrophic illnesses, such as cancer, kidney diseases requiring dialysis, hemophilia, and mental illness, and economically-disadvantaged citizens. Furthermore, the NHIA also provides medical and economic assistance to people living in remote areas or suffering from rare or critical illnesses. Current assistance measures include premium subsidies, relief loans, and installment payment plans（see Table 6-1 for assistance results）.

Premium Subsidies for Disadvantaged Groups

Various levels of government provide NHI premium subsidies to the members of specific disadvantaged groups, including low-income families, the near poor, unemployed veterans, unemployed workers and their dependents, persons with disabilities, and unemployed indigenous citizens under the age of 20 and over the age of 55. A total of approximately NT$26.1 billion in premium subsidies was provided to roughly 3.27 million individuals in 2016. During 2017, approximately NT$12.48 billion in premium subsidies had been provided to roughly 3.01 million individuals as of June 30, 2017.

Relief Loans

The NHIA provides interest-free loans to people facing economic hardship so that they can pay their NHI premiums and unpaid out-of-pocket medical expenses, thus safeguarding their right to care. During 2016, a total of 2,339 loans amounting to NT$170 million were made throughout the year, and 1,092 loans totalling NT$80 million had been made as of June 30, 2017.

Installment Payment Plans

Those who do not qualify for relief loans, but cannot pay their overdue premiums of NT$ 2000 or above at one time due to economic hardship, are eligible to repay the overdue amount in installments. Permission was granted in 91,000 cases to repay NT$2.64 billion in installments in 2016, and permission was granted in 39,000 cases to repay NT$1.11 billion in installments up until June 30 2017.

Referral to Premium Assistance from Public Interest Groups

The NHIA may refer persons unable to pay their NHI premiums to seek assistance from public interest groups, companies, and personal charities. In 2016, 8,489 cases were successfully referred to charitable sources of assistance, and a total of more than NT$25.8 million in subsidies were provided. In 2017, 3,713 cases were successfully referred and received over NT$9.44 in subsidies during the first six months of the year.

Protecting the Right to Care of the Economically Disadvantaged

In order to realize the universal right to equal medical care and fulfill President Tsai,

之無職業原住民，2016年全年補助金額約261億元，補助人數約327萬人。另，2017年截至6月30日止，補助金額約124.8億元，補助人數約301萬人。

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。2016年全年共核貸2,339件，金額1.70億元。2017年截至6月30日止，共核貸1,092件，金額0.80億元。

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，2016年全年辦理分期繳納共9.1萬件，合計26.39億元。另2017年截至6月30日止，辦理分期繳納共3.9萬件，合計11.12億元。

轉介公益團體補助保險費

對於無力繳納健保費者，健保署提供轉介公益團體、企業及個人愛心捐款，以補助其健保費。2016年全年轉介成功個案計8,489件，補助金額共2,578萬餘元。2017年截至6底止，轉介成功個案計3,713件，補助金額共944萬餘元。

保障弱勢民眾就醫權益

為落實醫療平權之普世價值，及蔡總統競選時醫療主張，有關符合健保投保資格就可憑健保卡就醫，全面廢除健保欠費鎖卡政見，健保署2016年6月7日起實施「健保欠費與就醫權脫鉤（全面解卡）案」，推動健保全面解卡，給予國人就醫權益的公平性保障，民眾只要辦理投保手續，均可安心就醫。健保全面解卡象徵著醫療人權更上一層樓，受惠對象絕非過去欠費遭鎖卡者，而是藉著廢除鎖卡制度，才能夠真正去除弱勢民眾心中恐懼欠費無法就醫的枷鎖，更加落實政府照顧弱勢，保障全民就醫權益之宗旨。

全民健保對弱勢民眾積極提供各種保障措施，建構完整的健保經濟困難民眾保護傘，排除民眾參加健保之經濟障礙，使經濟困難民眾隨時享有妥適之醫療照護，協助其辦理投保、健保費紓困、轉介、分期繳納等，2016年全年獲得醫療保障者計1,156件，金額0.4億元。2017年截至6月30日止，獲得醫療保障者計331件，金額696萬元。

爭取公益彩券回饋金協助弱勢族群

為落實照顧弱勢族群，保障其就醫權益，健保署除既有分期繳納、紓困貸款及愛心專戶等協助措施外，自2008年起爭取公益彩券回饋金辦理「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2017年6月底，累計補助金額已達36.63億元，累計補助人數達213,137人（表6-2）。

減輕特定病患就醫部分負擔費用

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

Ing-wen's campaign promise that all insured can use their NHI card to receive medical care, and the policy of locking the cards of persons who cannot afford their premiums would be abandoned, the NHIA instituted the "decoupling of the payment of premiums from the right to receive medical care" effective on June 7, 2016 to unlock all inaccessible cards, and guarantee all citizens enrolled in the NHI their rights to enjoy medical care. The full-scale unlocking of health insurance cards symbolizes a new level of protection of the human right to receive medical care. Furthermore, cards will no longer be locked for failure to pay premiums. By revoking the practice of card locking, the NHIA has removed the fear felt by the disadvantaged that they will not be able to receive care when they need it. The move embodies the government's goal of protecting of the weakest in society and safeguarding the people's right to healthcare.

The various protective measures for people suffering from economic hardships provided by the NHI form a comprehensive umbrella to safeguard the health of those disadvantaged. By eliminating economic obstacles to people participating in the NHI through assistance with the enrollment of insurance, premium relief loans, referrals to assistance, and installment payment plans, the NHIA has ensured that people suffering difficult economic circumstances can still enjoy adequate medical care at any time. The NHIA provided medical safeguards in the amount of NT$40 million in 1,156 cases during 2016, and NT$6.96 million in 331 cases during the first six months of 2017.

Obtaining Lottery Funds to Assist Disadvantaged Groups

In order to provide care to disadvantaged groups, in addition to installment plans, relief loans, and referrals to assistance, the NHIA has also used lottery funds since 2008 to implement the "Program to Ease the Medical Care Burden of Disadvantaged Persons." Under this program, the NHIA actively selects and notifies people who are eligible for this program, and helps them to pay overdue health insurance premiums. As of the end of June 2017, the cumulative subsidies provided to this program totaled NT$3.66 billion, and a cumulative total of 213,137 persons had benefited from it（Table 6-2）.

健保署長李伯璋視察東沙醫療持續關心離島偏鄉
NHI Director General, Dr. Po-Chang Lee, inspected the healthcare services in Pratas Island

Easing the Financial Burden of Copayments

Persons certified as having disabilities pay a basic clinic copayment of NT$50 for outpatient care, regardless of where they receive care; this amount is lower than the copayments paid by the general public（NT$80-NT$360）.

Individuals with catastrophic illnesses, such as cancer, chronic mental illness, kidney diseases requiring dialysis, and other rare and congenital diseases, are exempt from paying copayments for the treatment of those diseases.

表6-2 歷年公益彩券回饋金補助成果表
Table 6-2 Contributions from Public Welfare Lotteries Gains

年度 Year	計畫名稱 Program Description	人數 No. of Beneficiaries	金額（新臺幣：億元） Amount
2008	協助弱勢民眾繳納全民健康保險保險費計畫 Help the disadvantaged pay NHI premiums	26,446	4.00 NT$400 million
2009	協助弱勢族群減輕就醫負擔計畫 Help people in natural disaster-affected regions pay premiums owed	19,308	3.95 NT$395 million
	協助風災災民及災區民眾繳納健保欠費計畫 Help people in natural disaster-affected regions pay premiums owed	19,841	3.78 NT$378 million
2010	協助弱勢族群減輕就醫負擔計畫 Help the disadvantaged defray their medical expenses	7,888	3.79 NT$379 million
2011	協助弱勢族群減輕就醫負擔計畫 Help the disadvantaged defray their medical expenses	18,222	3.81 NT$381 million
2012	協助弱勢族群減輕就醫負擔計畫 Help the disadvantaged defray their medical expenses	13,882	3.24 NT$324 million
	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 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	0.03 NT$3 million
2013	協助弱勢族群減輕就醫負擔計畫 Help the disadvantaged defray their medical expenses	19,185	4.01 NT$401 million
	協助未成年人繳納健保欠費及紓困未還款計畫 Program to help minors pay premiums owed or offer relaxed payment terms	1,717	0.21 NT$21 million
2014	協助弱勢族群減輕就醫負擔計畫 Help the disadvantaged defray their medical expenses	32,025	4.00 NT$400 million
	協助未成年人繳納健保欠費及紓困未還款計畫 Program to help minors pay premiums owed or offer relaxed payment terms	249	0.02 NT$2 million
2015	協助弱勢族群減輕就醫負擔計畫 Help the disadvantaged defray their medical expenses	21,841	2.56 NT$256 million
	花東兩縣新住民健保弱勢保險欠費協助計畫 Program to assist disadvantaged new immigrants in Hualien and Taitung counties pay premiums owed	101	0.02 NT$2 million
2016	協助弱勢族群減輕就醫負擔計畫 Help the disadvantaged defray their medical expenses	20,264	2.34 NT$234 million
	協助偏鄉原住民、高齡邊緣戶及馬上關懷整合型試辦計畫 Help indigenous people living in remote areas, marginalized elderly ouseholds, and beneficiaries of the “Immediate Assistance” pilot program	309	0.06 NT$6 million
2017 上半年 First half of 2017	協助弱勢族群減輕就醫負擔計畫 Program to Ease the Medical Care Burden of Disadvantaged Persons	11,709	0.80 NT$80 million
	協助弱勢兒少、高齡家庭及偏鄉原住民整合型計畫 Integrated Program to Assist Disadvantaged Children, Elderly Households, and Indigenous Persons Living in Isolated Areas	39	0.01 NT$1 million
總計		213,137	36.63 NT$3,663 million

註：資料時間截至2017年6月底。

Note: Figures as of the end of June 2017

To safeguard the rights of patients with rare diseases, the NHI uses special earmarked funds to pay for drugs designated by the Ministry of Health and Welfare as necessary to treat rare diseases, easing the economic burden of care for such patients.

Care for Medically Vulnerable Groups

People with disabilities

The trial program for providing dental services to persons with disabilities, introduced by NHIA in 2002, offers higher reimbursements to encourage dentists to provide dental care to patients with congenital cleft lips and palate, and other groups with specific disabilities.

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

People with catastrophic illnesses

The 30 catastrophic illnesses announced by the NHIA include cancer, chronic mental illness, end-stage renal failure, and congenital

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

對疾病弱勢族群照護

身心障礙者：

健保署自2002年起施行「牙醫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。

至2006年起放寬可由各縣市牙醫師公會或牙醫團體組成醫療團，定期至身心障礙福利機構服務、支援未設牙科之精神科醫院或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，新增提供入住身心障礙機構之長期臥床者牙醫服務。2014年1月1日起增加政府立案收容發展遲緩兒童機構者機構服務。2015年1月1日起進一步提供衛生福利部所屬老人福利機構內，長期臥床者牙醫診療服務。

重大傷病患者：

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

截至2017年6月底，重大傷病證明有效領證數約有95萬5千餘張（人數為89萬餘人，約占總保險對象的3.77%），而2016年全年重大傷病醫療費用約1,814億餘元（占全年總醫療支出的27.4%），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。

罕病患者：

罕見疾病屬重大傷病範圍項目，就醫時可免除部分負擔，衛生福利部公告的罕見疾病種類有216項，截至2016年12月底止，領證數共10,509張。經統計2016年罕見疾病之醫療費用約45.3億元，其中藥品費用約為41.6億元。

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

多重慢性病患者：

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

conditions, all of which are very costly to treat. Insured individuals with a catastrophic illness card are exempt from copayments when obtaining treatment of these conditions.

As of the end of June 2017, a total of more than 955,000 catastrophic illness cards had been issued（to over 890,000 people, who accounted for 3.77% of all insured）. In 2016, the cost of treating catastrophic illnesses totalled approximately NT$181 billion, and accounted for 27.4% of all NHI medical expenditures. Roughly NT$40 billion in NHI expenditures goes for the purchase of drugs needed to treat catastrophic illnesses, and this amount is nearly 30% of the NHI system's total medication expenditures. These high level of spending on the treatment of catastrophic illnesses reveals the tremendous assistance that the NHI system provides to these individuals.

中部地區醫師響應投入居家醫療服務
Physicians from Central Taiwan declared their supports to home health care.

People with rare diseases

Individuals with rare diseases classified as catastrophic illnesses are exempt from copayments when being treated for their condition. The Ministry of Health and Welfare currently recognizes 216 types of rare diseases, and had issued 10,509 rare disease verification cards as of the end of December 2016. Medical expenditures for the treatment of rare diseases totalled approximately NT$4.53 billion during 2016, of which roughly NT$4.16 was used for the purchase of medications.

People with multiple chronic diseases

Patients with multiple chronic diseases consume the largest share of resources in Taiwan's healthcare system. With the aging of Taiwan's population, the prevalence of multiple chronic diseases has been increasing steadily, and the care of these individuals is becoming an important issue. To ensure that such patients obtain integrated care services, and avoid redundant or inappropriate medications, examinations and treatment, the NHIA initiated the "Hospital Integrated Care Program" on December 1, 2009. Patients participating in this program have lower copayments and registration fees, reduced visit and transportation time, and increased care safety and quality.

In order to provide necessary care to patients with rare diseases and ease their medical care burdens, reimbursement standards for all medications designated for use in the treatment of rare diseases must be promptly included in the NHI Drug List and Fee Schedule.

In the years since this program was introduced, participants have consistently made fewer doctor visits than they did during the previous year, which reveals the program's excellent effectiveness. Under this program

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。2017年參與整合照護之醫院計189家，照護對象中屬失智、三高疾病及高齡多重慢性疾病等，截至2017年6月重點照護對象約收案19.8萬餘人（其中多重慢性病患約13萬人），醫院自行收案者約21.8萬餘人，合計整體約41.6萬餘人接受整合照護。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。

山地離島地區醫療給付效益提升計畫回顧與前瞻研討會
Integrated Delivery System Program Review Seminar

對山地離島、偏鄉及醫療資源缺乏地區族群的照護

全民健康保險山地離島地區醫療效益提昇計畫：

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

目前全國公告之山地離島鄉計有50鄉，共26家特約院所承作30項計畫，支援當地醫療服務。

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6.4億元，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。

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，2017年計有90家醫院參與。

in 2017, a total of 189 hospitals participated in providing integrated care to patients who chiefly suffered from dementia, hypertension/hyperglycemia, and chronic disease of the elderly. As of June 2017, core target patients numbered 198,000 of which 130,000 had multiple chronic diseases), and another 218,000 patients had been directly accepted into the program by hospitals. As a result, a grand total of approximately 416,000 persons are receiving integrated care. 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

Integrated Delivery System (IDS)

Due to their isolated geographical environment and inconvenient transportation, Taiwan's mountain areas and offshore islands are universally lacking in medical resources. As a consequence, the NHIA has drafted plans to induce willing and capable hospitals and clinics to send adequate medical manpower to these underserved areas. Introduced in November 1999, the Integrated Delivery System (IDS) encourages large hospitals to provide specialized medical service, emergency services, and overnight care in mountain areas and on offshore islands at fixed locations or through roving services.

Improvement Plan for Medically Underserved Areas

The IDS program currently covers 50 townships in mountain areas and on offshore islands. A total of 26 contracted hospitals and clinics are implementing 30 projects to support local medical service in these areas.

The NHIA devotes an additional NT$640 million annually to towns and townships with insufficient medical resources, and is implementing the Improvement Plan for Medically Underserved Areas to encourage dentists, physicians, and Chinese medicine physicians to work in underserved areas in the spirit of "local service," or provide healthcare services in such areas on a roving basis.

Upgrading Medical Services in Underserved Areas

The NHIA introduced the Medical Service Improvement Program for Underserved Areas in 2012 in order to strengthen medical services and preventive healthcare at the community level on offshore islands, in mountainous areas, and other areas lacking in medical resources. This program, which has an earmarked budget and guaranteed point values, encourages hospitals in the foregoing areas or nearby to provide 24-hour emergency services, and internal medicine, surgical, gynecological/obstetric, and pediatric outpatient and inpatient services. Ninety hospitals were participating in 2017, helping to improve the provision of convenient services at a more local level.

Chapter 7

民眾滿意　國際肯定

Public Satisfaction and International Recognition

民眾滿意　國際肯定
Public Satisfaction and International Recognition

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、等候時間短、全民納保及行政經費最有節制等等成就，更在國際上贏得好評。

今年世界衛生組織（WHO）在瑞士日內瓦召開「世界衛生大會」期間，我國衛生福利部在5月23日於當地與瑞士衛生政策協會（SGGP）合辦「台瑞健保交流座談會」，這場座談會由日內瓦大學全球健康研究院包利許教授（Prof. Bettina Borisch）主持，由衛福部陳時中部長率領健保署李伯璋署長等人出席，陳部長開場致辭後，李伯璋署長以「新世代台灣健保成就與挑戰」為題發表專題演講，與會者有瑞士方面產、官、學、界等對健保改革具影響力之重要人士，雙方討論熱烈，因我國採行單一保險人制度，且有行政成本低，而瑞士則採多元保險人制度，因此該協會希望向我方取經，供瑞士當局參考。

除此之外，健保署自2003年起，即參加國際健康經濟學會（International Health Economics Association，簡稱iHEA）每兩年舉行一次國際研討會，並於該學會大會期間辦理「台灣健保專題會議」，邀請國際重量級經濟學家、國際組織成員，例如世界銀行、世界衛生組織、OECD專家參加，會議中由健保署代表報告台灣全民健保成果，再請國際學者評論，2017年7月亦由健保署李署長代表參加假美國波士頓大學舉辦之大會，並於「台灣健保專題會議」中發表「利用健康資訊大數據提升健保服務品質及效率」（Big Data and Health Information as Drivers for Efficiency and Quality Improvements），由美國普林斯頓大學鄭宗美（Ms. Tsung-Mei Cheng）研究員主持，美國智

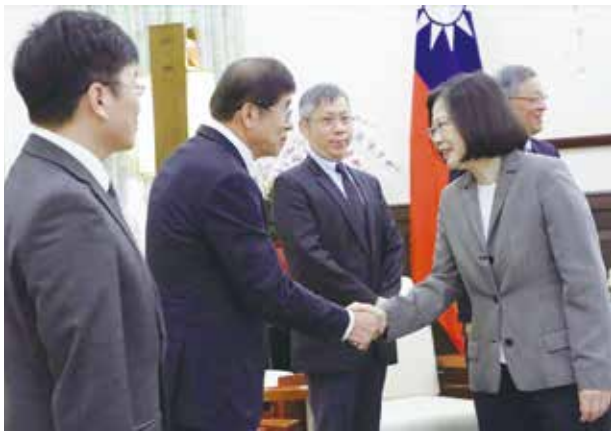
台瑞健保交流座談會
Taiwan-Switzerland National Health Insurance Workshop

Internationally Acclaimed NHI Experiences

Since the introduction of the NHI, the NHIA has gradually achieved its goal of easing the public's medical care burden with the support of the people of Taiwan and the medical community. In particular, the NHIA has succeeded in easing the NHI premium burden, reducing administrative expenditures, shortening waiting time, and minimizing the insurance administration cost, which has earned the NHIA widespread international acclaim.

During the World Health Organizaiton Assembly held in Geneva, Switzerland this year by the World Health Organization WHO）, the Ministry of Health and Welfare jointly hold the "Taiwan-Switzerland National Health Insurance Workshop" with the Swiss Society for Health Policy SGGP）on May 23, 2017. This workshop was hosted by Prof. Bettina Borisch of the Institute of Global Health, University of Geneva. The Minister of Health and Welfare Shih-Chung Chen, the NHIA Director General Po-Chang Lee, and other officials from Taiwan were in attendance. After Minister Chen gave an opening speech, Director General Lee gave a talk on the topic of "Accomplishments and Challenges of Taiwan's NHI in the New Era." Participants at the workshop included experts from Swiss health insurance industry, government, and academia who have exerted significant influence on health insurance reforms in the country. The two parties engaged in enthusiastic discussions. Because Taiwan has a single-payer system and low administrative costs, while Switzerland has a multiple-payer system, the SGGP hoped to learn from Taiwan's experiences and provide reference information to the Swiss authorities.

Furthermore, the NHIA has participated in the biennial International Health Economics Association iHEA）Congress and held a Special Session on National Health Insurance in Taiwan during the congress period since 2003. The NHIA's representative would present one selected topic of Taiwan's NHI performances followed by two or three international scholars to respond on the subject. A number of heavy-weighted international health economists and members of international organizations as the World Bank, the WHO, and the OECD, were invited to this event. In July 2017, Director General Po-Chang Lee attended an iHEA



蔡總統接見世衛行動團
President Tsai Ing-wen meets members of Taiwan's WHA Action Team

iHEA 台灣健保專題會議
iHEA Symposium on Health Insurance in Taiwan.

美國南達科他州衛生廳廳長 Ms. Kim Malsam-Rysdon、阿拉巴馬州公共衛生廳廳長 Dr. Tom Miller、新墨西哥州社福廳廳長 Mr. Brent Earnest、科羅拉多州公共衛生與環境廳廳長 Dr. Larry Wolk、猶他州社福廳廳長 Ms. Ann Silverberg Williamson 及美國杜克大學教授 Pikuei Tu 及 Sheryl Lin 來訪。

Ms. Kim Malsam-Rysdon, secretary of the South Dakota Department of Health, Alabama State Health Officer Dr. Tom Miller, Brent Earnest, Secretary for the Human Services Department of New Mexico, Dr. Larry Wolk, executive director of the Colorado Department of Public Health and Environment, Ms. Ann Silverberg Williamson, Executive Director of Utah's Department of Human Services, and professors Pikuei Tu and Sheryl Lin of Duke University visit the NHIA.

庫聯邦基金會總裁、前美國國家健康資訊整合辦公室主任暨哈佛大學David Blumenthal教授，以及南丹麥大學Terkel Christiansen教授為回應人，現場反應極為熱烈。

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。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。2016年6月至2017年6月健保署共接待全球54國，計700位外賓參訪。過去也有許多國際媒體來台灣報導全民健保實施的成功經驗。

2017年3月日本NHK生活及健康情報節目「ガッテン！」（中譯：瞭解！）即介紹台灣的健保成果與大數據資料應用，因台灣許多健康類學術研究都以健保資料庫作為來源，令日人稱奇，加上國人拿健保卡做為就醫憑證，是日本所未見的，故以整集節目介紹台灣的健保卡與健保資料庫的應用，同時也介紹健保署推動「雲端藥歷系統」、「健康存摺」等成果。

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。

2008年美國公共電視網（Public Broadcasting Service, PBS）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

conference held at Boston University, and spoke on the topic of "Big Data and Health Information as Drivers for Efficiency and Quality Improvements" at the Taiwan Session. The session was chaired by Ms. Tsung-Mei Cheng, a researcher affiliated with Princeton University, and excellent responses were given by Dr. David Blumenthal, the president of The Commonwealth Fund and professor of Harvard University; and Dr. Terkel Christiansen of the University of Southern Denmark at the event.

Taiwan's NHI employs a single-payer insurance system with centralization and overall planning of resources and a broad range of applicability. Compared with other countries' health care systems, Taiwan has relatively low administrative costs and achieves the advantage of fair and consistent premiums, which makes it a subject of study by other countries. Large numbers of foreign experts, scholars, and official representatives visit Taiwan each year to learn about its health insurance system. From June 2016 to June 2017, the NHIA hosted 700 visiting foreign guests from 54 countries worldwide. Many international media personnel have also visited Taiwan to report on the successful experience of the NHI system.

In March 2017, Japan's NHK life and health information program "Tameshite Gatten" ("Understand!") introduced Taiwan's health insurance results and big data applications. Japanese researchers are surprised that so many academic studies on health-related studies in Taiwan rely on the NHI database as their source of data, and the Japanese cannot simply obtain medical care upon presentation of their health insurance card, as the people of Taiwan can. As a result, this program provided a thorough introduction to Taiwan's health insurance cards and health insurance database applications, and also introduced the performances of NHIA's PharmaCloud and My Health Bank systems.

In 2012, the American cable news network CNN presented a special report comparing the strengths and weaknesses of the health insurance systems of Taiwan, the Great Britain, and the Switzerland, and discussed how the experiences of these three countries could be applied to reform the health insurance system in the US. 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 and concluded that Taiwan's NHI program has been a success over the years because it has managed to deliver high standards of care, while keeping costs down and enabling all citizens to receive comprehensive health care.

In 2008 the US Public Broadcasting Service (PBS) produced a Frontline series called "Sick Around the World," which focused on the health care systems of Britain, Taiwan, Germany, Switzerland, and Japan as a reference for health insurance issues in the US. On top of praising the Western medicine, dental, Chinese medicine, and mental illness care services provided in Taiwan, the report on Taiwan's healthcare system also examined Taiwan's smart health insurance card use and the fact that medical care expenses are only one-half of those in the US. This report not only attracted attention to Taiwan's National Health Insurance achievements, but also did much to burnish Taiwan's international reputation.

Aside from international media coverage, a number of international journals have examined Taiwan's health insurance experience and achievements in the hopes that Taiwan can serve as a model for other countries to learn from. For instance, in 2008, the US-based Annals of Internal Medicine published an article

供西醫、牙醫、中醫及精神疾病照護服務外、智慧型健保卡的使用、醫療照護費用不及美國一半等優勢，都成為探討的重點，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。

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 January 2008 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，強調美國人民所擔憂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研究員發表的 “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。

HealthAffairs	健康經濟雜誌	"Reflections on the 20th Anniversary of Taiwan's Single-Payer National Health Insurance System," Health Affairs March Issue
	美國參議院聽證會	The United States Senate Subcommittee Hearing - Access and Cost: What the US Health Care System Can Learn from Other Countrie
HSBC	英國匯豐銀行	Taiwan has a well-run health care system
The New York Times	紐約時報	Taiwan's Progress on Health Care by Uwe E. Reinhardt
NATIONAL GEOGRAPHIC CHANNEL	國家地理頻道	NGC Documentary featuring "Taiwan's Medical Miracle" to premiere
TIME	時代雜誌	Health Insurance Is for Everyone by Fareed Zakaria
CNN	美國有線電視新聞網	GPS Special: Global Lessons-The GPS Road Map for Saving Health Care
The Washington Post	華盛頓郵報	5 Myths About Health Care Around the World by T.R. Reid
PBS	美國公共電視	Taiwan featured in one of the U.S. Public Broadcasting Service's (PBS)Frontline series called "Sick around the world"
The New York Times	紐約時報	"Pride, Prejudice, Insurance" by Paul Krugman

entitled "Learning from Taiwan: Experience with Universal Health Insurance," which 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 healthcare policies had helped improve the life expectancies of socially disadvantaged groups and narrowed the disparity in care between the wealthy and the poor. Around the same time, in a column in the January 12, 2008 issue of the British Medical Journal（BMJ, Vol. 336）entitled "Humbled in Taiwan," noted health economist Uwe Reinhardt stressed the high administrative efficiency of Taiwan's NHI system and suggested that the United States should be humbled and inspired by Taiwan's experience. Also in 2008, an article in the US political magazine Dissent entitled "Health Care in Taiwan: Why Can't the United States Learn Some Lessons?" introduced Taiwan's healthcare system and stressed that the government abuses that Americans fear would result from a single-payer scheme had yet to materialize in Taiwan. In Africa, a column in the summer 2009 issue of the quarterly Jamahiriya Medical Journal in Libya introduced the special characteristics of Taiwan's NHI system and suggested that countries around the world should be like Taiwan and learn from the experience of others. It argued that free market healthcare 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, in 2015, the American health policy journal Health Affairs published an analysis entitled "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, 2008 Nobel Laureate and Princeton University professor, Paul Krugman, praised Taiwan's health care system in a November 7, 2005 New York Times column entitled "Pride, Prejudice, Insurance," writing that Taiwan had reached nearly universal coverage without much of an increase in health expenditures. An October 2009 special report on "Health Care in Taiwan" on the US online news site Global Post praised Taiwan's health insurance system, which it called "the most acclaimed health insurance system in Asia," 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 emulate Taiwan.

Delivering Satisfaction

The NHI system has faced many difficulties, and the public's satisfaction with the system was below 40% in the early days. Today, public satisfaction is over 80%, making it clear that the system enjoys a high level of public approval. Although the system's satisfaction rating fell following increases in premiums and copayments in 2002 and in the wake of some fine-tuning of the system in 2005, it quickly rebounded to over 70% in the wake of these changes. Second-generation NHI, which was introduced since January 2013, collects supplementary premiums from individuals with higher incomes. Although public satisfaction again dropped during the first half of the year, it rose again to around 80% during the second half of 2013（Chart 7-1）. In comparison with the member states of the OECD, Taiwan has been able to provide more comprehensive healthcare and medical

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，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。

全民健保　民眾滿意

全民健保實施曾面臨諸多困難，從一開始的滿意度不到4成，到目前持續成長至8成以上，顯見民眾十分肯定健保。其中雖曾因2002年度保險費率及部分負擔調整，以及2005年度開始進行多元微調，導致民眾對全民健保的滿意度稍有下降，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7-1）。與經濟合作暨發展組織（OECD）各會員國比較，我國因有全民健保，對經濟弱勢民眾的健康照護，能提供更完善的醫療保障。

充分發揮　互助功能

全民健保的核心價值在於透過社會互助，以「社會保險」的形式，來分擔保險對象罹病時的財務風險。重大傷病人口占全體保險對象人數的3.77%，醫療費用卻高達健保總醫療支出的27.4%。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5.5倍到113.6倍不等，顯示健保充分發揮了社會保險互助的功能，使重大傷病患者不致因病而貧（表7-1）。

表7-1　健保醫療資源利用情形
Table 7-1　NHI Medical Resource Utilization Status

類別 Category	醫療費用（點） Medical expenses（points）	平均值倍數 Equivalency
全國每人平均 National average	27,873	1.0
每一重大傷病患者 Average catastrophic illness patient	194,736	7.0
每一癌症患者 Average cancer patient	153,324	5.5
每一罕病患者 Average rare diseases patient	634,286	22.8
每一洗腎患者 Average kidney dialysis patient	601,203	21.6
每一呼吸器患者 Average patient on mechanical ventilation	725,171	26.0
每一血友病患者 Average hemophilia patient	3,166,342	113.6

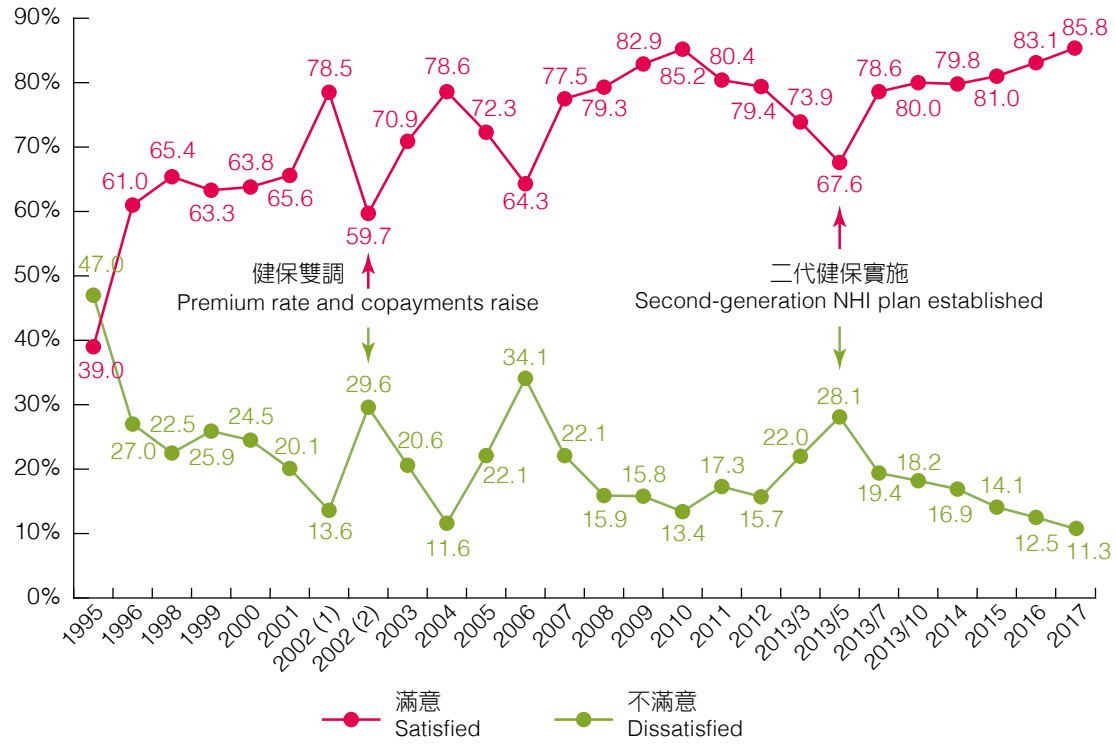
註：以2016年重大傷病年度統計資料為例（2017/8/9擷取）。
Note: The above figures are based on 2016 catastrophic illness statistics（retrieved on Aug. 9, 2017）.

protections to economically disadvantaged citizens.

Harnessing the Power of Mutual Assistance

The core value of the NHI system is its reliance on mutual assistance to have all of society share the financial risk of caring for those who get sick through a social insurance mechanism. Although patients with catastrophic illnesses account for 3.77% of all persons enrolled in the system, they also account for as much as 27.4% of all health insurance medical expenditures. Among these catastrophic illnesses, the average medical expenses of persons with cancer, kidney disease requiring dialysis, and hemophilia are from 5.5 to 113.6 times those of the general public. This situation manifested NHI's role as a social insurance system, and ensured that patients with catastrophic illnesses are not driven into poverty by medical bills（Table 7-1）.

圖7-1 Chart 7-1 全民健保歷年滿意度調查結果 Trend of NHI Satisfaction Surveys



註1：2002年，保險費率及部分負擔調整。
註2：2005年，投保金額上限、軍公教人員投保金額及菸品健康捐金額等調整。
註3：2013年，二代健保實施。
Note 1: The dip in satisfaction rates in 2002 corresponds with a period of adjustment for premium rates and copayments.
Note 2: Similarly, 2005 saw an adjustment to payroll bracket upper limits, the payroll brackets for military, civil service, and teaching personnel, and the amount of tobacco health and welfare surcharges.
Note 3: The year 2013 saw the implementation of the 2nd Generation NHI system.

跨步精進　展望未來

Recent Progress and
Future Outlook


alth Care Reform

跨步精進　展望未來
Recent Progress and Future Outlook

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

珍惜健保資源、加強分級醫療

為逐步推動分級醫療，已擬定「提升基層醫療服務量能」、「導引民眾轉診就醫習慣與調整部分負擔」、「調高醫院重症支付標準，導引醫院減少輕症服務」、「強化醫院與診所醫療合作服務，提供連續性照護」、「提升民眾自我照護知能」及「加強醫療財團法人管理」等6項策略及24項配套措施依序實施，短期內朝壯大基層醫療實力，建構基層診所與醫院好的合作機制等方向努力。提升醫療品質與量能，讓基層提供民眾優質的照護服務，亦可減輕大型醫院之負荷，並能更專注提供急重症醫療。

從社區到醫院連續性全人照護

居家醫療整合照護

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

為改善不同類型居家醫療照護片段式之服務模式，自2016年2月起健保署將一般居家照護、呼吸居家照護、安寧居家療護等4項服務，

After many years of laying the groundwork, the NHI system has earned international acclaim through its many major accomplishments, and also serving as a model for other countries in the process of building or reforming their systems. Looking ahead to the future, changes in Taiwan’ s overall environment and social structure, and growing constraints on medical resources, the NHI will continue to perform rolling reviews for improvements. The NHIA plans to implements reforms in the following areas as it maps out its blueprint for the future:

Making the Most of Resources and Strengthening Hierarchically Integrated Healthcare System

In order to gradually implement hierarchically integrated healthcare system, the NHIA has drafted six strategies of “enhancing the capacity of primary care,” “diverting the public to get used to the referral system and adjusting copayments,” “Increasing payments to hospital for cirtical care as an incentive to reduce their services for minor illnesses,” “strengthening cooperation between hospitals and clinics to ensure continuous care,” “promoting the public’s capacity for self-care,” and “bolster the management of medical foundations,” and 24 accompanying measures. In the short-term, the NHIA seeks to strengthen primary care capabilities, and develop effective cooperation mechanisms among primary care clinics and hospitals. By enhancing medical quality and capabilities, it is hoped that primary care providers can offer the public superior care services, so that large hospitals can reduce their burden and focus more on the provision of emergency and critical care.

Continuous and Holistic Care from the Community to Hospitals

Residential Integrated Care

The NHI began implementing seven types of residential care, including basic home care for patients with impaired mobility, home care for patients with chronic mental illness, home care for ventilator-dependent patients, and hospice care since 1995. More than 100,000 people received home care medical services in 2015. It is well known that patients’ care needs can change during the home care process as their conditions shift. If a patient’s condition stabilizes, their treatment can be changed from general home care to home medical visits; if however their illnesses become terminal, their treatment can be changed from general home care to hospice care. As the type of treatment changes, patients may have to be transferred to institutions providing the necessary services.

In order to improve the fragmented service models of different types of home care, the NHIA integrated four types of service, including general home care, respiratory home care, and hospice care, as the “Integrated Home Health Care Program” in February 2016. In addition to strengthening case management mechanisms and promoting cooperative team care in the community, this program also calls for the horizontal integration of various types of medical personnel and the vertical integration of upstream and downstream hospitals and clinics, and seeks to provide comprehensive patient-centered medical services.

As of the end of May 2017, 1,453 medical organizations had organized 157 teams to provide care to 15,611 persons. The NHIA will continue to encourage the establishment of

整合為「居家醫療照護整合計畫」。計畫的特色為擴大照護對象、強化個案管理機制，且著重於促進社區內照護團隊之合作，包括各類醫事人員間之水平整合，及上、下游醫療院所之垂直整合，以病人為中心提供完整醫療服務。

截至2017年6月底，有1,453家醫事服務機構組成157個團隊，就近照護15,611人。健保署將持續鼓勵組成社區內照護團隊，並均衡分布於各區域，以照顧更多行動不便患者，讓病患回歸社區生活，減少不必要之社會性住院。

安寧療護維護生命品質

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

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

為推動社區化之安寧照護，健保署持續結合居家醫療整合團隊及家庭醫師群來推動，由住家附近之醫療院所提供服務，讓末期病患回歸社區與在地安老。2016年接受全民健保安寧居家服務人數為8,739人（較2015年成長14%），2017年1-6月有5,814人（較2016年同期成長17%），顯示接受安寧居家療護的末期病人，逐漸成長。

擴大提升急性後期照護品質計畫

全民健保2014年開始推動「急性後期整合照護計畫」，經醫學中心協助轉診至居家附近有「急性後期照護團隊」之社區醫院，對急性期後失能且有復健潛能之病人，提供短期積極性之復健整合照護，初期選擇腦中風試辦，2015年9月納入燒燙傷病人。推動迄今，全國共有176家醫院組成38個醫院團隊參與，2016年收案超過4,000人，87.6%整體功能有進步，

專家演講：從安寧緩和醫療條例到病人自主權立法
Expert talk: from hospice palliative care statute to patient autonomy legislation.

community care teams, with the goal of having teams distributed evenly throughout the country. By caring for patients with impaired mobility, the teams will help patients resume life in their communities and reduce unnecessary "social hospitalization."

Hospice Care Focused on Quality of Life

The NHI offers many hospice care services, including "hospital hospice care," "hospice shared care" and "hospice home care" to deliver holistic care and ease the physical, mental, and emotional suffering of patients facing life threatening illnesses. Medical teams provide integrated hospice care depending on patients' needs, from hospital admission and discharge to home care.

The hospice home care program delivers services to terminally ill patients at their homes or an institution after they are diagnosed and given a referral for hospice care by their doctors. Featuring regular visits by medical personnel such as physicians, nurses, social workers, and psychologists, and measures to give patients effective pain relief, this holistic approach not only provides comprehensive hospital-to-home care, but also enhances the quality of care.

To promote hospice care within the community, the NHIA has continued its efforts to increase local hospital participation in integrated home health care teams and family doctor care teams. This initiative enables terminal patients to return to the community and live out their lives in dignity. In 2016, the number of patients receiving NHI hospice care totaled 8,739（an increase of 14% compared with 2015）, and 5,814 people received such care during the first six months of 2017（an increase of 17% compared with the same period in 2016）, which reveals that the number of terminally-ill patients receiving residential hospice care is gradually increasing.

Enhancing Post-acute Care Quality

Under the "Post-acute Care Quality Enhancement Program" introduced by the NHIA in 2014, medical centers assist referral of patients to nearby community hospitals with post-acute care teams. This program provides short-term integrated rehabilitation care to post-acute patients who are disabled but have rehabilitation potential. The program initially targeted stroke patients on a trial basis, and was extended to burn patients in September 2015. A total of 176 hospitals nationwide have organized 38 participating teams since the start of the program, and over 4,000 cases were accepted in 2016. Of these patients, 87.6% enjoyed improvement in overall function, such as improvement from severe dependency to preliminary ability to perform self-care, and 88% were able to successfully return to their homes and life in the community. The program also reduced patients' re-hospitalization rate and emergency treatment rate.

The NHIA's revised "NHI Post-acute Integrated Care Program," which was introduced on July 1, 2017, expanded the scope of patients' eligible for care to include those with traumatic nerve injuries, insufficiency fractures, heart failure, and frailty due to old age, as well as the stroke and burn patients already covered by the program. To help patients receive care in the community, the revised program also incorporated an integrated post-acute care home model and encouraged even more hospitals and clinics to form inter-institutional, inter-professional service teams.

Expanding Family Doctor Integrated Care

To emphasize primary level community care, while also responding to the country's aging population and concomitant increase in chronic

由嚴重依賴進步至初步可以生活自理的程度，88%病人成功返家回歸社區，也能降低病人的再住院率與急診率。

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

擴大家庭醫師整合照護計畫

為重視社區基層醫療，因應人口老化、慢性病之增加，提倡預防醫學，促進分級醫療，健保署自92年起，推動辦理「全民健康保險家庭醫師整合性照護計畫」，在台灣建立本土化之家庭醫師制度，由5個以上的基層診所組成社區醫療群，以群體力量提供「以病人為中心」的全人醫療照護，對民眾健康管理及衛教，提升預防保健執行率與基層醫療品質，並建立基層醫療院所與醫院之合作關係，共同辦理轉診、個案研討、社區衛教等活動；另設置24小時諮詢專線，提供民眾周全性、協調性與持續性的服務。

新北市金山區公所辦理健保在地製卡服務
New Taipei's Jinshan District Public Office initiates on-site NHI card production service.

配合推動分級醫療六大策略廿四項配套措施，2017年家庭醫師整合性照護計畫朝擴大社區醫療群服務量能與品質方向執行，將符合醫療給付改善方案收案條件之病人納入照護範圍，並增加3-5歲（含）兒童收案，同時結合居家醫療與院所間垂直與水平合作及新增整合服務項目，如鼓勵社區醫療群醫師支援醫院、基層診所轉介失智症病患至適當醫院就醫、接受醫院轉介之出院病人並辦理出院後續追蹤等服務，以達到強化醫療群與醫院垂直合作之目的，並提供民眾周全性、協調性與持續性的醫療照護。

截至2017年6月底，有4,063家基層診所與183家醫院共同組成526個醫療群，共同照護超過413萬名收案會員。健保署將持續鼓勵社區醫療群結合藥局、衛生所、物理治療所、檢驗所擴大組成，並於各次級醫療區內提供服務，以落實在地化、社區化的全人照護與醫療。

便民服務貼近民眾需求

關懷偏鄉住民一直是健保署持推動之工作重點，因此自2016年起規劃與10處鄉、鎮、市（區）公所跨機關合作辦理在地製發健保卡便民服務，讓偏遠地區民眾換發健保卡時有更多選擇，可就近至附近鄉、鎮、市（區）公所現場申辦，並在15分鐘內領取新的健保卡，以節省申辦健保卡往返健保署各聯合服務中心或

diseases and the need to promote preventive medicine and hierarchically integrated medical system, the NHIA has been implementing the "Family Doctor Integrated Care Program" since 2003 as a means of establishing a localized family doctor system in Taiwan. Under this program, five or more primary-level clinics can organize community healthcare groups, which rely on collective resources to provide patient-centered holistic medical care. The program has also sought to boost the preventive healthcare implementation rate and quality of primary-level medicine through public health management and health education, and establish cooperative relationships among primary-level clinics and hospitals involving joint referrals, case review, and community health education activities. Under this program, the NHIA has established a 24-hour consulting hotline to ensure that the public can receive comprehensive, coordinated, and ongoing services.

In conjunction with the implementation of the six strategies and 24 accompanying measures for enhancing a hierarchically integrated medical system, the Family Doctor Integrated Care Program will emphasize the expansion of community medical teams' service capabilities and improving quality in 2017. Patients who meet pay-for-performance plan inclusion criteria are now included within the scope of care, and cases involving children aged between three to five years are also accepted. The program also calls for horizontal and vertical integration of home care with hospitals and clinics, and the addition of integrated services, such as encouraging doctors in community healthcare groups to support hospitals, having primary-level clinics refer dementia patients to appropriate hospitals for care, and the follow-up tracking of patients after discharge from the hospitals to which they had been referred. By strengthening vertical cooperation between

健保署於花東兩縣建置 5 處鄉鎮公所在地製卡便捷服務
The NHIA has set up on-site card production service stations in 5 townships in Hualien and Taitung counties.

在地製卡公所一覽表
List of Public Offices with On-site NHI Card Production

新北市 New Taipei City	金山區 Jinshan District
宜蘭縣 Yilan County	宜蘭市 Yilan City
桃園市 Taoyuan City	復興區 Fuxing District
新竹縣 Hsinchu County	尖石鄉 Jianshi Township
	五峰鄉 Wufeng Township
苗栗縣 Miaoli County	泰安鄉 Tai-an Township
彰化縣 Changhua County	芳苑鄉 Fangyuan Township
南投縣 Nantou County	埔里鎮 Puli Township
雲林縣 Yunlin County	虎尾鎮 Huwei Township
嘉義縣 Chiayi County	阿里山鄉 Alishan Township
台南市 Tainan City	佳里區 Jiali District
屏東縣 Pingtung County	春日鄉 Chunri Township
	潮州鎮 Chaozhou Township
花蓮縣 Hualien County	玉里鎮 Yuli Township
	光復鄉 Guangfu Township
台東縣 Taitung County	大武鄉 Dawu Township
	成功鎮 Chenggong Township

各縣市所屬聯絡辦公室的交通路程、交通費或等候新卡寄送時間。截至2017年7月，健保署已與花東地區之玉里鎮、光復鄉、成功鎮及大武鄉，新北市金山區、宜蘭縣宜蘭市、桃園市復興區、新竹縣尖石鄉及五峰鄉、苗栗縣泰安鄉、南投縣埔里鎮、彰化縣芳苑鄉、雲林縣虎尾鎮、嘉義縣阿里山鄉、台南市佳里區、屏東縣春日鄉及潮州鎮等17處公所合作，提供民眾在地製卡便民服務。

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

未來健保署將提供健保「創新智慧服務平

medical teams and hospitals, the program aims to provide the public with seamless comprehensive and coordinated care.

As of the end of June 2017, 4,063 primary-level clinics and 183 hospitals had jointly formed 526 medical teams, and over 4.13 million people were eligible to receive joint care. The NHIA will continue to encourage community healthcare groups to include pharmacies, local health stations, physical therapists, and test laboratories, and provide service at all levels of medical service area. The program's ultimate goal is to realize holistic community care and medicine at the local level.

Convenient and Responsive Services

Because caring for residents of remote areas has always been one of the NHIA's top priorities, it implemented a plan to work with 10 city, district, and township offices in producing and issuing NHI cards on-site in 2016. This convenient service gives people living in rural areas the option of applying for and receiving a new NHI card within 15 minutes at a nearby district office. This saves their time and expense of having to travel to a more distant regional NHIA service center or service office in an urban area. As of July 2017, the NHIA was cooperating with 17 district offices respectively located in the Hualien-Taitung area's Yuli Township, Guangfu Township, Chenggong Township, and Dawu Township; New Taipei City's Jinshan District; Yilan County's Yilan District; Taoyuan's Fuxing District; Hsinchu County's Jianshi Township and Wufeng Township; Miaoli County's Tai-an Township; Nantou County's Puli Township; Changhua County's Fangyuan Township; Yunlin County's Huwei Township; Chiayi County's Alishan Township; Tainan City's Jiali District; and Pingtung County's Chunri Township and Chaozhou Township to provide the public wconvenient on-site card production service.

To simplify NHI card application procedures and shorten waiting times at service locations, the NHIA adopted full-scale paperless operations at the end of 2013. As a result, waiting times have fallen dramatically since the NHIA went paperless and began employing electronic application procedures. Furthermore, to take advantage of the trend towards "e-wallets," NHIA offices offer different electronic payment options for NHI premiums and new NHI card fees depending on their location. The NHIA began offering credit card payment services during the second half of 2016 to reduce the amount of cash handled at NHIA service counters. This move lessened the risk of receiving counterfeit bills, improved administrative efficiency, and gave customers more payment options without the need to carry cash.

In the future, the NHIA will provide a "Smart Services Platform" to serve as an NHI "omni-channel" cloud customer service system. The new system will make it possible for the public to obtain health insurance information from the NHIA at any time or place using various means（including landline, mobile phone, smart mobile devices, and computer）through multiple channels, including instant message customer service, video call service, and fax. At the same time, in the event of an emergency, the NHIA can activate inter-regional backup mechanisms to provide the public with timely, comprehensive, convenient, and high-quality services.

Better Self-care with My Health Bank

As part of its ongoing efforts to develop holistic patient-centered care, the NHIA has merged the cloud computing and big data

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

健康存摺提升自我照護能力

健保署持續發展以人為中心的全人照護，結合雲端運算（Cloud Computing）及巨量資料（Big Data）概念，運用互聯網（Internet of Things）的便利性，串連個人資料（My Data），改變民眾的健康生活方式。健保署建置的「健康存摺2.0」，可作為民眾管理個人健保就醫紀錄的雲端工具。透過一目瞭然的視覺化資訊圖表，搭配個人健保資料篩選及分類功能，可快速瞭解個人的健康情況、就醫情形、歷程、醫師診斷處置及用藥情形，還能預估未來10年罹患肝癌的機率與腎臟病預後風險評估，於是，健康存摺在手，就是每個人的隨身健康管理師，

在這個醫療照護由疾病治療，導向自我照護及預防的時代，健保署配合衛生福利部臺灣健康雲計畫，持續推展跨機關健康資料整合，並發展電子化、雲端化的服務。透過雲端技術，將健保資料庫中個人資料還給民眾，進一步提升醫療應用及自我保健價值。在行動化服務搭配穿戴式裝置（Wearable Device）應用的熱潮中，珍貴的健保資料將是促成未來醫療照護品質大幅提升的關鍵。健保署期待結合產業應用，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，提昇健保服務滿意度。

concepts with the convenience of the Internet of Things and its “My Data” database of personal information in an effort to get people to live healthier lifestyles. In addition, the NHIA’s “My Health Bank 2.0” system is a cloud tool that enables users to manage their medical records. Thanks to its easy-to-understand graphic presentation of information alongside personal health insurance data filtering and sorting functions, this system allows users to quickly understand their overall health situation, recent doctor visits, treatment history, diagnoses and treatments, and prescriptions. The system can also forecast users’ likelihood of developing liver cancer during the next 10 years and can assess kidney function and risk. Having access to the “My Health Bank 2.0” system is like having a personal health manager at one’s side at all times.

In an era when the prevailing focus of medical care is evolving from treatment of disease to self-care and prevention, the NHIA is working with the Ministry of Health and Welfare on the “Taiwan Health Cloud” project, which seeks to integrate health data across different agencies and develop digital and cloud-based services. The NHIA hopes to put personal information from the NHI database back in the hands of the public through cloud technology in order to encourage self-care and promote new medical applications. In view of the popularity of mobile services delivered through wearable devices, the NHIA’s valuable health insurance data will play a critical role in improving the quality of future medical care. The NHIA looks forward to combining industry applications, driven care, the health industry, and commercial creativity in extending the system as a “Lifelong Care Database” that will strengthen the public and the medical community’s appreciation of medical resources and overall satisfaction with value-added health insurance services.

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