2018-2019

全民健康保險年報

National Health Insurance Annual Report

2018-2019

全民健康保險年報

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署長的話
Message from the Director General

本人擔任健保署署長所秉持的信念就是如何讓台灣的健保好上加好，更上一層樓！2018年底國人對健保滿意度衝上86.5%的新高，但是無論何種制度想要永續發展，都必須經過實施、檢討、再改進的過程，所以在民眾就醫無虞之後，我們要面對的是醫療環境的改善。

現今衛福部和健保署積極推動分級醫療制度，即希望引導民眾改變就醫習慣，促進醫療院所分工合作，以免大型醫院塞滿輕症病患，排擠到其他急、重症病人的救治，病人無法獲得適切的照顧。

因此，自2018年7月起，健保實施「區域級以上醫院門診件數降低2%」政策及相關轉診獎勵措施，鼓勵大醫院將穩定的慢性病病人與簡單手術盡量下轉至社區醫院及基層診所，讓大醫院醫療人員能專心於急症、重症與困難疾病的醫療工作，以均衡醫療資源配置。

此外，本署積極強化「健保醫療資訊雲端查詢系統」功能，在2018年新增加查詢電腦斷層（CT）、磁振造影（MRI）、超音波、鏡檢及X光等醫療檢查影像功能，使診所醫師也看得到大醫院檢查的影像及報告，作為病人日後病情追蹤參考。如此透過雲端資料分享，既可避免重複醫療，也能協助落實分級醫療。

我們也由健保大數據發現，近年來健保醫療支出每年成長約5%，其中病人檢驗檢查的支出比醫師診療費及其他的服務成長幅度顯著許多，其中不乏短期內重複檢查及因重複就醫而多領取之藥物，形成醫療浪費。未來，健保署會落實利用大數據做精準審查，加強違規浮報、虛報、溢報健保費用的醫療行為的查核，由健保署與醫界共同管理不必要醫療行為，以將資源回饋於新藥、新科技及改善醫療環境。

健保改革永遠不嫌晚，有開始才有改變的機會，期待全國民眾支持健保改革，共同減少不必要的醫療浪費，再將醫療資源妥善回饋於改善醫療環境，這樣才是全民之福。

衛生福利部中央健康保險署　署長

李伯璋

As the Director General of National Health Insurance Administration, it is always our priority to improve Taiwan's National Health Insurance (NHI) and taking it to the next level. At the end of 2018, the public satisfaction with the National Health Insurance (NHI) reached a record high of 86.5%. However, in order to achieve sustainable development, all system must go through the process of implementation, review, and improvement. Provided there is no obstacles over medical treatment people can receive, improving medical environment would be our main focus in the future.

Nowadays, the Ministry of Health and Welfare and the National Health Insurance Administration are actively promoting a tiered healthcare system, hoping to guide the people to change their medical care seeking behavior, promote the division of labor in medical institutions, and prevent major hospitals from being filled with mild disease patients, which keep ER and critically ill patients from receiving appropriate treatment.

Therefore, since July 2018, the NHI has implemented the policy of "reducing the number of outpatient clinic cases by 2% for hospitals above the regional level" and related referral incentive measures in order to encourage major hospitals to refer their stable chronic patients or patients in need of simple surgical procedures to community hospitals and clinics, allowing medical staff of major hospitals to concentrate on the medical treatment of acute and severe diseases, so as to balance medical resource allocation.

In addition, the NHIA has actively strengthened the "NHI MediCloud System" features. In 2018, the CT, MRI, ultrasound, microscopic exams, X-ray, and other medical imaging features were added to enable physicians to view examination images and reports from major hospitals, which shall serve as a reference for diagnosing patients' conditions. Through cloud data sharing, repeated medical care can be prevented, thereby aiding in implementing a sound healthcare system.

From the NHI big data, it is shown that NHI medical expenditures grow at a rate of about 5% annually. Among them, expenditures on patients' examinations and checkups significantly exceeds those of physicians' diagnosis and treatment fees and other services, let alone short-term repeated examinations and excessive medication claims due to repeated medical attention, leading to medical waste. In the future, the NHIA will adopt big data to perform accurate reviews, so as to reinforce auditing on illegal reporting, false reporting, and over-reporting of NHI medical claims. The NHIA and the medical community shall jointly manage unnecessary medical activities in order to reinvest resources in new drugs, new technologies, and the improvement of medical environment.

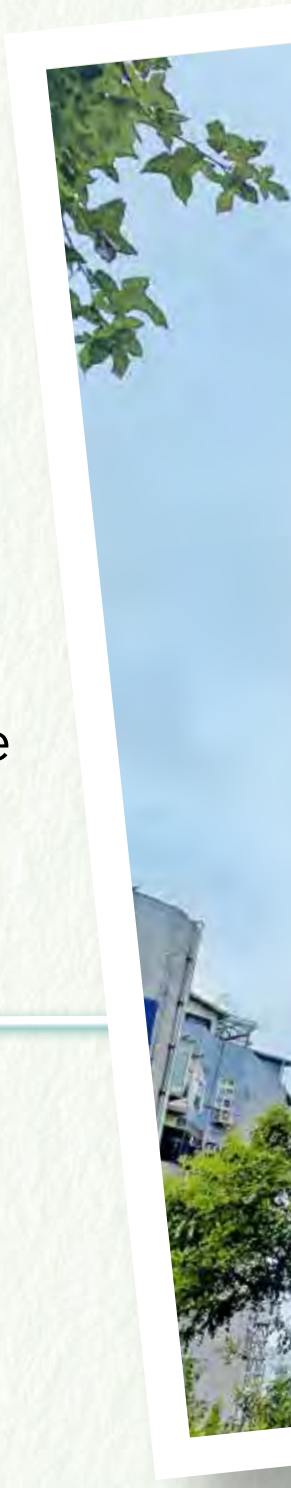
It is never too late to carry out NHI reform. We must get started to make the change. We hope that our people will support NHI reform, reduce unnecessary medical waste in concerted efforts, and properly reinvest medical resources to improve the medical environment, which will bring benefits to all.

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 Structure and History




健保23週年
醫免重複就醫病患 注意用藥安全
落實分級醫療
信任社區好醫療 居家好醫師

Chapter 1

組織沿革　承先啓後
Organization Structure 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22個聯絡辦公室，服務在地民眾。至2018年6月30日，人員編制共有2,807名。

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	23,848,272 / 28,528
臺北業務組 Taipei Division	8,901,045 / 9,182
北區業務組Northern Division	3,820,965 / 3,760
中區業務組 Central Division	4,308,298 / 6,111
南區業務組 Southern Division	3,074,903 / 4,172
高屏業務組 Kaoping Division	3,276,869 / 4,658
東區業務組 Eastern Division	466,192 / 645

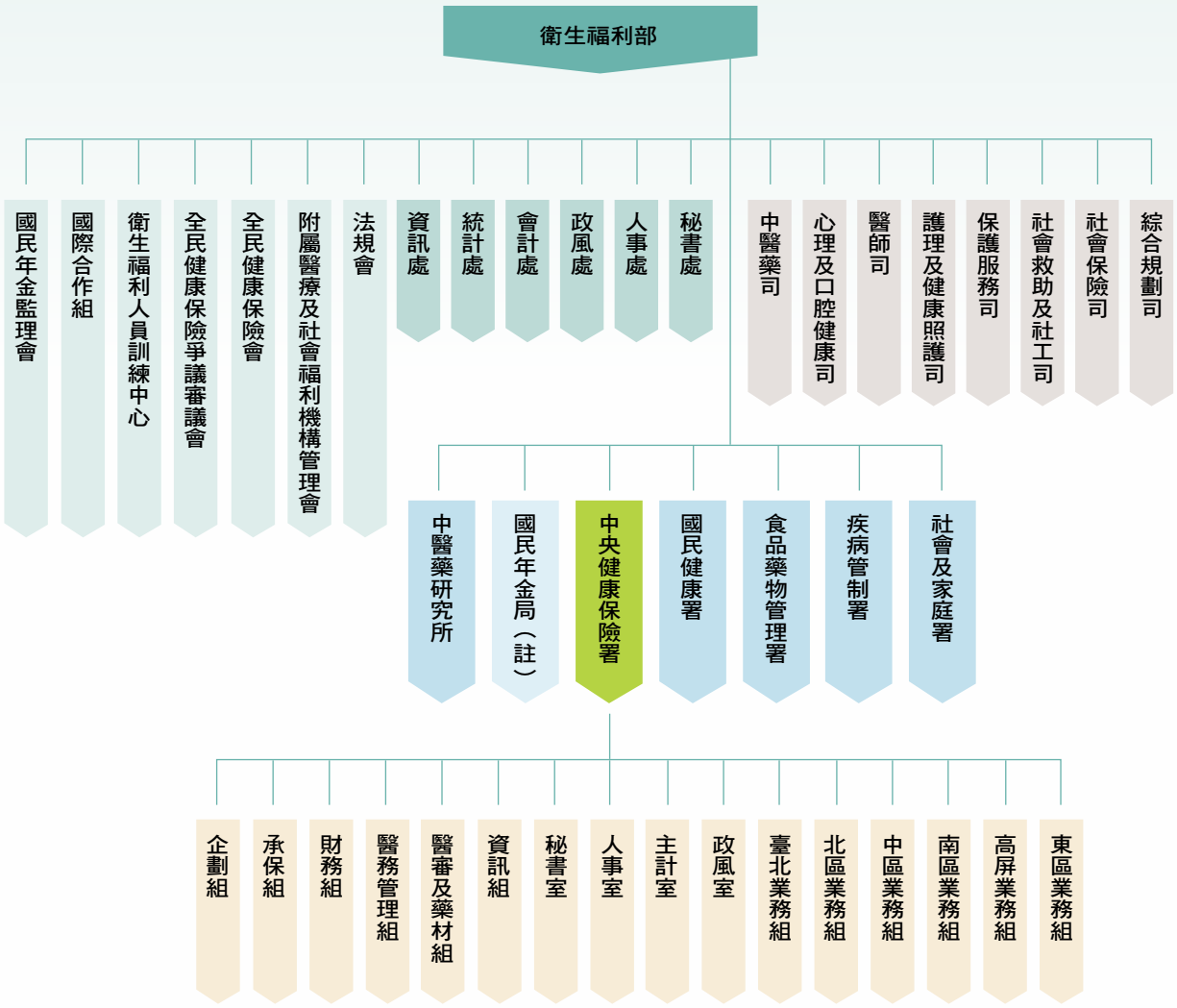
註1：各主要縣市及金門、澎湖等地，設立7個聯合服務中心及22個聯絡辦公室，為民眾提供在地化服務。
註2：資料統計至2018年6月。
Note 1: Seven united services centers and 22 liaison offices in major cities and counties, and on Kinmen and Penghu, have been established to provide local services to the public.
Note 2: Dated: June 30, 2018.

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

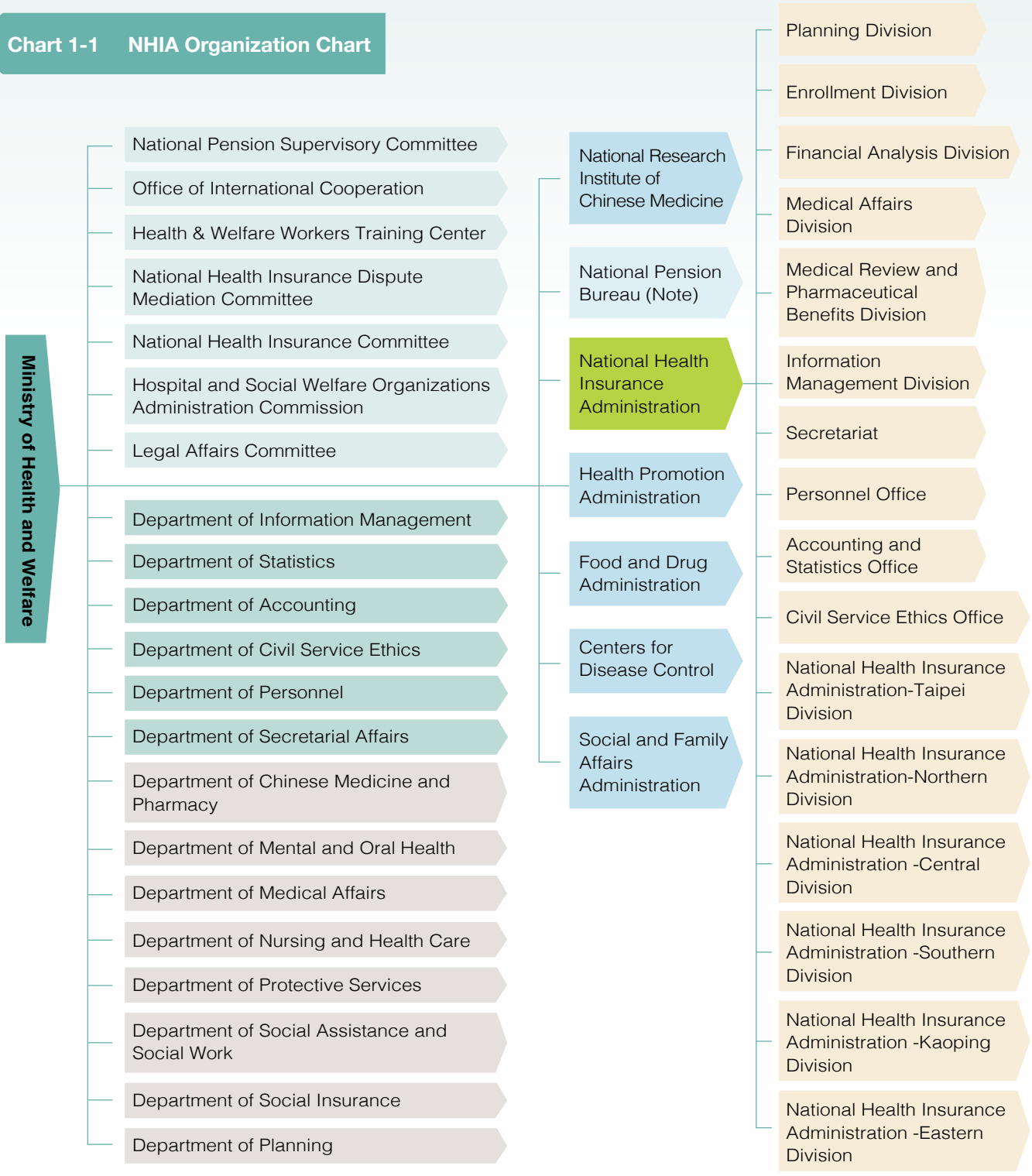
圖1-1　全民健康保險組織架構圖



（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。

contracted medical service organizations. At the same time, the NHIA has established 22 contact offices to serve local residents. As of June 30, 2018, the NHIA had 2,807 employees.

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

全民有保　財務永續

全民有保　就醫平權

政府開辦全民健康保險的初衷，即在透過自助、互助制度，將全體國民納入健康保障。因此舉凡健康保險開辦前非屬工作人口的眷屬、榮民及無職業者，含婦女、學生、孩童、老人等，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連續居留滿6個月始可加入健保，以符合社會公平正義之期待。

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 in a row 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.

As of the end of June 2018, a total of 23,848,272 people were participating in NHI (Table 2-2), and there were 893,289 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

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 Enrollees		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
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 category 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

類 別 Category	保險對象 NHI Enrollees		投保單位 Insured Units
	本人 The Insured	眷屬 Dependents	
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.

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

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	13,887,294	3,658,080	2,254,371	113,510	300,238	3,634,779	23,848,272
占總納保人數百分比 Percentage of the Insured	58.23%	15.34%	9.45%	0.48%	1.26%	15.24%	100%

資料時間：2018年6月30日。 Dated: June 30, 2018.

截至2018年6月底止，參加全民健保的總人數有23,848,272人（表2-2），投保單位有893,289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。

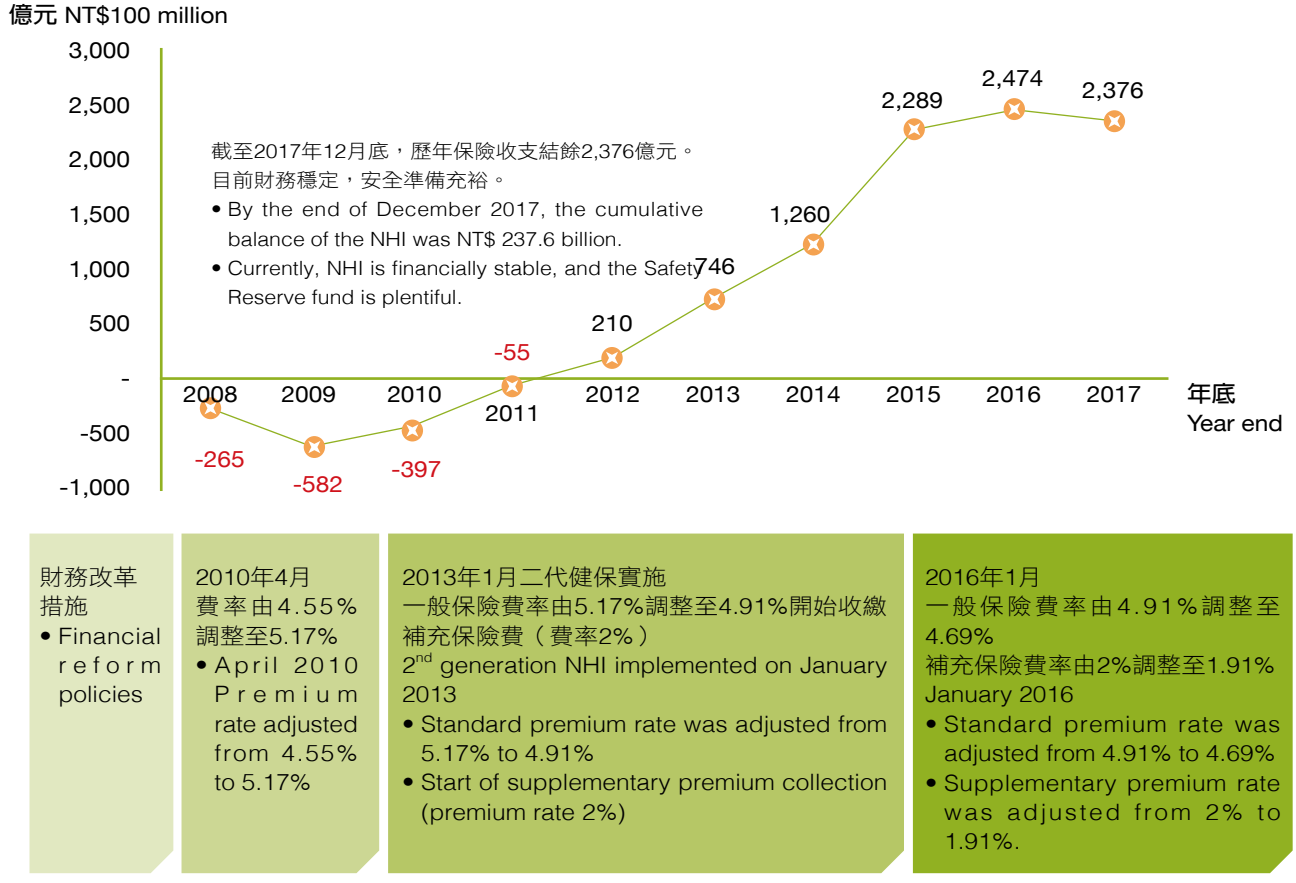
二代健保實施後，因擴大費基收繳補充保險費及政府總負擔比率提高等財源挹注，保費收取更符合量能負擔的公平原則，財務亦明顯改善（圖2-1）。故依據「全民健保財務平衡及收支連動機制」，自2016年1月1日起，一般保險費費率由4.91%調降為4.69%，補充保險費費率連動由2%調降為1.91%。此外，為回應民情，自2016年起執行業務收入、股利所得、利息所得及租金收入單次給付金額扣取下限由5,000元調整為2萬元；另加強資本利得補充保險費查核及監控；截至2018年6月底保險收支累計結餘為2,276億元。

目前財務狀況穩定，惟因人口老化及醫療

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 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

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



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2018年1月1日起共有49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2018年1月1日起為24,000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，

on capital gains. As of the end of June 2018, the cumulative balance was NT$227.6 billion.

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, 2018 has 49 brackets (Table 2-5). The payroll basis of category 1 insured are reported by their insured units (employers), based as the brackets in the table corresponding to the insureds'monthly wage income. Starting from January 1, 2018, the minimum payroll basis of insured 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$24, 000.

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

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

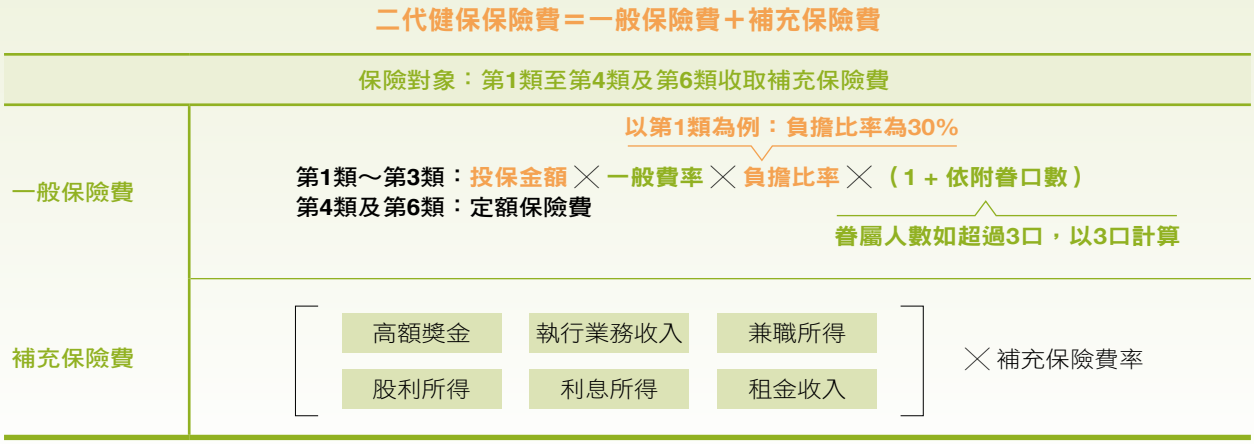
註：1.負擔比率：請參照表2-4全民健保保險費負擔比率。
2.一般保險費費率：2016年1月起為4.69%。
3.投保金額：請參照表2-5全民健保投保金額分級表。
4.眷屬人數：依附投保的眷屬人數，超過3口的以3口計算。
5.平均眷屬人數：自2016年1月1日起公告為0.61人。
6.第4類及第5類平均保險費: 自2016年1月起為1,759元，由政府全額補助。
7.第6類地區人口平均保險費: 2010年4月起為1,249元，自付60%、政府補助40%，每人每月應繳保險費為749元。

Notes: 1. Contribution Ratio: Based on Table 2-4.
2. Regular 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　全民健保一般保險費計算公式
Table 2-4　Salary Brackets on which Premiums Are Calculated

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

圖2-2　二代健保保險費示意圖



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。

再加上「補充保險費」，把以往沒有列入投保金額計算的高額獎金、兼職所得、執行業務收入、股利所得、利息所得或租金收入等項目，納入「補充保險費」的計費基礎，計收補充保險費。希望藉由擴大保險費基，拉近相同所得者之保險費，達到負擔之公平性（圖2-2），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%；2017年全年補充保險費計收約449億元，占同年保險費收入約7.83%。

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2018年6月累計收支結餘為2,276億元（表2-6）。

Chart 2-2　2nd Generation NHI Premiums Overview

2nd generation NHI premium = standard premium + supplementary premium

NHI enrollees: supplementary premium is collected from Category 1 to 4 and Category 6

Regular Premiums	**Category 1 ~ Category 3:** Salary Basis × Standard Premium Rate × Contribution Ratio (If Category 1, individual contribution ratio 30%) × (1 + Number of Dependents) (Maximum of 3) **Category 4 and Category 6:** Fixed Premium
Supplementary Premium	[High Bonuses, Professional Fees, Part-time Wages, Stock Dividends, Interest Income, Rental Income] × Supplementary Premiums Rate

Notes: 1. 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.

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 2017, supplementary premium income totaled approximately NT$44.9 billion and accounted for roughly 7.83% 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$227.6 billion as of June 2018 (Table 2-6).

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 Tiers	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	23,100	23,100 以下
第二組 級距1,200元 Bracket 2 NT$1,200	2	24,000	23,101-24,000
	3	25,200	24,001-25,200
	4	26,400	25,201-26,400
	5	27,600	26,401-27,600
	6	28,800	27,601-28,800
第三組 級距1,500元 Bracket 3 NT$1,500	7	30,300	28,801-30,300
	8	31,800	30,301-31,800
	9	33,300	31,801-33,300
	10	34,800	33,301-34,800
	11	36,300	34,801-36,300
第四組 級距1,900元 Bracket 4 NT$1,900	12	38,200	36,301-38,200
	13	40,100	38,201-40,100
	14	42,000	40,101-42,000
	15	43,900	42,001-43,900
	16	45,800	43,901-45,800
第五組 級距2,400元 Bracket 5 NT$2,400	17	48,200	45,801-48,200
	18	50,600	48,201-50,600
	19	53,000	50,601-53,000
	20	55,400	53,001-55,400
	21	57,800	55,401-57,800
第六組 級距3,000元 Bracket 6 NT$3,000	22	60,800	57,801-60,800
	23	63,800	60,801-63,800
	24	66,800	63,801-66,800
	25	69,800	66,801-69,800
	26	72,800	69,801-72,800
第七組 級距3,700元 Bracket 7 NT$3,700	27	76,500	72,801-76,500
	28	80,200	76,501-80,200
	29	83,900	80,201-83,900
	30	87,600	83,901-87,600
第八組 級距4,500元 Bracket 8 NT$4,500	31	92,100	87,601-92,100
	32	96,600	92,101-96,600
	33	101,100	96,601-101,100
	34	105,600	101,101-105,600
	35	110,100	105,601-110,100

組別 Bracket 級距 Income Differential	投保等級 Income Tiers	月投保金額（元） Salary Basis（Amount on which Premiums are Calculated） （NT$）	實際薪資月額（元） Actual Registered Monthly Salary（NT$）
第九組 級距5,400元 Bracket 9 NT$5,400	36	115,500	110,101-115,500
	37	120,900	115,501-120,900
	38	126,300	120,901-126,300
	39	131,700	126,301-131,700
	40	137,100	131,701-137,100
	41	142,500	137,101-142,500
	42	147,900	142,501-147,900
	43	150,000	147,901-150,000
第十組 級距6,400元 Bracket 10 NT$6,400	44	156,400	150,001-156,400
	45	162,800	156,401-162,800
	46	169,200	162,801-169,200
	47	175,600	169,201-175,600
	48	182,000	175,601 以上

註：2019 年1月1日起生效。
Note: Effective from Jan. 1, 2019.

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

年度 Year	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（%）		
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	5,900	0.53	5998	5.54	-98	2,376
2018/1~6	2,979	—	3,079	—	-100	2,276
1995/3~2018/6	94,091	—	91,816	—	—	—

說明：1. 資料截至2018年6月。
2. 保險收入＝保險費＋滯納金＋資金運用淨收入＋公益彩券盈餘及菸品健康捐分配數＋其他淨收入－呆帳提存數－利息費用。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 2018.
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

Chapter 3

給付完整　就醫便利
Comprehensive Benefits and Convenient Access

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，可於急診、門診治療當日或出院之日起6個月內申請核退國外自墊醫療費用，但核退費用的標準則以支付國內特約醫院及診所之平均費用為最高上限。

截至2018年6月底止，全民健保特約醫療院所合計達21,163家，占全國所有醫療院所總數92.86%（表3-1）；另有特約藥局6,272家、居家護理機構613家、精神社區復健機構210家、助產所17家、醫事檢驗機構211家、物理治療所22家、醫事放射機構10家、職能治療所7家及呼吸照護所3家，保險對象可自由選擇醫療院所，接受醫療照護服務。

2017年，平均每人每年門診就醫次數15.1

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	22,789	471	11,609	7	3,881	6,821
特約醫療院所數 Contracted Medical Institutions	21,163	471	10,386	5	3,623	6,678
特約率 Percentage of Contracted Institutions	92.86%	100%	89.47%	71.43%	93.35%	97.90%

資料時間：2018年6月30日。　Dated: June 30, 2018

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. The reimbursement will be based on the average payment for domestic hospitals and clinics.

As of the end of June 2018, NHI contracted hospitals and clinics totaled 21,163, and accounted for 92.86% of all hospitals and clinics in Taiwan（Table 3-1）. There were also 6,272 contracted pharmacies, 613 home nursing care institutions, 210 psychiatric community rehabilitation centers, 17 midwife clinics, 211 medical examination institutions, 22 physical therapy clinics, 7 medical radiation institutions, 3 occupational therapy clinics, and 1 respiratory care clinic. Insureds may freely choose at which hospital or clinic they will receive medical services.

In 2017, the average per capita outpatient visit reached an average of 15.1 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 1.4 days.

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,

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1.4日。

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（中度一複

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

單位：新臺幣元 Unit: NT$

類型 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.

表3-3　全民健保住院部分負擔
Table 3-3　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.

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 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%.

林口長庚醫院—雁行計畫記者會
Flying Geese Medical Care Group Launching Press Conference

分級醫療雙向轉診論壇
Reinforcing Medical Referral System Conference

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2018年6月底，已有567個社區醫療群在運作，參與之基層診所4,558家，參與率為43.6%，參加醫師數5,924位，參與率為37.8%；透過社區醫療群受益者超過473萬人。

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

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 2018, 567 community healthcare groups were operating, 4,558 primary-level clinics were participating, which represented a participation rate of 43.6%, 5,924 doctors were participating, for a participation rate of 37.8%, and more than 4.73 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 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,

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。

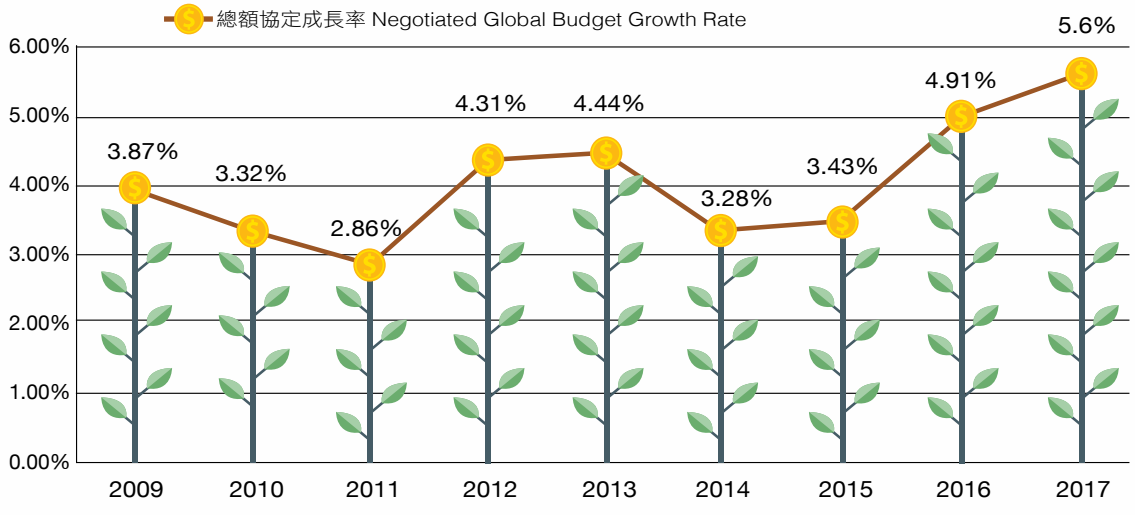
全民健保實施初期，為迅速整合公、勞、農保既有系統，鼓勵醫療院所申請為健保特約機構，以論量計酬（Fee-for-Service）方式為主，在公、勞保支付標準表的基礎下，配合保險給付範圍的調整及參酌醫療團體建議加以增修，但該制度容易造成醫療費用無限成長，對醫療品質亦有影響。

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, P4P）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、西醫基層、醫院等部門總額支付制度，至2002年起全面採行總額預算支付制度，以有限健保資源提供有效率且高品質之醫療服務，有效將醫療費用成長率控制在5%以下。醫療費用收支連動機制如圖3-1，2010年起各總額部門醫療費用協定成長率如表3-4。

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.

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 5%. See Chart 3-1 for the NHI medical expenditure growth rates since 2009. Starting 2010, the global budget departments' medical expenditure agreement growth rates are as shown in Table 3-4.

To ensure that the quality and scope of the care provided by medical service organizations is not affected by the implementation of the 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

圖3-2　全民健保醫療費用總額收支連動機制
Chart 3-2　Total NHI Medical Income and Expenditure Linkage Mechanism

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2018年6月，支付標準共計有4,477項診療項目，經統計2004年至2018年6月，共計89次公告調整支付標準，共修訂2,025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。

另為配合分級醫療推動，2017年以醫院總額部門「醫療服務成本指數改變率」增加之預算，用於調整急重症項目（共60億元）及偏鄉與地區醫院診療項目（共22億元）之支付點數。自2017年10月1日起，調升167項診療項目支付點數，放寬1,513項手術之兒童加成方式，以及放寬手術通則、急診例假日加成時間、兒童專科醫師加成，另調高偏鄉及地區醫院49項基本診療支付點數。為壯大西醫基層診所服務量能，擴大其服務範疇，於西醫基層總額部門以編列2.5億元預算，自2017年5月1日起，開放「流行性感冒A型病毒抗原」等25項診療項目至基層院所執行。

醫療給付改善方案

全民健保醫療給付改善方案，係透過調整支付醫療院所醫療費用的方式，提供適當誘因，引導醫療服務提供者朝向提供整體性醫療照護發展，並以醫療品質及效果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

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

總額部門 Sector	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
整體 Total	3.874%	3.317%	2.855%	4.314%	4.436%	3.275%	3.430%	4.912%	5.642%	4.711%
牙醫門診 Dental	3.033%	2.515%	1.783%	2.264%	1.421%	1.888%	2.140%	3.463%	3.246%	4.001%
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%	3.699%
西醫基層 Clinics	3.756%	2.742%	1.874%	2.986%	2.818%	2.391%	3.191%	4.274%	5.157%	4.053%
醫院 Hospitals	4.887%	3.256%	3.173%	4.683%	5.587%	3.281%	3.659%	5.672%	6.021%	4.800%

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.

In addition, in conjunction with the promotion of a tiered medical system, in 2017, increased budget for the "medical service cost change index" in the hospital global budget was used to adjust payment points for acute/severe disease items (totaling NT$6 billion) and service items in remote areas (totaling NT$2.2 billion). Beginning on October 1, 2017, the payment points for 167 service items were adjusted, markups for children in 1,513 surgery items were relaxed, general principles for surgery were relaxed, and markups for ER on weekends, pediatric specialists, and raising payment points for 49 basic diagnosis and treatment in remote towns and regional hospitals. In order to strengthen

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。

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	2010	2011	2012	2013	2014	2015	2016	2017
氣喘 Asthma	32.5%	34.8%	35.2%	31.3%	31.6%	47.0%	45.5%	39.3%	37.5%	41.9%	36.0%	28.2%	29.5%
糖尿病 Diabetes	23.5%	23.2%	24.7%	26.3%	27.6%	29.3%	31.4%	33.9%	35.1%	41.9%	41.1%	43.4%	47.9%
結核病 Tuberculosis	68.8%	79.0%	91.8%	導入支付標準 Incorporated in the Fee Schedule	-	-	-	-	-		-	-	-
乳癌 Breast cancer	12.1%	13.0%	13.6%	14.6%	14.5%	14.6%	13.7%	13.4%	13.1%	10.9%	10.6%	9.7%	8.2%
高血壓 Hypertension	未實施 N/A	基層試辦9.3% Trial-basis 9.3%	6.5%	3.9%	2.7%	2.6%	2.9%	1.4%	註 See Note	註 See Note	註 See Note	註 See Note	註 See Note
思覺失調症 Schizophrenia	未實施 N/A					40.7%	46.9%	51.2%	52.2%	59.1%	62.0%	63.9%	68.2%
B型C型肝炎帶原者 Hepatitis B and C carriers	未實施 N/A					9.8%	19.4%	26.1%	30.6%	37.2%	32.6%	35.3%	36.6%
初期慢性腎臟病 Early stage chronic kidney diseases	未實施 N/A						20.2%	26.4%	32.1%	26.7%	38.5%	42.1%	41.8%
孕產婦全程照護 Full-course maternity care	未實施 N/A					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%	32.3%
早期療育 Early treatment for development retardation	未實施 N/A											15.3%	14.9%
慢性阻塞性肺病 Chronic obstructive pulmonary lung disease	未實施 N/A												24.3%

註：高血壓方案自2006年起於西醫基層開始試辦，2007年則擴大至醫院，其照護率因涵蓋基層診所及醫院，呈現照護率下降情形，又因病患常合併多重疾病，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.

the service capacity of basic western medical clinics and extend the service scope, the Western medicine primary care global budget department has allocated a budget of NT$250 million. Beginning on May 1, 2017, “influenza A virus antigen” and others totaling 25 service items are available at primary care medical institutions.

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 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

Chapter 4

專業審查　提升品質
Professional Review and Quality Improvement

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。醫療服務案件審查重點為：醫療服務項目、數量及品質。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。

專業審查

由於申報案件量甚鉅，健保署於專業審查時採抽樣審查，即以抽樣方式調閱部分病歷送請審查醫藥專家審查，抽樣方式包括隨機抽樣與立意抽樣。隨機抽樣審查結果會以樣本的核減率按比例回推至全部母體案件進行核減，但立意抽樣審查結果則不回推。

自1998年起總額支付制度漸進實施後，健保署配套進行醫療服務專業審查勞務委託，另訂定審查醫藥專家之遴聘管理方式，並逐步與受託之相關醫療團體建立了各分區專業審查共同管理的機制。

醫療專業審查注意事項之訂定，需先蒐集專科醫學會與醫師公會及醫院協會意見後，經具有相關臨床或實際經驗之醫藥專家組成分科專家諮詢會議討論後訂立。自2017年起，作業時程由原來兩年辦理一次調整為隨案隨辦，以醫療專業常見治療模式或手術為主題，對審查注意事項進行整體性改版修訂，並採邏輯性編排，比照藥品給付規定進行編碼，以利資訊化勾稽，提供審查醫師參考。

運用科技提高審查效率

健保署逐步推動醫療申報電子化，累積至今，已成為全球獨一無二的全民健保資料庫。透過電子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，啟動相關措施，避免醫療資源浪費。

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 key points 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.

Professional Review

Due to the immensity of reported cases, the NHIA adopts sampling during professional reviews. That is, a part of the medical records are sampled and submitted for review by medical experts. The sampling methods include random sampling and purposive sampling. The results of random sampling will be scaled down based on the deduction rate of the samples to the total population cases for deduction, while the review results obtained through purposive sampling will not be scaled down.

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 medical service reviews and established management guidelines for recruiting medical review experts. The NHIA and the commissioned related medical groups have also gradually developed mechanisms for jointly managing the various professional reviews in every region.

The setup of medical professional review notices requires first collecting the opinions of specialized medical associations, physician associations, and hospital associations after discussions at specialized expert consultation meetings made up of medical experts with relevant clinical or practical experience. Beginning 2017, the operational schedule was adjusted from once every two years to a case by case basis. With common professional medical treatment practices or surgeries as themes, the review notices underwent overall review and revision, logical arrangements were made, and drug payment regulations served as references to carry out coding, thereby facilitating informatization and providing a reference for review physicians.

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.

電腦醫令自動化審查

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。

檔案分析

近年健保署也積極採行以檔案分析為主軸的審查制度，進行醫事機構醫療利用異常之審查管理，目前已採行之措施如下：

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

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

（3）健保署自2014年9月起，建置「全民健康保險中央智慧系統」（Central Intelligence System, CIS），對重要項目納入統一管控，將疑似異常耗用健保醫療資源的申報項目，由電腦自動篩選出異常案件，列入抽樣樣本或予以標記，並提供異常資訊，抽調病歷送專業審查確認是否符合健保規定，提升審查效率。該系統目前以健保門診、健保住診、健保藥品及健保特定診療等4項主構面開發出約100項篩異指標。

健保署自2016年10月起，以醫院總額醫療費用為範圍實施「專業雙審及公開具名」試辦方案

輔助專業審查

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。

專業雙審及公開具名

為回應各界因審查專業見解差異而提出公開具名以示負責之建議，健保署自2016年10月起，以醫院總額醫療費用為範圍實施「專業雙審及公開具名」試辦方案，在「專業雙審」部分，針對特定案件由2位醫師審查；在「公開具名」部分，依審查醫師之意願，分為「個別核減案件具名」及「團體公開姓名」兩類；前者，有小兒科、婦產科、耳鼻喉科、眼科、神經科、精神科及泌尿科等7個科別於部分地區試辦；後者，於健保資訊網服務系統中依科別公布姓名，累計至2017年底同意率達51%。試辦方案後，醫療費用核減之爭議審議件數由2015年的10.4萬件下降至2017年的5.5萬件，故已達到「減少個人專業見解差異，提升醫療費用核減合理性」之目的。

Automated Review System for Medical Orders

The NHIA has developed automated review system for medical 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.

Profile Analysis

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

(1) Use of statistical 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) Medical community representatives are invited to discuss and co-develop file analysis to review anomaly non- payment indicators, use claims data to carry out reviews on diagnosis and treatment types of medical institutions, and set threshold values targeting various indexes. For the anomaly part, the procedure review is used to carry out payment reduction to save labor costs.

(3) The NHIA has since September 2014 set up the “Central Intelligence System, CIS” to unify control of important items. For claims suspected of abnormally consuming NHI medical resources, the computer automatically selects anomaly cases, and lists them in the sampling or and flags them. The abnormal information and retrieved medical records are sent for professional review to confirm whether they meet NHI requirements. The system has currently developed about 100 anomaly-screening indicators through the use of 4 main dimensions, namely NHI outpatient care, NHI hospital ambulatory care, NHI pharmaceutical drugs, and NHI specified diagnosis and treatment.

Facilitating Professional Review

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”. 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.

Named Professional Double Review

In response to the suggestions from all sides to reveal names of the reviewers to show responsibility due to disparities in professional review opinions. The NHIA has since October 2016 implemented the “named professional double review” pilot plan, with hospital global budget medical expenditure as the scope. For the professional “double review” part, specific cases are targeted for review by two

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700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。

為落實健保整體藥費之管控，健保署公告實施「全民健康保險藥品費用分配比率目標制」試辦方案，自2013年1月1日起試辦至今已有5年，主要是預設每年藥費支出「目標值」，並與實際藥費支出做連結，當超過目標值時，自動啟動每年一次之藥價調整，讓藥費維持於穩定及合理範圍。

給付C型肝炎全口服新藥

過去C肝治療需每週施打一次長效型干擾素，並配合每日口服雷巴威林（ribavirin），療程半年至一年。自從治療C肝的全口服新藥上市後，可提高治癒率、降低副作用並縮短療程，全民健保於2017年1月起納入給付，2017年健保醫療費用總額分配24.3億元預算用於C肝全口服新藥之給付，依台灣消化系醫學會建議之優先治療對象先給予給付，約有9,538名個案受惠。另於2018年醫療總額分配47.3億元預算給付C肝全口服新藥，預估約有18,000名個案受惠，並將視財務及實際治療成效逐步擴大適用範圍。

physicians. For the “named review part”, depending on the willingness of reviewing physicians, it is divided into two types: “individual reviewer named deduction cases” and “reviewer groups named”. For the former, seven departments, namely, pediatrics, obstetrics and gynecology, otolaryngology, ophthalmology, neurology, psychiatry, and urology, have carried out the pilot plan in some areas; for the latter, names are announced through the NHI information network service system. As of the end of 2017, the consent rate reached 51%. After the pilot plan was carried out, medical expenditure deduction dispute cases decreased from 104 thousand cases in 2015 to 55 thousand cases in 2017, thus achieving the purpose of “reducing disparity in individuals’ professional opinions and enhancing medical expenditure deduction reasonability”.

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 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, it has been 5 years since the NHIA announced trial implementation of the four-year “NHI Drug Expenditure Allocation Ratio Target System” from 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.

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
新增功能類別人工心律調節器 Pacemaker with additional function	1995/08/03
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
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
客製化電腦輔助型顱顏骨固定系統 Mesh Cranial Fixation System	2017/08/01
治療心房顫動之冷凍消融導管 Cardiac Cryoablation Catheter	2017/11/01
伽瑪加長隨內釘 GAMA Nail (long)	2018/06/01

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1995年起陸續將新增功能類別人工心律調節器、塗藥及特殊塗層血管支架、特殊材質人工髖關節（陶瓷材料）、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、治療淺股動脈狹窄之塗藥裝置、客製化電腦輔助型顱顏骨固定系統、治療心房顫動之冷凍消融導管及伽瑪加長隨內釘等9類（共10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。

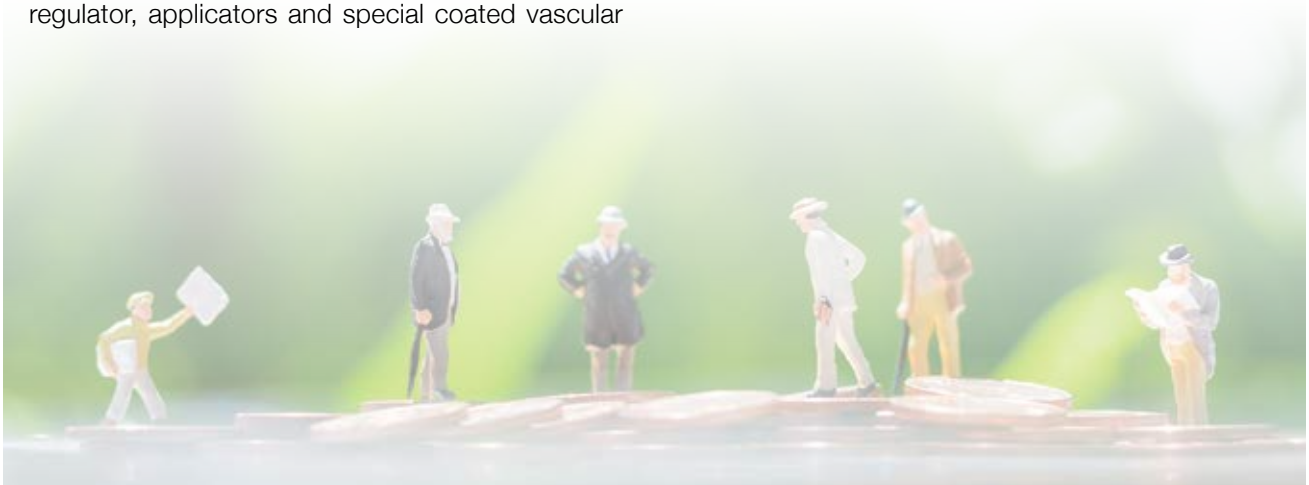
Payment Coverage for New Hepatitis C Oral Drug

In the past, hepatitis C treatment required the injection of peginterferon once a week, coupled with daily oral intake of ribavirin. The treatment session lasts from six months to a one year. The introduction of the new hepatitis c full oral drug can improve, the cure rate, reduce side effects, and reduce the course of treatment. The NHI has since January 2017 included it in the coverage. In 2017, the NHI global budget allocated of NT$2.43 billion to cover the new hepatitis c full oral drug to cover prioritized patients recommended by the Gastroenterological Society of Taiwan, benefiting about 9,538 cases. In addition, a budget of NT$ 4.73 billion was allocated in 2018 for to cover this new hepatitis c full oral drug benefiting 18,000 cases. Moreover, depending on the financial impact and treatment effectiveness, the application scope will be gradually expanded.

Special Medical Materials with Balance Billing

Although some new medical devices offer improved functions, they are often far more expensive than existing similar items in the NHI fee schedule. To ease the financial burden of patients who benefit from these new medical devices and give them more choices, beginning 1995, newly added functional categories have been listed as balance billing items, including artificial heart rhythm regulator, applicators and special coated vascular stent, special material artificial hip joint (ceramic material), special function artificial crystal, durable biological tissue heart valve, regulated ventricle abdominal drainage system, applicator device for treating superficial femoral artery stenosis, customized computer-assisted cranial bone fixation system, ablation catheters for treating arterial fibrillation, and GAMA Nail (long), (10 items in total). (Table 4-1). Whenever an insured person wishes to use the more costly medical devices or materials, NHI will provide reimbursement in accordance with the payment standards of existing similar items, and the rest parts are out of patients' pocket. In order to protect the public's rights and interests, hospitals and clinics must provide the consumer with adequate information of this new medical device before performing surgery or treatment in such cases.

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



Chapter 5

健康科技　服務加值

Health IT and Value-added Services

Chapter 5

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

舉辦「以雲端醫療為根基，邁向AI健保」研討會，由本部陳時中部長、科技部陳良基部長與國家發展委員會邱俊榮副主任委員共同開幕致詞，邀集產、官、學、研、醫各界人士與會，共同為台灣醫療人工智慧發展尋找新契機。
Organized a seminar on the theme of "Cloud-based Healthcare: Toward AI Health Insurance" which was presided over by Shih-Chung Chen, Minister of Health and Welfare; Chen Liang-Gee, Minister of Science and Technology and Qiu Jun-Rong, Deputy Minister of the National Development Council. Guests from the industry, public, academic, research and medical sectors were invited to participate in the discussion on Taiwan's medical artificial intelligence development.

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

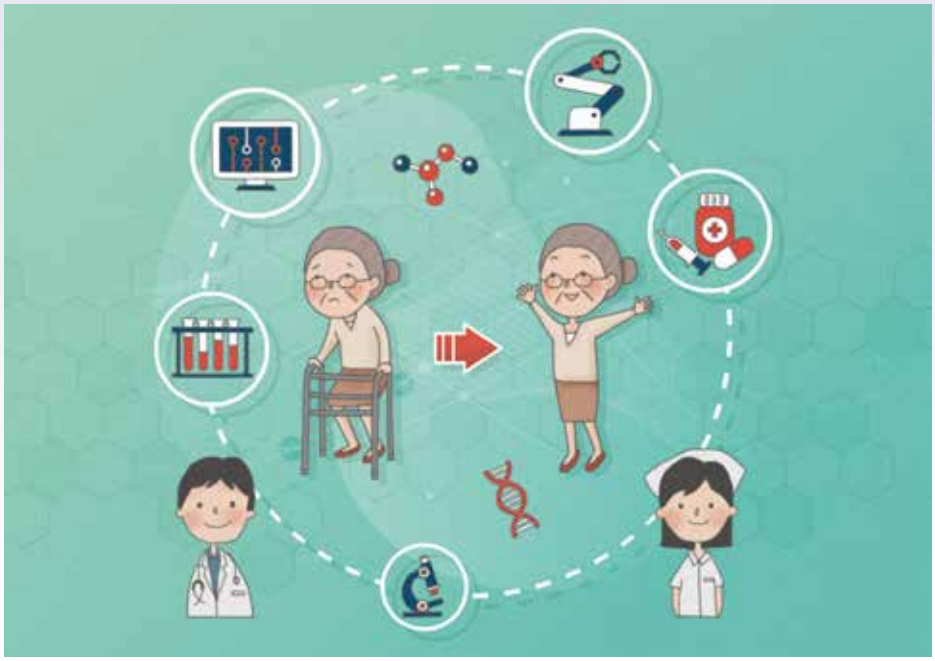
Value-added Cloud Services-My Health Bank

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.

新一代健保憑證規劃協作會議。
New generation NHI certificate planning meeting.

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



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2015年起，鼓勵醫療院所上傳病患各項檢驗檢查結果，2018年1月起，各大醫院為病患執行CT、MRI、超音波、胃鏡、大腸鏡及X光檢查，其他的基層院所即可透過健保醫療資訊雲端查詢系統調閱影像及報告內容，對民眾而言，至同層級醫院尋找第二醫療意見或後續照護，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

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

According to the NHI big data analysis, it was found that controlling unnecessary examinations, checkups and medication administration are an important key. Therefore, beginning 2015, medical institutions have been encouraged to upload various examination and checkup results. Starting on January 2018, primary care medical institutions may retrieve images and repor contents of CT, MRI, ultrasound, gastroscopy, colonoscopy, and X-ray examinations performed on patients by major hospitals through the MediCloud System. As far as the general public is concerned, seeking second medical opinions or subsequent care from a hospital of the same level can be achieved by retrieving data from the cloud to view test and checkup reports, thereby saving the time from waiting for hospital operating processes and money, while reducing potential health risks arising from repeated examination. Through the implementation of the concept of grading medical care “good hospitals in the community; good doctors in the neighborhood”, patients’ medical care quality and convenience can be improved, and the problem of medical center crowdedness can be reduced.

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

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（2018年5月增加行動電話認證）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2018年6月30日止，健康存摺使用人數約71.5萬人，使用人次已達606.7萬人次。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。2018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201萬筆、醫令約745萬筆資料。

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月建置完成並啟用「電子化專業審查系統」，建立了醫療費用專業審查（含文字及影像資料）作業e化環境，以期協助醫療院所進行醫療專業審查電子化申請或申報，並經由醫療影像儲傳系統（PACS：Picture-Archiving and Communication System）傳遞送審案件之影像檔案；為有效應用資訊資源及善用人力資源，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。

電子申報提升作業效率，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%

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, 2018, the system had approximately 715,000 users, and downloads had been made over 6.06 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 2018, an average of 2.01 million patient visit summaries containing approximately 7.45 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, 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

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，另外，因醫療資訊雲端查詢系統之資料呈現約有2-3天的落差，但透過健保卡登錄藥品及檢驗（查）項目，可讓醫師在診療時即時參考。

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

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. In addition, since the data in the MediCloud system has a 2 to 3-days lag, but drugs and test (checkup) items stored in the NHI Card serve as immediate references for physicians during diagnosis and treatment.

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. 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.

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2018年6月底，使用之投保單位已有19.7萬家，每個月透過網路申報之異動資料約142萬筆，占全部異動量之77%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、信用卡及健保快易通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2018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40%）、金融機構轉帳代繳（占29%）及便利超商繳費（占30%），另有部分民眾選擇自動櫃員機繳費、信用卡臨櫃繳費及網路繳費，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。

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 January 2018, 197,000 insurance registration units (chiefly employers) had used this section, and had reported approximately 1.42 million data updates online each month, which accounted for more than 77% 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.

The NHIA began offering multiple payment channels since January 2007. Premium payment data from January 1 to June 30, 2018 revealed that service counter payments at financial institutions (40%), account transfers by financial institutions (29%), and convenience store payments (30%) 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

Chapter 6

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歲以上之無職業原住民，2017年全年補助金額約250億元，補助人數約303萬人。另，2018年截至6月30日止，補助金額約125億元，補助人數約301萬人。

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.	2017.1～12	303萬人 3.03 million people	250億元 NT$25 billion
		2018.1～6	301萬人 3.01 million people	125億元 NT$12.5 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	2017.1～12	2,324件 2,324 cases	1.74億元 NT$174 million
		2018.1～6	1,107件 1,107 cases	0.85億元 NT$85 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	2017.1～12	7.7萬件 77,000 cases	21.73億元 NT$2.173 billion
		2018.1～6	3.9萬件 39,000 cases	11.06億元 NT$1.106 billion

資料時間：2017年1 月1 日～2018年6 月30 日。
Note: Dated from Jan. 1, 2017 to June 30, 2018

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$25 billion in premium subsidies was provided to roughly 3.03 million individuals in 2016. During 2017, approximately NT$12.5 billion in premium subsidies had been provided to roughly 3.01 million individuals as of June 30, 2018.

於短期災民安置中心（福康收容所）說明有關民眾健保權益。
Explaining the NHI rights and benefits to the public at the temporary disaster victim shelter（Fullkind Shelter）.

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 2017, a total of 2,324 loans amounting to NT$174 million were made throughout the year, and 1,107 loans totalling NT$85 million had been made as of June 30, 2018.

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 77,000 cases to repay NT$2.173 billion in installments in 2017, and permission was granted in 39,000 cases to repay NT$1.106 billion in installments up until June 30 2018.

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.

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。2017年全年共核貸2,324件，金額1.74億元。2018年截至6月30日止，共核貸1,107件，金額0.85億元。

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，2017年全年辦理分期繳納共7.7萬件，合計21.73億元。另2018年截至6月30日止，辦理分期繳納共3.9萬件，合計11.06億元。

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。2017年全年轉介成功個案計6,799件，補助金額共2,369萬餘元。2018年截至6底止，轉介成功個案計3,160件，補助金額共1,614萬餘元。

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。

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2018年6月底，累計補助金額已達38.5億元，累計補助人數達21萬9,710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（80-420元）為低。

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

In 2017, 6,799 cases were successfully referred to charitable sources of assistance, and a total of more than NT$23.7 million in subsidies were provided. In 2018, 3,160 cases were successfully referred and received over NT$16.14 million 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, 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.

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 2018, the cumulative subsidies provided to this program totaled NT$3.85 billion, and a cumulative total of 219,710 persons had benefited from it (Table 6-2).

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$420).

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） 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	4億元 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	3.95億元 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	3.78億元 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	3.79億元 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	3.81億元 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	3.24億元 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	0.03億元 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	4.01億元 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	0.21億元 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	4億元 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	0.02億元 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	2.56億元 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	0.02億元 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	2.34億元 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	0.06億元 NT$6 million
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	14,910	1.60億元 NT$160 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	458	0.09億元 NT$9 million

年度 Year	計畫名稱 Program Description	人數 No. of Beneficiaries	金額（新臺幣） Amount
2018 上半年 First half of 2018	協助經濟弱勢民眾重返健保醫療照護計畫。 Plan to help the financially disadvantaged to be re-covered by NHI medical care.	2,681	0.95億元 NT$95 million
	協助弱勢兒少、偏鄉原住民、無力就醫及急難家庭脫離健保欠費困境計畫。 Plan to relieve the disadvantaged children, indigenous people in remote areas, distressed and medically impaired households from overdue premium.	272	0.04億元 NT$4 million
總計 Total		219,710	38.5億元 NT$3,850 million

註：資料時間截至2018年6月底。
Note: Figures as of the end of June 2018.

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. 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 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 2018, a total of more than 954,000 catastrophic illness cards had been issued (to over 890,000 people, who accounted for 3.76% of all insured). In 2017, the cost of treating catastrophic illnesses totalled approximately NT$191 billion, and accounted for 27.4% of all NHI medical expenditures. Roughly NT$58 billion in

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特殊教育學校提供牙醫特殊巡迴醫療服務。2011年7月1日起，更進一步針對特定身心障礙類別且符合居家照護條件者，提供到宅服務。2013年1月1日起，新增提供入住身心障礙機構之長期臥床者牙醫服務。2014年1月1日起增加政府立案收容發展遲緩兒童機構者機構服務。2015年1月1日起進一步提供衛生福利部所屬老人福利機構內，長期臥床者牙醫診療服務。

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2018年6月底，重大傷病證明有效領證數約有95萬4千餘張（人數為89萬餘人，約占總保險對象的3.76%），而2017年全年重大傷病醫療費用約1,916億餘元（占全年總醫療支出的27.4%），健保藥品費用中，每年約有580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220項，截至2018年6月底止，領證數共9,972張。經統計2017年罕見疾病之藥品費用約為53億元。

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。

本計畫執行多年，每年收案照護對象平均就醫次數較上年同期呈現減少，施行成效良好。每年參與照護，提供整合服務之醫院約180餘家，接受整合照護對象人數約50萬餘人。

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. The high level of spending on the treatment of catastrophic illnesses reveals the tremendous assistance that the NHI system provides to these individuals.

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 220 types of rare diseases, and had issued 9,972 rare disease verification cards as of the end of June 2018. Drug expenditures for the treatment of rare diseases totalled approximately NT$5.3 billion in 2017.

People with multiple chronic conditions

Patients with multiple chronic conditions consume the largest share of resources in Taiwan's healthcare system. With the aging of Taiwan's population, the prevalence of multiple chronic conditions 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.

This plan has been implemented for many years. Each year, the average medical visits of cases accepted decreased compared to the same period in the previous year, indicating positive effectiveness. Each year, about 180 hospitals take part in this program providing integrated care services, and targets receiving integrated care exceed 500,000 people.

Providing Care in Remote Areas Lacking Medical Resources

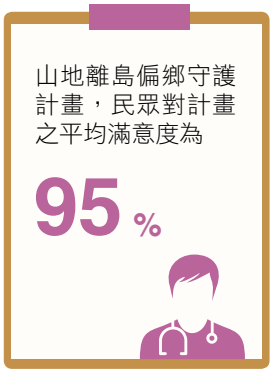
According Article 60 of the Enforcement Rules of the National Health Insurance Act, where a beneficiary receives outpatient care service, emergency care services or home-care service in a resource depletion area, the self-bearing amount may be reduced by 20%. In addition, the NHIA has also implemented the following plans in order to enhance medical services in remote areas or areas deficient of medical resources.

對山地離島、偏鄉及醫療資源缺乏地區族群的照護

依據健保法施行細則第60條，經公告之醫療資源缺乏地區就醫之門診、急診與居家照護服務，減免20%部分負擔，除此之外，健保署亦實施下列計畫以提昇偏遠地區或醫療資源缺乏地區之醫療服務：

全民健康保險山地離島地區醫療效益提昇計畫：

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



目前全國公告之山地離島鄉計有50鄉，共26家特約院所承作30項計畫，服務民眾達46萬餘人，當地民眾對計畫之平均滿意度為95%。

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。106年共有541家特約院所至資療資源不足地區巡迴，服務民眾達60.9萬餘人。

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。

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.

At present, there are 50 townships in the outskirts of the country. A total of 26 contract institutions have undertaken 30 projects, serving more than 460,000 people, with the average satisfaction of the local people reaching 95%.

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. In 2017, 541 contract institutions have conducted tours in areas deficient of medical resources, serving more than 609,000 people.

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 Satisfactions and International Recognition

李署長於「2017年國際衛生服務會議」演講。
Director General Lee gave a speech at the “International Congress of Health Services CISS- 2017”.

Chapter 7

民衆滿意　國際肯定
Public Satisfactions and International Recognition

健保經驗　蜚聲國際

臺灣的全民健保採行集中、統籌資源且適用層面廣的單一保險人體制，相較於其他國家健康照護體制，行政成本較低並可達保險費公平性及一致性的優點，也是許多國家取經的優點。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，2017年7月至2018年6月健保署共接待全球56國，計466位外賓參訪。

2018年世界衛生大會的主軸是實現「全民健康覆蓋」（UHC），各國領袖也都承諾在2030年，保障人人能獲得基本的醫療服務，不因疾病面臨經濟困難。台灣以單一保險人制度於1995年開辦全民健康保險，全體國民從出生起，不分性別、年齡、貧富，人人均享有平等就醫的權利，復針對收入面與支出面進行改革，於2013年起實施二代健保，這對許多發展中國家而言，是舉世稱羨的「台灣經驗」。

健保署於台北舉辦世界衛生日健康大步走活動。
Walk for the World Health Day held by NHIA in Taipei.

2018年「世界衛生大會」（WHA）召開期間，我國衛生福利部亦組團前往日內瓦展開醫衛交流行動，充分發揮我專業、務實、深化與他國交流的目的。我國衛福部與國外專家學者於5月22日假瑞士日內瓦洲際飯店共同舉辦「全球衛生安全—遏止抗生素抗藥性傳播專業論壇」（Forum on Antimicrobial Resistance（AMA）—A Threat to Global Health Security），針對全球共同面臨之抗生素抗藥性及超級細菌威脅，進行深入討論與交流。健保署李伯璋署長於會中擔任與談人，發表保險人在給付抗生素政策及用藥管理之措施，包括利用雲端藥歷（PharmaCloud）減少重複用藥，以及透過「健保醫療品質資訊公開網」公開院所抗生素使用情形，藉由資訊公開及同儕制約方式遏止抗生素濫用，並說明台灣願與世界各國同心協力防範抗生素抗藥性的決心。

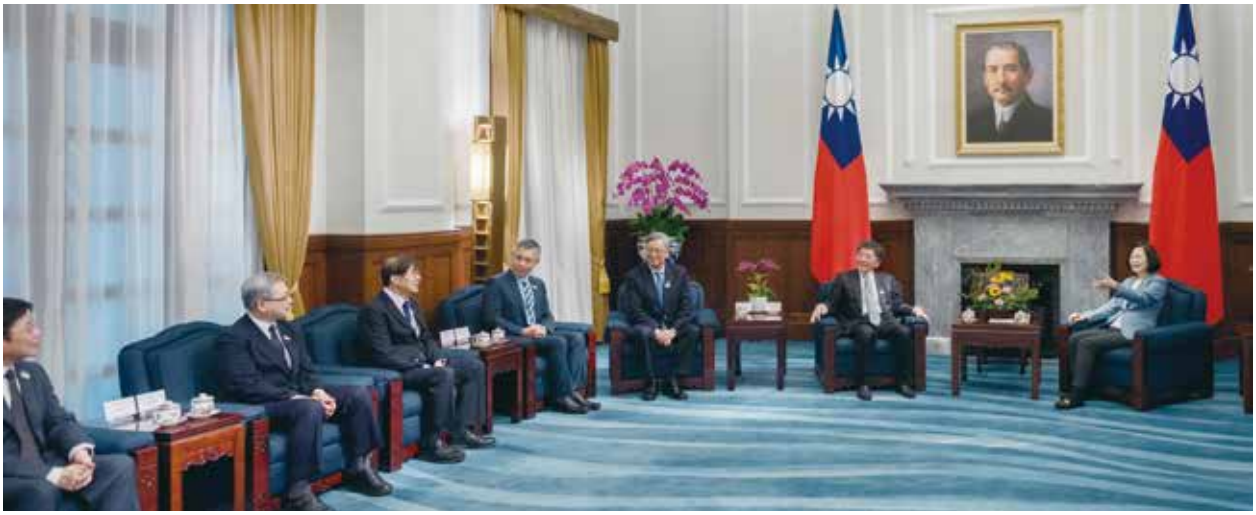
此外，李署長亦應邀於「亞洲國家健康照護未來成本挑戰與價值機會圓桌會議」（The Future Cost Challenge and Value Opportunities for Healthcare in the ASEAN Nations Round Table Meeting）發表演講，分享台灣以低保

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. Each year, a large number of foreign experts, scholars or official representatives are attracted to visit Taiwan to investigate its National Health Insurance system. From July 2017 to June 2018, the NHIA has received 466 foreign visitors from 56 countries from around the world.

The theme of the 2018 WHA is Universal Health Coverage (UHC). Leaders from around the world have also promised to ensure everyone have access to basic medical services by 2030, to be free from having to worry about financial difficulties caused by their diseases. Taiwan launched the National Health Insurance adopting the single-payer system in 1995. All citizens, regardless of gender, age, and wealth, are entitled to equal medical rights since birth. Then the 2nd-generation NHI was implemented in 2013 to conduct financing and payment reform. As far as many developing countries are concerned, Taiwan's NHI is a world-famous "Taiwan experience".

During the WHA held in 2018, Taiwan's Ministry of Health and Welfare also organized a delegation to Geneva with the practical purpose of exchange professionalism while deepening relationships with other countries. Taiwan's Ministry of Health and Welfare and foreign experts and scholars jointly held the "Forum on Antimicrobial Resistance (AMA)-A Threat to Global Health Security" in Geneva, Switzerland on May 22 to engage in in-depth discussions and exchanges on antibiotic resistance and superbug threats confronting the world. The NHIA Director General, Dr. Po-Chang Lee, served as a panelist in the meeting and presented antibiotic payment policies and medication management measures, including the use of PharmaCloud to reduce repeated medication and the use of "NHI



蔡總統召見世衛行動團。
President Tsai summoned Taiwan's Delegation to WHA.

費、低行政成本提供民眾高品質的醫療照護，在面對開源不易的情形況，透過大數據分析進行有效管理，加強節流措施，一方面避免重複用藥及檢驗檢查，另一方面則進行給付合理化改革，並強化各醫療院所的分工合作，進而減少不必要的醫療行為，達到醫療費用控管的目標。

2017年5月李署長也受邀參加於巴西舉行的「2017年國際衛生服務會議（International Congress of Health Services CISS-2017）」並就Universal Health Coverage: Taiwan's National Health Insurance - Achievements and Innovations主題進行演講，分享臺灣全民健保相關執行經驗。

目前政府正積極推行「新南向政策」，當前東南亞不少國家努力朝向實施全民健保之目標，台灣可以研議如何將健保制度輸出，以協助他國發展健保為策略，並建立雙邊長期合作關係。菲律賓衛生部及健保局（PhilHealth）官員即於107年8月28日至8月30日來台參訪，本署安排課程講授我國全民健保實施總額支付制度之歷程、疾病診斷關聯群制度規劃執行及資訊系統，讓菲國官員深入瞭解相關內容，並安排菲國官員參訪醫院，瞭解醫療品質監控、資訊系統等，協助菲律賓規劃健保相關制度。

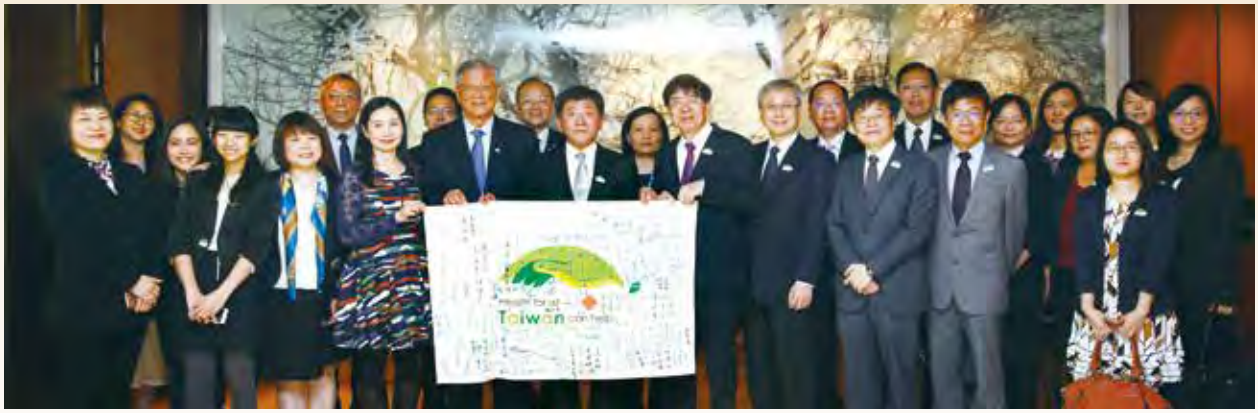
全民健保　民眾滿意

全民健保實施曾面臨諸多困難，從一開始的滿意度不到4成，到目前持續成長至8成以上，顯見民眾十分肯定健保。其中雖曾因2002年度保險費率及部分負擔調整，以及2005年度開始進行多元微調，導致民眾對全民健保的滿意度稍有下降，但隨後即快速回升至7成以上。2013年1月起二代健保實施，針對所得收入高者加收補充保險費，滿意度曾一度下滑後隨即回穩至8成左右，2018年民眾對健保的

2018年民眾對健保的滿意度更創下高峰達到

86.5%

菲律賓衛生部及健保局（PhilHealth）官員來訪。
The officials from the Department of Health and PhilHealth of the Republic of the Philippines visited the NHIA.



2018 世衛行動團。
Taiwan' delegation in Geneva during 2018 WHA.

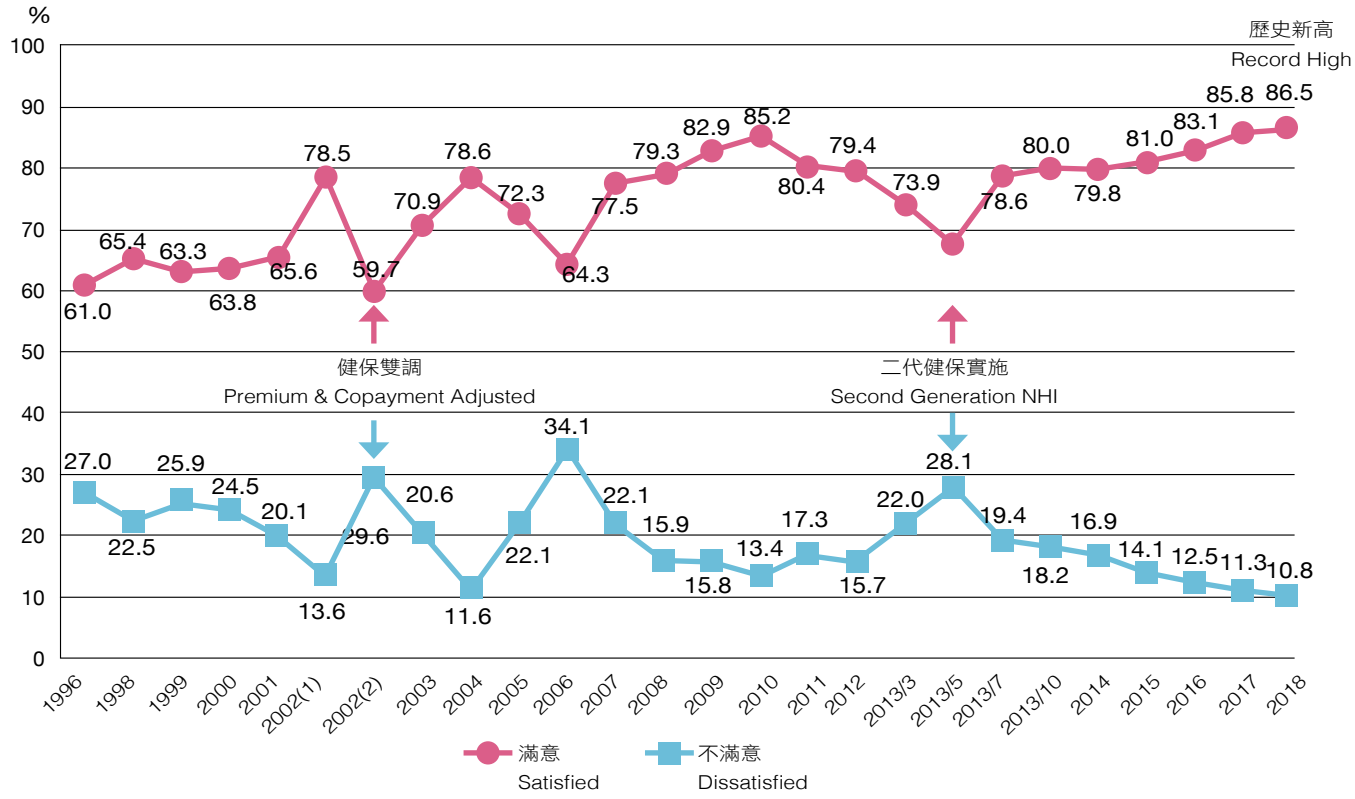
medical quality information disclosure network" to disclose antibiotic usage in medical institutions. Antibiotic abuses can be curbed through the information disclosure and peer-to-peer restrictions. He also explained Taiwan's determination to work with countries around the world in antibiotic resistance prevention.

In addition, Director General Lee was also invited to give a lecture at "The Future Cost Challenge and Value Opportunities for Healthcare in the ASEAN Nations Round Table Meeting". Dr. Lee shared with other countries high-quality medical care in Taiwan provided to the general public at low premiums and low administrative costs, how the NHIA, when facing limited budgets, uses big data to carry out effective management and strengthen cost-containment measures. The NHIA works to prevent, repeated medication, tests and checkups; and at the same time carry out payment reforms and reinforcing the division of labor and cooperation in medical institutions to prevent unnecessary medical behaviors, thereby achieving cost control purposes.

In May 2017, Director General Po-Chang Lee was invited to attend the International Congress of Health Services CISS-2017 in Brazil, where he gave a lecture on "Universal Health Coverage: Taiwan's National Health Insurance - Achievements and Innovations" and shared Taiwan's NHI related implementation experiences.

At present, the government is actively promoting the "New Southbound Policy". While a number of Southeastern Asian countries are striving towards the goal of implementation national health insurance, Taiwan may formulate ways to output the NHI system in order to assist other countries in developing health insurance strategies and establishing long-term bilateral cooperative relationships. The officials from the Department of Health and PhilHealth of the Republic of the Philippines visited Taiwan from August 28 to August 30, 2018. The NHIA scheduled classes to lecture on the course of the NHI's implementation of the global budget payment system, disease diagnosis related group system plan implementation and information system in order for the delegations to gain an insight into relevant contents. Arrangements were also made for them to visit hospitals to understand quality monitoring mechanism, information systems, and etc. as a reference for the Philippines to plan for their health insurance related systems.

圖7-1 全民健保滿意度趨勢圖
Chart 7-1 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.

滿意度更創下高峰達到86.5%（圖7-1），我國因有全民健保，對經濟弱勢民眾的健康照護更能提供完善的醫療保障。

充分發揮　互助功能

全民健保的核心價值在於透過社會互助，以「社會保險」的形式，來分擔保險對象罹病時的財務風險。重大傷病人口占全體保險對象人數的3.77%，醫療費用卻高達健保總醫療支出的27.3%。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5.7倍到102.6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	29,378	1.0
每一重大傷病患者 Average catastrophic illness patient	203,360	6.9
每一癌症患者 Average cancer patient	165,927	5.6
每一罕病患者 Average rare diseases patient	678,998	23.1
每一洗腎患者 Average kidney dialysis patient	607,451	20.7
每一呼吸器患者 Average patient on mechanical ventilation	737,274	25.1
每一血友病患者 Average hemophilia patient	3,014,347	102.6

註：以2017年重大傷病年度統計資料為例。
Note: The above figures are based on 2017 catastrophic illness statistics.

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. The 2nd Generation NHI system has been implemented since January 2013, and supplementary premium was imposed on high-income households. The satisfaction that had at one point dropped climbed back to around 80%. In 2017, the general public's satisfaction towards the NHI even peaked at 85.8% (Chart 7-1). Due to the implementation of NHI in Taiwan, comprehensive medical protection can be better provided to the needs of disadvantaged people.

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 27.3% 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 5.7 to 102.6 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).

Chapter 8

跨步精進　展望未來

Recent Progresses and Future Outlook

Concluding Remarks:

跨步精進　展望未來
Recent Progresses 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，達成病人分流之目的。醫療院所間組成「垂直整合策略聯盟」，藉由聯盟進行上下游垂直整合、醫院及診所間分工合作，運用電子轉診平台及雲端資訊之上傳及分享，落實雙向轉診，提供病人連續性、以病人為中心的醫療照護、並提升照護品質。

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 Division of Labor in the Healthcare System

In order to gradually implement a tiered healthcare system with a soud division of labor, 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.The "vertical integration strategic alliance" formed by medical institutions have implemented two-way referrals to provide patients with continuous and patient-centered medical care and enhancing care quality through a vertical integration of the alliance's upstream and downstream, collaboration among hospitals and clinics, use of electronic referral platform, and uploading and sharing of medical information using cloud technologies.

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

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，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2018年6月底，有2,234家醫事服務機構組成211個團隊，就近照護40,828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。2017年接受全民健保安寧居家服務人數為10,686人（較2016年成長22%），2018年1-6月有7,011人（較2017年同期成長18%），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，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。

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 June 2018, 2,234 medical organizations had organized 211 teams to provide care to 40,828 persons. The NHIA will continue to encourage the establishment of 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 2017, the number of people who received NHI palliative home care totaled 10,686 people (an increase of 22% compared to 2016). From January to June, 2018, the number totaled 7,011 people (an increase of 18% compared to 2017), indicating a gradual increase in the number of terminal patients who received palliative care.

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

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。推動迄今，全國共有38個醫院團隊、201家醫院參與。

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。

配合推動分級醫療六大策略廿四項配套措施，2018年家庭醫師整合性照護計畫除持續擴大基層服務量能，積極促進社區醫療群與合作醫院間進行實質合作，包括對病人之雙向轉診及慢性病共同照護，以確保病人照護之連續性與協調性；並推廣社區醫療群應規劃主動電訪（Call out）服務，以加強個案健康管理，提升照護品質，並與一般診所建立差異化之服務模式。

截至2018年6月底，有4,558家基層診所與202家醫院共同組成567個醫療群，共同照護超過473萬名收案會員。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、檢驗所並建立醫療群合作診所，提供復健科、眼科及精神科醫療服務，以提升社區醫療群照護能力，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2018年7月，健保署已與花東地區之光復鄉、成功鎮、大武鄉及關山鎮，新北市金山區、宜蘭縣宜蘭市及南澳鄉、桃園市復興區、新竹縣尖石鄉及五峰鄉、苗栗縣泰安鄉、南投縣埔里鎮及水里鄉、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及車城鄉等20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

care home model and encouraged even more hospitals and clinics to form inter-institutional, inter-professional service teams. Up to now, 38 hospital groups and 201 hospitals have participated.

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 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 promoting a tiered healthcare system, six medical strategies and 24 package measures, the 2018 family doctor integrated care project continues to expand primary care momentum, and actively promote substantial cooperation between community medical groups and cooperating hospitals', which includes two-way referrals and joint care of chronic disease to ensure patient care continuity and coordination. Moreover, it promotes community medical groups' to provide

本署「醫療送到家」專案榮獲第一屆政府服務獎。
The NHIA was granted with 1st Government Service Award.

call out services to strengthen case management, enhance care quality, and establish differentiated service models with clinics.

As of the end of June 2018, 4,558 primary care clinics and 202 hospitals have jointly set up 567 medical groups who have jointly offered care to over 4.73 million accepted members. The NHIA will continue to encourage community medical groups to cooperate with pharmacies, public health centers, physical therapy institutions, and examination institutions and establish cooperated medical groups to provide rehabilitation, ophthalmology, and psychiatry medical services in order to enhance community medical groups' care capacity to be able to provide localized holistic care and services.

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

花蓮玉里辦公室開幕。
Opening of the Yuli Liaison Office in Hualien.

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「創新智慧服務平台」服務，打造健保全渠道（Omni-channel）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，透過即時啟動跨區的備援機制，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顧知能

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，以網路取代馬路，運用互聯網（Internet of Things）的便利性，串聯個人資料（My Data），建置「健康存摺」，提供個人線上數位服務，落實知情權，協助民眾做好自我健康管理，並可利用健康存摺做為醫病間溝通橋樑，減少醫病間醫療資訊的不對等，提升就醫安全與效率。

健康存摺透過視覺化資訊圖表，搭配個人健保資料篩選及分類功能，讓民眾可快速瞭解個人的就醫情形，包括醫師臆斷、處置、用藥、檢驗（查）結果及醫療影像等資料，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，目前已整合之跨機關資料包括醫事司器捐或安寧緩和醫療意願、疾病管制署預防接種資料、國民健康署成人預防保健結果、四癌篩檢結果及金門縣政府補助縣民自費健檢結果等資料。另外，為便利民眾申請健康存摺於107年5月導入手機快速認證，只要是本國籍保險對象，手機門號是自己的名義申辦，

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 2018, the NHIA was cooperating with 20 district offices respectively located in the Hualien-Taitung area's Guangfu Township, Chenggong Township, Dawu Township and Guanshan Township; New Taipei City's Jinshan District; Yilan County's Yilan District and Nan'ao Township; Taoyuan's Fuxing District; Hsinchu County's Jianshi Township and Wufeng Township; Miaoli County's Tai-an Township; Nantou County's Puli Township and Shuili 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 and Checheng 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 concepts with the convenience of the Internet of Things and its"My Data"database of personal information 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. My Health Bank provides an easy-to-understand graphic presentation of information alongside personal health insurance data filtering and sorting functions, this system allows users to quickly understand their 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

且為月租型搭配行動上網，就能透過「全民健保行動快易通」APP認證身分，查詢健康存摺。

為增進民眾使用黏著度，持續精進健康存摺，新增APP推播，主動提醒應接受洗牙、癌症篩檢、成人預防保健，強化行事曆功能，主動串聯就醫紀錄，並可匯入及匯出，讓民眾更清楚掌握就醫行程。

未來將持續擴充健康存摺資料的豐富性、互動性及友善度，規劃新增包括「兒童預防接種時程提醒」，讓家長不要忘了孩子的常規疫苗施打，鼓勵健檢機構若民眾簽署同意書，則協助將「自費健檢」結果傳送本署載入其個人的健康存摺，或可由民眾自行登錄健檢資料，另增加「軟體開發套件（Software Development Kit, SDK）」功能，讓當事人下載資料後，可依自主意願，將資料提供給信任APP、健康管理服務系統，或其他公私立單位進行後續加值服務，讓健康存摺更能彰顯其價值，作為民眾最可靠的健康管理後盾。

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 南澳鄉 Nan'ao Township
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 水里鄉 Shuili 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
	車城鄉 Checheng Township
花蓮縣 Hualien County	光復鄉 Guangfu Township
台東縣 Taitung County	大武鄉 Dawu Township
	成功鎮 Chenggong Township
	關山鎮 Guanshan Township

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.

Currently, cross-agency data that has been integrated includes: an organ donation or hospice/palliative care survey from the MOHW's Department of Medical Affairs; preventive inoculation data from the Centers for Disease Control; outcomes of adult preventive health services from the Health Promotion Administration; results of four cancer screenings; and health check-up data from Kinmen County residents (as reimbursed by the county government). Additionally, to encourage new registrations for My Health Bank, a mobile phone-based fast certification service was introduced in May 2018. Local citizens may apply via a mobile number in his/her name, with a monthly cell phone data plan. Qualified users can then use the NHIA mobile app to certify their identity and browse My Health Bank.

健保快易通圖FB。
APP of National Health Insurance Administration, Ministry of Health and Welfare.

動動手指～加保不中斷，健保網路服務超方便！
It is convenient and uninterrupted to apply the healthy insurance by clicking on the website system.

To improve app user loyalty among the public, improvements made to My Health Bank include: push notifications, which provide active reminders for health-related services such as dental scaling, cancer screening, and adult preventive health services; enhanced calendar functions; and linking to user medical history for convenient data import and export in the app, allowing users to easily manage his/her medical service usage.

In the future, the administration will continuously improve on the interactivity, user-friendliness, and diversity of My Health Bank. Planned updates include parental reminders for children's scheduled inoculations and routine vaccinations. Health checkup institutions are also encouraged to send out-of-pocket health checkup results to the administration which can then be made available for download in My Health Bank. Users can also input their own health checkup data. Additional functions include a software development kit (SDK) in which users are able to authorize his/her data to be provided to services such as trusted apps, health management systems, and other public/private organizations for further value-added services. These improvements will continue to enhance My Health Bank and solidify its role as the most reliable health management service.

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