



全民健康保險年報

National Health Insurance

2025 — 2026

Annual Report



為提供保險醫療服務
增進全體國民健康

- 提升品質
- 關懷弱勢
- 健保永續
- 國際標竿





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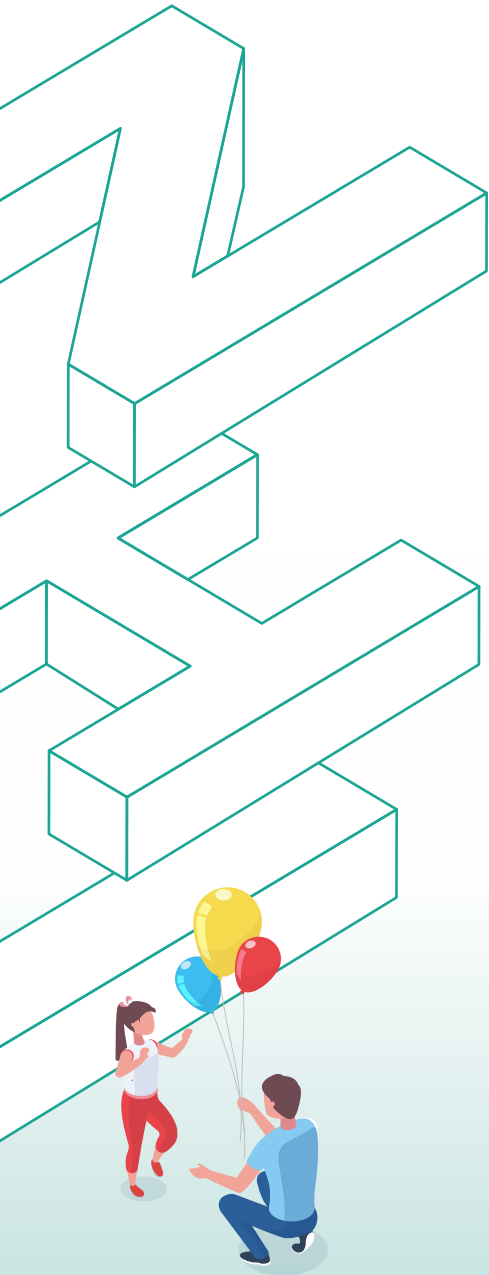


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署長的話

Message from the Director General

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

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

我國慢性病患者約850萬人，從源頭著手控制三高、改善生活型態，並推動慢性病888計畫，將健康促進的概念融入健保。再者，癌症已連續43年位居臺灣十大死因之首，健保推動百億癌症新藥基金，減輕癌友與其家庭的負擔，治療指引接軌國際

建立評估機制並加速新藥及新醫材收載，兼顧病人權益與財務永續。

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

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

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

衛生福利部中央健康保險署 署長

陳亮婷





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

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

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

been accelerated, thereby balancing patient rights with financial sustainability.

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

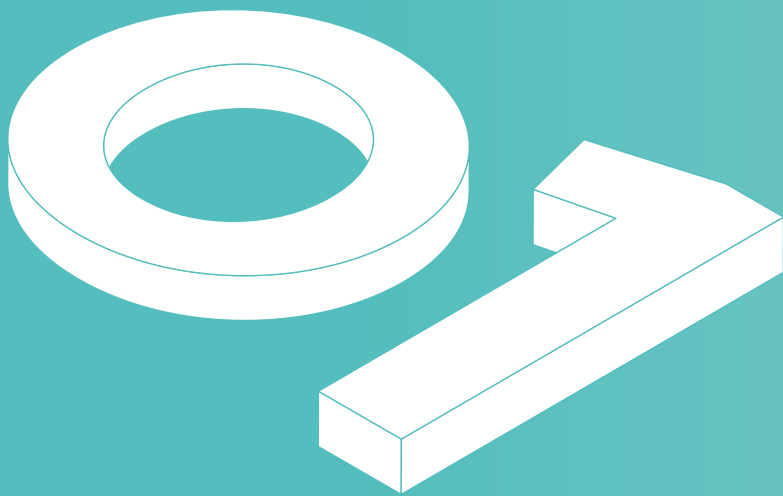
To accelerate innovation in medical information systems and align with international standards, the NHIA will invest in next-generation digital healthcare platforms to create a smart and secure healthcare environment. At the same time, data protection will be strengthened, and the transparency and trustworthiness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

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

Lian-Yu Chen

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

Chapter



組織沿革 承先啟後

**Organization Structure
and History**





組織沿革 承先啟後

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

全民健康保險為政府辦理之社會保險，以衛生福利部為主管機關。衛生福利部設有全民健康保險會，以協助規劃全民健保政策及監督辦理保險事務之執行，並設有全民健康保險爭

議審議會，處理健保相關爭議事項。健保署為保險人，負責健保業務執行、醫療品質與資訊管理、研究發展、人力培訓等業務；健保署所需之行政經費由中央政府編列預算支應。

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

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

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

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

總計Total: 23,959,972 / 31,316



註1：各主要縣市及金門、澎湖等地，設立7個聯合服務中心及22個聯絡辦公室，為民眾提供在地化服務。

註2：資料統計至2024年12月。

Notes: 1. Seven joint service centers and 22 liaison offices have been established in major counties and cities and on the offshore islands of Kinmen and Penghu to deliver localized services.

2. Statistics as of December 2024.



Organization Structure and History

The National Health Insurance Administration (NHIA) was formerly a finance/insurance business entity known as the Bureau of National Health Insurance, Department of Health, Executive Yuan. In 1995, it was charged with integrating the country's three major occupational medical insurance systems for laborers, farmers, and government employees that covered approximately 59% of the population. As well as following the principles of sustainability and caring for the disadvantaged, this move was intended to develop a complete social insurance scheme that covers the entire population. In 2010, the NHIA was transformed as an administrative agency and consolidated in 2013. Today, it becomes the National Health Insurance (NHI) system, which is a government-run, single-payer scheme.

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

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

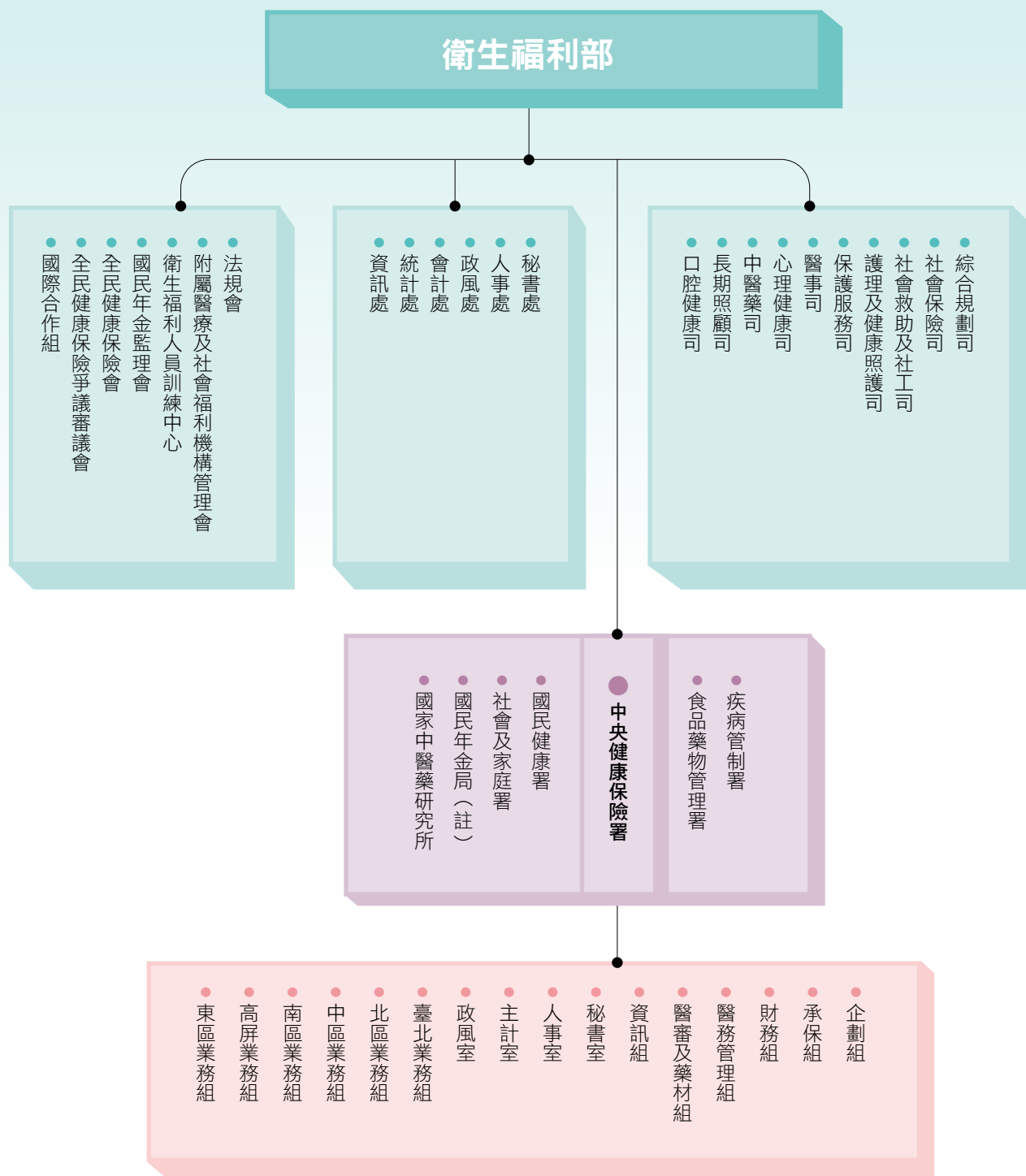
The NHIA has established various specialized departments to handle operations for the provision of NHI services. Six regional divisions (Table 1-1 and Chart 1-1) are in place to handle enrollment, premium collection, medical expense review and approval, and the management of contracted medical institutions.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



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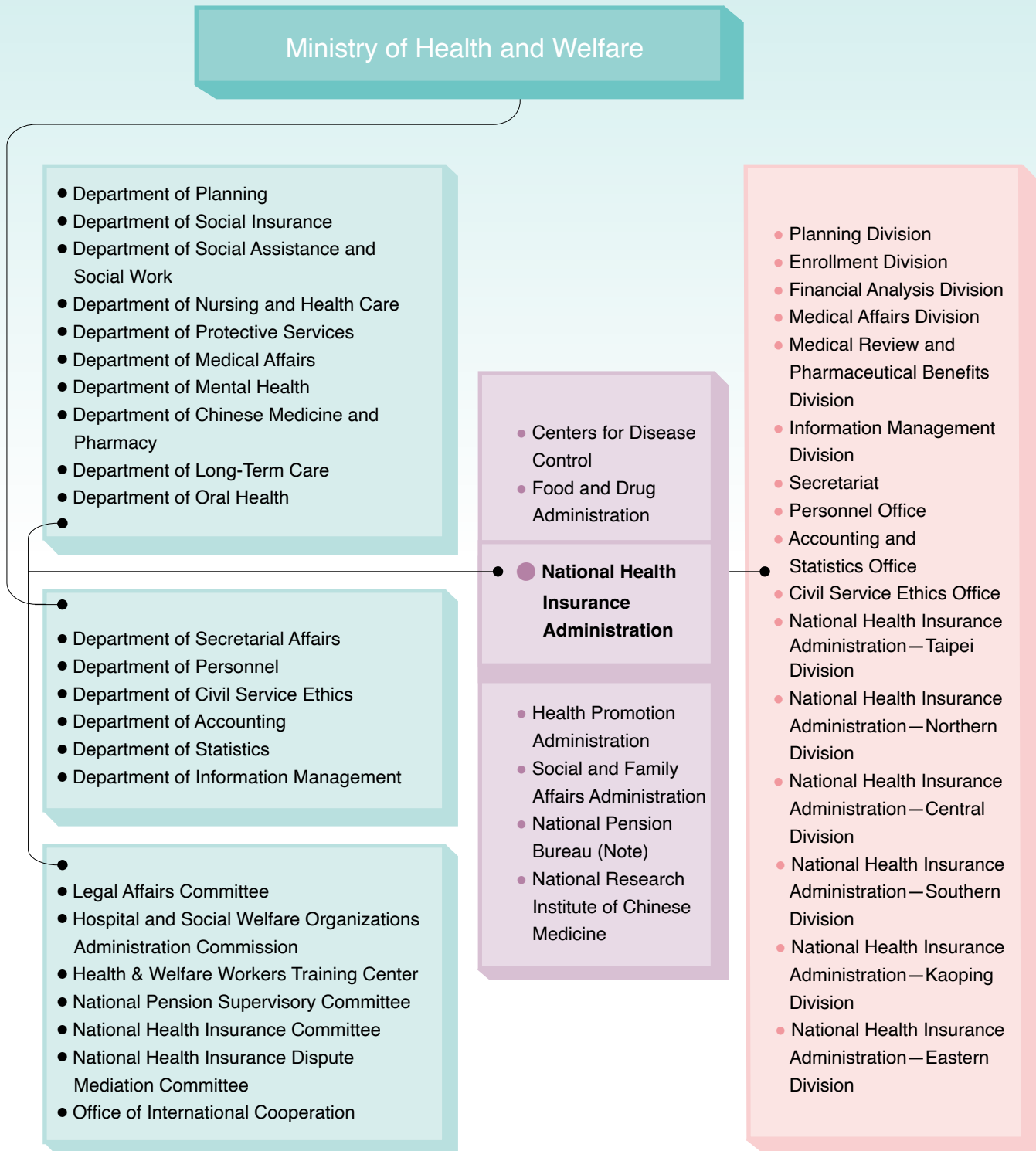
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圖1-1 中央健康保險署組織架構圖



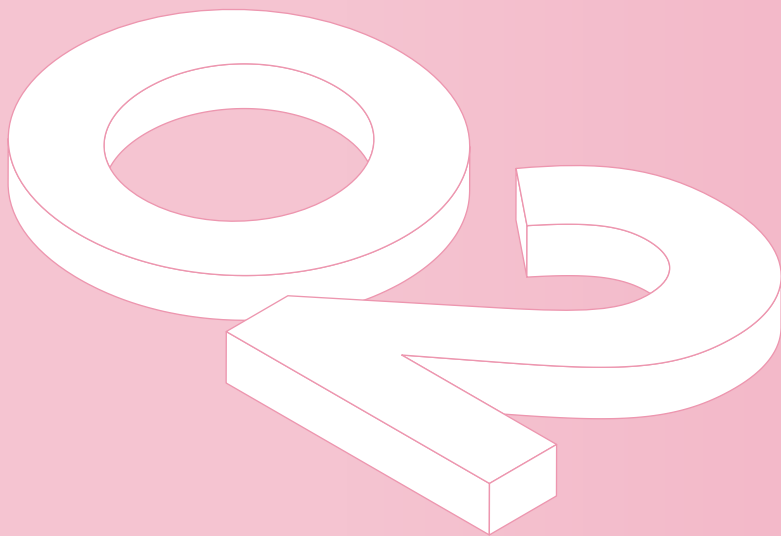
註：國民年金局暫不設置，衛生福利部組織法明定其未設立前，業務得委託相關機關（構）執行。

Chart 1-1 NHIA Organization Chart



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

Chapter



全民有保 財務永續

**Universal Coverage and
Financial Sustainability**





全民有保 財務永續

全民有保 就醫平權

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

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

二代健保施行後，為全面落實平等醫療服務及就醫之權利，矯正機關之受刑人亦納入健保納保範圍內；本國人久居海外返國重新設籍欲參加健保時，必須有在2年內參加健保的紀錄，或是在臺灣設籍滿6個月才能加入健保；外籍人士也必須在臺灣地區領有居留證明文件且連續居留滿6個月始可加入健保，以符合社會公平正義之期待。

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

財務平衡 永續經營

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

然而，隨著整體環境與社會人口結構等影響，醫療支出增加速度遠較於保費收入成長速度為快，健保署除積極開源節流外，分別於2002年、2010年及2021年三次調高保險費率，更以量能負擔的精神，陸續調整投保金額分級表上下限與級距及最高付費眷屬人數、逐年將軍公教人員由本薪改以全薪投保、將未列入投保金額的六項所得計收補充保費、明確規範政府負擔比率下限等，積極穩固財務，維持全民健保系統運作及平衡。

2013年二代健保實施後建立收支連動的機制，將「全民健康保險監理委員會」（收入面監督）及「全民健康保險醫療費用協定委員會」（支出面協定）整併為「全民健康保險會」，並由被保險人、雇主、保險醫事服務提供者、專家學者、公正人士及有關機關代表組成，每年協議訂定醫療給付費用總額，完成各年度保險費費率審議，報衛生福利部轉報行政院核定。透過收支連動機制，確保長期財務穩定。

Universal Coverage and Financial Sustainability

Universal Healthcare Coverage, Equal Access to Medical Care

The government initiated the National Health Insurance (NHI) scheme to provide the entire population with health security via a self-help and a mutual assistance system. As such, NHI coverage was extended to dependents, veterans, and the unemployed—people in the non-working population (including women, students, children, and the elderly—who were not covered prior to its inception. All are equally entitled to medical services when they get sick, are injured, or give birth. On the basis of this premise, it is mandatory for all nationals of the Republic of China, who have had a registered domicile in Taiwan for six months or more, and all newborns in the Taiwan area to participate in NHI. The insured are classified into six categories (Table 2-1), based on which insurance premiums are calculated.

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

To further promote equal right to medical care, second-generation NHI included inmates in correctional facilities as well. ROC nationals who have lived abroad for an extended period of time and wish to re-enroll in the NHI program, must have either participated in the system at some point during the previous two years or

established residency in Taiwan for at least six months. To be eligible for NHI coverage, foreigners must also possess an Alien Resident Certificate (ARC) and have resided in Taiwan for at least six consecutive months, so as to respond to public expectations of social fairness and justice.

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

Balanced Finances and Sustainable Operations

Since its integration of Taiwan's various social insurance systems in 1995, NHI has operated under the principles of financial self-sufficiency and pay-as-you-go. At present, NHI derives its income chiefly from premiums paid by the insured, employers, and the government. A small amount is supplemented by premium overdue charges and contributions from the Public Welfare Lottery surplus and the tobacco health and welfare surcharge.

Social and demographic changes, however, have led to NHI expenditure growing far faster than premium income. In addition to broadening sources of income and conserving funds, the NHIA increased the premium rate in 2002, 2010, and 2021. In keeping with the spirit of the ability to pay, the NHI adjusted the upper / lower limits and tiers of the payroll bracket table meant for premium calculation as well as the cap on the number of dependents for whom the highest premiums are collected. Measures also phased



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表2-1 全民健保保險對象分類及其投保單位
Table 2-1 Classification of NHI Enrollees and Group Insurance Applicants

類 別 Category	保險對象 the Insured		投保單位 Group Insurance Applicants
	本人 Insured Person	眷屬 Dependents	
第1類 Category 1	公務人員、志願役軍人、公職人員 Civil servants, volunteer military personnel, public office holders	1.被保險人之無職業配偶。 2.被保險人之無職業直系血親尊親屬。 3.被保險人之2親等內直系血親卑親屬未成年且無職業，或成年無謀生能力或仍在學就讀且無職業者。 1.Unemployed spouse 2.Unemployed lineal blood ascendants 3.Lineal blood descendants within 2 nd degree of kinship who are either minors and not employed or adults incapable of making a living, including those who are in school without employment	所屬機關、學校、公司、團體或個人 Agencies, schools, companies, groups, or individuals
	私校教職員 Private school faculty / staff		
	公民營事業、機構等有一定雇主的受僱者 Employees of public / private enterprises and organizations		
	雇主、自營業主、專門職業及技術人員自行執業者 Employers, self-employed, independent professionals and technical specialists		
第2類 Category 2	職業工會會員、外僱船員 Occupational union members, foreign crew members	同第1類眷屬 Same as the dependents in Category 1	所屬的工會、船長公會、海員總工會 Unions, Master Mariners Association, National Chinese Seamen's Union
第3類 Category 3	農、漁民 Members of farmers' and fishermen's associations	同第1類眷屬 Same as the dependents in Category 1	農會、漁會 Farmers' associations, fishermen's associations
第4類 Category 4	義務役軍人、軍校軍費生、在卹遺眷 Military conscripts, military academy students who receive grants from the government, dependents of military personnel on pensions	無 None	國防部指定之單位 Agencies designated by the Ministry of National Defense
	替代役役男 Substitute Services Draftees	無 None	內政部指定之單位 Agencies designated by the Ministry of the Interior
	矯正機關受刑人 Inmates in correctional facilities	無 None	法務部及國防部指定之單位 Agencies designated by the Ministry of Justice and Ministry of National Defense

類別 Category	保險對象 the Insured		投保單位 Group Insurance Applicants
	本人 Insured Person	眷屬 Dependents	
第5類 Category 5	合於社會救助法規定的 低收入戶成員 Members of low-income households as defined by the Public Assistance Act	無 None	戶籍地的鄉（鎮、市、 區）公所 Administration office of the village, township, municipality, or district where the household is registered
第6類 Category 6	榮民、榮民遺眷家戶代表 Veterans, household representatives of survivors of veterans	1.榮民之無職業配偶。 2.榮民之無職業直系血親尊親屬。 3.榮民之2親等內直系血親卑親屬 未成年且無職業，或成年無謀生 能力或仍在學就讀且無職業者。 1.Veterans' unemployed spouse 2.Veterans' unemployed lineal blood ascendants 3.Veterans' lineal blood descendants within 2 nd degree of kinship who are either minors and not employed or adults incapable of making a living, including those who are in school without employment	
	一般家戶戶長或家戶代表 Heads or representatives of households	同第1類眷屬 Same as the dependents in Category 1	

註：1.各類眷屬及第6類被保險人均為無職業者。

2.第4類矯正機關受刑人於2013年1月1日起參加全民健保。

Notes: 1. Being unemployed is a prerequisite for an insured person to qualify as a dependent or a member of Category 6.

2. From January 1st, 2013, inmates in correctional facilities were included as Category 4 beneficiaries in the NHI system.





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

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

資料時間：2024年12月31日

Dated: As of December 31st, 2024

一般保險費的計算

全民健保的一般保險費費率自開辦起到2002年8月底均維持4.25%，2002年9月起調整為4.55%；2010年4月為穩固健保財務，調整至5.17%。二代健保實施後，因加收補充保險費（當時費率為2%），一般保險費費率從2013年1月起調整為4.91%；2016年1月起一般保險費費率調整為4.69%，補充保險費費率調整為1.91%；惟因醫療支出成長遠高於保費

收入成長的問題仍存在，健保財務短絀數逐年擴大，2021年1月1日起一般保險費費率調整為5.17%，補充保險費費率調整為2.11%。

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



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

In 2013, the launch of second-generation NHI introduced a revenue-expenditure linkage mechanism. The National Health Insurance Supervisory Committee (responsible for revenue oversight) and the National Health Insurance Medical Expenditure Negotiation Committee (responsible for expenditure negotiation) were merged to become the National Health Insurance Committee. Comprising the insured, employers, insurance medical service providers, experts and scholars, impartial persons, and representatives of related agencies, the committee is entrusted to review the premium rate based on the negotiated total of medical benefit payments each year. The review outcome is then presented first to the Ministry of Health and Welfare (MOHW) and then to the Executive Yuan for approval. The aim is that this revenue-expenditure linkage mechanism can help ensure the NHI system's financial stability over the long run.

Calculation of General Premiums

From its inception to the end of August 2002, NHI's general premium rate was maintained at 4.25%. For NHI financial stability, it was increased to 4.55% from September 2002 and to 5.17% from April 2010. With the levy



of supplementary premiums (at 2%) upon the launch of second-generation NHI, the general premium rate was lowered to 4.91% from January 2013. Taking effect in January 2016, NHI's general and supplementary premium rates were further reduced to 4.69% and 1.91% respectively. Over the years, NHI's financial shortfall worsened, however, as increases in medical expenditures continued to well outpace the growth in premium income. From January 1st, 2021, the general premium rate was raised to 5.17% and the supplementary premium rate to 2.11%.

NHI premiums are jointly paid by the insured, group insurance applicants, and the government. The premium payable by the insured in Categories 1 to 3 is calculated as the insured's premium ratable wage multiplied by the general premium rate. The premium of Categories 4-6 insured is calculated according to the average premium paid by those classified in categories 1 to 3 (Table 2-3 and Table 2-4).



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

薪資所得者 Wage Recipients	被保險人 The Insured	投保金額×一般保險費費率×負擔比率×（1+眷屬人數） Premium ratable wage × general premium rate × contribution ratio × (1 + number of dependents)
	投保單位或政府 Group Insurance Applicant or the Government	第1類第1目至第3目：投保金額×一般保險費費率×負擔比率×（1+平均眷屬人數） Category 1 (subcategories 1-3) : premium ratable wage × general premium rate × contribution ratio x (1 + average number of dependents)
		第2、3類：投保金額×一般保險費費率×負擔比率×實際投保人數 Categories 2 and 3 : premium ratable wage × general premium rate × contribution ratio × actual number of people insured
地區人口 （無薪資所得者） Non-Wage Earning Individuals	被保險人 The Insured	平均保險費×負擔比率×（1+眷屬人數） Average premium × contribution ratio × (1 + number of dependents)
	政府 The Government	平均保險費×負擔比率×實際投保人數 Average premium × contribution ratio × actual number of people insured

註：1.負擔比率：請參照表2-4全民健保保險費負擔比率。

2.一般保險費費率：2021年1月1日起調整為5.17%（調整前為4.69%）。

3.投保金額：請參照表2-5全民健保投保金額分級表。

4.眷屬人數：依附投保的眷屬人數，超過3人的以3人計算。

5.平均眷屬人數：自2024年1月1日起公告為0.56人。

6.第4類及第5類平均保險費：2025年1月1日起調整為2,237元（調整前為2,160元），由政府全額補助。

7.第6類地區人口平均保險費：2021年1月1日起調整為1,377元（調整前為1,249元），自付60%、政府補助40%，每人每月應繳保險費為826元（調整前為749元）。

Notes: 1. Contribution ratios: Please refer to Table 2-4.

2. General premium rate: Raised to 5.17% (from 4.69%) from January 1st, 2021.

3. Premium ratable wages: Please refer to Table 2-5.

4. Number of dependents: The maximum number of dependents is three even if the actual number is higher.

5. Average number of dependents: 0.56 from January 1st, 2024

6. Average premium for Categories 4-5 insured persons: Fully subsidized by the government, the premium was raised to NT\$2,237 (from NT\$2,160) from January 1st, 2025.

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



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

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



投保金額之訂定

第1類至第3類被保險人之投保金額，由衛生福利部擬訂分級表，報請行政院核定，自2025年1月1日起共有59級（表2-5）。第1類被保險人的投保金額，由投保單位（雇主）

依被保險人每月的薪資所得，對照該表所屬的等級申報；第2類無一定雇主勞工被保險人的最低投保金額及第3類農民、漁民等被保險人的投保金額自2025年1月1日起為2萬8,590元。

表2-5 2025年投保金額分級表
Table 2-5 2025 Income Brackets for Premium Calculation

組別級距 Bracket	投保等級 Income Tier	月投保金額（元） Monthly Premium Ratable Wage (NT\$)	實際薪資月額（元） Actual Monthly Wage (NT\$)
第一組級距1,200元 Bracket 1 NT\$1,200	1	28,590	28,590以下 Less than 28,590
	2	28,800	28,591~28,800
第二組級距1,500元 Bracket 2 NT\$1,500	3	30,300	28,801~30,300
	4	31,800	30,301~31,800
	5	33,300	31,801~33,300
	6	34,800	33,301~34,800
	7	36,300	34,801~36,300
第三組級距1,900元 Bracket 3 NT\$1,900	8	38,200	36,301~38,200
	9	40,100	38,201~40,100
	10	42,000	40,101~42,000
	11	43,900	42,001~43,900
	12	45,800	43,901~45,800
第四組級距2,400元 Bracket 4 NT\$2,400	13	48,200	45,801~48,200
	14	50,600	48,201~50,600
	15	53,000	50,601~53,000
	16	55,400	53,001~55,400
	17	57,800	55,401~57,800
第五組級距3,000元 Bracket 5 NT\$3,000	18	60,800	57,801~60,800
	19	63,800	60,801~63,800
	20	66,800	63,801~66,800
	21	69,800	66,801~69,800
	22	72,800	69,801~72,800
第六組級距3,700元 Bracket 6 NT\$3,700	23	76,500	72,801~76,500
	24	80,200	76,501~80,200
	25	83,900	80,201~83,900
	26	87,600	83,901~87,600
第七組級距4,500元 Bracket 7 NT\$4,500	27	92,100	87,601~92,100
	28	96,600	92,101~96,600
	29	101,100	96,601~101,100
	30	105,600	101,101~105,600
	31	110,100	105,601~110,100

Set Payroll Brackets for Calculating Premiums

When it comes to the premium ratable wages of Categories 1-3 insured, the MOHW is responsible for setting a table of payroll brackets and presenting it to the Executive Yuan for

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

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



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補充保險費計收

二代健保實施後，除了以經常性薪資對照投保金額所計算出的「一般保險費」之外，再加上「補充保險費」，把以往沒有列入投保金額計算的高額獎金、兼職所得、執行業務收入、股利所得、利息所得或租金收入等項目，納入「補充保險費」的計費基礎，計收補充保險費。希望藉由擴大保險費基，拉近相同所得

者之保險費，達到負擔之公平性（圖2-1），低收入戶之保險對象則不列為補充保險費之收取對象。另外，雇主每月所支付薪資總額與其受僱者當月投保金額總額間之差額，亦增列為計費基礎，收取補充保險費；2024年全年補充保險費計收約715億元，占同年保險費收入約8.9%。



圖2-1 二代健保保險費示意圖

健保財務收支情形

健保歷年保險收支自1998年起開始發生短絀，至2007年3月底，累計健保財務收支首度呈現短絀，故自2010年4月起調整保險費率，歷年累計保險收支自2012年2月開始轉虧為盈，另自2013年1月起實施二代健保財務新制，擴大費基加收補充保險費及提高政府總

負擔比率等財源挹注，財務亦明顯改善（圖2-2），惟醫療支出成長始終高於保險費收入成長，自2017年起保險收支短絀數逐年擴大，故自2021年1月起調整保險費率，至2024年12月累計收支結餘為1,622億元（表2-6）。

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

Calculation of Supplementary Premiums

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

income—are now included for calculating supplementary premiums. It is hoped that the expansion of NHI's premium base can move it closer toward the goal of fair contribution (Chart 2-1) by having persons with equivalent incomes pay similar premiums. Nevertheless, the insured in low-income households are exempt from paying supplementary premiums. Furthermore, supplementary premiums are also collected on the gap between the total salaries that employers actually pay their employees each month and the total monthly premium ratable wages adopted. In 2024, NHI supplementary premiums amounted to around NT\$71.50 billion, accounting for 8.9% of all premium income for the year.

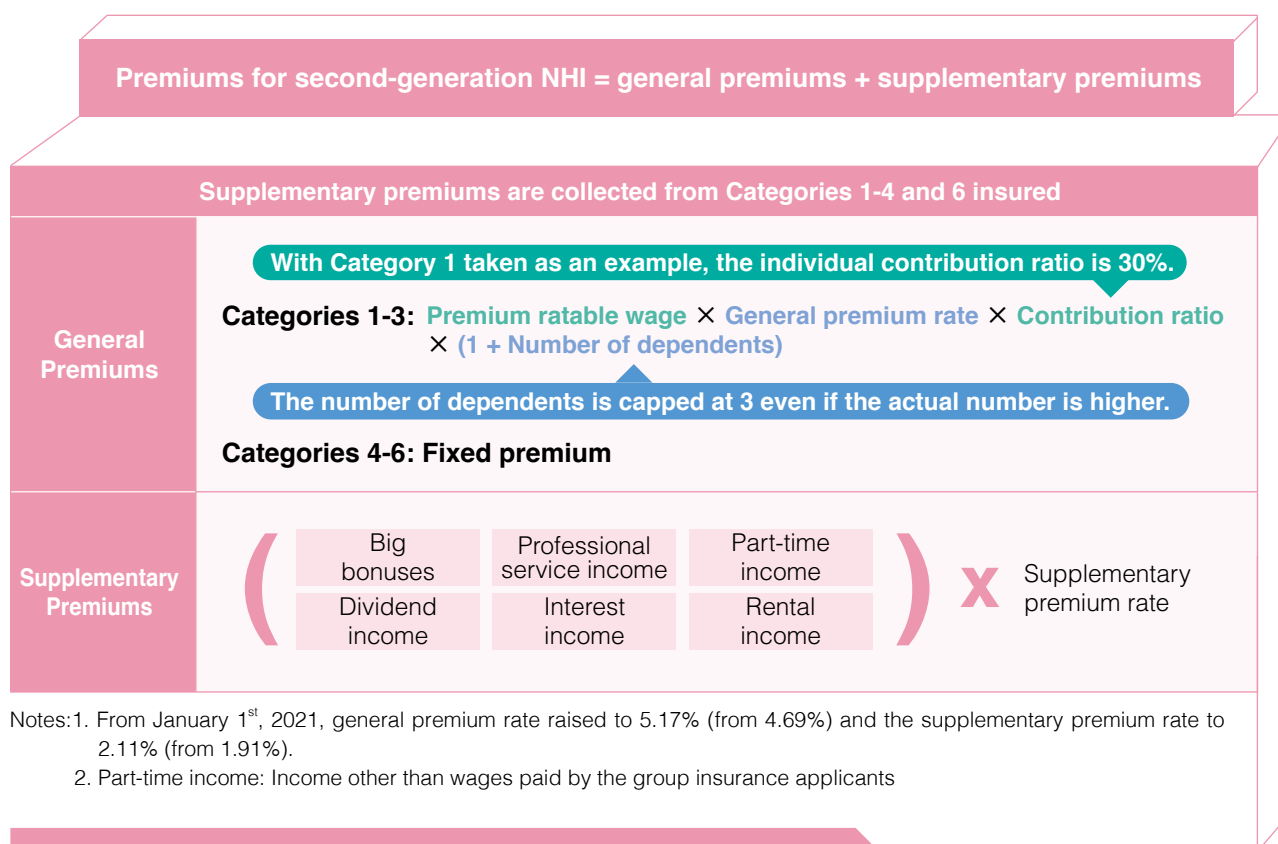


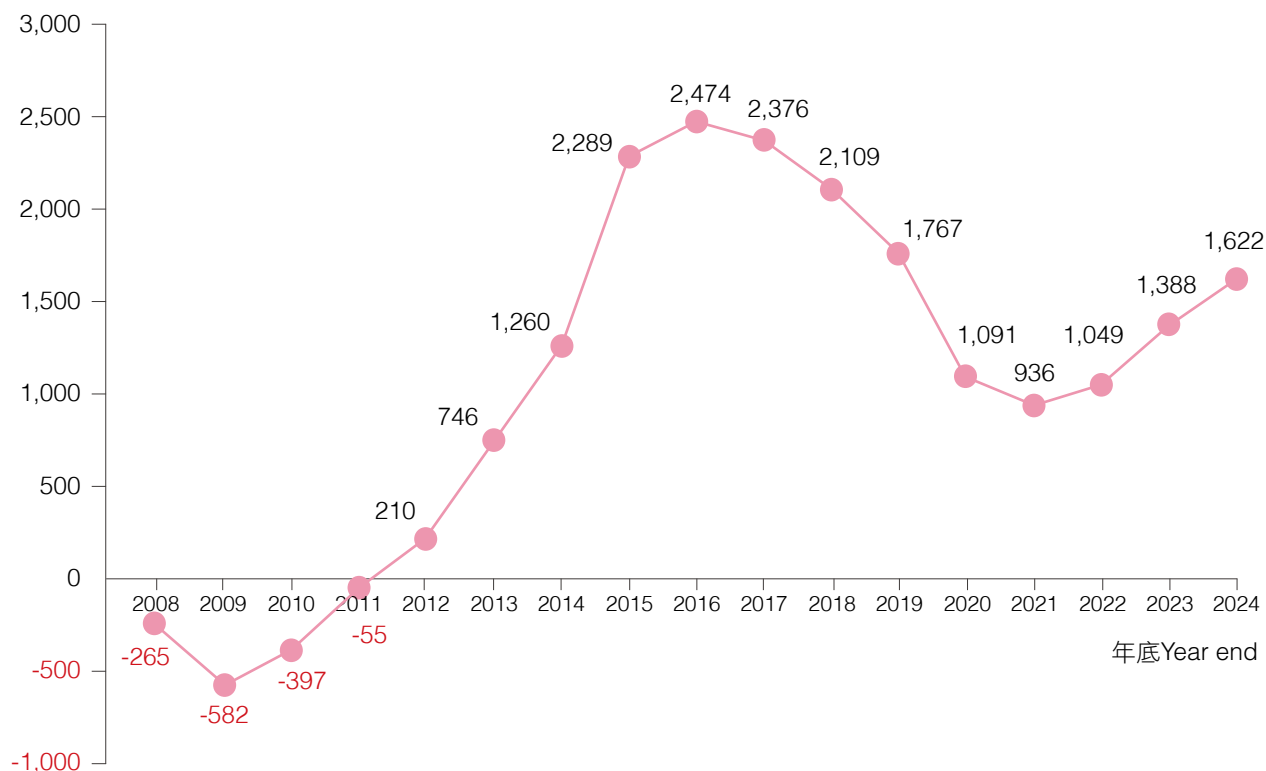
Chart 2-1 Premiums for Second-Generation NHI



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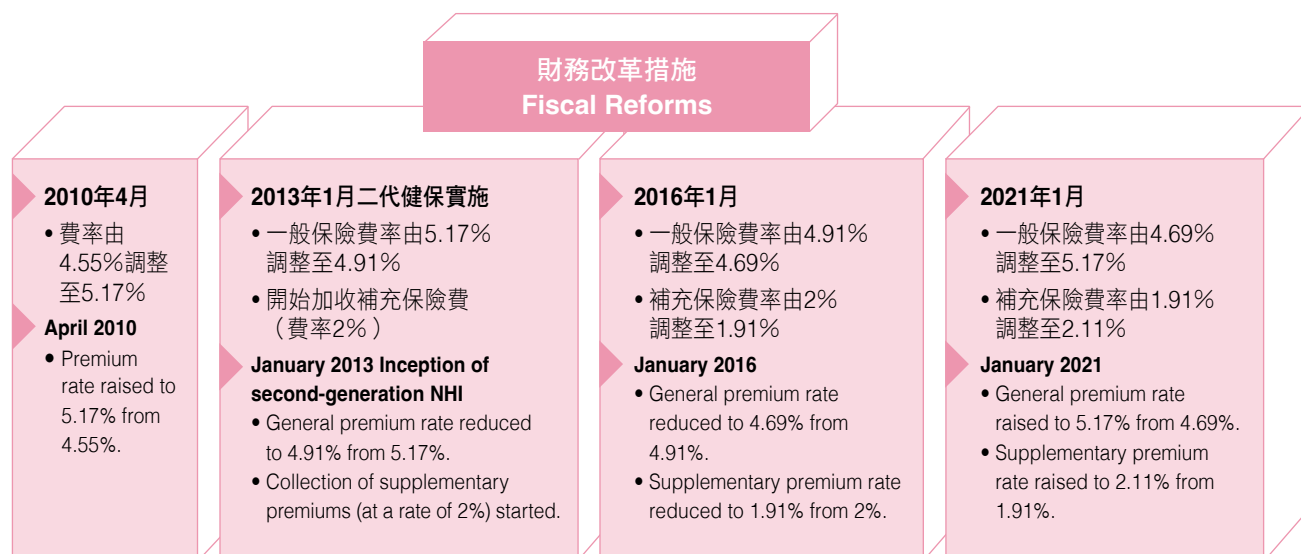
億元 NT\$100 million



- 截至2024年12月底，歷年保險費收支結餘1,622億元，尚符合健保法第78條健保安全準備總額以1至3個月保險給付支出為原則之規定。
- As of the end of December 2024, NHI recorded a cumulative surplus of NT\$162.2 billion, a tally in compliance with Article 78 of the National Health Insurance Act: the aggregate amount of the reserve fund shall be equal to the aggregate amount of benefit payments in the most recent one to three months based on actuarial principles.

圖2-2 二代健保實施前後財務收支累計餘絀情形

Chart 2-2 Cumulative balance before and after launch of second-generation NHI



Balance of NHI Revenues and Expenditures

The NHI system sustained its first annual deficit in 1998. On a cumulative basis, it was pushed into the red for the first time at the end of March 2007. A premium rate increase from April 2010 helped turn around NHI's outstanding balance from February 2012. An even more significant improvement in NHI finances (Chart 2-2) occurred when its second generation

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

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

年度 Year	保險收入 NHI Revenues		保險成本 NHI Expenditures		保險收支 當年餘絀 (億元) Annual Balance (NT\$100 million)	保險收支 累計餘絀 (億元) Cumulative Balance (NT\$100 million)
	金額 (億元) Amount (NT\$100 million)	成長率 (%) Growth rate (%)	金額 (億元) Amount (NT\$100 million)	成長率 (%) Growth rate (%)		
2020	6,278	0.87	6,954	5.91	-676	1,091
2021	7,119	13.39	7,274	4.60	-155	936
2022	7,603	6.81	7,491	2.98	113	1,049
2023	8,110	6.66	7,771	3.74	339	1,388
2024	8,344	2.89	8,110	4.37	234	1,622
1995/3~ 2024/12	140,852	-	139,231	-	-	1,622

註：1. 資料截至2024年12月

2. 保險收入 = 保險費 + 滯納金 + 資金運用淨收入 + 公益彩券盈餘及菸品健康捐分配數 + 其他淨收入 - 呆帳提存數 - 利息費用

3. 保險成本 = 保險給付醫療費用 + 其他保險成本

4. 部分資料因尾數四捨五入關係，致總數與細數之間，容有未能完全吻合情況。

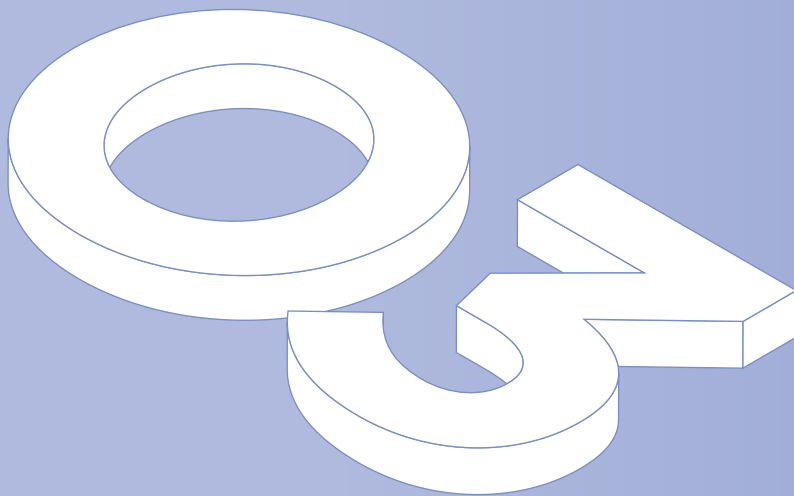
Notes: 1. Statistics as of December 2024.

2. NHI revenues = premiums + overdue charges + net investment income + contributions from public welfare lottery net revenues and the tobacco health and welfare surcharge + other net revenues - provisions for bad debts - interest expenses.

3. NHI expenditures = reimbursements of medical expenses + other insurance expenses.

4. Discrepancies between totals and accumulations of individual numbers caused by rounding.

Chapter



給付完整 就醫便利

**Comprehensive Benefits
and Convenient Access**





給付完整 就醫便利

醫療給付範圍

參加全民健保的保險對象，凡發生疾病、傷害或生育事故時，皆可憑健保卡至醫院、診所、藥局及醫事檢驗機構等特約醫事服務機構接受醫療服務。

目前全民健保提供的醫療服務包括：門診、住院、中醫、牙科、分娩、復健、居家照護、慢性精神病復健等項目；醫療支付的範圍則包括：診療、檢查、檢驗、手術、麻醉、藥劑、材料、處置治療、護理及保險病床等，可說是將所有必要的診療服務都包含在內。

就醫便利

在全民健保制度之下，民眾可以自由選擇特約醫院、診所、藥局、醫事檢驗機構，接受妥善的醫療照護服務。即使在國外，民眾因不

可預期的緊急傷病或緊急分娩，須在當地醫事服務機構立即就醫，可於急診、門診治療當日或出院之日起6個月內申請核退國外自墊醫療費用，但核退費用的標準則以前一季支付國內特約醫院及診所之平均費用為最高上限。

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

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

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

單位：機構數
Unit: Number of Institutions

	總計 Total	西醫醫院 Hospitals	西醫診所 Clinics	中醫醫院 Chinese Medicine Hospitals	中醫診所 Chinese Medicine Clinics	牙醫醫院 Dental Hospitals	牙醫診所 Dental Clinics
全國醫療院所數 Total Medical Institutions	24,561	459	12,667	4	4,299	1	7,131
特約醫療院所數 Contracted Medical Institutions	22,352	459	10,901	4	4,024	1	6,963
特約率 Percentage of Contracted Institutions	91.01%	100%	86.06%	100%	93.60%	100%	97.64%

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

Comprehensive Benefits and Convenient Access

Scope of Benefits

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

Currently, the NHI offers the following healthcare services: outpatient care, hospitalization, Traditional Chinese Medicine (TCM), dentistry, childbirth, rehabilitation, home care, and chronic psychiatric rehabilitation. The scope of medical payments under NHI includes diagnosis and treatment, examination, testing, surgery, anesthesia, drugs, medial devices, therapy, nursing, and insured beds. It can be said that all necessary diagnostic and treatment services are within the scope of NHI.

Convenient Access to Healthcare

Under the NHI system, members of the public can choose to receive appropriate healthcare services at contracted hospitals, clinics, pharmacies, and medical testing laboratories. Even when people are overseas and encounter an emergency illness, injury, or childbirth, and require immediate care at a local medical institution, they can apply for reimbursement of their self-paid overseas medical expenses within 6 months of the date of emergency care, outpatient treatment, or hospital discharge. The reimbursed expenses may not exceed the average expenses paid to domestic contracted hospitals and clinics in the preceding quarter.

As of the end of December 2024, there were a total of 22,352 NHI contracted hospitals and clinics, accounting for 91.01% of all hospitals and clinics nationwide (Table 3-1). There were also 7,649 contracted pharmacies, 741 home care institutions, 284 psychiatric rehabilitation institutions, 16 midwifery institutions, 211 medical testing institutions, 29 physical therapy clinics, 9 medical radiological test institutions, 8 occupational therapy clinics, and 17 home respiratory care institutions. The insured can freely choose the hospital or clinic at which they wish to receive healthcare services.

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





大家醫計畫 落實整合照護

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

未來將以家庭醫師計畫為基礎，透過四大面向打造「大家醫計畫」，包括：提升服務涵蓋率、數位化追蹤管理、支付制度調整、精進醫療品質，建構家醫大平台，落實全人全程健康照護理念。

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

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

疾病重症之發生。2024年計127家地區醫院、471位醫師參與，已收案4萬5,655人。

居家整合照護計畫與健保遠距醫療提升就醫可近性

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

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

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

Grand Family Physician Integrated Care System implements integrated care service

To ensure that people can receive continuous, comprehensive healthcare nearby, the “NHI Family Physician Plan” introduced in March 2003 allows five or more contracted medicine clinics in the same area to join a community hospital to form a community healthcare group. As long as people take a physician at a primary care clinic near their home as a family doctor, they can easily obtain first-line healthcare. Family doctors can provide professional preventive care counseling, establish comprehensive medical data on their patients, and provide 24-hour healthcare service hotlines. If a patient's condition requires further examination, surgery, or hospitalization, a family doctor can give a referral, reducing the time and expense spent on seeking a doctor.

In the future, the Grand Family Physician Plan will be expanded mainly as follows: expanding service coverage, digitalized tracking and management, adjusting the payment system, and enhancing healthcare quality. This will establish a comprehensive platform for family medicine, thereby achieving the goal of holistic and lifelong healthcare for all individuals.

Since 2024, the Family Physician Plan has focused on strengthening participating physicians' disease management and care capabilities for diabetes and early-stage chronic kidney disease. As of the end of December 2024, a total of 522 community healthcare groups had been set up for operation. They comprised 5,544 primary care clinics and 7,949 physicians,

translating into participation rates of 51.6% and 44.7% respectively. More than six million people benefit from these community healthcare groups.

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

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

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



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

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

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



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

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

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

A Medicare Telemedicine Benefit Plan was launched on December 29th, 2020, ensuring

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

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



醫療給付改善方案

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

子宮頸癌方案自2006年起業務移由國民健康署辦理外，該年亦同時於西醫基層診所試辦高血壓醫療給付改善方案，2007年更擴及醫院執行。另結核病醫療給付改善方案，自2008年起，導入支付標準全面實施辦理。2010年1月新增思覺失調症、慢性B型肝炎帶原者與C型肝炎感染者等2項論質方案，2011年1月再新增初期慢性腎臟病論質方案，該方案自2016年4月起導入支付標準全面實施辦理。

2015年孕產婦全程照護醫療給付改善方案從衛生福利部醫療發展基金回歸至健保署；同年10月新增早期療育門診醫療給付改善方案，2017年新增慢性阻塞性肺病方案，2019年新增提升醫院用藥安全與品質方案。

高血壓方案收案對象常合併有糖尿病、慢性腎臟病等疾病，為整併照護方式，自2013年起不再列為單獨項目，而併入其他論質方案推行。糖尿病方案因執行成效良好，於2012年10月導入支付標準全面實施，考量糖尿病及初期慢性腎臟病具多項共同風險因子，照護族群多有重疊或具因果關係，2022年3月1日起整併初期慢性腎臟病方案為「糖尿病及初期慢性腎臟病照護整合方案」，鼓勵院所組成跨疾病之整合性照護團隊提供服務；近年各方案之照護率如表3-2。

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

Pay-for-Performance Plans

NHI's pay-for-performance plans rely on adjustment of hospital and clinic medical expense payments to provide appropriate incentives for medical care providers to offer comprehensive care. Healthcare quality and effectiveness are also taken as a basis for payments. Since October 2001, the NHIA has phased in five pay-for-performance plans for cervical cancer, breast cancer, tuberculosis, diabetes, and asthma.

The cervical cancer management program was transferred to the Health Promotion Administration (HPA) in 2006, and that same year a pay-for-performance plan for hypertension treated at medicine clinics was initiated. In 2007, hospitals became eligible to treat hypertension under the plan, and in 2008, pay-for-performance for the treatment of tuberculosis was included in the NHI fee schedule. Two additional pay-for-performance plans were implemented in January

2010: for schizophrenia and for persons with HBV and HCV. In January 2011, another plan was introduced for patients with early-stage chronic kidney disease. This was followed by the inclusion of a pay-for-performance plan for early-stage chronic kidney disease in the NHI fee schedule in April 2016.

In 2015, the management of the pay-for-performance program covering full-course maternal care for pregnant women returned to NHIA from the MOHW's Medical Development Fund. A pay-for-performance plan for treatment of development retardation was added in October of the same year, followed by that for chronic obstructive pulmonary disease in 2017. In 2019, the NHIA launched the program to improve hospital medication safety and quality.

Patients enrolling in the hypertension plan usually also suffer from concomitant diabetes and chronic kidney disease. Since 2013, these conditions have been removed from the list of independent items and included in other pay-for performance plans to consolidate care services. Implementation of the diabetes pay-for-performance plan has yielded favorable results, and the plan was included in fee schedules and implemented on a full scale in October 2012. Taking into consideration the multiple common risk factors between diabetes and early-stage chronic kidney disease, the care groups often overlap or have a causal relationship. Beginning on March 1st, 2022, the plan for "Diabetes Combined with Early-Stage Chronic Kidney Disease" was implemented to encourage healthcare institutions to form inter-disciplinary care teams to provide services. The care rates of each plan in recent years are shown in Table 3-2.



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

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

註：高血壓方案自2006年起於西醫基層開始試辦，2007年則擴大至醫院，其照護率因涵蓋基層診所及醫院，呈現照護率下降情形，又因病人常合併多重疾病，例如糖尿病、慢性腎臟病等，故未再以疾病別單獨另列計畫追蹤，自2013年起停止試辦。慢性阻塞性肺病自2017年4月實施，糖尿病合併初期慢性腎臟病照護自2022年3月起推動，故糖尿病及初期慢性腎臟病之照護率將糖尿病合併初期慢性腎臟病照護人數納入列計。

單位：％ Unit:％

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

Note: The hypertension plan was first implemented on a trial basis at the primary care level in 2006, and expanded to hospitals in 2007. Because of the plan's coverage of both primary care clinics and hospitals, the care rate displays a decreasing trend. As hypertension is commonly accompanied by diabetes and chronic kidney disease among others, trial implementation of the hypertension plan was ended in 2013 and tracking of hypertension cases under an individual plan was discontinued. The chronic obstructive pulmonary disease plan was implemented in April 2017, and the plan for "Diabetes Combined with Early-Stage Chronic Kidney Disease" was launched in March 2022. The care rate for diabetes and early-stage chronic kidney disease will include the care number of "diabetes combined with early-stage chronic kidney disease" plan.



部分負擔 使用者付費

全民健康保險部分負擔的設計是社會保險制度重要的一環，是為避免保險對象認為已交繳健保費，就可以隨意使用健保資源，同時不致影響真正有需要的人就醫，自開辦後，門、急診之部分負擔已經調整多次，同時也藉以導正醫療資源利用，使不同層級醫療院所各司其職。

為鼓勵民眾小病到當地診所就醫，需要進一步檢查或治療時再轉診到區域醫院、醫學中心等大醫院，西醫門診基本部分負擔按「未轉診」及「轉診」兩種方式計收。民眾若未經轉診直接到醫學中心、區域醫院、地區醫院就醫，就會付比較高的部分負擔。牙醫、中醫不分層級一律計收50元。此外，民眾看病時，如藥費超過一定金額，則須加收藥品部分負擔。同一療程中接受第2次以上的復健物理治療（中度一複雜、複雜項目除外）或中醫傷科治療，每次須自行繳交50元的部分負擔費用，但凡因重大傷病、分

娩、山地離島地區就醫者及其他符合健保署規定者，均免收部分負擔。

2023年7月起，調整藥品部分負擔及急診部分負擔；為強化分級醫療，醫學中心及區域醫院門診藥品部分負擔調高負擔上限；醫院開立之慢性病連續處方箋第一次調劑比照一般藥品收取部分負擔，第二次以後調劑維持免收，為推動分級醫療及保障弱勢，基層診所、中低收入和身心障礙者不調整。急診部分，為實務作業順暢並減少爭議，取消依檢傷分類計收規定，僅依就醫院所層級別收取部分負擔，將大型醫院資源保留給急重症病人。門診、急診及住院部分負擔如表3-3至表3-5。

此外，於醫療資源缺乏地區就醫的民眾，部分負擔費用均可減免20%，且居家照護之部分負擔費用比率由原來10%調降為5%，以嘉惠醫療資源缺乏地區及外出就醫困難之民眾。



Copayment and the User-Pays Principle

NHI copayments are designed to be an important link in the social insurance system. They are also intended to stop the insured from thinking that the payment of NHI premiums entitles them to use health insurance resources without restraint. Copayments are not meant to prevent persons from receiving care that they truly need. Outpatient and emergency care copayments have been adjusted several times since the introduction of NHI, and these adjustments have simultaneously sought to guide the utilization of medical resources and ensure that hospitals and clinics at different levels carry out their respective duties.

The NHIA is keen to encourage people to seek care at clinics when suffering from minor illnesses. Only when there is need for further examination or treatment should they secure a referral to a larger institution such as a regional hospital or medical center. On July 15th, 2005, the NHIA thus introduced a system under which patients' copayments stay low when they comply with referral procedures while adjusting basic outpatient copayments accordingly at the same time. As such, the basic medicine outpatient copayment is calculated on the basis of either "no referral" or "referral." If people seek care at a medical center, regional hospital, or district hospital without obtaining a referral, they must pay a higher copayment. However, dental care and TCM incur a fixed NT\$50 copayment regardless of the level of care. In addition, if the cost of drugs exceeds a certain amount, patients must pay an additional drug copayment. When patients need to undergo two or more

rehabilitation or physical therapy sessions (apart from moderate complex and complex items), or TCM trauma treatment, in the same course of treatment, a copayment of NT\$50 must be paid for each session. Copayments are waived, however, in case of major illness/injury or childbirth, care in mountainous regions or on offshore islands, and other cases meeting NHIA requirements.

In July 2023, the copayment for OPD medication and emergency care was increased. To further tiered healthcare, a higher limit for medical centers and regional hospitals is set. Additionally, for the first dispensation of chronic disease prescriptions issued by hospitals, copayments will be charged for general medications. From the second dispensation onwards, copayments will be waived. In order to promote tiered medical care and protect vulnerable populations, there will be no adjustments for primary clinics, middle and low income individuals and persons with disabilities. Regarding emergency department copayments, in order to streamline operations and reduce disputes, copayments will be based on the level of the treating hospital, with the aim of reserving resources in large hospitals for critically ill patients. The copayments for outpatient and inpatient services are detailed in Tables 3-3 to 3-5.

In addition, the copayments of patients seeking care in areas lacking medical resources are given a 20% discount; their home care copayment rate is also reduced from 10% to 5%. Such measures certainly benefit areas with shortages of medical resources and people who cannot easily travel to other places for medical attention.



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

單位：新臺幣元
Unit: NT\$

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

- 註：1.凡領有《身心障礙證明》者，門診就醫時不論醫院層級，基本部分負擔費用均按診所層級收取新臺幣50元。
2.持轉診單就醫後一個月內未逾四次之回診、門診手術後、急診手術後、生產出院後6周內或住院患者出院後30日內第一次回診視同轉診，得由醫院開立證明供病患使用。
3.「低收入戶」指合於社會救助法規定之低收入戶成員；「中低收入者」指符合社會救助法規定之中低收入戶及符合老人參加全民健康保險無力負擔費用補助辦法規定之年滿七十歲中低收入老人；「身心障礙者」指領有社政主管機關核發之身心障礙證明者。
4.低收入戶應自行負擔之費用，依法由中央社政主管機關補助。

- Notes: 1. Regardless of the level of medical institutions, all persons bearing proof of physical and mental disability must pay a basic copayment fixed at the clinic-level fee of NT\$50 for outpatient care.
2. Outpatients with a referral with not more than 4 follow-up visits within one month of seeking medical attention and the first follow-up visit after outpatient or emergency surgery, within 6 weeks of hospital discharge after giving birth, or within 30 days after hospital discharge, shall be considered to have a referral, and hospitals shall provide patients with proof.
3. "Low-income individuals" refer to those who qualify as low-income households under social assistance regulations. "Near-poor individuals" refer to those who qualify as near-poor households under social assistance regulations and elderly individuals over the age of 70 who qualify for subsidies for the elderly who are unable to bear NHI expenses. "Persons with disabilities" refer to individuals who hold a disability certificate issued by the competent social welfare authority.
4. The expenses that low-income households need to bear shall be subsidized by the central competent social welfare authority according to the law.



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

單位：新臺幣元
Unit: NT\$

藥品費用 Medication fees	應自行負擔費用 Copayment	
	西醫基層醫療單位 / 地區醫院 / 中醫 Clinic/ District Hospital/ Traditional Chinese Medicine	區域醫院 / 醫學中心 Medical Center/ Regional Hospital
100元以下 Under NT\$100	0元 (NT\$)	0元 低收入戶 / 中低收入者 / 身心障礙者 (註1) Low-income household (Note 1)/ Near-poor household/ Persons with disabilities NT\$0
101 ~ 200元 (NT\$)	20元 (NT\$)	10元 (NT\$)
201 ~ 300元 (NT\$)	40元 (NT\$)	20元 (NT\$)
301 ~ 400元 (NT\$)	60元 (NT\$)	40元 (NT\$)
401 ~ 500元 (NT\$)	80元 (NT\$)	60元 (NT\$)
501 ~ 600元 (NT\$)	100元 (NT\$)	80元 (NT\$)
601 ~ 700元 (NT\$)	120元 (NT\$)	100元 (NT\$)
701 ~ 800元 (NT\$)	140元 (NT\$)	120元 (NT\$)
801 ~ 900元 (NT\$)	160元 (NT\$)	140元 (NT\$)
901 ~ 1,000元 (NT\$)	180元 (NT\$)	160元 (NT\$)
1,001 ~ 1,100元 (NT\$)	200元 (NT\$)	200元 (NT\$)
1,101 ~ 1,200元 (NT\$)		220元 (NT\$)
1,201 ~ 1,300元 (NT\$)		240元 (NT\$)
1,301 ~ 1,400元 (NT\$)		260元 (NT\$)
1,401 ~ 1,500元 (NT\$)		280元 (NT\$)
1,501以上 More than NT\$1,501		300元 (NT\$)
		200元 低收入戶 (註2) / 中低收入者 / 身心障礙者 Low-income household (Note 2) / Near-poor household/ Persons with disabilities NT\$200

(一) 保險對象持醫院開立之慢性病連續處方箋調劑 (開藥二十八天以上)，第一次調劑以當次調劑慢性病藥品費用與一般藥品費用併計應自行負擔之門診藥品費用。

(二) 下列情形之一者，免計應自行負擔之門診藥品費用：

1. 接受牙醫醫療服務。
2. 接受全民健康保險醫療服務給付項目及支付標準所定論病例計酬項目服務。
3. 低收入戶、中低收入者及身心障礙者持慢性病連續處方箋調劑 (開藥二十八天以上)。
4. 持西醫基層醫療單位及中醫門診開立之慢性病連續處方箋調劑 (開藥二十八天以上)。
5. 持醫院開立之慢性病連續處方箋第二次及第三次調劑 (開藥二十八天以上)。

註：1. 「低收入戶」指合於社會救助法規定之低收入戶成員；「中低收入者」指符合社會救助法規定之中低收入戶及符合老人參加全民健康保險無力負擔費用補助辦法規定之年滿七十歲中低收入老人；「身心障礙者」指領有社政主管機關核發之身心障礙證明者。

2. 低收入戶應自行負擔之費用，依法由中央社政主管機關補助。

3. 其他保險對象門診應自行負擔之費用，依現行規定辦理。

1. For insured individuals who obtain chronic disease prescriptions from hospitals with a duration of 28 days or more, outpatient medication expenses that need to be paid by themselves shall include the medication expenses for chronic disease and general medications incurred during the first dispensation.

2. The following situations are exempted from calculating outpatient medication expenses that need to be paid by the insured individuals:

- a) Receiving dental services.
- b) Receiving services covered by the NHI medical service payment items and payment standards for specific cases.
- c) Low-income households, near-poor and low-income individuals, and persons with disabilities obtaining chronic disease prescriptions with a duration of 28 days or more.
- d) Obtaining chronic disease prescriptions from primary medicine clinics and TCM clinics with a duration of 28 days or more.
- e) Second and third dispensing of chronic disease prescriptions from hospitals with a duration of 28 days or more.

Notes: 1. "Low-income households" refer to members who meet the criteria of low-income households as defined by social assistance regulations.

"Near-poor and low-income individuals" refer to those who qualify as near-poor and low-income households under social assistance regulations and elderly individuals over the age of 70 who qualify for subsidies for the elderly who are unable to bear NHI expenses.

"Persons with disabilities" refer to individuals who hold a disability certificate issued by the competent social welfare authority.

2. The expenses that low-income households need to bear shall be subsidized by the central competent social welfare authority according to the law.

3. Outpatient expenses for other insured individuals shall be paid by themselves according to current regulations.



多元支付制度

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

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

爰此，健保署參考其他先進國家制度，再根據不同醫療照護的特性，設計不同支付方式，例如自2002年7月起，全面實施醫療費用總額預算支付制度（Global Budget Payment System）；同時透過支付制度策略，如論病例計酬（Case Payment）、論質計酬（Pay-for-Performance, P4P）方案，改變診療行為；此外，推動山地離島地區醫療給付效益提升計畫（IDS）、偏鄉地區全人整合照護執行方案、家庭醫師整合照護計畫，以增進醫療服務體系整合；並以品質與結果支付，例如論質計酬支付等。另為提升醫療服務效率，更自2010年1月1日起實施全民健保住院診斷關聯群支付制度（Taiwan Diagnosis Related Groups, Tw-DRGs），並於2014年7月1日起實施第2階段Tw-DRGs。

總額預算支付制度

健保署自1998年起陸續推動牙醫、中醫、西醫基層、醫院等部門總額支付制度，至2002年起全面採行總額預算支付制度，以有限健保資源提供有效率且高品質之醫療服務，全民健康保險費用總額預算研擬流程如圖3-1。歷年全民健保總額協定成長率如圖3-2，近十年各總額部門醫療費用協定成長率如表3-6。

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



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

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

註：依衛生福利部公告2025年以同一疾病每次住院上限為51,000元，全年累計住院上限為86,000元。

Note: In accordance with the MOHW's announcement, the copayment for each hospitalization for the same condition was capped at NT\$51,000 in 2025; the annual limit of hospitalization copayments was NT\$86,000.

Diversified Payments

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

After the NHI system was initiated, it sought to quickly integrate the existing civil service, labor, and farmers' insurance systems. The fee-for-service approach was adopted as the major payment system. With the government employee and labor insurance fee schedule as the basis, revisions were made in accordance with the recommendations of medical groups alongside adjustments to the scope of insurance payments. However, this system fostered the unchecked growth of medical expenses and thus had a negative impact on healthcare quality.

Accordingly, the NHIA has taken its lead from leading countries in designing different payment methods based on the characteristics of various types of medical care. For instance, the NHIA

has implemented the global budget payment system across the board since July 2002 while simultaneously employing different revised payment strategies, such as case payment and pay-for performance (P4P), to change treatment behavior. In addition, the Integrated Delivery System (IDS) implemented by the NHIA in mountainous regions and on offshore islands, the Remote Area Integrated Holistic Implementation Plan and the "NHI Family Physician Plan," have enhanced integration of medical service systems. Under the P4P plan, hospitals and clinics get paid based on their care quality and outcomes. To further enhance patient health and medical efficiency, the Taiwan Diagnosis Related Groups (Tw-DRGs) program was launched on January 1st, 2010. The second stage of this program went into effect on July 1st, 2014.

Global Budget Payment System

The NHIA started to phase in global budget payments for dentistry, TCM, medicine primary care, and hospitals in 1998 before implementing the system across the board in 2002 in a bid to deliver efficient, high-quality medical care by



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年度醫療給付費用總額，由主管機關於年度開始6個月前擬訂其範圍，經諮詢健保會後，報行政院核定

The competent authority determines the global budget for the year six months before the start of the year, and the global budget is approved by the Executive Yuan after consultation with the National Health Insurance Committee.

健保會於年度開始3個月前，在行政院核定總額範圍內，協議訂定醫療給付總額及其分配方式，報主管機關核定

The National Health Insurance Committee determines the global budget within the scope approved by the Executive Yuan and its allocation through negotiations within three months before the start of the year. The global budget is then sent to competent authority for approval.

保險人於健保會協議訂定醫療給付總額後1個月，將保險費率提請審議

The NHIA submits the premium rate for review one month after the National Health Insurance Committee has set the global budget.

健保會應於年度開始1個月前依協議訂定之醫療給付總額，完成該年度應計之收支平衡費率之審議

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

費率公告實施

The premium rate is then announced and implemented.

不能於期限內完成審議時，由主管機關逕行報行政院核定後公告

When review cannot be completed within the allotted time, the competent authority shall directly announce the premium rate after reporting it to the Executive Yuan for approval.

年度開始6個月前

Six months before the fiscal year begins

年度開始3個月前

Three months before the fiscal year begins

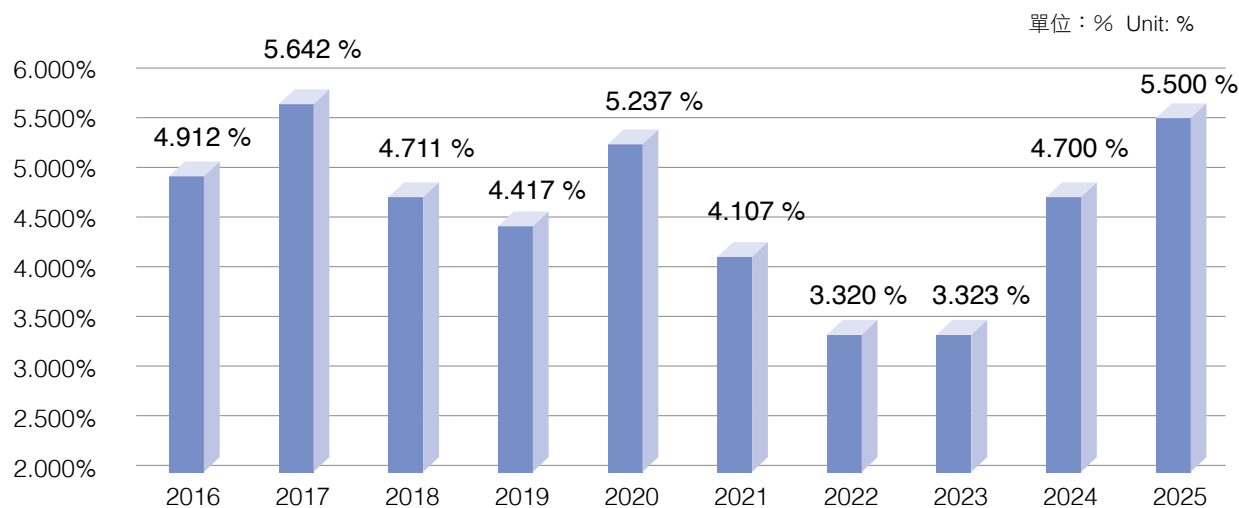
次年度開始2個月前

Two months before the fiscal year begins

次年度開始1個月前

One month before the fiscal year begins

圖3-1 全民健保醫療費用總額預算研擬流程
Chart 3-1 NHI Global Budget Drafting Procedures



資料來源：衛生福利部全民健康保險會委員會議全民健康保險業務執行報告

Source: National Health Insurance Service Implementation Report, Meeting of the National Health Insurance Committee, Ministry of Health and Welfare.

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

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

單位：% Unit: %

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

drawing on NHI's limited resources. NHI's global budget drafting procedures are shown in Chart 3-1, the growth rates of negotiated total budgets over the years are shown in Chart 3-2, and the growth rates of such negotiated totals by sector over the past ten years are shown in Table 3-6.

To maintain the quality and scope of care available at medical institutions under the global budget payment system, the NHIA has also implemented quality assurance programs for global budget sectors when negotiating global medical expense budgets. These quality assurance programs include medical care quality satisfaction surveys, mechanisms for

handling complaints and violation reports, and insured care accessibility monitoring. The NHIA has also drafted clinical diagnostic and treatment guidelines for medical care quality, compiled standards for professional review and medical records, established a hospital and clinic assistance system, and established medical care quality indicators. To ensure information disclosure transparency, the NHIA has also posted medical care quality information on its website for the reference of hospitals and clinics in further improving healthcare quality.



增修支付標準

為平衡醫療發展，自全民健保開辦起，配合醫療科技發展及實際臨床需要，持續新增診療項目，以提供民眾與時並進之醫療技術。截至2024年12月，支付標準共計有4,872項診療項目，經統計2004年至2024年12月，共計125次公告調整支付標準，另統計自健保開辦迄今，本署已陸續新增及調整支付點數，共計3,389項。

為鼓勵醫院重視臨床護理照護人力，促使醫療院所配合增加護理人力，2009年起辦理「全民健康保險提升住院護理照護品質方案」，截至2014年挹注經費累計達91.65億元，用以鼓勵醫院增聘護理人力、提高夜班費，增加護理人員留任的意願。2015年更投入經費20億元用於調整住院護理費支付標準，除提升支付點數外，透過護病比與支付連動制度，盼減輕護理人員工作負擔。每年亦持續投入預算用以調整護理費相關支付標準，2016年投入約18億元調整各類病床護理費，2017年投入1.98億元調整地區醫院住院護理費，2018年投入約3.72億元提升重症護理照護品質及6.14億點調整護病比支付標準，2019年投入約4.75億元調升急性一般及經濟病床（皆含精神病床）住院護理費。2020年投入約16.14億元調升各類病床護理費（除慢性病床），其中隔離病床護理費調升27.65%。2021年投入約15億元保障區域級以上醫院加護病床之住院護理費以1點1元支應。2022年投入約30億元調升住院首日護理費支付點數30%，並保障區域級（含）以上

醫院加護病床、地區醫院急性一般及經濟病床（含精神）之住院護理費以1點1元支應。2022年起編列3億元辦理住院整合照護服務試辦計畫，2025年5月1日起調升急性一般及經濟病床（含精神）之病床護理費12%至16%。

另外，為配合分級醫療推動，2017年以醫院總額部門「醫療服務成本指數改變率」增加之預算，用於調整急重症項目（共60億元）及偏鄉與地區醫院診療項目（共22億元）之支付點數。自2017年10月1日起，調升167項診療項目支付點數，放寬1,513項手術之兒童加成方式，以及放寬手術通則、急診例假日加成時間、兒童專科醫師加成，另調高偏鄉及地區醫院49項基本診療支付點數。續於2018年及2020年分別新增「地區醫院假日門診診察費加計」及「地區醫院夜間門診診察費加成10%」。2021年以2020年之醫院總額部門「醫療服務成本指數改變率」增加預算，調升急診診察費及400項急重症診療項目支付點數。2022年以一般服務「提升重症照護費用，促進區域級（含）以上醫院門住診結構改變」預算用於提升重症照護費用，保障區域級（含）以上醫院加護病床之住院診察費及病房費採固定點值，及提升住院照護品質。2023-2024年編列醫院總額專款15億元，以專款計畫方式用於區域級（含）以上醫院加護病床住院診察費及病房費、新生兒中重度住院診察費、急診觀察床病房費及護理費之支付點數差額，及地區醫院慢性呼吸照護病房論日計酬、急診診察費之額外加

Revision of the Fee Schedule

Since the inception of NHI, the NHIA has continually added diagnostic and treatment items that reflect advances in medical technologies and meet clinical needs, fostering balanced development of medical care and giving local people access to the latest medical technologies. As of December 2024, the fee schedule covered a total of 4,872 diagnostic and treatment items after a cumulative 125 adjustments from 2004 to 2024. Separately, changes have been made to payment for a total of 3,389 diagnostic and treatment items since the launch of NHI.

To encourage hospitals to prioritize and hire more nursing personnel, the NHIA initiated the NHI Hospital Nursing Care Quality Improvement Program in 2009. As of 2014, this program had allocated NT\$9.165 billion to encourage hospitals to hire more nursing staff and to improve nurse retention by increasing pay for night shifts. In 2015, an additional NT\$2 billion was set aside for adjusting hospital nursing fee. These measures have increased payment points and eased the burden on nursing personnel through linkage of payments and the nurse- to-patient ratio. The NHIA has used budgetary funds to adjust nursing fee on an annual basis: provision of NT\$1.8 billion in 2016 to adjust nursing fees for all types of patients, NT\$198 million in 2017 to adjust hospital nursing fees at district hospitals, NT\$372 million to improve critical nursing care quality and NT\$614 million to adjust nurse-to-patient ratio based fee standards in 2018, and NT\$475 million in 2019 to increase hospital nursing fees for acute general beds (include psychiatric beds). In 2020, approximately NT\$1.614 billion was provided to increase nursing fees for various types of beds (apart from chronic beds), and



nursing fees for isolation beds were increased by 27.65%. In 2021, around NT\$1.5 billion was earmarked to support the nursing fees for intensive care unit beds in hospitals at the regional hospitals and higher level hospitals, at a rate of NT\$1 per point. In 2022, some NT\$3 billion was set aside to sustain a 30% increase in the payment for the first day of hospital nursing fees and ensure that the nursing fees for intensive care unit beds in regional hospitals and higher-level hospitals, as well as acute general beds (including psychiatric beds) in district hospitals, are covered at NT\$1 per point. In 2022, another NT\$300 million was allocated for the implementation of a pilot program for skill-mixed care model during hospitalization. Starting from May 1st, 2025, nursing care fees for acute general beds (including psychiatric bed) will be increased by 12% to 16%.



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

為壯大西醫基層診所服務量能，擴大其服務範疇，自2017年起至2024年累計編列70.2億元用於基層開放表別項目，其中2017年開放「流行性感胃A型病毒抗原」等25項診療項目、2018年起開放「陰道式超音波」等9項診療項目、2019年起開放「淋巴球表面標記-感染性疾病檢驗」等11項診療項目、2020年起開放「部分凝血活酶時間」等17項診療項目、2021年起開放「無壓迫性試驗」等5項診療項目、2022年起開放「輸卵管剝離術」等3項診療項目及2023年起開放「頸動脈聲圖檢查」1項診療項目至基層院所執行。

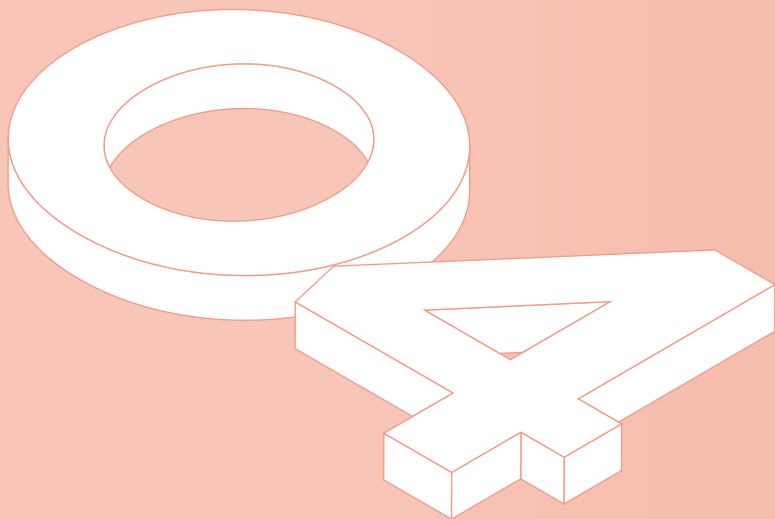


As part of the implement for tiered healthcare system, the NHIA drew from increased funds from the “Medical Consumer Price Index” in the hospital global budget to adjust payment for acute/severe disease items (totaling NT\$6 billion) and service items in remote areas and district hospitals (totaling NT\$2.2 billion) in 2017. Beginning on October 1st, 2017, the payment for 167 diagnostic and treatment items were increased, the markup rate for children in 1,513 surgical items was relaxed, and general principles for surgery, emergency care on weekends and holidays, and pediatricians’ markup rate were relaxed. In addition, payment for 49 primary care diagnostic and treatment items at district hospitals and in remote areas were increased. The NHIA subsequently introduced the “additional weekend and holiday outpatient consultation fees at district hospitals” in 2018 and the “10% nighttime markup on outpatient consultation fees at district hospitals” in 2020. In 2021, the global budget for hospitals was increased on the basis of the “Medical Consumer Price Index,” which increased emergency care fees and payment for 400 critical diagnostic and treatment items. In 2022, the budget was meant to “enhance the fees for intensive care services and promote structural changes in outpatient and inpatient services in regional-hospitals and higher hospitals.” Such budget was used to increase fees for intensive care services, ensuring fixed-point values for the inpatient examination fees and ward charges of intensive care beds at regional hospitals and higher hospitals, and enhancing the quality of inpatient care. For 2023-2024, a special hospital budget allocation of NT\$1.5 billion was designated through special funding programs for payment differentials in

intensive care bed hospitalization consultation fees and ward fees at regional hospitals (and above) hospitals, neonatal moderate-to-severe hospitalization consultation fees, emergency observation bed ward fees and nursing fees, as well as an additional 3%-15% enhancement for daily payment in chronic respiratory care wards at district hospitals and emergency consultation fees. In 2024, NT\$338 million was allocated for neonatal moderate-to-severe hospitalization consultation fees, pediatric ICU hospitalization consultation fees, ward fees, and nursing fees. In 2025, NT\$4.156 billion from other budgets will be used for emergency-related basic medical service items (emergency consultation fees split into consultation fees and nursing fees, emergency observation bed consultation fees and nursing fees), basic medical service items for designated emergency hospital ICUs, medical service payments for emergency cases at offshore designated emergency hospitals, and payment points for acute general (including psychiatric) bed hospitalization nursing fees.

To enhance the capacity of primary care, the NHIA has allowed items previously limited to hospitals to also be claimed by western medicine primary clinics. Between 2017 and 2024, the NHIA provided NT\$7.02 billion for expansion, including 25 items (such as influenza A virus antigen test) in 2017, a total of 9 items (including vaginal ultrasonography) in 2018, 11 items (including Lymphocyte surface marker for infectious disease detection) in 2019, 17 items (including activated partial thromboplastin time) in 2020, 5 items (including non-stress test) in 2021, 3 items (including salpingolysis with microscopic) in 2022, and 1 item (carotid phonoangiography) in 2023.

Chapter



專業審查 提升品質

**Professional Review and
Quality Improvement**





專業審查 提升品質

為避免醫療浪費，保障醫療品質，醫療服務審查制度為必要機制。醫療服務審查重點為：醫療服務項目、數量及適當性。一年門診申報件數約3億9千萬件，平均每日約107萬件，一年住院約353萬件，平均每日約9.7千件。基於人力及行政成本考量，有關醫療服務審查可區分為「程序審查」與「專業審查」；在工具面，亦大量運用電腦科技與資料分析技術，並致力於發展「電腦醫令自動化審查」及「檔案分析」等電腦輔助審查系統以提升審查效率。

專業審查

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

全民健康保險醫療費用審查注意事項之訂定，需先蒐集專科醫學會與醫師公會及醫院協會意見後，經具有相關臨床或實際經驗之醫藥專家組成分科專家諮詢會議討論後訂定。自2017年起，以醫療專業常見治療模式或手術為主題改版修訂採邏輯性編排，比照藥品給付規定進行編碼，以利資訊化勾稽，提供審查醫師參考。

運用科技提高審查效率

健保署逐步推動醫療申報電子化，累積至今，已成為全球獨一無二的全民健保資料庫。透過e化，健保署可快速有效率的審查醫療院所申報資料及發現異常狀態，並從大量的倉儲資料中，輔助分析協助政策方向之訂定，啟動相關措施，避免醫療資源浪費。

電腦醫令自動化審查

針對全民健康保險醫療服務給付項目及支付標準、全民健康保險藥物給付項目及支付標準等給付規定，明確規範不給付醫令項目（例如年齡限制、性別限制、專科醫師限制等），建立醫令自動化審查邏輯，透過電腦邏輯程式檢核，直接核減不給付醫令項目，逐步導正醫療院所申報之正確性，以提升審查效率。



Professional Review and Quality Improvement

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

Professional Review

Due to the huge volume of reimbursement claims, the NHIA employs a sampling approach in professional review. A sample of patient records is sent for review by medical experts. The sampling methods include random sampling and purposive sampling. The discard rate found in random sampling review is used to infer the discard rate in the entire case population. Because purposive sampling review focuses on all cases with certain characteristics, their results are not used for inferential purposes.

The Directions of National Health Insurance Claims Review were set after collecting the opinions of medical specialist associations, physicians' associations, and hospital associations, followed by

discussion at advisory conferences of specialists from among the group of medical experts with relevant clinical or practical experience. Since 2017, these guidelines have been revised to rearrange more logically on the basis of the most common modes of treatment or procedures in various medical specializations. They have also been coded in parallel with medication payment regulations to facilitate computerized audits and to provide reference for reviewing physicians.

Applying Technology to Increase Review Efficiency

The NHIA has gradually promoted medical claims computerization, and has accumulated the globally unique NHI database. Thanks to digitization, the NHIA can quickly and efficiently review reimbursement claim data from hospitals and clinics, and can discover any abnormalities. In addition, analysis of the NHIA's vast amounts of accumulated data assist the formulation of policies, and facilitate the initiation of preventive measures against the waste of medical resources.

Automated Review System

The NHIA has established automated review procedures that focus on payment regulations such as NHI medical care payment items and fee schedules, and specific no-payment rules (such as age, gender, and specialist physician restrictions). Computer programs are used to check medical orders, and can directly weed out medical order items that are ineligible. This approach has gradually enhanced the accuracy of claims made by hospitals and clinics, improving review performance.



檔案分析

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

1. 依據各項統計資料分析、偵測病患就醫、醫療院所診療型態與費用申報之異常狀況，供審查參考，使專業審查重點由個案審查轉變為診療型態的審核。
2. 邀請醫界代表討論，共同發展檔案分析審查異常不予支付指標，利用申報資料對醫療院所診療型態進行審核，並針對各指標值設定閾值，就異常部分，以程序審查方式進行核減，以節省人工審查成本。
3. 健保署自2014年9月起，建置「全民健康保險中央智慧系統」（Central Intelligence System, CIS），對重要項目納入統一管控，將疑似異常耗用健保醫療資源的申報項目，由電腦自動篩選出異常案件，列入抽樣樣本或予以標記，並提供異常資訊，抽調病歷送專業審查確認是否符合健保規定，以提升審查效率。該系統目前以健保門診、住診、藥品、特定診療與處置及特定個案名單等，5項主構面開發出約150項篩異指標。

輔助專業審查

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

醫療品質資訊公開

健保署自2005年起建置醫療品質資訊公開平台，公開健保「專業醫療服務品質報告」、各特約院所之醫療品質指標、服務類指標、特定疾病類指標等資訊，期藉由品質資訊公開，激勵院所提升醫療服務品質，及增進大眾瞭解國內之醫療品質與醫療利用概況，作為就醫選擇之參考。

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



Profile Analysis

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

1. Statistical analysis is employed to detect irregularities in patient care, diagnosis and treatment patterns at hospitals and clinics, and in expense reimbursement claims. The results of this analysis are provided as review reference, enabling a shift in the focus of professional review from individual cases to diagnosis and treatment patterns.
2. Representative medical personnel are invited to jointly discuss and develop indicators based on profile analysis for review irregularities where payment is not approved. Claims data is used to review diagnosis and treatment patterns at hospitals and clinics, and set threshold values for individual indicators. Procedural review can then be employed to weed out irregular cases, thus reducing manual review costs.
3. The “Central Intelligence System (CIS)” established by the NHIA in September 2014 allows the unified management of important items. Computer programs automatically detect anomalous cases suspected of involving the irregular utilization of NHI medical resources, which are then included in review samples or marked. This system also provides information on irregularities, and allows patient records to be sent for professional review to confirm whether they comply with NHI regulations. This system has improved review performance, enabling the development of approximately

150 irregularities screening indicators for the following five areas: outpatient care, inpatient care, medication, specific diagnosis and treatment, and specific case lists.

Assisted Professional Review

The NHIA has been promoting computerized review processes since 2014, with priority given to enhancing the capacity of the “Intelligent Peer Review Learning System (IPL)” for information integration. This system automatically links NHI payment regulations, review guidelines, patient record e-files, and review focal points, and provides reminder mechanisms and customized setting options to help medical experts perform review with efficiency and precision.

Disclosure of Medical Quality Information

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

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



合理調整藥價

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

自1999年起，依據調查的結果調降藥價，除了縮小藥價差距，亦減緩藥費支出成長。每次藥價調降所節省的费用，用於加速新藥收載及給付、放寬藥品給付範圍、調整支付標準偏低之項目，以提供國內民眾享有與世界先進國家同步的醫療用藥，同時也提升了醫療品質，對於全民的健康保障，具有實質的效益。

為落實健保整體藥費之管控，健保署公告實施「全民健康保險藥品費用分配比率目標制」試辦方案，自2013年1月1日起試辦至今已超過10年，主要是預設每年藥費支出「目標值」，並與實際藥費支出做連結，當超過目標值時自動啟動每年一次之藥價調整，讓藥費維持於穩定及合理範圍。



Reasonable Drug Price Adjustment

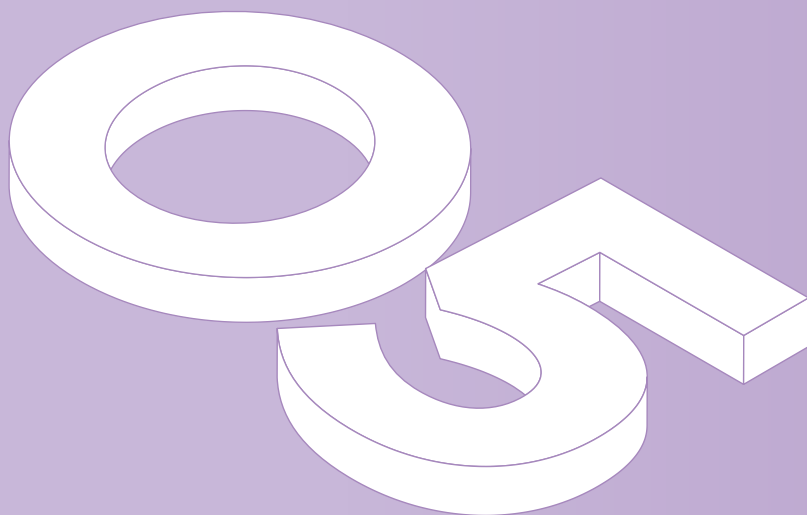
Under the current drug payment system, medical institutions make reimbursement claims to the NHIA in accordance with drug dispensing items and fee schedules; the NHIA will obtain the actual transaction prices through periodic drug price surveys to adjust the drug payment prices to make them closer to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

Beginning in 1999, the NHIA's reduction in drug prices on the basis of survey results has reduced drug pricing differences and eased the growth in medication expenditure. The money saved from reductions in drug prices is used to accelerate the entry of new drugs and approval of payment, expand the scope of drug payments,

and adjust items with low fees. This allows people in Taiwan to obtain drugs concurrently with the world's leading nations, while also improving healthcare quality and achieving tangible improvements in people's health.

To maintain control over NHI drug costs overall, the NHIA implemented the "NHI Drug Expenditure Target" on a trial basis on January 1st, 2013. This system presets target values for annual drug expenditures and ties them to actual drug expenditures each year. When the target values are exceeded, the system automatically activates an annual adjustment of drug prices, thereby ensuring the drug prices to stay within a stable, reasonable range.

Chapter



創新給付 數位升級

**Innovative Payments and
Digital Enhancement**





創新給付 數位升級

新藥與新科技給付改革

醫療科技評估提升健保給付效益

隨著醫療科技日新月異，新藥及新醫材不斷推陳出新，2024年健保支出藥品費用約2,500億點，特材費用約408億點，在健保資源有限的情況下，如何決定新醫療科技的臨床經濟效益納入健保給付，需要一個良好的評估工具。

健保署為精進健保給付效益之管理，並與國際接軌，自2008年起導入醫療科技評估管理（Health Technology Management, HTM）中之醫療科技評估（Health Technology Assessment, HTA），就新藥物進行人體健康、醫療倫理、醫療成本效益及健保財務等面向評估，以輔助新藥物納入健保收載之決策，並於2020年起循環式管理，透過前瞻式評估（Horizon Scanning, HS）瞭解新藥物上市到健保決定收載前之臨床使用情形與需求，並蒐集真實世界實證資料（Real World Data），對於健保已收載品項就臨床療效、成本效益、安全性及財務影響等面向進行醫療科技再評估（Health Technology Reassessment, HTR），作為健保持續給付或調整給付條件之依據，又為將醫療科技再評估機制納入常規運作，將規劃建立公開透明之作業程序。透過從健保給付前至給付後之成本效益循環式管理，增進低效益的醫療科技轉移到高效益的新醫療

科技，使健保資源有效合理配置，進而提升健保給付效益。

NGS 納入健保給付

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

健保署2021及2022年委託財團法人醫藥品查驗中心進行醫療科技評估（Health Technology Assessment, HTA），針對各國NGS給付現況及對健保整體財務衝擊進行研究報告，廣續邀集各領域專家凝聚給付共識，配合「特定醫療技術檢查檢驗醫療儀器施行或使用管理辦法」於2024年落地，於同年5月1日將NGS納入健保給付，針對檢測結果有對應治療藥物且效果明確之癌別優先給付，以BRCA panel、小panel（ ≤ 100 個基因）、大panel（ > 100 個基因）定額給付，並收載檢測結果，結合申報資料及臨床真實數據資料，評估基因檢測準確性及標靶藥物之治療成效以精進給付政策，協助高風險族群精準投藥，減輕民眾財務負擔，合計給付12種癌症之NGS檢測，預估每年約2萬多名病人受惠，挹注經

I Innovative Payments and Digital Enhancement

Payment Reform for New Drugs and Technologies

Raising NHI Payment Efficiency via Health Technology Assessment

Given the rapid advances in medical technologies, new drugs and medical devices are constantly emerging. In 2024, around 250 billion NHI convert points and 40.8 billion convert points were spent on drugs and special medical materials, respectively. In light of NHI's limited resources, it is crucial to have a robust assessment tool to determine the clinical and economic benefits of including new medical technologies in NHI coverage.

To better manage NHI payment and align with international standards, the NHIA introduced health technology assessment (HTA), a key component of health technology management (HTM) in 2008. HTA evaluates new drugs from various aspects, including human health, medical ethics, cost-effectiveness, and financial impact. It assists in the decision-making process on the inclusion of new drugs for NHI coverage. Under the cyclical management approach adopted in 2020, horizon scanning (HS) is used to understand the clinical usage and demand of new drugs before their inclusion in NHI coverage. Real-world data is collected, and health technology reassessment (HTR) is conducted for NHI coverage items to reassess their clinical efficacy, cost-effectiveness, safety, and financial impact. Through this cyclical management approach, from pre-coverage

assessment to post-coverage evaluation of cost effectiveness, the efficient and rational allocation of NHI resources is achieved, enhancing the effectiveness of NHI coverage.

NHI Coverage Policy for NGS Testing

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

Commissioned by the Center for Drug Evaluation, NHIA conducted Health Technology Assessment (HTA) in 2021 and 2022. A research report was conducted on the payment situation of NGS overseas and its effect on the financial impact of health insurance, and opinions and consensus were reached among different types of professionals. Also, the Regulations Governing the Application or Use of Specific Medical Techniques, Examinations, laboratory testing, or Medical Devices went into effect in 2024. On May 1st of the same year, NGS was incorporated into National Health Insurance (NHI) coverage. Priority coverage was given to cancer types with available targeted therapies and clear evidence of clinical efficacy based on test results. Fixed-payments were established for the BRCA 1/2 gene panels, small panels (≤ 100 genes), and large panels (> 100 genes). Test results are collected and integrated with claims data and



費約3億元。另於同年12月1日再納入7類癌症單基因檢測，預估每年約1萬人受惠，挹注經費約1億元。

實施新（癌）藥暫時性支付制度

為推動賴總統健康台灣政策，臺灣癌症死亡率在2030年降低三分之一及為滿足病人用藥需求，健保署致力加速新藥納入給付，包含優化核價流程與管控、精進新藥預算預估模式、建立多元風險分攤模式及強化廠商與審查專家溝通等，2025年1月1日由公務預算50億元挹注全民健康保險基金，用於「癌症新藥暫時性支付專款」，並於2025年2月25日公告「癌症新藥暫時性支付專款作業原則」，適用之藥品為領有藥品許可證，臨床療效證據明確，但受總額預算限制尚未收載之癌症新藥或新適應症者，以及其他經健保署認定有必要者。推動暫時性支付制度後，可加速引進新藥，提升病人使用具治療潛力之新藥可近性，並可降低病人經濟負擔。

以暫時性支付制度收載之項目，將搭配風險分擔模式，並依需要建置登錄系統，期間蒐集臨床試驗數據、真實世界實證資料，評估其療效及成本效益，以利健保再評估是否納入常規健保給付。截至2025年6月，已有11項新藥及5項擴增給付以暫時性支付收載，其中癌藥癌症新藥9項及擴增給付4項，包含用於治療肺癌、乳癌、大腸直腸癌、神經纖維瘤、多發性骨髓瘤及細胞治療產品CAR-T等。

透過暫時性支付機制及專款使用，以縮短新（癌）藥給付時程，讓病友及早取得突破性

新藥，提升新藥可及性及減輕民眾治療負擔，有效照顧經濟弱勢病友。

健保癌症治療數位治理

健保署推動數位轉型，結合「國家癌症防治計畫」精進數位醫療之基礎建設，藉由採用快捷式健康照護可互通性資源（Fast Healthcare Interoperability Resources, FHIR）國際標準格式，實現病人資訊有效互通（Interoperability），並整合癌症病人從篩檢、診斷、治療到成果追蹤的完整癌症歷程資料，建立以病人為中心之全人全程真實世界資料，以利醫師更精準之診斷與處方，提升癌症治療效率及醫療品質。自113年起規劃NGS申報資料收載、癌症重大傷病申請、癌藥事前審查申請及癌症個案療效追蹤等癌症治療資訊。



real-world data (RWD) to evaluate the accuracy of genetic testing and the therapeutic effectiveness of targeted therapies. These evaluations aim to refine payment policies, support precision medicine for high-risk populations, and reduce the financial burden on the public. A total of 12 cancer types are covered under NGS testing, with an estimated 20,000+ or more patients benefiting annually supported by approximately NT\$300 million in the NHI budget. Furthermore, on December 1st of the same year, single-gene testing for 7 additional cancer types was included, with an estimated 10,000 patients benefiting annually, supported by approximately NT\$100 million in the NHI budget.

Implementing the Provisional Payment System for New (Cancer) Drugs

To promote President Lai's Healthy Taiwan policy regarding Taiwan's cancer mortality rate reduction by one-third by 2030 and meet patient needs, the NHIA strives to speed up the inclusion of new drugs, including optimizing the procedure, supervising the budget for new technological products or techniques, establishing a model of risk diversification, and strengthening communication between pharmaceutical companies and review experts. On January 1st, 2025, a total of NT\$5 billion from the government budget was allocated to the National Health Insurance Fund for cancer drugs. On February 25th, 2025, the "Operation Directions on Provisional Payment Funds for New Cancer Drugs" were announced. The applicable drugs are those with drug permits and clear clinical efficacy evidence. They are specifically new cancer drugs or new indications which have not yet been included due to global budget limitations. Such applicable drugs also include

these deemed necessary by the National Health Insurance Administration. The implementation of the provisional payment can expedite new drug introduction, enhance patient access to potentially therapeutic new medications, and alleviate patients' financial burden.

The items included under the conditional reimbursement system will be paired with a risk-sharing model and, as needed, a registration system will be established. During this period, clinical trial data and real-world evidence will be collected to assess efficacy and cost-effectiveness, facilitating NHI's re-evaluation of whether to include them in routine NHI coverage. As of June 2025, a total of 11 new drugs and 5 expanded coverage items have been listed under the provisional payment, including 9 cancer drugs and 4 expanded coverage items for treating lung cancer, breast cancer, colorectal cancer, neurofibromatosis, multiple myeloma, and cell-based therapeutical products (e.g., CAR-T).

Through the provisional payment and special fund usage, the timeline for new (cancer) drug coverage is shortened, allowing patients to obtain breakthrough new drugs earlier, improving new drug accessibility and reducing the public's treatment burden, effectively caring for economically disadvantaged patients.

Digital Governance in Cancer Treatment Under National Health Insurance

The National Health Insurance Administration (NHIA) is advancing digital transformation by integrating with the "National Cancer Control Program" to enhance digital healthcare infrastructure. By adopting the Fast Healthcare Interoperability Resources (FHIR) international standard format, the NHIA aims to achieve



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於114年啟動醫院均得以FHIR送件，期能達到資訊數位化、系統自動化及標準一致化等三大目標，讓雙盲審查機制得以實現，提升審查公正性。展望未來，健保署將繼續擴展數位轉型範圍，強化數據整合與AI技術應用，提升癌症病人的照護品質與治療精準度，實現以病人為中心的全面照護。

成立國家級健康政策及醫療科技評估中心

健康政策與醫療科技評估中心（Center for Health Policy and Technology Assessment，簡稱CHPTA）於2024年1月1日正式運作，協助健保進行新醫療技術、藥品及醫材給付審查，提供藥物經濟學評估及政策評估、人才培訓外，扮演與國際HTA組織間資訊交流及經驗分享之重要角色，加速新藥收載，並擷取國際HTA組織發展經驗，奠定我國醫療科技評估之發展基礎。未來朝向設立行政法人為目標。



推動平行審查新措施

自2024年1月1日起，健保署推動平行送審新措施，廠商申請新藥查驗登記時，符合特定條件者，得同時向健保署申請建議給付，縮短等待許可證審查及健保核准給付時間，預估藥品於取得許可證後6個月內公告生效。截至2025年6月，共有15項藥品提出申請，其中2項藥品已於2025年5月1日及6月1日生效，可用於治療復發性或難治性多發性骨髓瘤成人病人及肺動脈高壓病人。

擴大新藥預算

2024年已於健保總額預算編列相關預算，包括新增新藥預算、藥品給付範圍改變預算及暫時性支付專款預算，共計60.49億元，為2023年的兩倍。2025年編列藥品相關預算共約101.27億元，包含以公務預算挹注50億元設立之「癌症新藥暫時性支付專款」；另亦爭取公務預算20億元挹注罕病藥費。將積極爭取多元財源挹注健保新藥預算，並視財源及醫療需求，滾動檢討逐步擴大癌症新藥暫時性支付專款。

interoperability of effective patient information. It also integrates the complete cancer care data journey from screening, diagnosis, and treatment to outcome tracking, creating patient-centered, real-world data for holistic care. This also enables more precise diagnoses and prescriptions by doctors, improving cancer treatment efficiency and healthcare quality.

Starting in 2024, the plan includes collecting NGS (Next-Generation Sequencing) claim data, major illness applications for cancer, prior authorization applications for cancer drugs, and treatment outcome tracking for individual cancer cases. In 2025, all hospitals will be able to submit documents using the FHIR format, aiming to achieve three major goals: digitalization of information, system automation, and standardization. This will enable a double-blind review mechanism, enhancing review fairness and impartiality.

Looking ahead, the NHIA will continue expanding the scope of digital transformation, strengthening data integration and AI technology applications to improve care quality and treatment precision for cancer patients, realizing comprehensive patient-centered care.

Setting up the Center for Health Policy and Technology Assessment

The Center for Health Policy and Technology Assessment (CHPTA) started operation on January 1st, 2024. In addition to assisting in new medical technology, medication and review for payment of medical materials in the NHI, offering assessments for medicine economics and policies, personal training, the CHPTA has an important role in communicating with international NHA organizations and sharing experiences. The

CHPTA also uses the experiences of international HTA organizations as a basis for health policy and technology assessments. The goal is to set up an incorporated administrative agency.

Launching Parallel Review Methods

On January 1st, 2024, the NHIA launched the parallel submission review system. When a company submits a drug licensing request, a request for NHI payment can be made at the same time, reducing waiting time between permit review and payment approval. Following receipt of the license, the drug should go into effect within six months. As of June 2025, a total of 15 drugs have submitted applications, of which 2 drugs took effect on May 1st, 2025 and June 1st, 2025, respectively, for the treatment of adult patients with relapsed or refractory multiple myeloma and patients with pulmonary arterial hypertension.

Expanding the Budget for New Drugs

The new drug budget was allocated in global budget. In 2024, a total of NT\$6.049 billion is allocated for the addition of new drugs, budget for medication payment change and budget for provisional payment, doubling the amount allocated for 2023. The 2025 budget allocation for drug-related expenses totals approximately NT\$10.127 billion, including NT\$5 billion from the government budget to establish a cancer drug fund. Additionally, NT\$2 billion from the government budget has been secured for rare disease drug expenses. Diversified funding sources to support the NHI budget for new drugs will be sought. Rolling reviews will be conducted to gradually expand the cancer drug budget for provisional payment mechanism and designated funds.



國際合作與醫療科技評估人才培訓

健保署除了和英國國家健康暨照護卓越研究院（National Institute for Health and Care Excellence，簡稱NICE）於2023年5月18日共同簽署醫療科技評估合作協定，以醫療科技評估趨勢、真實世界資料應用、創新藥品基金和癌藥基金財務運作等面向為合作重點，更進一步與法國國家健康管理機構（Haute Autorité de Santé，簡稱HAS）於2025年2月7日簽署合作協議，未來將持續聚焦數位醫療之科技評估，深化雙方在HTA領域的交流與能力建構，涵蓋專業人才培訓及高層互訪與經驗交流等，為臺灣在新醫療科技與政策發展上之挑戰，持續提供國際化視野與專業支持。

健保署於2025年5月28日及29日舉辦第3屆「臺英醫療科技評估合作協議工作坊」，邀請英國NICE專家來臺，以癌症藥物基金（Cancer Drugs Fund, CDF）之制度設計與執行為主軸，針對給付協議（Managed Access Agreements, MAA）之設計邏輯、執

行架構、資料蒐集協議與再評估機制等議題進行系統性探討。

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

醫療資訊上雲端 調閱分享無弗屆

健保醫療資訊雲端查詢系統

全民健保累積30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」，提供特約醫事服務機構於診療需要時，可即時查詢病人過去6個月的用藥紀錄，作為醫師處方開立或藥事人員用藥諮詢參考，以提升民眾就



International Cooperation and Medical Technology Assessment Personnel Training

Beyond signing a medical technology assessment cooperation agreement with the United Kingdom's National Institute for Health and Care Excellence (NICE) on May 18, 2023, focusing on medical technology assessment trends, the application of real-world data, innovative drug funds, and the financial operation of cancer drug funds, the NHIA has further advanced international collaboration by signing a cooperation agreement with France's Haute Autorité de Santé (HAS) on February 7, 2025. Going forward, the partnership will continue to focus on technology assessment in digital healthcare, deepening bilateral exchanges and capacity building in the HTA field, including professional personnel training, high-level mutual visits, and experience sharing. This provides Taiwan with an international perspective and professional support to address challenges in new medical technology and policy development.

The NHIA held the 3rd "Workshop for Partnership Agreement between Taiwan and the United Kingdom on Health Technology Assessment" on May 28th-29th, 2025, inviting UK NICE experts to Taiwan. Centered on the institutional design and implementation of the Cancer Drugs Fund (CDF), the workshop conducted systematic discussions on topics including the design logic of Managed Access Agreements (MAA), implementation frameworks, data collection protocols, and re-evaluation mechanisms.

The NHIA will work in cooperation with CHPTA and establish a mechanism based on payment review in other countries, constructing

a three-in-one human resource system of education, training and employment, to enhance our health technology assessment and management capabilities.

NHI MediCloud System for Sharing Information Anytime, Anywhere

The "NHI MediCloud System"

The NHIA has accumulated 30 years of health insurance reimbursement claim data. With big data technology improvement, the NHIA began to gradually compile data from various fields, and to use cloud technology to provide doctors necessary data for clinical judgments under secure environment. In July 2013, the NHIA established the patient-centered "NHI PharmaCloud System," allowing contracted medical institutions to immediately access patients' medication records of the previous six months for diagnostic or treatment purposes. Such information can be of great value to doctors in making out prescriptions or to pharmacists in providing medication counseling to patients, thereby enhancing healthcare quality and reducing the redundant consumption of medical resources. By integrating information from the NHI PharmaCloud System with in-hospital information systems, contracted medical institutions gradually established their own dedicated in-hospital medication management mechanisms, thereby enhancing medication safety.

Based on the NHI PharmaCloud System, since 2016, the NHIA has developed the expanded "NHI MediCloud System" after referring to users' feedback and clinical needs. The "NHI MediCloud System" incorporates 12



醫品質，減少不必要之醫療資源重複使用。特約醫事服務機構整合健保雲端藥歷資訊及院內用藥管理系統，紛紛建置院內專屬之用藥管理機制，強化用藥安全環境。

基於前述推動基礎，健保署參考使用者回饋意見及臨床實務需求，自2015年起擴大發展「健保醫療資訊雲端查詢系統」，增建中醫用藥紀錄、檢查檢驗紀錄、檢查檢驗結果（含醫療影像、國民健康署成人預防保健及篩檢結果）、手術明細紀錄、牙科處置及手術紀錄、過敏藥物紀錄、特定管制藥品用藥紀錄、特定凝血因子用藥紀錄、復健醫療紀錄、出院病歷摘要及疾病管制署預防接種紀錄等共12類主題式資料。

2018年起「健保醫療資訊雲端查詢系統」陸續發展跨院重複用藥/檢查檢驗、西藥交互作用及過敏藥、中西藥交互作用、高風險腎臟病病人非類固醇抗發炎口服藥用藥等多項主動提示功能，提醒醫師於處方時留意病人藥品使用情形，節省醫師於診間需閱讀大量資訊時間，提升醫療效率及品質，保障病人安全。為提供使用者更友善之使用介面與客製化、視覺化功能，健保署2024年4月推出健保醫療資訊雲端查詢系統2.0，除優化介面及擴充客製化功能外，整合西醫用藥、檢查(驗)紀錄與結果【包含電腦斷層（CT）、磁共振造影（MRI）、超音波、X光、胃鏡及大腸鏡等醫療影像】、手術紀錄、牙科處置及手術、出院病摘、中醫醫療、復健醫療、過敏紀錄、特定管制用藥及特定凝血因子用藥、疾病管制署預防接種、特材紀錄等13類病人跨院就醫資訊與預防接種資

料，提供醫師、藥師、護理師等9類醫事人員使用，涵蓋基層社區精神復健、物理治療所、職能治療所、居家護理機構、醫事檢驗所、放射所、呼吸照護所、助產所等醫事機構，以創造健康大數據資訊共享，協助醫療團隊推動全人全程健康照護，讓健保資源能更加有效運用。

基層院所 HIS 雲端轉型

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

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

電子處方箋，銜接就醫數位流程

響應ESG永續發展，本署以民眾需求及提升醫療可近性為出發，2024年9月起規劃推動電子處方箋，邀集花蓮縣各層級院所執行試辦，試辦過程因應臨床使用者及醫療資訊廠商相關意見優化整體資訊流，朝向足以普及於各醫療院所應用之推動方向。經前開試辦驗證可行，並於2025年7月起各區擇點推動中。

types of thematic data, including medication records, traditional Chinese medicine records, examination and test records and results (including medical imaging, adult preventative care services, colorectal cancer screening, oral cancer screening, breast cancer screening and cervical cancer screening conducted by the Health Promotion Administration, MOHW), surgical records, dental treatment and surgical records, drug allergy records, records on use of specific controlled drugs, records on use of drugs for specific coagulation factors, rehabilitation records, hospital discharge summaries, and vaccination records provided by the Taiwan Centers for Disease Control.

Since 2018, the NHIA has gradually developed active reminders for duplicated orders, drug interaction, drug allergies, and nonsteroidal anti-inflammatory drugs usage for high-risk kidney disease patients. With the technology, the NHI MediCloud System could remind the doctors to pay attention to drug prescriptions in a more active way for improving the quality and efficiency of healthcare services and ensuring the safety of patients. To offer more customized, visualized interface for users, the NHIA has launched the 2nd-generation NHI MediCloud system in April, 2024. In addition to optimize interfaces and expanding customized functions, the system integrates 13 categories of cross-institutional patient medical information and vaccination data, including medication records, examination records such as medical imaging, computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, X-rays, gastroscopy, and colonoscopy), surgical records, dental treatments records, discharge summaries, traditional Chinese medicine, rehabilitation medicine, allergy records, specific

controlled drugs and coagulation factor medication records, Taiwan Center for Disease Control's vaccination records, and special material records. The system serves 9 categories of healthcare professionals including physicians, pharmacists, and nurses, covering medical institutions such as community mental health rehabilitation facilities, physical therapy clinics, occupational therapy clinics, home nursing institutions, medical laboratories, radiology centers, respiratory care facilities, and midwifery centers, creating shared health big data to assist healthcare teams in promoting comprehensive lifelong healthcare and enabling more effective utilization of NHI resources.

HIS in Community Hospitals

In response to international digital transformation, the NHIA plans to transform the on-premise system used by community hospitals to a cloud-based system. Using Cloud technologies, hospitals will be able to integrate medical information, improving system resilience.

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

Electronic prescriptions connect the digital medical process

In response to ESG, the NHIA plans to promote electronic prescriptions starting in 2024, driven by public demand and the goal of enhancing healthcare accessibility. Since September 2024, medical institutions at all levels in Hualien County have been invited to participate in pilot programs. During the trial process, feedback



雲端加值 精進健保快易通 App | 健康存摺運用

為避免不必要的檢驗檢查，健保署自2015年起，鼓勵醫療院所上傳病患各項檢驗檢查結果。2018年1月起，鼓勵醫療院所上傳CT、MRI、超音波、胃鏡、大腸鏡及X光檢查之醫療檢查影像，其他的院所即可透過健保醫療資訊雲端查詢系統調閱影像及報告內容。對民眾而言，至同層級醫院尋找第二醫療意見或在居家附近基層院所接受後續照護，只要由雲端調閱資料，就可看到檢驗檢查報告，節省等待醫院作業流程與金錢花費，也降低重複檢查的潛在健康風險。藉此落實分級醫療「社區好醫院，厝邊好醫師」的理念，提升病患就醫品質及方便性，也減少醫學中心壅塞的問題。

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

健康存摺自2014年截至2024年12月31日止，健康存摺使用人數約1,191萬人，使用人次已達4億6,133萬人次。約9成使用者認同透過健康存摺可了解個人就醫情形，有助於掌

握自我健康情形，顯示健康存摺對於促進民眾自我健康照護有正向幫助。健保署於2019年3月開發健康存摺資料介接服務(Software Development Kit, SDK)，為公部門首創的資料開放服務模式，截至2025年11月共12個單位24支App介接完成提供民眾服務。

隨著行動裝置的普及化，民眾運用行動裝置紀錄個人生理量測數據（包括血壓、血糖、心率等）已成趨勢潮流，2023年健康存摺連結Google Fit（2025年起改為Health Connect）及Apple Health將行動裝置紀錄個人生理量測數據載入健康存摺，讓民眾可以透過單一健康管理工具（健康存摺）查閱個人就醫及量測數值，便利管理個人健康；另健康存摺提供公費癌症篩檢結果異常主動推播功能，提醒癌症篩檢結果異常個案回診接受後續診療服務，積極主動照顧民眾健康。



from clinical users and healthcare IT vendors has been incorporated to optimize the overall information flow, aiming to establish a system that can be widely adopted across medical institutions. The program has been expanded to all regions, starting with selected pilot sites in July 2025.

Value-Added Cloud Services: Application of My Health Bank

The NHIA has encouraged hospitals and clinics to upload patients' testing and examination results since 2015 to avoid unnecessary tests, examinations, and medications. Beginning in January 2018, after patients have undergone CT, MRI, ultrasound, gastroscopy, colonoscopy, and x-ray examinations at a large hospital, other primary care hospitals and clinics can use the NHI MediCloud System to view patient images and reports. As a result, when people wish to obtain a second opinion from a hospital at the same level, or receive follow-up care at a primary care hospital or clinic near their home, medical personnel need only obtain their data from the cloud, and can then view the patients' testing and examination reports. This saves patients' money and time spent waiting for hospital procedures, and also lessens the potential health risk of multiple examinations. This also realizes the hierarchical healthcare ideal of "a good hospital in the community, a good doctor nearby," boosting the quality and convenience of healthcare, and easing congestion at medical centers.

Furthermore, the NHIA's individualized cloud service—My Health Bank—enables people who have registered their NHI cards to log into the system and make queries. With easy-to-understand charts and tables, My Health Bank allows users to quickly view and understand

their recent healthcare records, testing and examination results, and preventive care data, helping them monitor health status and perform health management. People can also download My Health Bank data for other applications or use a mobile device to log into the App and access their personal healthcare data for the reference of physicians during visits. This goes a long way toward improving the information asymmetry between doctors and patients and enhancing medical care safety and effectiveness.

From its launch in 2014 through December 31st, 2024, My Health Bank has reached approximately 11.91 million users, with usage exceeding 461.33 million times. Roughly 90% of users agree that My Health Bank can help them understand their healthcare situation and monitor their state of health. It is fair to say that My Health Bank effectively promotes improved health self-management among the public. In March 2019, the NHIA developed the My Health Bank SDK (Software Development Kit, SDK), a pioneering new data-sharing service model for the public sector. As of November 2025, a total of 24 apps developed by 12 institutes provide services to the public.

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



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

健保卡資料上傳格式 2.0 精進醫療資訊串接

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

為提高健保卡就醫資料之正確性及完整性，減少紙本處方箋重複調劑、重複檢查的情形，健保署2023年9月1日實施「就醫識別碼（健保卡資料上傳格式2.0）」（以下簡稱健保卡2.0），藉由民眾就醫當下，產生一組就醫時之人、時、地特定編碼即就醫識別碼，作為各項就醫資料的唯一鍵值，以串聯就醫後各項檢查/驗結果、醫療影像、出院病歷摘要、醫療費用申報、醫療資訊雲端查詢系統及健康存摺系統等資料，並進一步推動電子處方箋，藉由就醫資訊的整合，即時管理監控異常就醫紀錄。亦訂定「健保卡資料上傳格式2.0改版獎勵」提供院所改版誘因。實施初期採申請制逐步推動，上線後因應各界使用後之回饋意見，持續精進系統功能，歷經二年積極宣導及推動，健保卡2.0已於2025年9月1日全面單軌上線。

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

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

Smart NHI cards were formally introduced on January 1st, 2004 to make people's access to medical care more convenient. These IC cards integrate the medical records and information originally contained in paper NHI cards, children's health booklets, maternal health booklets, and catastrophic illness certificates. The information

has been originally recorded on the NHI cards' chips in encrypted and encoded form. Apart from offering greater convenience, the IC cards also better protect medical privacy.

To increase the accuracy and integrity of medical records in the NHI card and to reduce the possibilities of repeat prescription and examination, the NHIA implemented the identification code for medical treatment (2.0 version of the NHI card). As a person seeks medical treatment, an identification code will be generated based on the information regarding the person, the time, and the place of treatment. The code serves as reference for a range of examination records, medical imaging, discharge medical record summary, declaration of medical expenses, MediCloud, My Health Bank App and digital prescription. The abnormalities can be monitored immediately with the integration of medical records. Incentives for upgrading the NHI Card to 2.0 version were also set to encourage hospitals to upgrade the system. In the initial stage, the new system can be approached via application. Subsequent advancement of the system will base on later users' feedback on the version. After two years of active promotion and implementation, the NHI Card 2.0 has been fully launched on a single-track system as of September 1, 2025.



多重機制縱深防禦確保資訊安全

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

在網路系統上，則採用健保資訊網封閉性專屬網路，設有多道防火牆，可降低駭客入侵系統或盜取資料之風險；健保卡紀錄均以代碼登載及亂碼傳輸，有效保障個人隱私。

為強化健保卡和健保資料的安全管理機制，健保署自2003年8月即成立「資通安全小組」，負責相關工作及推動認證，另外，健保署為落實資訊安全工作，全面推動資訊安全管理系統（ISMS）建置作業，讓資訊安全確實向下扎根。對外網路採單一入口並建構縱深防禦機制，布建各式偵測及防禦機制（如SOC、防火牆、郵件過濾、入侵偵測、應用系統防火牆、防毒防駭軟體、進階持續性威脅攻擊防禦措施），以進行全年無休之網路及電子郵件安全監控作業，於資料庫內可資識別個人資料之欄位加密方式儲存，以確保健保署整體資通安全。



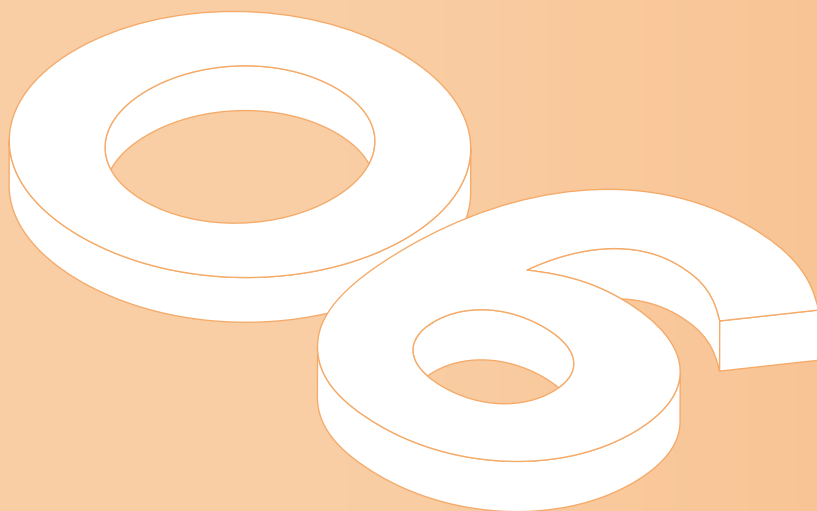
Multiple Mechanisms for Ensuring Information Security

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

NHI information is transmitted through the NHIA's closed VPN system, with multiple firewalls to reduce the risk of hackers breaking into the system or stealing data. In addition, to protect personal privacy, NHI card records are entered in encoded form and transmitted after encryption.

To further strengthen NHI card and health insurance data security, the NHIA established an information security task force in August 2003 to be responsible for relevant tasks and promote certification. In addition, the NHIA has established an information security management system (ISMS). The NHIA's information security measures also include the establishment of a single network entry point, in depth defense mechanisms, and various detection and defense mechanisms (such as SOC, firewalls, email filters, intrusion detection, application system firewalls, anti-virus/anti-spyware software, and advanced continuous threat and attack prevention measures). There are constant network and e-mail security monitoring. Personal information fields in databases are stored in encrypted form, ensuring the NHIA's overall information security.

Chapter



照顧弱勢 守護偏鄉

Care for the
Disadvantaged and
Watch over Isolated Areas





照顧弱勢 守護偏鄉

對經濟弱勢民眾的補助措施

全民健保採強制納保，社會上難免有一部分繳不起保險費的低收入戶及經濟邊緣人口，如何貫徹全民納保政策，有賴多項協助措施，以確保社會安全網的穩固，更彰顯自助互助的精神。為了照顧癌症、洗腎、血友病、精神病

等重大傷病患者，以及經濟困難弱勢民眾的就醫權益，健保署提出多項協助繳納保險費的措施。另外，對於罕見疾病、重症患者及偏遠地區民眾，亦提供醫療及經濟上的協助。現行的協助措施包括保險費補助、紓困貸款及分期繳納等，執行成果請見表6-1。

表6-1 繳納健保費之協助措施成效

Table 6-1 Results of Premium Payment Assistance Measures

項目 Item	對象 Assistance recipients	年度 Year	人（件）數 Number of persons/ cases	金額（新臺幣） Amount (NT\$)
保費補助 Premium subsidies	政府對特定弱勢者補助健保費，包括低收入戶、中低收入戶、無職業榮民、失業勞工及眷屬、身心障礙者、未滿20歲及55歲以上之無職業原住民 The government provides premium subsidies for members of underprivileged groups, including low income households, near-poor households, unemployed veterans, unemployed workers and their dependents, the physically and mentally disabled, and unemployed indigenous citizens who are under the age of 20 or over the age of 55.	2023	394.5 萬人 3.945 million persons	344.6 億元 NT\$ 34.46 billion
		2024	401.2 萬人 4.012 million persons	361.7 億元 NT\$ 36.17 billion
紓困貸款 Relief fund loans	符合衛生福利部所訂經濟困難資格者 Persons meeting economic hardship requirements set by the MOHW	2023	1,598 件 1,598 cases	1.52 億元 NT\$ 152 million
		2024	1,276 件 1,276 cases	1.29 億元 NT\$ 129 million
分期繳納 Installment payment plans	欠繳保險費無力一次償還者 Persons who are unable to immediately repay owed premiums in one go	2023	7.2 萬件 72,000 cases	22.20 億元 NT\$ 2.22 billion
		2024	7.1 萬件 71,000 cases	22.26 億元 NT\$ 2.226 billion
愛心轉介 Referral to charities	無力繳納健保費者 Persons who are unable to pay premiums	2023	5,963 件 5,963 cases	5,107 萬元 NT\$ 51.07 million
		2024	5,609 件 5,609 cases	6,005 萬元 NT\$ 60.05 million

資料時間：2023年1月1日至2024年12月31日。

Data period: January 1st, 2023 to December 31st, 2024

Care for the Disadvantaged and Watch over Isolated Areas

Subsidies for the Economically Disadvantaged

NHI enrollment is mandatory. However, some low-income households and people on the margins of society cannot afford to pay their premiums. To fully implement the government's blanket enrollment policy, the NHIA has taken a number of assistance measures to strengthen the social welfare net and realize the spirit of mutual help. In addition, the NHIA has also introduced

premium payment assistance measures to help care for patients suffering from cancer, hemophilia, or severe mental illness or receiving dialysis, as well as underprivileged persons in need of medical attention against economic difficulties. Medical and economic assistance is also offered to persons with rare or critical illnesses and those living in isolated areas. Such assistance measures include premium subsidies, relief loans, and installment payment plans. Refer to Table 6-1 for the results of implementation.





弱勢群體保費補助

各級政府對特定弱勢者補助健保費，包括低收入戶、中低收入戶、無職業榮民、失業勞工及眷屬、身心障礙者、未滿20歲及55歲以上之無職業原住民，2022年全年補助人數約365.3萬人，補助金額約322.7億元。2024年全年補助人數約401.2萬人，補助金額約361.7億元。

紓困貸款

提供經濟困難的民眾，無息申貸健保費用及應自行負擔而尚未繳納之醫療費用，以保障就醫權益。2023年全年共核貸1,598件，金額1.52億元。2024年全年共核貸1,276件，金額1.29億元。

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，2023年全年辦理分期繳納共7.2萬件，合計22.2億元。2024年全年辦理分期繳納共7.1萬件，合計22.26億元。

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。2023年全年轉介成功個案計5,963件，補助金額共5,107萬餘元。2024年全年轉介成功個案計5,609件，補助金額共6,005萬餘元。

保障弱勢民眾就醫權益

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

惟為健全全民健保制度，健保署依據健保法第37條，於2018年起陸續針對長期出國及有經濟能力之欠費者，經查證後先通知輔導繳納欠費，如仍未繳納健保欠費者始予鎖卡，目的在促請保險對象善盡健保費繳納之義務。

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協助弱勢族群減輕就醫負擔，主動篩選並發函通知符合資格的民眾，協助其繳納健保相關欠費等。迄2024年12月底，累計補助金額已達52.20億元，累計補助人數達27萬1,828人（表6-2）。

Premium Subsidies for Underprivileged Groups

Governments at different levels provide premium subsidies to various underprivileged groups, including low-income households, middle-to-low-income households, unemployed veterans, unemployed workers and their dependents, the physically and mentally disabled, and unemployed indigenous citizens who are under the age of 20 or over the age of 55. A total of NT\$34.46 billion in such subsidies was provided to 3.945 million people in 2023, followed by a total outlay of NT\$36.17 billion that benefitted 4.012 million people in 2024.

Relief Fund Loans

To protect people's right to healthcare, the NHIA provides interest-free loans to members of the public in economic difficulties so that they can pay their premiums and cover unpaid copayments. A total of NT\$152 million went toward such loans granted to 1,598 cases in 2023, and NT\$129 million was loaned to 1,276 cases in 2024.

Installment Payment

For people not eligible for relief loans, the NHIA offers installment payment plans to persons who owe premiums totaling more than NT\$2,000, but due to economic hardship, cannot repay this debt in one go. Installment payment plans for a total of NT\$2.22 billion were provided in about 72,000 cases during 2023, followed by NT\$2.226 billion in nearly 71,000 cases in 2024.

Referral to Charitable Groups for Premium Subsidies

For persons who are unable to pay their premiums, the NHIA also provides referral to charitable groups, companies, and individuals for premium subsidies. Such referrals were made in 5,963 cases involving total subsidies of NT\$51.07 million in 2023, and NT\$60.05 million in 5,609 cases in 2024.

Protecting the Right to Healthcare of the Underprivileged

The NHIA proactively upholds the universal value of equal access to healthcare. The “decoupling of the right to healthcare from unpaid NHI premiums and fees” policy was launched on June 7th, 2016. As long as individuals have completed their subscription procedures, they can enjoy access to NHI-covered healthcare. The unblocking of all NHI cards represented a significant milestone in safeguarding the right to healthcare, ensuring that beneficiaries will not have their cards blocked due to unpaid premiums or fees. The abolition of the card blocking system has alleviated the concerns of individuals who previously feared being denied essential health care due to outstanding payments. This further demonstrates the government's commitment to caring for the underprivileged and protecting the healthcare rights of citizens.

However, to maintain the integrity of the National Health Insurance system, the NHIA has, since 2018, gradually implemented measures under Article 37 of the National Health Insurance Act targeting long-term overseas residents and financially capable delinquent payers. After verification, these individuals are first notified and



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表6-2 最近2年公益彩券回饋金補助成果表
Table 6-2 Public Welfare Lottery Contributions during the Last Two Years

年度 Year	計畫名稱 Program	人數 Persons	金額 (新臺幣) Amount (NT\$)
2023	協助中度以上身心障礙者及貧戶家庭脫離健保欠費困境計畫 Plan to Help Persons with Moderate or More Severe Physical or Mental Disabilities and Low-income Households Obtain Relief from Unpaid NHI Premiums and Fees	7,662	2.14 億元 NT\$ 214 million
2024	協助中度以上身心障礙者、未成年及貧戶家庭脫離健保欠費困境計畫 Plan to Help Persons with Moderate or More Severe Disabilities, Minors, and Low-income Households Obtain Relief from Unpaid NHI Premiums and Fees	8,269	1.79 億元 NT\$ 179 million
2008/1~2024/12 總計 Total		271,828	52.20 億元 NT\$ 5.220 billion

註：資料時間截至2024年12月底。 Note: The data period ends in December 2024.

減輕特定病患就醫部分負擔費用

對於領有「身心障礙證明」者，門診就醫時不論醫院層級，門診基本部分負擔和藥品部分負擔費用均按診所層級，較一般民眾為低。

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

對疾病弱勢族群照護

身心障礙者

健保署自2002年起施行「牙醫門診總額特殊醫療服務計畫」，以醫療服務加成支付方式服務，鼓勵醫師提供先天性唇顎裂患者及特定身心障礙者牙醫醫療服務。

至2006年起放寬可由各縣市牙醫師公會或牙醫團體組成醫療團，定期至身心障礙福

利機構服務、支援未設牙科之精神科醫院或特殊教育學校提供牙醫特殊巡迴醫療服務。2011年7月1日起，更進一步針對特定身心障礙類別且符合居家照護條件者，提供到宅服務。2013年1月1日起，新增提供入住身心障礙機構之長期臥床者牙醫服務。2014年1月1日起增加政府立案收容發展遲緩兒童機構者機構服務。2015年1月1日起進一步提供衛生福利部所屬老人福利機構內，長期臥床者牙醫診療服務。2016年1月1日新增提供重度以上重要器官失去功能者牙醫服務。2020年1月1日起新增出院準備個案及經衛生福利部護理及健康照護司擇定之一般護理之家牙醫服務。2021年1月1日起新增腦傷及脊髓損傷之中度肢體障礙者牙醫服務。2024年1月1日起調高特定身心障礙者加成，極重度身心障礙病人、自閉症及失智症得加11成、重度病人得加9成、中度病人（含發展遲緩兒童）及中度以上精神疾病病人得加5成、輕度病人（含失能老人）得加3成。

guided to pay their outstanding premiums. Only those who still fail to pay their NHI arrears will have their cards suspended, with the purpose of urging insured persons to fulfill their obligation to pay NHI premiums.

The NHIA implements multiple measures to support underprivileged individuals, establishing a healthcare safety net for citizens experiencing economic hardships. By eliminating barriers to NHI coverage, the NHIA ensures that individuals in financial difficulties can access necessary medical care whenever needed. Furthermore, the NHIA provides assistance to these individuals by offering support in NHI enrollment, premium relief, referrals to aid programs, and flexible installment payment plans.

Seeking for Public Welfare Lottery Contributions to Help the Disadvantaged

To ensure healthcare access for underprivileged groups and safeguard their right to healthcare, the NHIA implements various assistance measures, including installment payment plans, relief loans, and referrals to charitable programs. Since 2008, the NHIA has also utilized contributions from the Public Welfare Lottery to alleviate the medical financial burdens of eligible underprivileged individuals. Proactively identifying qualified persons, the NHIA notifies them about available assistance for paying NHI premiums and fees. As of the end of December 2024, a cumulative NT\$5.220 billion in subsidies had been disbursed to support 271,828 individuals (Table 6-2).

Easing Copayment Burden on Specific Patients

Persons who have received a disability certificate need only pay a clinic-level outpatient copayment when seeking care at any level of hospital or clinic. This copayment is lower than that paid by the general public.

For patients with conditions such as cancer, chronic mental illness, dialysis needs, rare diseases, or congenital disorders who possess a major illness/injury certificate, there is no requirement for copayment when they are seeking medical care specifically related to these conditions. To safeguard the rights of patients with rare diseases, the NHI covers the costs of all medications necessary for the treatment of rare disorders, as designated by the MOHW, through a fund for a specified purpose. This initiative has substantially alleviated the financial burden on individuals with rare diseases.

Caring for the Medically Vulnerable

Persons with disabilities

Initiated in 2002, the NHIA's "Dental Outpatient Global Budget Special Medical Service Plan" provides services under a medical service markup payment system. Dentists are encouraged to serve patients with congenital cleft lip and palate and other specific disabilities.

In 2006, the NHIA expanded to allow local dentist associations or groups to establish dental teams catering specifically to institutions providing care for individuals with disabilities. These dental teams are authorized to offer regular services, including mobile health dental



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2024年12月底，重大傷病證明有效領證數約有106萬餘張（人數為99萬7千餘人，約占總保險對象的4.2%），而2024年全年重大傷病醫療費用約2,629億餘元（占全年總醫療支出的28.4%），健保藥品費用中，每年約有903億元（約3.5成）用於重大傷病，顯示重大傷病的醫療費用支出比重高，全民健保的確為他們提供實質的協助。

罕病患者

罕見疾病屬重大傷病範圍項目，就醫時可免除部分負擔，截至2024年12月衛生福利部公告的罕見疾病種類有245項，截至2024年12月底止，重大傷病罕見疾病項目領證數共1萬5,398張。經統計2024年罕見疾病之藥品費用約為109億元。

為照顧罕見疾病患者，凡經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。



care, to psychiatric hospitals without dental departments and special education schools for individuals with special needs. Since July 1st, 2011, dentists from these teams have provided in-home dental services to individuals with designated disabilities who meet the criteria for home health care. On January 1st, 2013, the dental teams expanded their services to include bedridden patients at institutions dedicated to the care of individuals with disabilities. From January 1st, 2014, these teams began providing dental care at government-registered institutions catering to children with developmental delays. The scope of their services was further extended to include bedridden individuals at elderly care facilities under the MOHW from January 1st, 2015. Further services to persons suffering from severe loss of major organ functions on January 1st, 2016, as of January 1st, 2020, dental care has been made available to individuals preparing for hospital discharge and general nursing homes selected by the MOHW's Department of Nursing and Health Care. Furthermore, dental services have been extended to individuals with moderate functional disabilities caused by brain and spine injuries since January 1st, 2021. Starting January 1st, 2024, the premium subsidies for specific persons with disabilities were increased: patients with the most severe disabilities, autism, and dementia receive an 110% increase; patients with severe disabilities receive a 90% increase; patients with moderate disabilities (including children with developmental delays) and those with moderate or above mental illnesses receive a 50% increase; patients with mild disabilities (including elderly with functional impairments) receive a 30% increase.

Persons with catastrophic illnesses and injuries

The NHIA currently recognizes 30 types of catastrophic illnesses and injuries, including cancer, chronic mental illness, conditions requiring dialysis, and congenital disorders. These illnesses often incur substantial medical expenses that pose financial challenges. To alleviate the burden on the insured, the NHIA has implemented a policy of waiving copayments for the treatment of these catastrophic illnesses and injuries for all those who possess a major illness/injury certificate.

As of the end of December 2024, more than 1.06 million valid catastrophic illness/injury certificates had been issued (to more than 997,000 persons, who accounted for roughly 4.2% of all insureds). Total medical expenditures for catastrophic illnesses and injuries exceeded NT\$262.9 billion in 2024 (accounting for 28.4% of all NHI medical expenditures for the year). Of the annual expenses for NHI-covered drugs, about NT\$90.3 billion (nearly 35%) is spent on those meant for catastrophic illnesses and injuries each year. It is clear that catastrophic illnesses and injuries account for a very large share of medical expenses, and the NHI consequently is a godsend for patients with these conditions.

Persons with rare diseases

Since rare diseases are considered catastrophic illnesses and injuries, copayments are waived when patients seek treatment. As of December 2024, the MOHW had recognized 245 rare diseases, and 15,398 major illness/injury certificates had been issued for rare diseases accordingly. NHI's drug expenditures for rare diseases totaled NT\$10.9 billion in 2024.



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，避免重複不當用藥或處置等，影響病人安全，健保署自2009年12月1日起，推動「醫院以病人為中心之整合照護計畫」，提升醫療照護品質。

本計畫執行多年，每年收案照護對象平均就醫次數較上年同期呈現減少，施行成效良好。2024年12月參與照護，提供整合服務之醫院共134家。

對山地離島、偏鄉及醫療資源缺乏地區族群的照護

依據健保法第43條暨施行細則第60條，經公告之醫療資源缺乏地區就醫之門診、急診與居家照護服務，減免20%部分負擔，除此之外，健保署亦實施下列計畫以提升山地離島地區或醫療資源缺乏地區之醫療服務：

全民健康保險山地離島地區醫療給付效益提昇計畫

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

區提供專科診療、急診、夜診等定點或巡迴醫療服務。

目前全國公告之山地離島鄉計有50鄉鎮區，共26家特約院所承作30項計畫，其中，自2022年起花蓮縣秀林鄉由IDS計畫轉型為「山地鄉全人整合照護執行方案」，2025年起於宜蘭縣、連江縣、桃園市、南投縣、嘉義縣、高雄市、花蓮縣的9個山地離島地區擴大辦理「全民健康保險偏鄉地區全人整合照護方案（全人整合照護方案）」。2024年IDS計畫及山地鄉全人方案服務山地離島鄉民眾服務民眾達48萬餘人，當地民眾對計畫平均滿意度為96%。



To care for patients with rare diseases, payments for all drugs needed in the treatment of these diseases are quickly added to the “National Health Insurance Drug Dispensing and Fee Schedule.” This has ensured that persons with rare diseases receive the care they need while easing their healthcare burden.

Persons with multiple chronic conditions

Individuals with multiple chronic conditions represent the highest utilization of healthcare resources in Taiwan’s healthcare system. With the country’s aging population, the prevalence of multiple chronic conditions is steadily rising, making the care of these individuals an issue of concern. To ensure that people with multiple chronic conditions receive comprehensive and coordinated care services, while also minimizing the risks associated with repeat or incorrect medications or treatments, the NHIA introduced the “Patient-Centered Hospital Integrated Care Program” across local hospitals on December 1st, 2009.

Since its implementation, the program has demonstrated effectiveness, as evidenced by a steady decline in the average number of medical visits among program participants over the years. As of December 2024, a total of 134 hospitals participated in the program.

Providing care in medically underserved isolated areas

According to Article 43 of the National Health Insurance Act and Article 60 of its enforcement rules, persons seeking outpatient, emergency, and home care services in areas officially recognized as lacking in medical resources

receive a 20% discount on copayments. In addition, the NHIA has also implemented the following programs to enhance healthcare services in mountain areas, on offshore islands, and in other medically underserved areas:

NHI Integrated Delivery System for mountain areas and offshore islands

Due to the geographical constraints and inconvenient transportation, mountain areas and offshore islands often face difficulties in accessing healthcare services. In response, the NHIA has planned for capable and willing medical institutions with relatively sufficient medical personnel to be dispatched to these regions. In November 1999, the NHIA has implemented the Integrated Delivery System (IDS) program for mountain areas and offshore islands. This program encourages large hospitals to offer specialized medical services, emergency care, and evening clinics either at fixed locations or through mobile healthcare services, ensuring that residents in these areas receive the necessary healthcare support.

Currently, there are 50 townships and districts in mountainous and outlying island areas have been officially designated nationwide, with 26 contracted medical institutions implementing 30 projects. Among these, Xiulin Township in Hualien County has transformed from the IDS program into the “Mountain Township Integrated Holistic Implementation Plan” since 2022. In 2025, the “National Health Insurance Remote Area Integrated Holistic Implementation Plan” (hereafter referred to as Holistic Integrated Care Program) has been expanded to 9 mountain and outlying island areas in Yilan County, Lienchiang County, Taoyuan City, Nantou County, Chiayi



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醫療資源不足地區改善方案

2024年投入9.22億元，持續辦理醫療資源不足地區改善方案，以「在地服務」的精神鼓勵中、西、牙醫醫師至醫療資源不足地區執業，或是以巡迴方式提供醫療服務。2024年共有667家特約院所至醫療資源不足地區巡迴，服務民眾達75.4萬餘人次。

醫療資源不足地區之醫療服務提升計畫

一、任務型補助：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」，對象為離島、山地鄉及醫療資源不足或相鄰鄉鎮提供24小時急診及內、外、婦、兒科服務之醫院（不限地區醫院），以專款預算給予點值保障，2024年計有99家醫院參與。

二、基本營運保障：燈塔型地區醫院（2024年開始）符合本計畫對象條件之地區醫院，且符合離島醫院、急救責任醫院及該鄉鎮（區）僅有一家醫院者，補助該等醫院收入或予以點值保障，2024年計符合補助條件計33家醫院。

全民健保遠距醫療給付計畫

遠距會診（不限西醫專科）或急診遠距會診（不限科別），提升偏鄉地區專科門診可近性。2024年專科門診遠距會診服務人次計12,651人次，急診遠距會診服務人次計3,050人次。

County, Kaohsiung City, and Hualien County. In 2024, the IDS program and Integrated Holistic Care Implementation Plan served over 480,000 residents in mountain and outlying island townships, with an average satisfaction rate of 96% among local residents.

Improvement Project for Regions Deficient in Medical Resources

The NHIA allocated NT\$922 million for the 2024 Improvement Project for Regions Deficient in Medical Resources. Dentists and Traditional Chinese Medicine (TCM) and medicine physicians are encouraged to demonstrate their commitment to serving local communities by starting practices in areas that lack sufficient medical resources or providing mobile healthcare services. In 2024, a total of 667 contracted hospitals and clinics conducted mobile healthcare services, benefiting over 754,000 individuals in medically underserved areas.

Medical Service Improvement Program for Medically Underserved Areas

1. Task-based subsidies: Since 2012, the “National Health Insurance Medical Service Improvement Program for Medically Underserved Areas” has been implemented. The program targets hospitals (not limited to regional hospitals) that provide 24-hour emergency services and internal medicine, surgery, obstetrics and gynecology, and pediatric services in outlying islands, mountain townships, and medically underserved or adjacent townships and districts. These hospitals receive point value guarantees through dedicated budget

funding. In 2024, a total of 99 hospitals participated in the program.

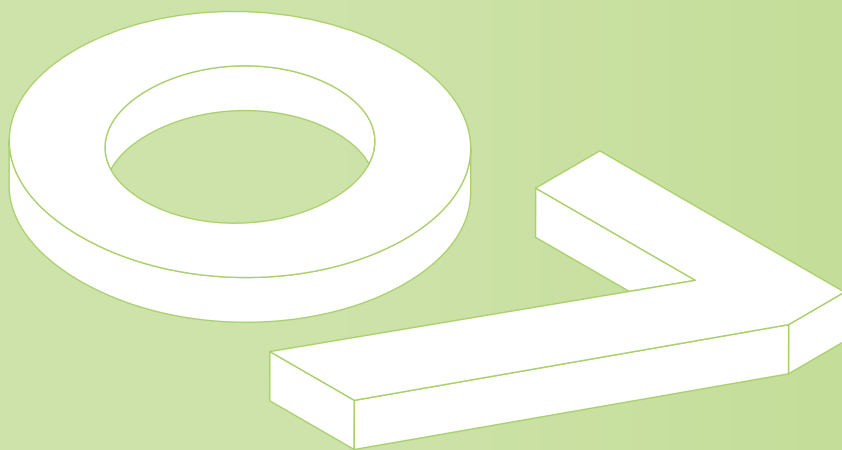
2. Basic operating subsidies: Lighthouse-type regional hospitals (starting in 2024) are regional hospitals that meet the criteria of this program and qualify as outlying island hospitals, designated emergency hospitals, and hospitals that are the sole medical facility in their township or district. These hospitals receive revenue subsidies or guarantees. In 2024, a total of 33 hospitals met the subsidy criteria.

Medicare Telemedicine Benefit Plan

Remote consultation (not limited to any western medicine specialty) or emergency remote consultation (not limited to any specialty) were set up to improve the accessibility of specialized outpatient services in remote areas. In 2024, specialized outpatient remote consultation services totaled 12,651 person-times, and emergency remote consultation services totaled 3,050 person-times.



Chapter



民眾滿意 國際肯定

**Public Satisfaction and
International Recognition**





民眾滿意 國際肯定

健保經驗 蜚聲國際

全民健康覆蓋（Universal Health Coverage）為聯合國永續發展目標的重要項目之一，其宗旨是為了保障每個人都能獲得基本的醫療照護服務，而我國自1995年開辦健保至今，即是為了讓全體國民均享有平等就醫的權利，提供民眾高可近性且低負擔的就醫環境。根據CEOWORLD雜誌（世界著名商業雜誌），2025年全球資料庫網站Numbeo公布的健康照護指標（Health Care Index），臺灣連續第七年排名第一，展現我國醫療衛生軟實力。

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

雙方資訊交流及人員訓練，以提升健保新藥給付評估及財務管理機制。為達成具體效益，自2023年起至2025年，每年辦理臺英醫療科技評估合作協議工作坊，邀請英國NICE來臺交流，探討癌症藥物基金的運營經驗與流程。

為更進一步優化我國醫療科技評估機制以強化健保財務，並與國際HTA組織建立合作關係，提升評估品質與決策透明度，2024年本署與法國國家健康管理機構（Haute Autorité de Santé, HAS）啟動雙邊交流，並於2025年2月7日正式簽署合作協議（Partnership Agreement, PA）。雙方將透過高層互訪、專業培訓及數位轉型經驗分享，深化HTA在創新醫療與財務永續，透過雙方經驗分享及合作，共同因應新醫療科技發展之挑戰，及提升兩國醫療服務品質。

在國際組織方面，亞太經濟合作會議（Asia-Pacific Economic Cooperation, APEC）為我國參與之重要國際組織之一，衛生議題亦是我國積極參與之領域，為強化與APEC經濟體之交流網絡及分享我國經驗實例，本署自2019年起，辦理APEC健保議題相關會議，並從2022年每年辦理會議至今。2024年9月3日舉行「APEC醫療科技評估與永續全民健康覆蓋工作坊」（APEC Workshop on Advancing Health Technology Assessment for Sustainable Universal Health Coverage），邀請美國、加拿大、新加坡、

Public Satisfaction and International Recognition

Global Recognition of Taiwan's NHI Achievements

A key component of the UN's sustainable development goals is universal health coverage, which aims to ensure that each individual has access to essential health care. Taiwan's NHI launched in 1995, was designed to guarantee equal rights to health care for all citizens while providing accessible, affordable services. According to the Health Care Index published by the internationally renowned CEOWORLD magazine, Taiwan has ranked first among for seven consecutive years through 2025, further underscoring the soft power of Taiwan's healthcare system.

In recent years, rapid advances in cancer treatment has placed increasing pressure on the limited NHI resources. Ahead of the 76th World Health Assembly in 2023, Dr. Chung-liang Shih, then Director General of the NHIA, Dr. Chao-Chun Wu, then Director General of Health Promotion Administration, and Shyr-Yi Lin, Executive Director of The Center for Drug Evaluation, visited the UK's National Institute for Health and Care Excellence (NICE) and National Health Service (NHS) officials to explore ways of ensuring timely access to advanced cancer therapies while safeguarding NHI sustainability. During the visit, discussions covered the Innovative Medicines Fund (IMF), Cancer Drugs Fund (CDF), Health Technology Assessment (HTA), and multiple financial management mechanisms. On May 18th, 2023, NHIA also signed a collaboration agreement with NICE. Efforts will focus on strengthening

personnel training, refining the assessment of NHI reimbursement for new drugs, and enhancing financial management mechanisms. To achieve concrete benefits, from 2023 to 2025, Taiwan's NHIA has annually hosted Workshop for Partnership Agreement between Taiwan and the UK on Health Technology Assessment, inviting experts from the UK's National Institute for Health and Care Excellence (NICE) to Taiwan to exchange and share operational experiences regarding the mechanisms and processes of cancer drug funds.

To further optimize Taiwan's health technology assessment (HTA) mechanisms, strengthen the financial sustainability of the National Health Insurance, and establish cooperative ties with international HTA organizations to enhance assessment quality and decision-making transparency, the NHIA launched bilateral exchanges with France's Haute Autorité de Santé (HAS) in 2024. On February 7, 2025, the two sides formally signed a Partnership Agreement (PA). Both parties will deepen HTA collaboration in innovative healthcare and financial sustainability through high-level visits, professional training, and the sharing of digital transformation experience. By exchanging expertise and fostering cooperation, Taiwan and France will jointly address the challenges of emerging health technology development and improve the quality of healthcare services in both countries.

Regarding international organizations, the Asia-Pacific Economic Cooperation (APEC) forum is a leading international organization in which



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馬來西亞、菲律賓、泰國、越南、印尼、澳洲及秘魯等12國APEC經濟體衛生部官員以及包含英國及貝里斯等國內外產、官、學、研等各界專業人士100餘人與會，攜手亞太區域夥伴深化HTA能力，建構全民健康覆蓋，藉此更進一步促進我國與亞太區域外合作交流契機，深化國際聯繫網絡。2025年主辦台灣全球健康福祉論壇，以「健保30 共創永續未來」(Taiwan National Health Insurance at 30: Toward Sustainable Success in the 21st Century) 為主題，探討全民健保制度實踐健康平權與面對高齡化社會的創新思維，例如運用智慧醫療與全人整合性照護制度，促進全體國人健康與邁向健保永續。論壇吸引

13國25位衛生部長、次長級高階衛生官員出席，及10國40位國際重量級專家學者到訪演講交流。

為推動健保資訊系統升級並與國際標準接軌，並驅動國內各醫療體系加速數位轉型，進而提升醫療品質與效率，健保署和美國醫療資訊暨管理系統協會（Healthcare Information and Management Systems Society, HIMSS）於2023年11月13日共同簽署合作備忘錄，未來將深化雙方資訊交流及人員訓練，以加強我國醫療體系資訊管理系統、強化資訊安全韌性，並接軌國際醫療資訊標準，加速醫療體系成功數位轉型。

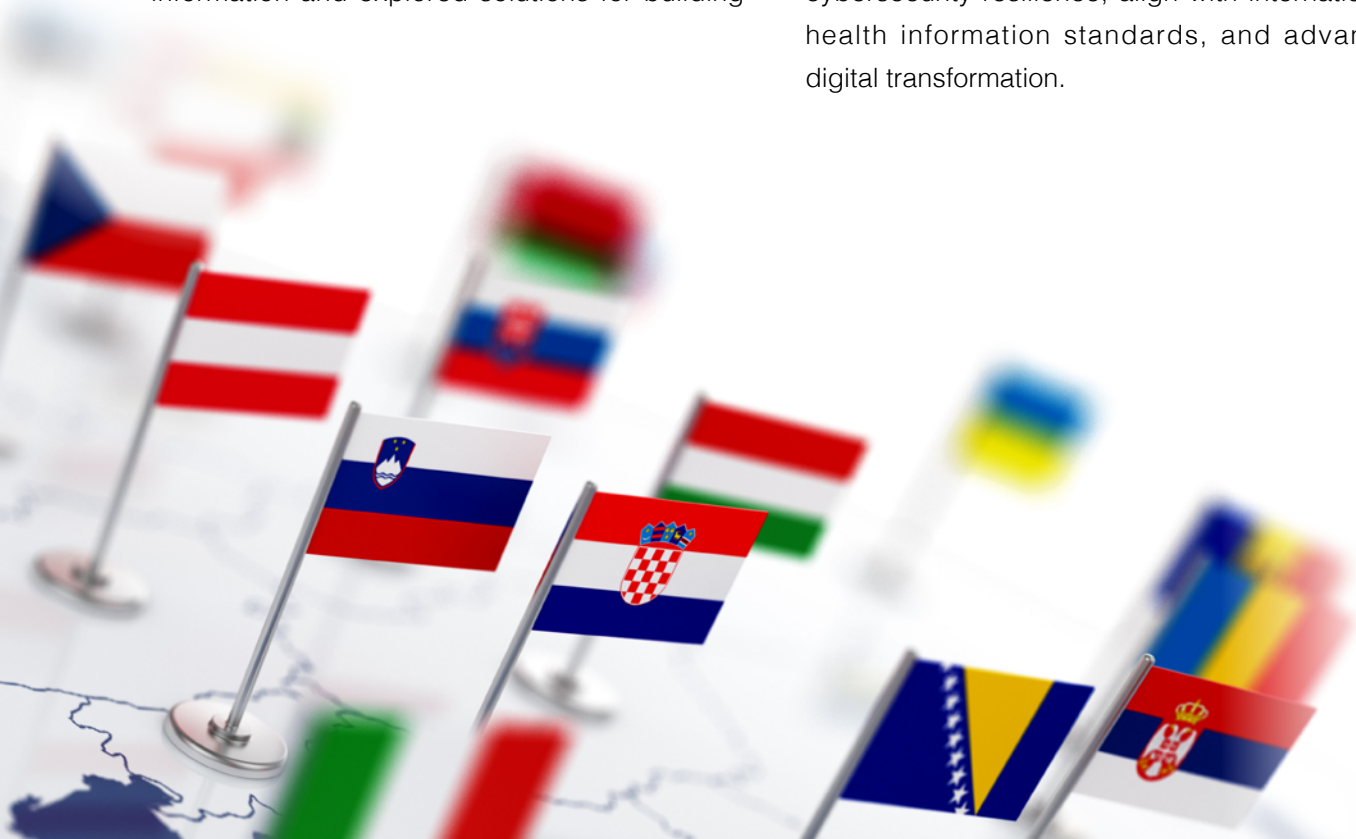


Taiwan actively participates, with health as a key area of engagement. To strengthen the APEC economic network and share Taiwan's practical experiences, the NHIA has been organizing APEC health insurance-related meetings since 2019, and has held them annually since 2022. On September 3rd, 2024, we hosted the "APEC Workshop on Advancing Health Technology Assessment for Sustainable Universal Health Coverage," which brought together health ministry officials from 12 APEC economies, including the United States, Canada, Singapore, Malaysia, the Philippines, Thailand, Vietnam, Indonesia, Australia, and Peru, along with more than 100 experts from industry, government, academia, and research sectors from Taiwan and abroad, including the United Kingdom and Belize.

By working hand in hand with Asia-Pacific partners to strengthen HTA capability and advance universal health coverage, the workshop also enhanced the application of digital health information and explored solutions for building

a resilient health care system in the region, thereby strengthening Taiwan's international collaboration. The event served as an important platform for showcasing Taiwan's National Health Insurance system and policy experience, attracting 25 ministers of health and senior health officials from 13 countries, as well as 40 internationally renowned experts and scholars from 10 countries visited Taiwan to deliver keynote speeches and engage in in-depth policy dialogues and knowledge exchange.

To upgrade the NHI information system, align with international standards, and accelerate the digital transformation of Taiwan's healthcare systems, efforts are being made to further improve health quality and efficiency, on November 13th, 2023, the NHIA and the Healthcare Information and Management Systems Society (HIMSS) signed an agreement to deepen personnel training, promote information exchange, strengthen domestic health information management and cybersecurity resilience, align with international health information standards, and advance digital transformation.





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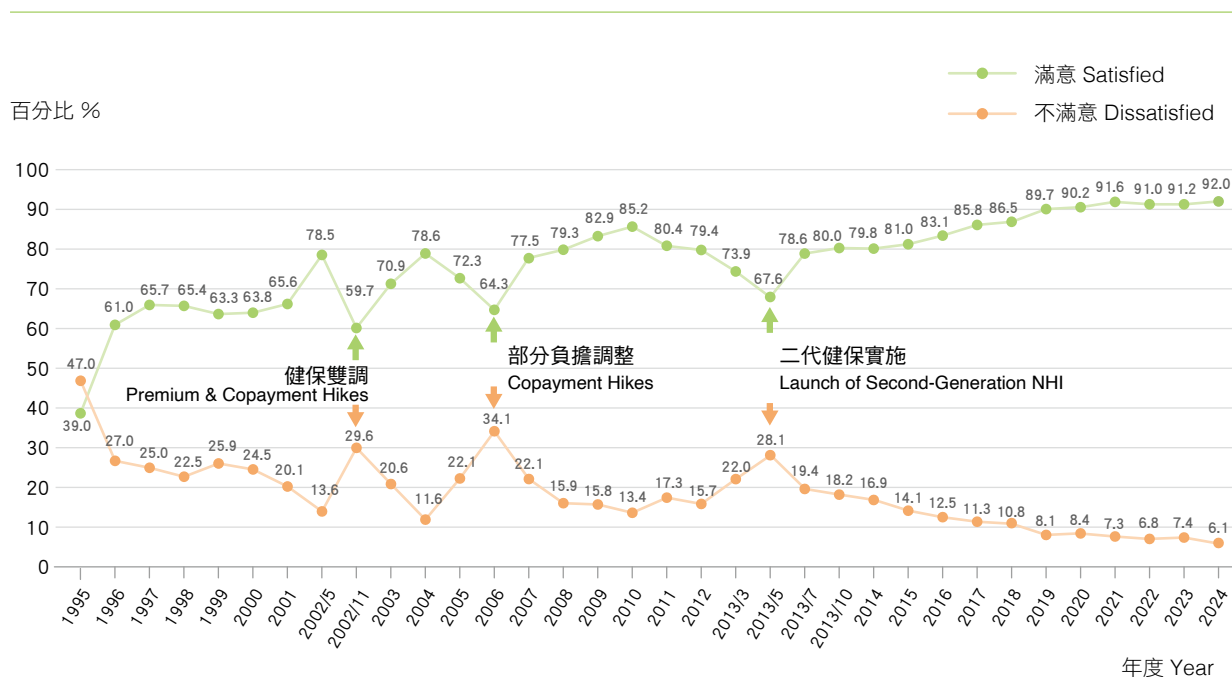
全民健保 民眾滿意

全民健保實施曾面臨諸多困難，從一開始的滿意度不到4成，到目前持續成長至8成以上，顯見民眾十分肯定。其中曾因2002年度保險費率及部分負擔調整，以及2005年度開始進行多元微調，導致民眾對全民健保的滿意度稍有下降，但隨後即快速回升至7成以上。2013年1月起二代健保實施，針對所得收入高者加收補充保險費，滿意度曾一度下滑後隨即回穩至8成左右，自2020年起民眾對健保的滿意度連續5年超過9成（圖7-1），我國因有全

民健保，對經濟弱勢民眾的健康照護更能提供完善的醫療保障。

充分發揮 互助功能

全民健保的核心價值在於透過社會互助，以「社會保險」的形式，來分擔保險對象罹病時的財務風險。重大傷病人口占全體保險對象人數的4.2%，醫療費用卻高達健保總醫療支出的28.4%。其中，癌症、洗腎及血友病等重大傷病之平均醫療費用是一般人的5.5倍到76.3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）。



註：1.2002年，保險費率及部分負擔調整。

2.2005年，投保金額上限、軍公教人員投保金額及菸品健康捐金額等調整。

3.2013年，二代健保實施。

Notes:1. The premium rate and copayments were increased in 2002.

2. The upper limit of payroll brackets, payroll brackets for military, civil service, and teaching personnel, and the amount of tobacco health and welfare surcharges were adjusted in 2005.

3. Second-Generation NHI was implemented in 2013.

圖7-1 全民健保滿意度趨勢圖
Chart 7-1 Public Satisfaction with NHI

High Satisfaction with NHI

NHI has endured quite a few difficulties over the years. However, NHI has come to enjoy a high level of public satisfaction, with an over 90% approval rate in comparison with a low of less than 40% in the early days. Indeed, public satisfaction with NHI sustained a slight decrease due to increases in the premium rate and copayments in 2002 and some further fine tuning of the system in 2005, but a rebound to over 70% soon followed. Likewise, another decrease following Second-Generation NHI's imposition of supplementary premiums on high income households in January 2013 was soon followed by a recovery to around 80%. For five straight years (since 2020), public satisfaction with NHI stayed above 90% (Chart 7-1). Thanks to NHI, Taiwan is able to provide comprehensive medical protection to even the economically underprivileged.

Maximizing the Power of Mutual Assistance

NHI's core value lies in drawing from a social insurance mechanism in which the financial risk of illness is dispersed among the insured through mutual assistance. For instance, although persons with catastrophic illnesses and injuries account for only 4.2% of all patients, they also account for as much as 28.4% of all NHI medical outlay. In particular, such catastrophic illnesses as cancer, conditions requiring dialysis, and hemophilia incur medical expenses 5.5-76.3 times average spending. This clearly attests to NHI's playing the crucial role of mutual assistance in social insurance, ensuring that patients with major illnesses are not driven into poverty (Table 7-1).

表7-1 健保醫療資源利用情形

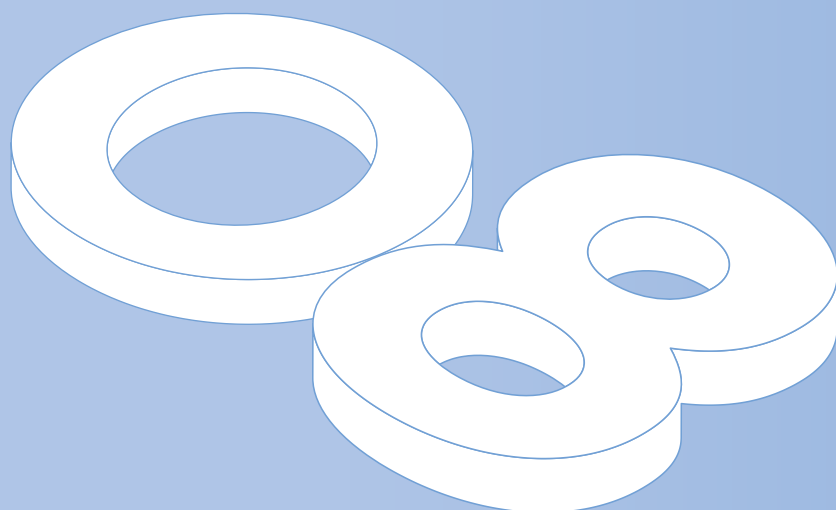
Table 7-1 Utilization of NHI Medical Resources

類別 Category	醫療費用（點） Medical expenses (points)	平均值倍數 Multiple of average
全國每人平均 Nationwide average	38,855	1.0
每一重大傷病患者 Each catastrophic illness patient	245,050	6.3
每一癌症患者 Each cancer patient	214,824	5.5
每一罕病患者 Each rare disease patient	861,799	22.2
每一洗腎患者 Each dialysis patient	654,905	16.9
每一呼吸器患者 Each ventilator patient	819,790	21.1
每一血友病患者 Each hemophilia patient	2,965,380	76.3

註：以2024年重大傷病年度統計資料為例。

Note: Based on 2024 statistics for catastrophic illnesses and injuries.

Chapter



跨步精進 展望未來

Progress and Prospects





跨步精進 展望未來

我國全民健保落實WHO Universal Health Coverage之重要社會制度，走過從前、邁向未來，在人口高齡化及醫療資源有限情形下，為健保永續發展，將以「體系、財務、科技、法治、社會溝通」五大面向，以發展全人照護、力推數位醫療，推動各項革新措施，並規劃遠景藍圖：

以人為本 建構全人全程照護體系

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

慢性病門診整合，協助處理安排病人轉診及追蹤治療結果，以提升慢性病人照護品質。透過提升服務涵蓋率、數位化追蹤管理、支付制度調整、精進醫療品質等四大面向，打造大家醫計畫，以家庭醫師為平台，向前延伸居家醫療整合照護計畫、代謝症候群防治計畫等政策，透過健康存摺獲得個人化的整合性照護，提供相關衛教，提升民眾自我照護的能力，落實初期照護精神。向後銜接病人出院後持續性照護，推動出院準備服務、急性後期照護，銜接居家安寧及長照服務，解決高齡化社會引發的醫療需求問題，持續以民眾健康為導向，落實全人、全家、全社區的整合照護。



Progress and Prospects

NHI is an important social system for implementing the WHO's Universal Health Coverage. As we reflect on the past and move towards the future, with the challenges posed by an aging population and limited healthcare resources, NHI sustainability efforts will be made on five key fronts: system enhancement, financial stability, technological advancements, legal governance, and social communication. Developing holistic care, promoting digital healthcare, and undertaking various reforms will be our blueprint for the future:

Creating a People-Centered Continuous Holistic Care System

The NHIA promotes people-centered healthcare and empowers individuals to manage their health. By gradually integrating the NHI Family Physician Plan and Pay-for-Performance scheme, we target on patients with diabetes and early-stage chronic kidney diseases. The aim is that family doctors can manage each patient's case to give a referral and keep track of patients' development with the integration of multiple chronic disease clinics. By expanding service coverage, digitizing tracking and management, adjusting the payment system, and enhancing healthcare quality, the NHIA Grand Family Physician Plan uses family physicians as the platform to undertake home health care integration and metabolic syndrome prevention and treatment, among other programs. My Health Bank acts as the foundation for delivering personalized and integrated home care with

health education to enhance people's self-care capability to implement the spirit of initial care. Emphasis is placed on offering continuous care for patients after hospital discharge. High on the list are discharge preparation services and post-acute care for seamless integration with home hospice and long-term care services. As society ages, a people-centered approach will prove crucial to providing continuous, holistic and whole family and community healthcare to the entire population.

Promoting NHI Digitization and Healthcare Transformation

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

In addition, the "My Health Bank App" also doubles as an interface for mobile payments to help promote a truly intelligent mode of seeking



健保數位升級 推動醫療轉型

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

另外，透過全民健保行動快易通 | 健康存摺App介接行動支付，完善智慧化就醫模式；利用健康存摺資料介接服務（Software Development Kit, SDK）開放結合產業，在民眾的授權使用下，體驗更完整的數位照護，並於2024年3月12日公告修訂「健康存摺系統軟體開發套件使用管理要點」，精進個人資料安全管理。

另外，在賴政府所提「三高防治 888 計畫」讓 80% 慢性病患納入以病人為中心的全人整合照護之目標下，本署運用健康數據管理

優勢，結合學研團體研究量能，開發疾病嚴重度分級及分流管理機制，並將利用AI模型生成個人化糖尿病風險智能衛教資訊。

強化資料治理 健保永續發展

配合憲法法庭2022年憲判字第13號對健保資料應用與個人資料保護法相關疑義判決，衛生福利部著手制定專法予以規範，立法院已於2025年12月通過「全民健康保險資料管理條例」。未來健保署對於全民健康保險法所定原始特定蒐集目的外之利用，將依循該專法於保護個人隱私及符合資安規範下，加值健保資料之應用價值，以強化支援決策及增進學術研究量能。

健保署以民眾為中心，為發展醫療研究，精進全民健康照護，未來持續強化健保資料目的外利用之管理機制及法制規範，在保障個人資訊隱私權益前提下，提升資訊安全及創造資料運用價值，並導入創新科技，透過客服中心、全球資訊網、FB、LINE@、IG等服務管道，提升為民服務品質，強化與各部會、醫界及民眾溝通，透過多元管道宣導珍惜醫療資源，促進醫療服務效率，使健保效益極大化，共創健保永續發展。



medical attention. The My Health Bank Data Interface Service (Software Development Kit, SDK) is also now available to further expand My Health Bank's applications. With the authorization of citizens, these initiatives will provide them with more complete digital care. Moreover, on March 12th, 2024, the revised Use Directions for My Health Bank Software Development Kit were announced to enhance personal data security management.

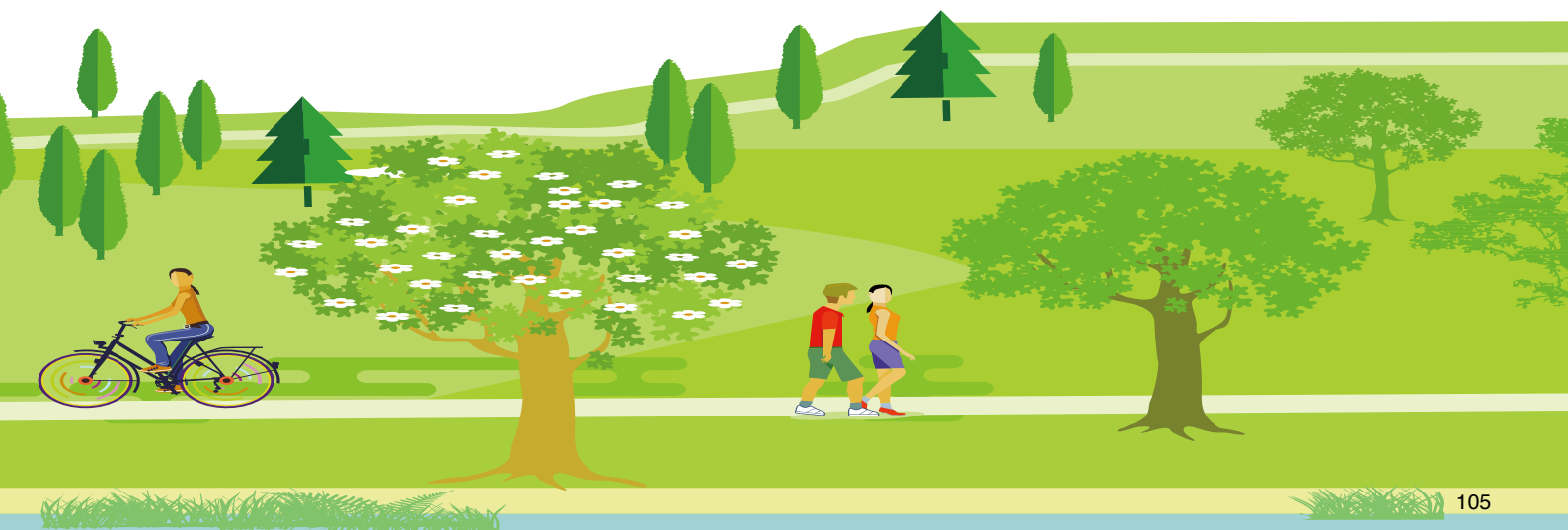
In addition, under the Lai administration's "Three Highs Prevention 888 Plan," which aims to include 80% of chronic disease patients in patient-centered holistic integrated care. The NHIA is leveraging its strengths in health data management and collaborating with academic and research institutions to develop a disease-severity stratification and triage management mechanism. It will also utilize AI models to generate personalized, intelligent diabetes-risk health education information.

Refining Data Governance Mechanisms for NHI Sustainability

In response to the 2022 ruling by Taiwan's Constitutional Court (Judgment 111-Hsien-Pan-13), which raised concerns about the

application of NHI data in relation to the Personal Data Protection Act, the MOHW has enacted the "National Health Insurance Data Management Statute." Passed by the Legislative Yuan in December 2025, this law will regulate the NHIA in safeguarding individual privacy and ensuring compliance with information security policies. Moving forward, the NHIA will adhere to this law to enhance the use of NHI data, strengthen decision-making processes, and improve academic research capabilities.

Always placing people first, the NHIA will continue to strengthen the mechanisms and legal regulations for managing NHI data beyond its original purposes, protect personal information and enhance information security, and create value from data utilization. Innovative technologies will be introduced to enhance the quality of services through such channels as its customer service center and website, Facebook, Line@ and IG. The NHIA will also strengthen communication with various government agencies, the medical community, and the general public to promote awareness of the importance of treasuring healthcare resources, enhance efficiency in healthcare services, and maximize NHI benefits, ensuring NHI's sustainable development.





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National Health Insurance

2025 – 2026 Annual Report

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