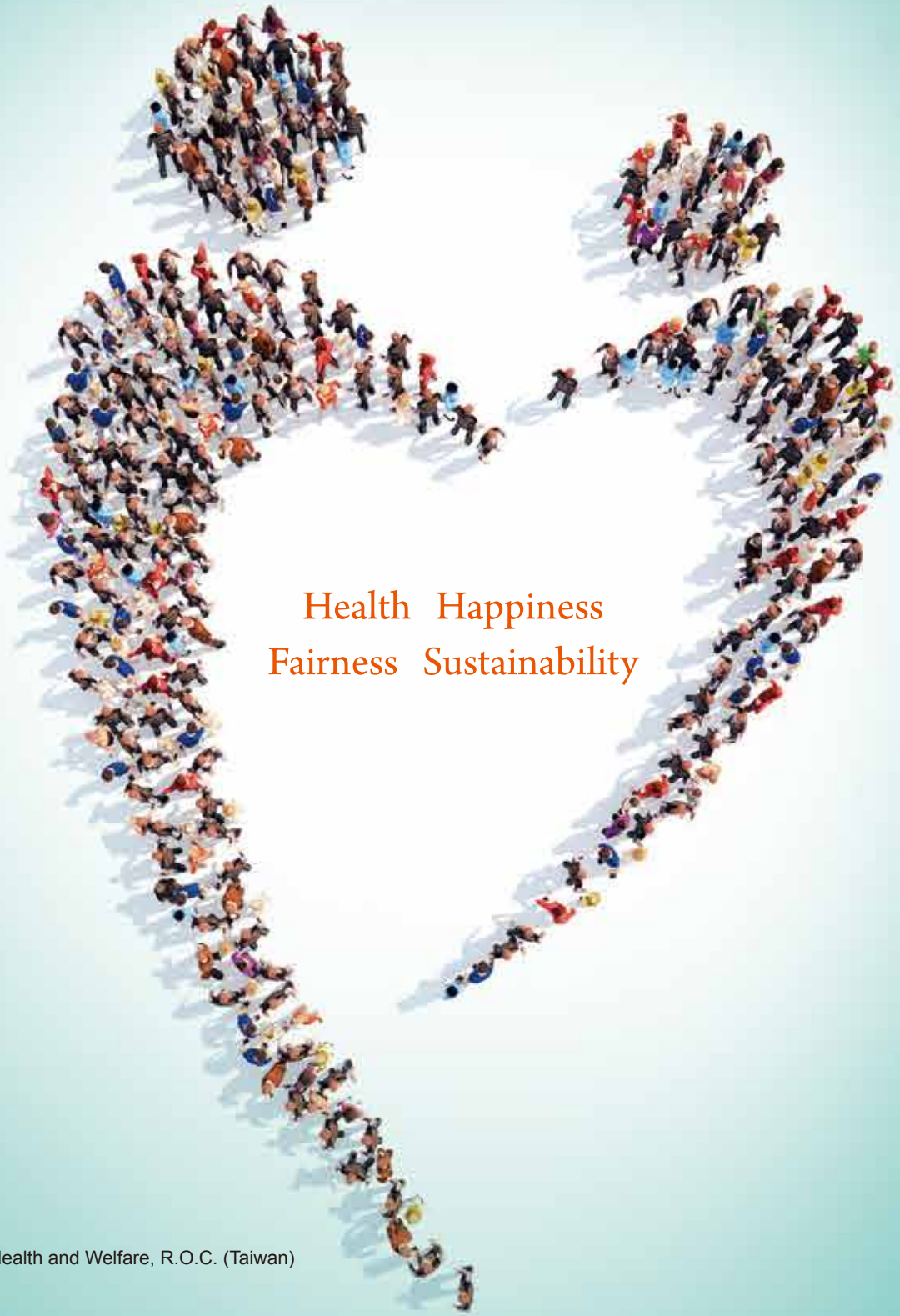
ISSN-24092630

2016 Taiwan Health and Welfare Report



Health Happiness
Fairness Sustainability

Ministry of Health and Welfare, R.O.C. (Taiwan)

Taiwan Health and Welfare Report 2016

Adhering to the Whole-Person Care Value,

Achieving Holistic Health and Social Welfare Policies.

Ministry of Health and Welfare, R.O.C.(Taiwan)

Foreword

The Ministry of Health and Welfare's responsibilities include health planning and promotion, prevention and control of disease, food safety, drug management, social insurance, and welfare, relief and protective services. Our mandate also includes biotechnology R&D, international health cooperation, and diverse other areas affecting public health and well-being far beyond Taiwan.

To explain our agency's health and social administration initiatives, we publish this annual report outlining our major policies and their concrete results.

Some important trends continue to develop. Taiwan has officially been an "aging society" since 1993, and the government has been building better living environments and a long-term care system for senior citizens. This system focuses on economic security, health care and maintenance, and living care.

June 2015 saw the enactment of the Long-term Care Services Act, which will be implemented beginning in 2017. Our agency continues to formulate the Act's sub-statutes and ancillary measures, and to implement the plan's second phase. This will coordinate provision of LTC resources, strengthen worker training, and make LTC more widely available and more closely integrated with communities. We established an LTC Development Fund to foster community-based care models that can optimally serve Taiwan's aging society.

We are expanding our efforts to address violence by providing various protective services. The Legislative Yuan approved Sexual Assault Prevention Law revisions that require an expert in a relevant field to be present when children and mentally handicapped persons are interviewed by police or judicial authorities. The Domestic Violence Prevention Act has also been revised so children who witness incidents of domestic violence can be included in protection orders. The duration of regular protection orders has been extended, and threatening behavior by non-household members is now covered by the Act.

We are promoting a revised Child and Youth Sexual Transaction Prevention Act, including renaming this as the Statute to Prevent Childhood Sexual Exploitation. This reflects the revision's wider scope, as it expands prohibitions against using children in sexual performances, making children accompany bar patrons, and involving children in sexual escort services. Regulatory authorities are encouraged to work with parents and children, and penalties have been added and made more severe.

The Formosa Fun Coast explosion occurred on June 27, 2015, when flammable starch-based color powder exploded and burned 499 people in an open-air "color party." On average, these patients had burns over 41% of their skin; 41 had burns over 80% or more of their skin. Our Ministry quickly mobilized hospitals in the Taipei, Taoyuan and Keelung areas to provide first-line emergency services; 53 more hospitals in 12 counties and cities provided follow-up treatment for this unprecedented number of burn patients.

Committed to supporting these explosion victims regardless of cost, the Ministry's dedicated project team scrambled to arrange funding for their care. Daily meetings were held about allocation of medical resources, supplies and equipment, and about funding medical expenses and providing psychological support services. Central and local government health and welfare agencies worked together with care providers, and the overall high standard of medical care saved many young lives. Taiwan's smooth handling of this disaster won widespread praise from the international community with regard to coordinated disaster response by medical and social welfare service providers.

In the area of contagious disease prevention, we continue to promote epidemic monitoring and surveys, disease prevention efforts and research, and preventive inoculation programs. The Communicable Disease Control Act was amended to expand infection control work in services for older adults, nursing homes, long-term care institutions, residential child care facilities, correctional facilities, etc. To expand infant immunization and care, in 2015 Pneumococcal Conjugate Vaccine was added to the list of required vaccinations.

To promote food safety, our Ministry is implementing stronger restaurant sanitation standards, including food products vendor registration. We require the food industry to implement compulsory testing, and we have promoted food product traceability systems. We work closely with local public health bureaus on food product testing, monitoring and auditing. The year 2015 also saw the launch of the #1919 National Food Safety Hotline, through which businesses and citizens can submit petitions or complaints, report questionable behavior, and request advice promptly.

Also in 2015, the Pharmaceutical Affairs Act was revised to establish a traceability mechanism and a notification mechanism for supply shortages. Other changes include assistive measures to make pharmaceuticals-related data easier to read, and a case-by-case approval mechanism for emergency pharmaceutical needs. Pharmaceuticals registration criteria now address sourcing to strengthen quality management.

Looking back over 2015, our Ministry faced many challenges. We continue to pursue the goals of effective teamwork and coordinated planning for health and welfare services that meet citizens' changing needs. I hope this report helps citizens understand the past year's issues and gains -- and earnestly hope readers will forward comments and criticism that can help us better meet Taiwan's wellness needs.

Minister of Health and Welfare

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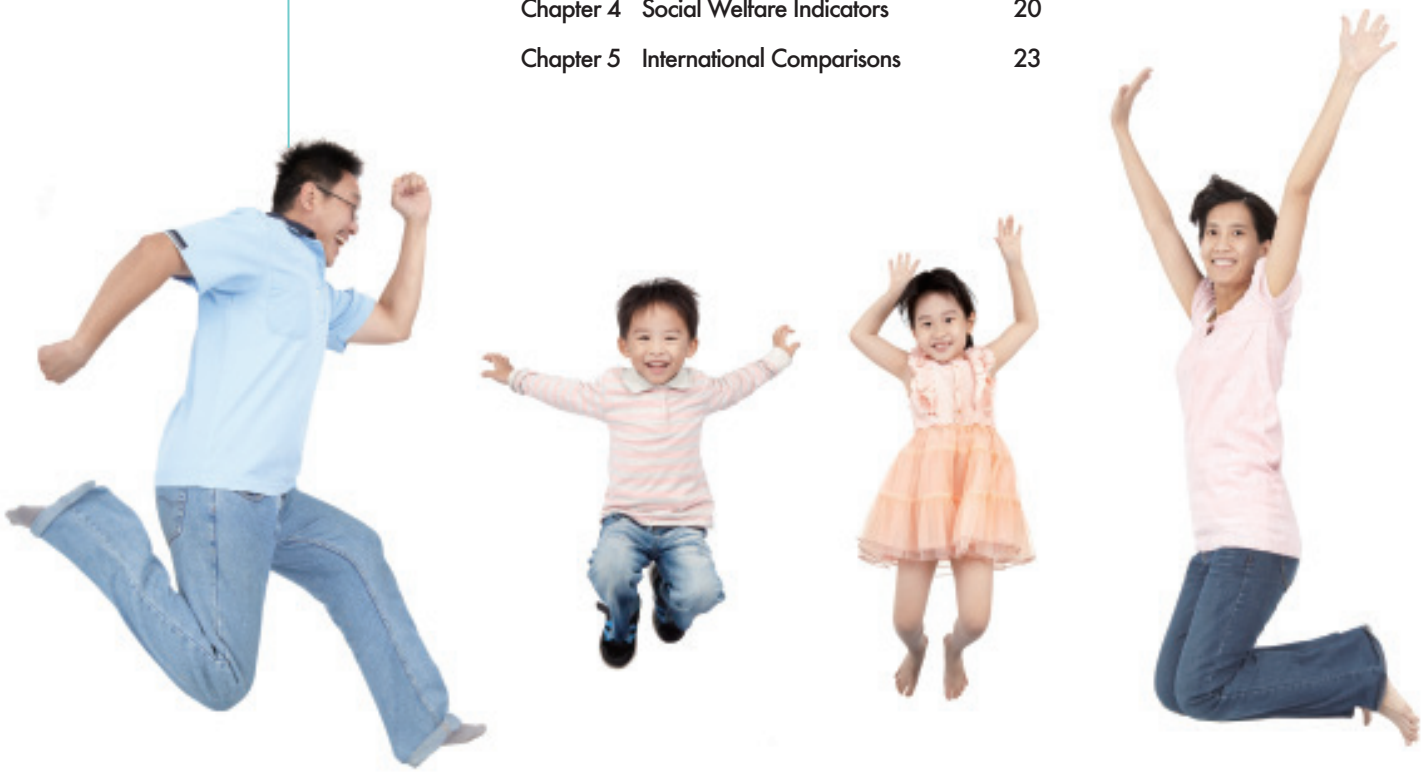

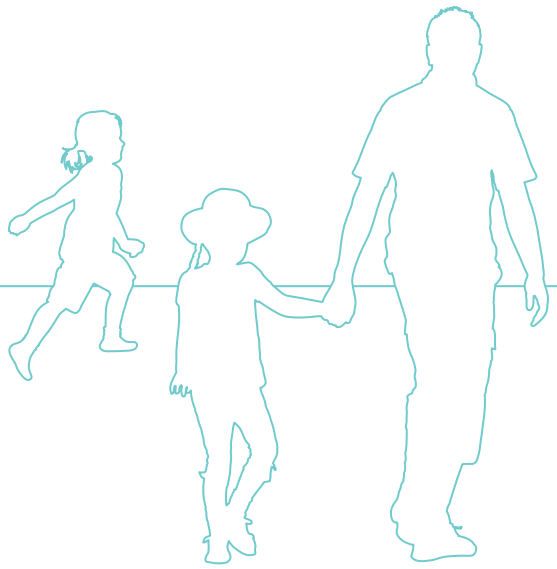

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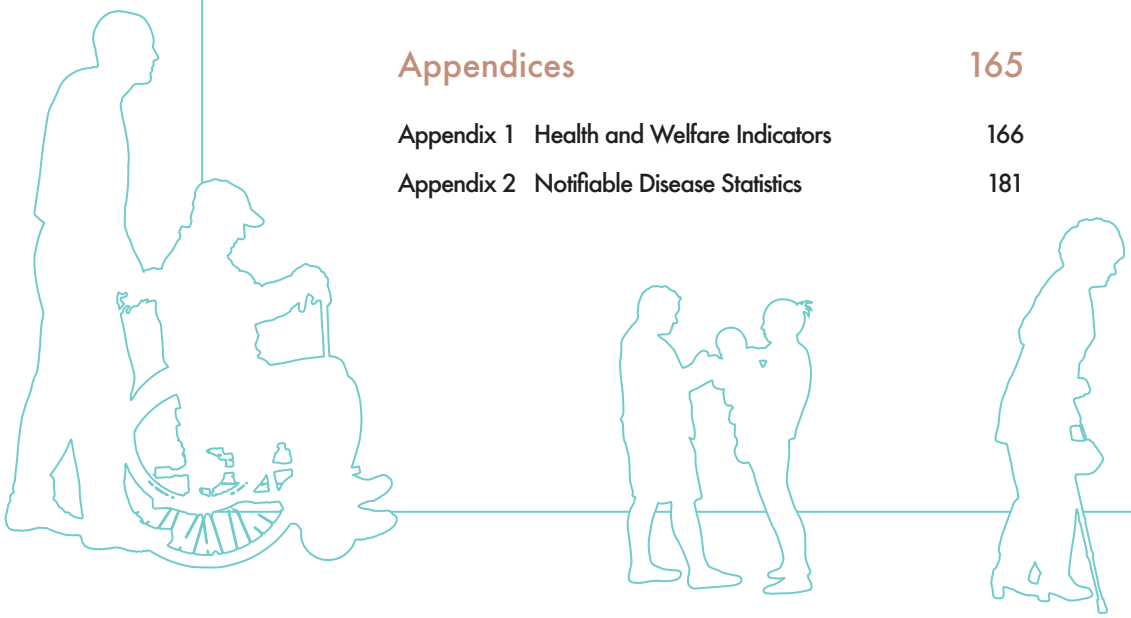


1 Health and Welfare Policies

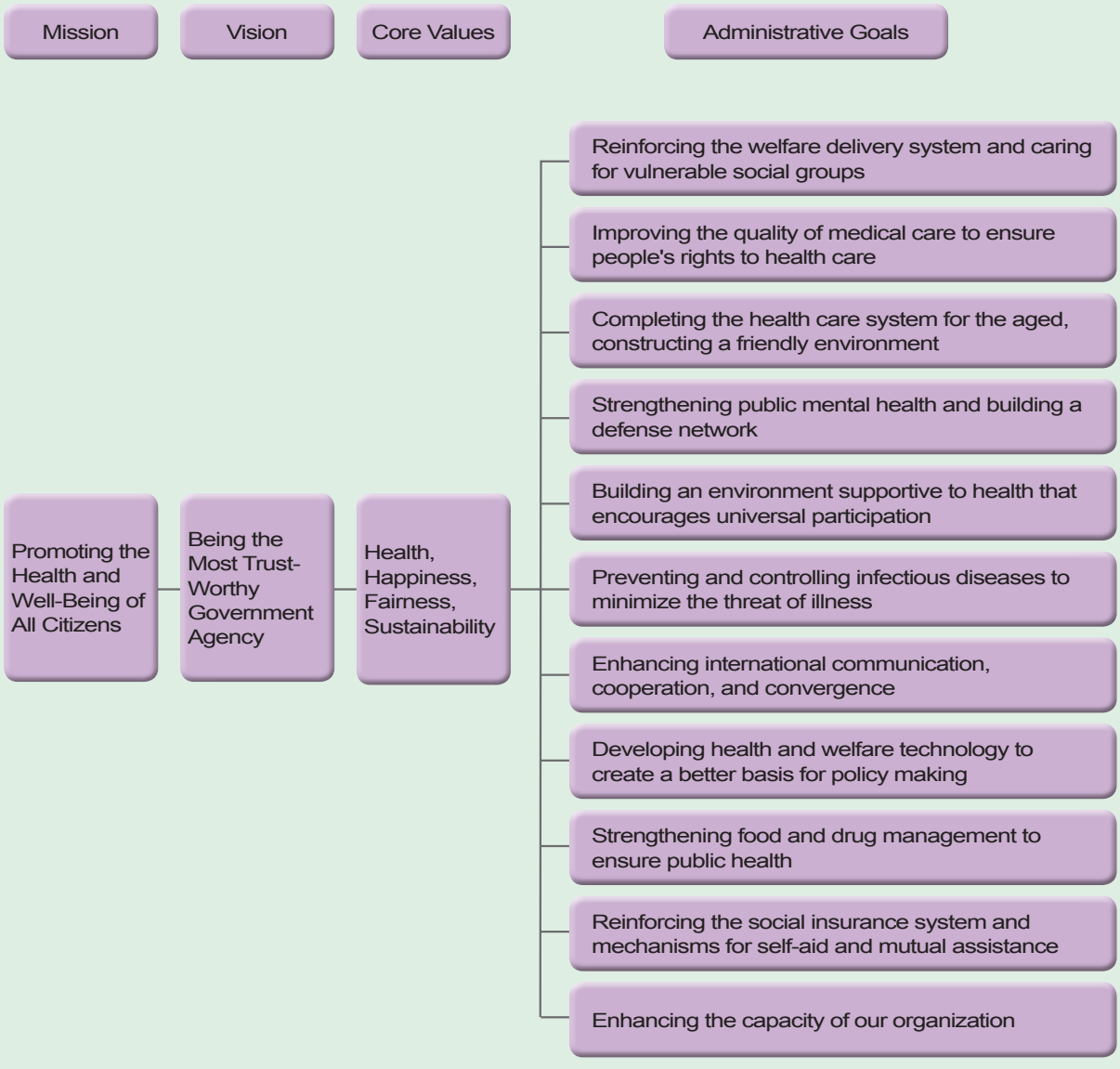
In order to safeguard the health and well-being of all citizens, the Ministry of Health and Welfare (MOHW) integrates social welfare and healthcare resources with globalized, localized, and innovative thinking. Our ministry has also diligently planned and laid out the blueprint for emerging issues in the delivery of welfare services, care for the disadvantaged, medical care, national health insurance, health promotion, disease control, and food and drug management. Through formulating cohesive public policies, we hope to provide comprehensive services to achieve the mission of promoting the health and well-being of all citizens and the vision of being the most trustworthy government agency. The MOHW aspires to shape a happier and healthier nation.

Chapter 1 Administrative Goals

Section 1 Annual Administrative Goals

In accordance with the 2015 administrative policy guidelines of the Executive Yuan, as well as social circumstances and national developmental needs, the MOHW established 11 major administrative goals for 2015 to fulfill the mission of promoting public health and well-being (Figure 1-1).

Figure 1-1 Administrative Goals of the MOHW, 2015



The MOHW was honored by the Executive Yuan at its 14th awards ceremony for the promotion of gender equality.

Section 2 Health and Welfare Policies for 2025

In recent years, globalization, the aging of the population, wealth inequality, and climate change have increased the threats posed by the burden of disease, insufficient long-term care (LTC) capacity, unequal distribution of resources, and emerging infectious diseases. These changes have intensely increased the challenges associated with national health and welfare policy planning. Faced with these threats, the MOHW integrated both health care and social welfare systems to provide holistic care, to fulfill future social needs and to advance public health and welfare; we compiled the 2025 White Paper on Health and Welfare Policy.

This white paper, which lays out a policy blueprint for the future health and welfare of Taiwan, is the fruit of more than two years of discussion and over 40 internal and expert conferences, and upholding the 2030 sustainable development goals (SDGs), World Health Organization(WHO), we took health, happiness, fairness, and sustainability as core values and aimed to achieve the objectives of "shared happiness and equality; assured holistic health care at every age." The major policies are:

1. Promoting holistic health care strategies at every age, reinforcing noncommunicable disease control systems and enhancing individual health behaviors with a lifecycle model.
2. Reconstructing health service systems by building an integrated holistic care system, strengthening disease control networks and constructing a safe consumer environment for food and drugs.
3. Strengthening the health insurance and pension systems by bringing greater quality, efficiency, and fairness to revision and review in order to achieve sustainable development.
4. Focusing on distribution of social welfare resources in order to build an excellent LTC service system that improves the overall social welfare support system.
5. Strengthening innovative applications of health and welfare information in order to increase the accessibility of health care and social welfare services.
6. Enhancing international participation, increasing our international prestige with professional images.

Section 3 Strategies for Promoting Gender Equality

In response to the attention placed on gender equality issues around the world and to promote gender equality, the MOHW complies with policies set forth by the Gender Equality Committee of the Executive Yuan. When formulating policies, plans, and other measures, the MOHW proactively incorporates gender considerations and is committed to promoting gender mainstreaming and implementing of the gender equality policy program as well as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and related actions. These measures are taken to improve gender equality in the areas of health, medical care, and social welfare.

Policies associated with women's rights must go beyond subsidies and assistance to achieve the greater goal of cultivating women who are economically independent and have high self-worth. To that end, the MOHW has implemented the Action Plan for Building Happy Living Environments for Women. The plan has subsidized the construction of Women's Dreams Pavilions and

Women's Welfare Centers by local governments, so women have a grassroots platform for social participation, study, and growth. This has empowered women's organizations, which in turn encourage women to bravely pursue their dreams, making them more employable and more competitive in order to reach the goal of economic independence.

In order to implement CEDAW and ensure women's right to health, the MOHW provides all pertinent health measures focused on women's special needs. Included are ongoing efforts to build an excellent reproductive health services system that provides appropriate health care before and during pregnancy and childbirth. Through the Mother-Friendly Childbirth Hospital Pilot Program, the MOHW also encourages obstetricians to work with medically trained midwives to improve the quality of obstetric care.

For women's safety, gender mainstreaming is adopted when planning ways to increase the rate of risk analysis for women in abusive relationships. Gender statistics shed light on cases of domestic violence, so at-risk women can be identified early and intervention can prevent them from being subjected to additional harm.

Chapter 2 Health and Welfare Organization

Formally established on July 23, 2013, the MOHW consists of eight departments, six administrative departments, seven mission-oriented units, and six affiliated third-level agencies (institutes). It oversees 26 hospitals and 13 social welfare institutions, as shown in Figure 1-2. The MOHW is responsible for health promotion, disease control, food and drug management, medical care, social insurance, social welfare, social assistance, and protective services.

Chapter 3 Health and Welfare Budget

Final accounts from 2015 showed health and welfare expenditures of NTD175,772,841,000, comprising NTD132,649,494,000 for social insurance (accounting for 75.47% of the total), NTD18,820,552,000 for welfare services (10.71%), NTD18,761,080,000 for medical and health care (10.67%), NTD4,069,984,000 for science (2.31%), NTD1,407,400,000 for social assistance (0.80%), and NTD64,331,000 for education (0.04%), as illustrated in Figure 1-3.

The total budget for 2016 is NTD198,667,127,000, comprising NTD153,980,938,000 for social insurance (77.51%), NTD19,272,773,000 for welfare services (9.70%), NTD19,124,980,000 for medical and health care (9.63%), NTD4,655,656,000 for science (2.34%), NTD1,526,274,000 for social assistance (0.77%), and NTD106,506,000 for education (0.05%), as illustrated in Figure 1-4.

Figure 1-2 Organization of the Ministry of Health and Welfare (MOHW)

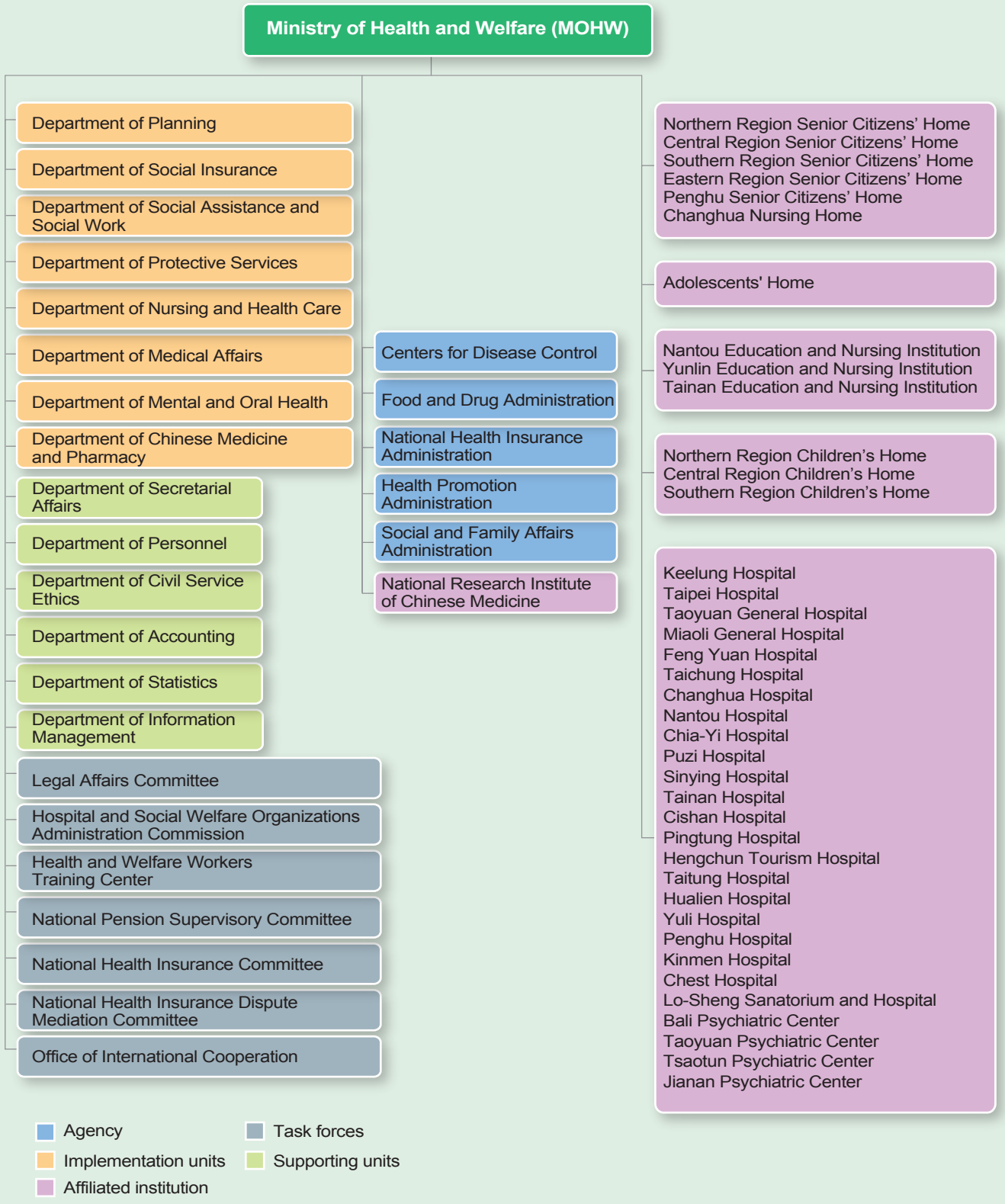
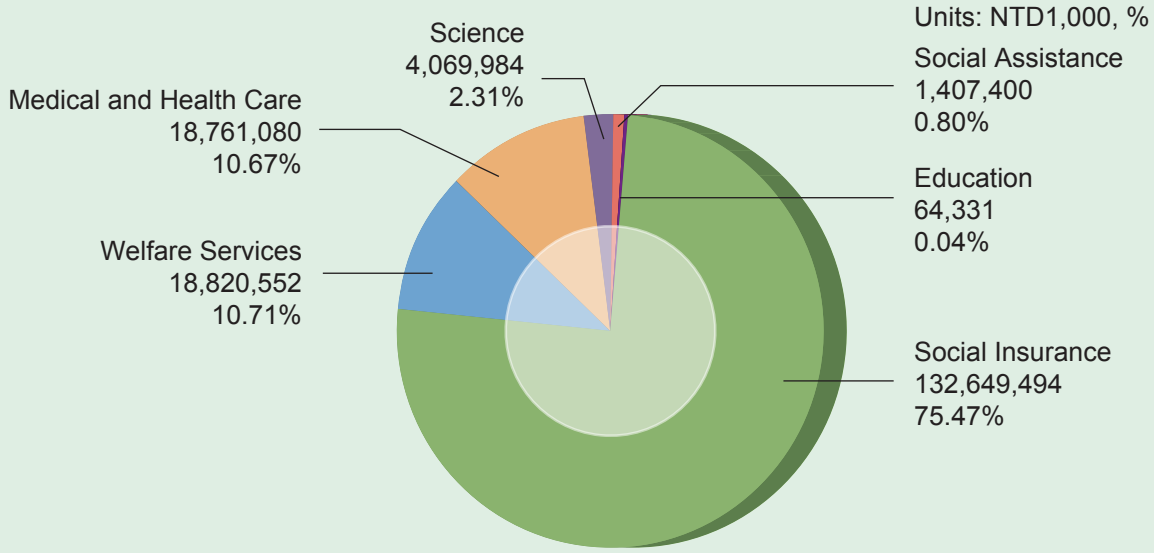
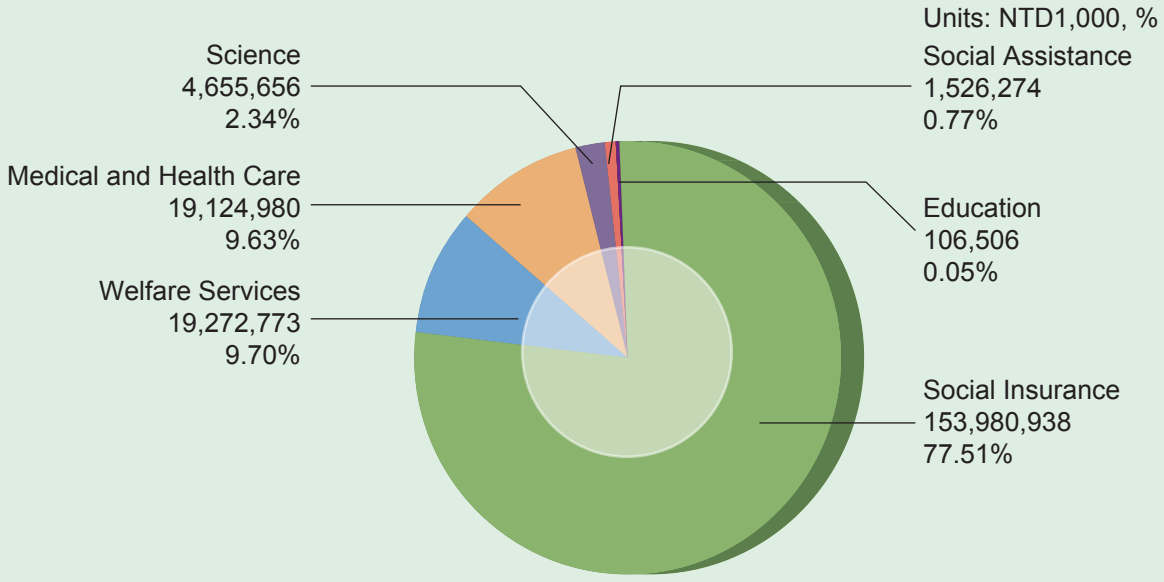


Figure 1-3 Distribution of 2015 Health and Welfare Final Account Expenditures



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Figure 1-4 Distribution of 2016 Health and Welfare Budget



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

2 Health and Welfare Indicators

In Taiwan, the gradual increase in life expectancy over the past half century is attributable to many factors, including growth of initial income level, improved living environment, improved nutrition, and medicine and health care advancement.

As baby boomers enter into aging population, aging-related health problems and diseases has been the main focus during the past years. Furthermore, the low birth rate has affected economic growth and the structure of health care demand.

In this section, core health and welfare indicators are examined, these indicators include population indicators, vital indicators, National Health Expenditure (NHE), social welfare indicators, International comparisons are also provided.

Chapter 1 Population Indicators

At the end of 2015, Taiwan had a registered population of 23.5 million, consisting of 11.7 million males and 11.8 million females. The sex ratio (the ratio of males to females in a population) was 99.4%, annual population growth rate was 2.5‰.

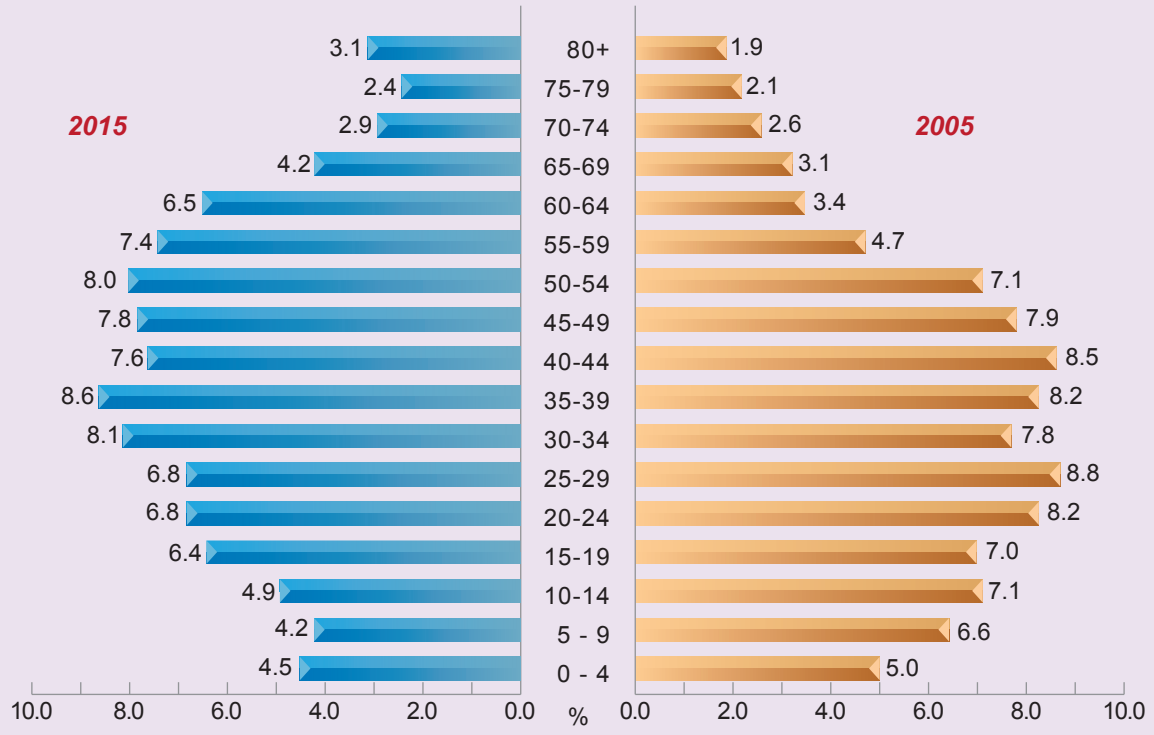
The population density at the end of 2015 was 649 people per square kilometers. The densest city was Taipei city, at 9,951/km^2, followed by Chiayi City, at 4,504/km^2. The least dense areas were Hualien County and Taitung County, at 72/km^2 and 63/km^2.

Section 1 Population Age Structure

Between 2005 and 2015, the gradually declining birth rate resulted in decreases proportion of young population and increased the proportion of elderly population (Figure 2-1).

Historical data showed that the percentage of the population aged 65 and above exceeded 7.0% in 1993, making Taiwan an aging society. From 2005 to 2015, the percentage of the population aged 0-14 dropped from 18.7% to 13.6% and the proportion of population aged 65 and above increased from 9.7% to 12.5%. The trend in population aging is significant (Figure 2-2 and Table 2-1).

Figure 2-1 Population Age Structure



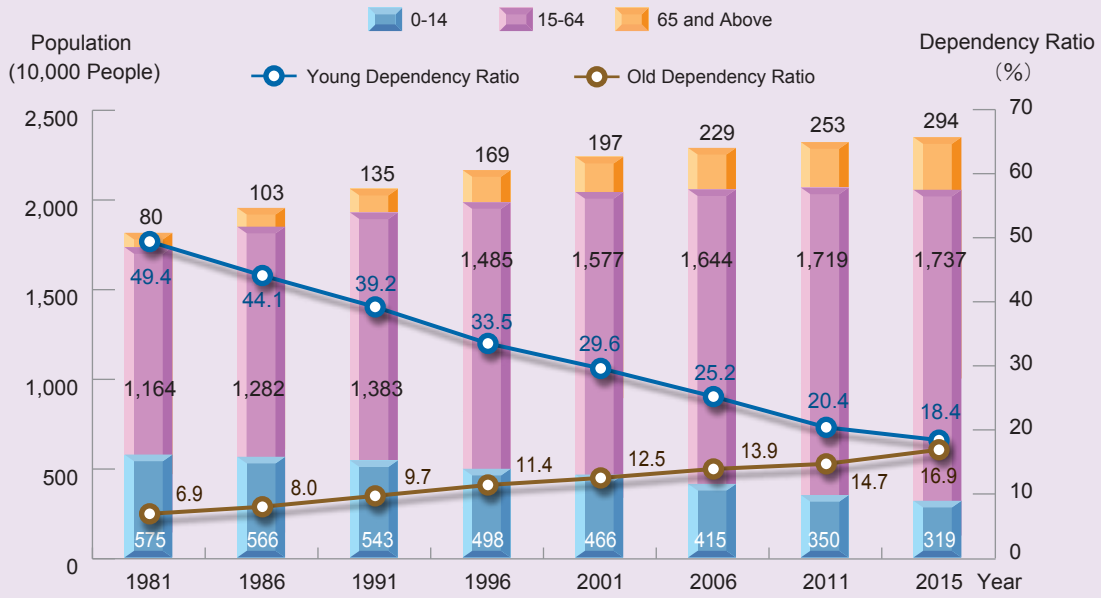
Source: Department of Statistics, Ministry of the Interior (MOI), R.O.C. (Taiwan)

The dependency ratio ((population aged 0-14 + population aged 65 and above)/population aged 15-64* 100) fell from 39.7% in 2005 to 34.7% in 2012. This was primarily due to the rapid decrease in the young dependency ratio (population aged 0-14 /population aged 15-64* 100) and the steady increase in the old dependency ratio (population aged 65 and above /population aged 15-64* 100). From 2013, a reverse trend was observed, such that the increase in old dependency ratio exceeded the decrease in young dependency ratio, causing the dependency ratio to increase to 35.3% in 2015.

Section 2 Birth and Death

Societal shifts and changes in social values have led to recent annual decreases in the fertility rate. The crude birth rate (births/mid-year population* 1000) fell from 9.1‰ in 2005 to a record low of 7.2‰ in 2010, before rising to 9.1‰ in 2015. The crude death rate (deaths/mid-year population* 1000) rose from 6.1‰ in 2005 to 7.0‰ in 2015. After a long decline, the rate of natural increase (crude birth rate minus crude death rate) fell to a record low of 0.9‰ in 2010 before rising slightly to 2.1‰ in 2015 (Figure 2-3).

Figure 2-2 Population Age Structure and Dependency Ratio, by Year



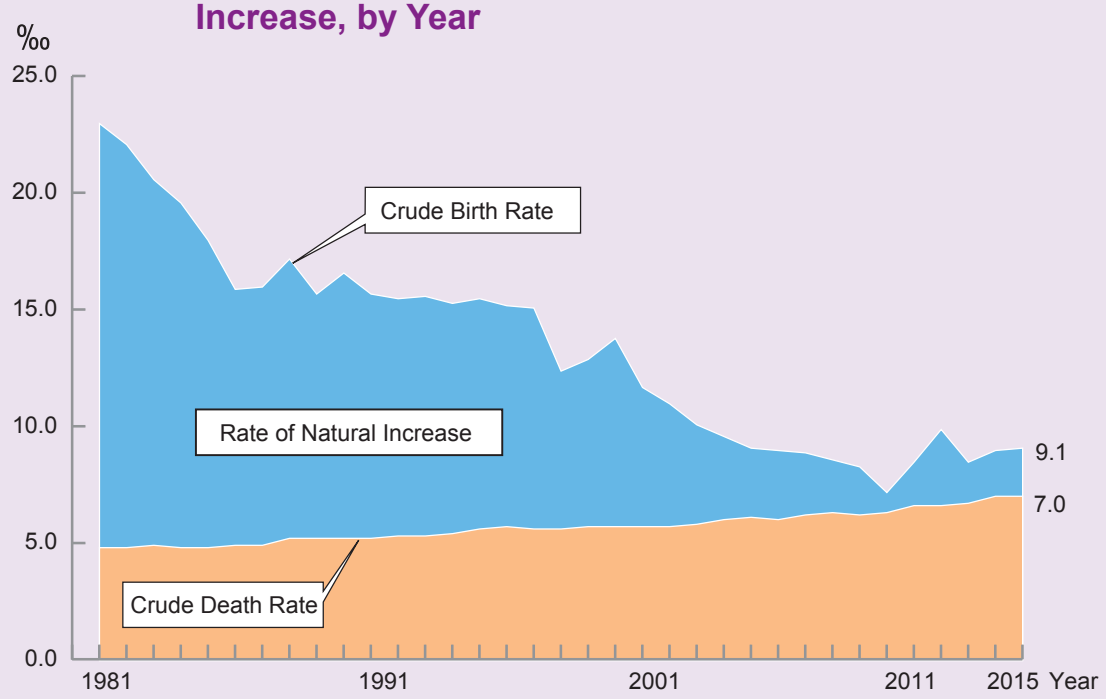
Source: Department of Statistics, MOI, R.O.C. (Taiwan)

Table 2-1 Population Age Structure and Dependency Ratio, by Year

End of Year	Total Population	Population Structure			Dependency Ratio	
		0-14	15-64	65 and Above	Young Dependency Ratio	Old Dependency Ratio
	10,000s	%	%	%	%	%
1981	1,819	31.6	64.0	4.4	49.4	6.9
1991	2,061	26.3	67.1	6.5	39.2	9.7
2001	2,241	20.8	70.4	8.8	29.6	12.5
2011	2,322	15.1	74.0	10.9	20.4	14.7
2012	2,332	14.6	74.2	11.2	19.7	15.0
2013	2,337	14.3	74.2	11.5	19.3	15.5
2014	2,343	14.0	74.0	12.0	18.9	16.2
2015	2,349	13.6	73.9	12.5	18.4	16.9

Source: Department of Statistics, MOI, R.O.C. (Taiwan)

Figure 2-3 Crude Birth Rate, Crude Death Rate, and Rate of Natural Increase, by Year



Source: Department of Statistics, MOI, R.O.C. (Taiwan)

Section 3 Life Expectancy

According to the MOI data, life expectancy at birth for all citizens was 80.2 in 2015, representing an increase of 2.8 years over the past decade. During the same period, life expectancy at birth increased by 2.5 years to 77.0 for males and 2.8 years to 83.6 for females, clearly showing that life expectancy improved more for women than for men. (Figure 2-4 and Table 2, Appendix 1.)

Chapter 2 Vital Indicators

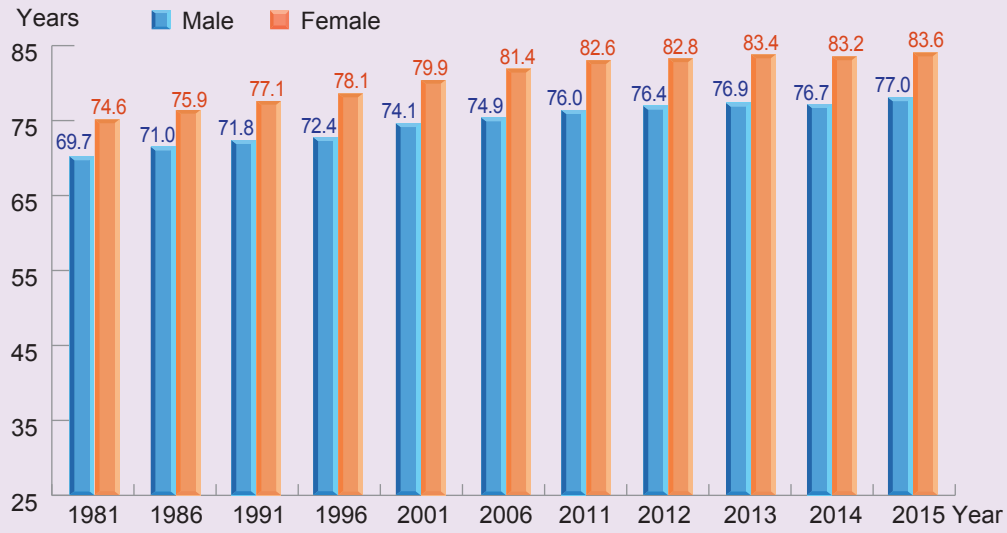
Section 1 Ten Leading Causes of Death

Economic transformation, better quality of life, and improved health care have led to changes in the leading causes of death. In 1952, acute and communicable diseases resulted in most death in Taiwan; today, malignant neoplasms, chronic diseases such as cardiovascular disease, and accidents are the main culprits.

In 2015, there were 163,574 deaths and the crude mortality rate was 697.2 per 100,000 population, an increase of 0.2% compared to the previous year and an increase of 14.1% compared to 2005. The standardized mortality rate (based on the WHO standard world population age structure for 2000) was 431.5 people per 100,000 population, an decrease of 2.7% over the previous year and a decrease of 18.6% compared to 2005.

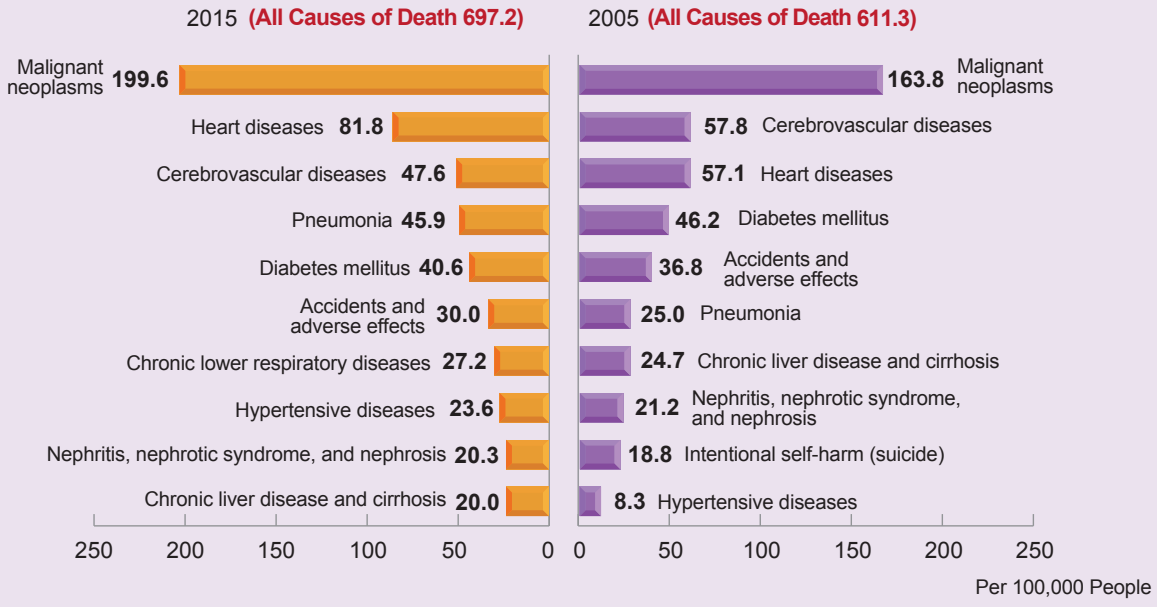
In 2015, the ten leading causes of death accounted for 77.0% of all deaths and were mainly attributed to chronic diseases. In order of significance: (1) malignant neoplasms, (2) heart diseases, (3) cerebrovascular diseases, (4) pneumonia, (5) diabetes mellitus, (6) accidents and adverse effects, (7) chronic lower respiratory diseases, (8) hypertensive diseases, (9) nephritis, nephrotic syndrome, and nephrosis (10) chronic liver disease and cirrhosis, Compared to 2005, heart disease, pneumonia and hypertensive diseases rose in the rankings; cerebrovascular diseases, diabetes mellitus, accidents and adverse effects, nephritis, nephrotic syndrome, and nephrosis, and chronic liver disease and cirrhosis fell (Figure 2-5).

Figure 2-4 Life Expectancy at Birth, by Year



Source: Department of Statistics, MOI, R.O.C. (Taiwan)

Figure 2-5 Changes in the Ten Leading Causes of Death



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Section 2 Cancer Incidence and Causes of Cancer Death

1. Cancer Incidence

   According to 2013 cancer registry data, the crude incidence rates of cancer for males and females were 467.3 and 381.1 people per 100,000 population, respectively. The age-standardized incidence rates for males and females were to 340.1 and 264.3 people per 100,000 population (age-adjusted to the 2000 WHO World Standard Population), respectively (Table 2-2).

2. Causes of Cancer Death

   In 2015, there were 46,829 deaths due to malignant neoplasms. This accounted for 28.6% of total deaths and a crude mortality rate of 199.6 per 100,000 population, an increase of 1.4% compared to the previous year and an increase of 21.9% compared to 2005. The standardized cancer mortality rate in 2015 was 128.0 per 100,000 population, a decrease of 1.7% compared to 2014 and a decrease of 9.3% compared to 2005.

   The ten leading causes of cancer death in 2015 were (1) cancers of trachea, bronchus, and lungs; (2) cancers of liver and intrahepatic bile ducts; (3) cancers of colon, rectum, and anus; (4) cancers of breast (female); (5) cancers of oral cavity; (6) cancers of prostate; (7) cancers of stomach; (8) cancers of pancreas; (9) cancers of esophagus; and (10) cancers of cervix uteri and uterus, part unspecified. When compared to 2005, cancers of the oral cavity, and prostate, and pancreas rose in the rankings; cancers of the stomach and cervix uteri fell (Figure 2-6).

Table 2-2 Incidence of 10 Leading Cancers, 2013

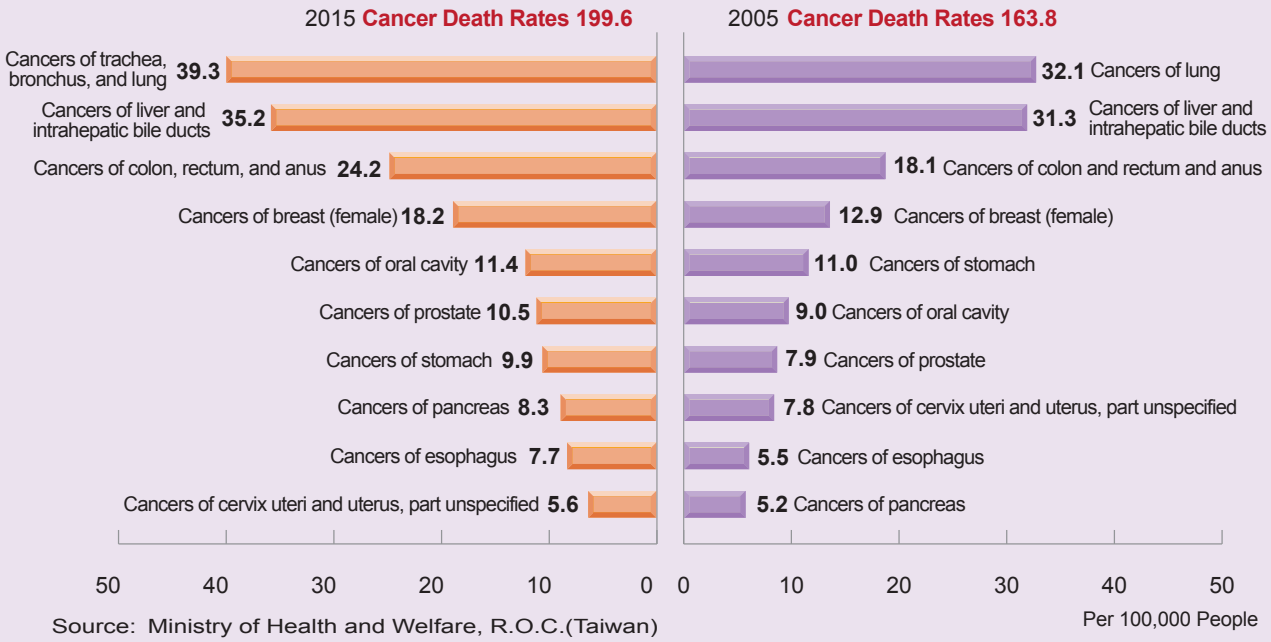
Male				Female			
Rank	Site	No. of Cases	Age-Standardized Incidence Rate (Per 100,000 Population)	Rank	Site	No. of Cases	Age-Standardized Incidence Rate (Per 100,000 Population)
1	Colon	8,681	53.2	1	Female Breast	11,281	69.1
2	Liver and Intrahepatic Bile Ducts	7,905	49.3	2	Colon	6,459	36.3
3	Lungs, Bronchus, and Trachea	7,093	43.0	3	Lungs, Bronchus, and Trachea	4,658	26.2
4	Oral Cavity, Oropharynx, and Hypopharynx	6,633	41.8	4	Liver and Intrahepatic Bile Ducts	3,519	19.7
5	Prostate	4,801	29.2	5	Thyroid	2,362	15.8
6	Stomach	2,348	14.5	6	Uterus	2,011	12.1
7	Esophagus	2,422	14.3	7	Cervix	1,579	9.5
8	Skin	1,944	11.5	8	Skin	1,711	9.1
9	Bladder	1,481	8.8	9	Ovary, Fallopian Tube, and Broad Ligament	1,321	8.6
10	Non-Hodgkin's Lymphoma	1,316	8.4	10	Stomach	1,346	7.5
Total		54,601	340.1	Total		44,542	264.3

Source: Cancer registry data (excluding carcinoma in situ)

Notes: 1. Ranked from highest to lowest by age-standardized incidence rate (per 100,000 population).

2. The age-standardized incidence rate is based on the standard world population age structure in 2000.
   Formula: Σ (Age-Specific Incidence Rate x Standard Age-Specific Population)/Standard Total Population

Figure 2-6 Changes in the Ten Leading Causes of Cancer Death

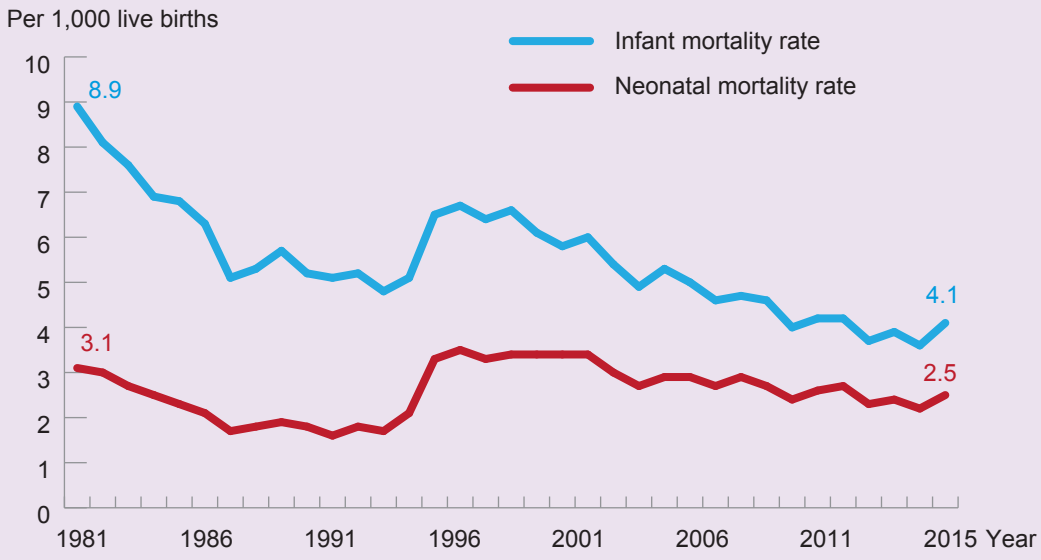


Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Section 3 Infant and Neonatal Mortality Rates

Advances in public health led to general declines in both the infant mortality rate (deaths before age one per 1,000 live births) and the neonatal mortality rate (deaths in the first four weeks of life per 1,000 live births), apart from a slight increase in 1995 attributed to a new birth reporting system. In 2015, the infant mortality rate had declined to 4.1‰, compared to 8.9‰ in 1981. Over the same period, the neonatal mortality rate dropped from 3.1 to 2.5‰ (Figure 2-7).

Figure 2-7 Infant and Neonatal Mortality Rates, by Year



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)
Note: The birth reporting system was launched on Mar. 1995.

Chapter 3 National Health Expenditure

Good health care is a basic need in modern society and a major indicator of a country's advancement. After steadily rising since 1991, NHE surpassed NT$996 billion in 2014. With the influence of the expansion of international medicine, development of biomedicine and technology, and a rapidly aging population, future NHE will continue its upward trend.

Implementation of NHI in March 1995 led to an 11.6% increase in NHE that year, exceeding the annual growth rate of GDP. NHE as a share of GDP rose from 5.0% in 1994 to 5.1% in 1995 and 6.2% in 2014. Per capita NHE increased from NTD10,555 in 1991 to NTD42,538 in 2014, for an average annual increase of 6.2% (Figure 2-8).

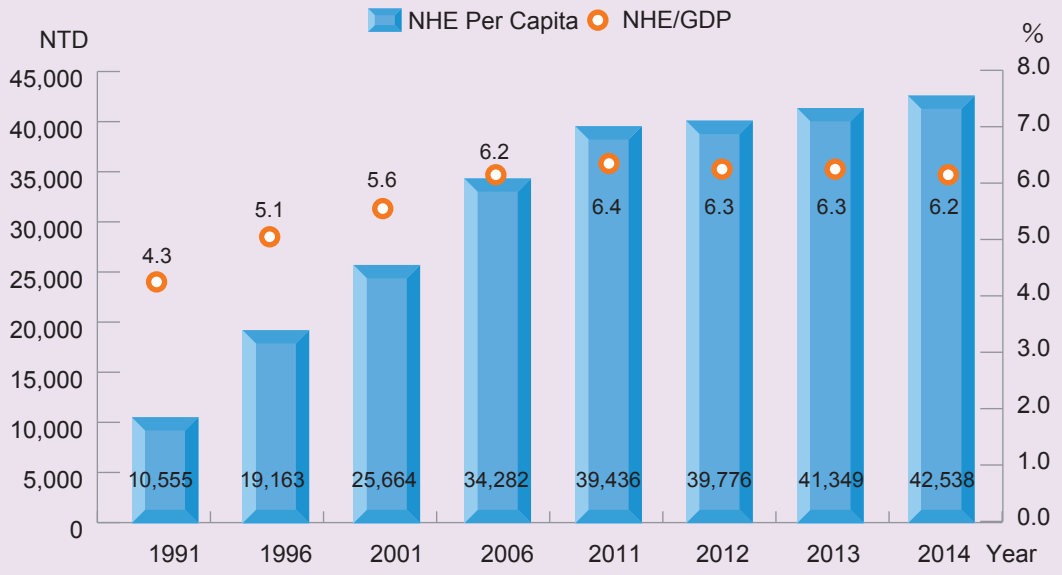
Chapter 4 Social Welfare Indicators

Section 1 Low-Income and Middle-to-Low-Income Households

To aim at looking after low-income families and helping disaster victims or persons facing emergencies, the government offers social assistance measures. In 2008 and 2011, the government adjusted the minimum cost of living and broadened the review thresholds for low-income households, causing the number of low-income households receiving care to increase rapidly.

Since July 2011, middle-to-low-income Households were included for social assistance, in other words, significantly expanding the reach of social assistance. At the end of 2015, there were 264,065 low-income and middle-to-low-income households (146,379 and 117,686 respectively). And it's the total of 698,675 members (342,490 in low-income households and 356,185 in middle-to-low-income households). They accounted for 3.1% of all households and 3.0% of the total population, respectively.

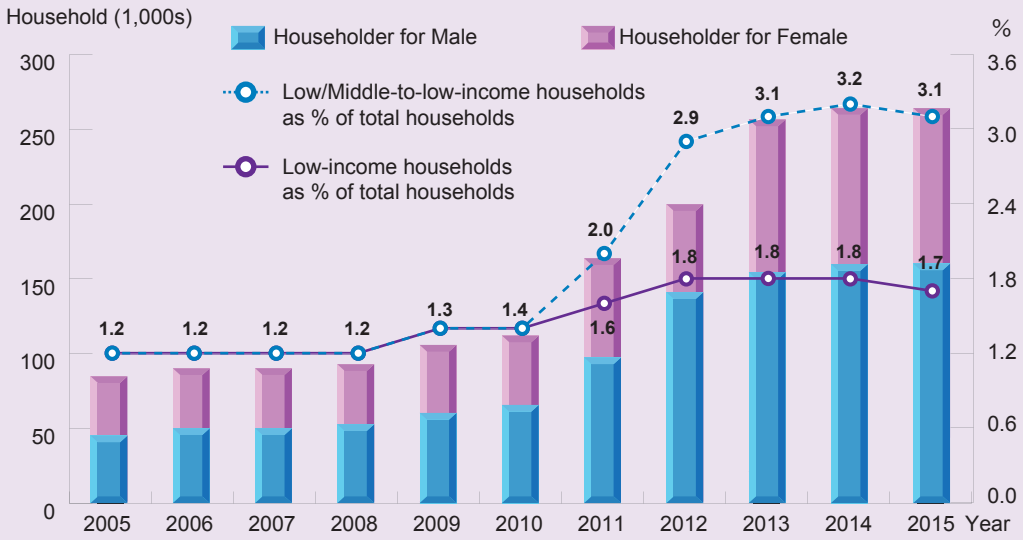
Figure 2-8 NHE/GDP Ratios and NHE Per Capita, by Year



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

In terms of gender, there were 160,021 low and middle-to-low-income households that householder for male, compared to 104,044 households that householder for female. Among all members of such households, males also exceeded females, 355,928 to 342,747 (Figures 2-9 and 2-10).

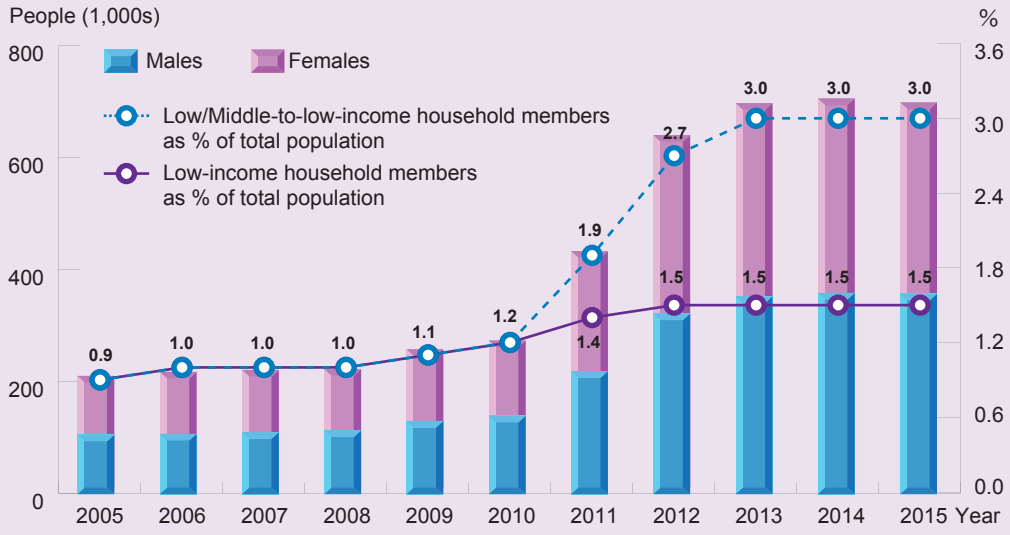
Figure 2-9 Low-Income and Middle-to-Low-Income Households, by Year



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Note: Implementation of the new Public Assistance Act on July 1, 2011, eased standards for inclusion and added middle-to-low-income households.

Figure 2-10 Low-Income and Middle-to-Low-Income Household Members, by Year



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Note: Implementation of the new Public Assistance Act on July 1, 2011, eased standards for inclusion and added middle-to-low-income households.

Section 2 Disabilities

At the end of 2015, there were 1,155,650 people with disability identification, accounted for 4.9% of the total population, wherein, there were 655,444 males (56.7%) and 500,206 females (43.3%).

In comparing 2015 and 2005, the number of disabilities were increased by 217,706 (23.2%), its imputed to population aging. As for age between 0-14 and 15-44, they were decreasing 13.1% and 7.6%, respectively; but age between 45 - 64, and 65 and above were increased by 40.9%, and 37.4% (Table 2-3).

Section 3 Domestic Violence

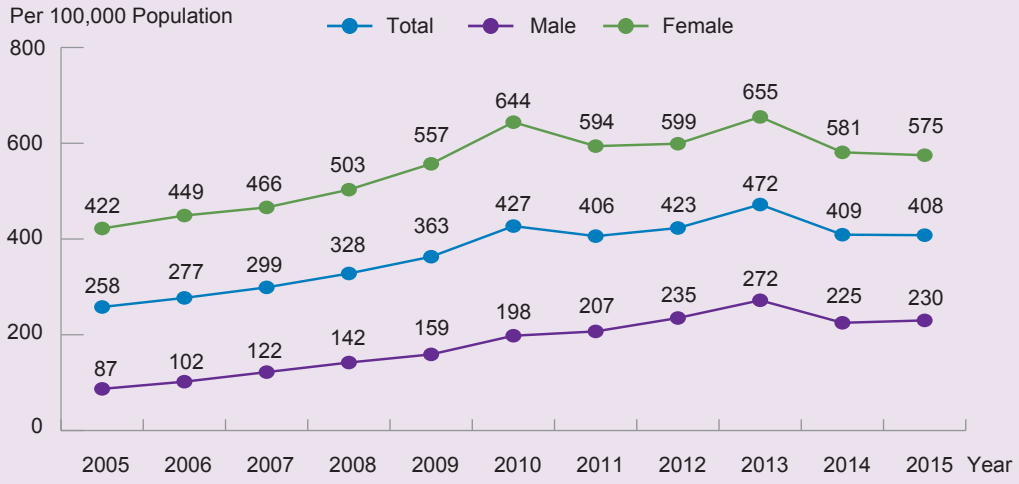
Government has promoted awareness of prevention of domestic violence, 113 Protection Hotline, and strengthened domestic violence prevention network services and assistant measures in recent years. Those are the reason why the reported victims increase year by year. In 2015, there were 408 reported victims per 100,000 population, an increase of 151 compared to 2005. By gender, there were 230 male victims in every 100,000 population and 575 female victims in every 100,000 population, with 2.5 times as many women as men (Figure 2-11)

Table 2-3 Historic Population of Disabled, by Gender and Age

Year (End)	Persons			Age group				As % of total population
	Total	Male	Female	0-14	15-44	45-64	65 and above	
2005	937,944	546,068	391,876	46,838	266,641	296,766	327,699	4.1
2006	981,015	569,234	411,781	48,031	267,331	315,289	350,364	4.3
2007	1,020,760	590,306	430,454	48,345	266,356	334,971	371,088	4.4
2008	1,040,585	599,664	440,921	47,911	262,443	350,245	379,986	4.5
2009	1,071,073	615,621	455,452	47,444	260,544	366,606	396,479	4.6
2010	1,076,293	616,675	459,618	46,485	256,294	379,735	393,779	4.6
2011	1,100,436	629,179	471,257	45,464	254,324	393,458	407,190	4.7
2012	1,117,518	636,287	481,231	45,090	255,687	405,297	411,444	4.8
2013	1,125,113	639,969	485,144	43,319	250,369	409,067	422,358	4.8
2014	1,141,677	648,807	492,870	42,677	248,469	414,583	435,948	4.9
2015	1,155,650	655,444	500,206	40,697	246,478	418,196	450,279	4.9

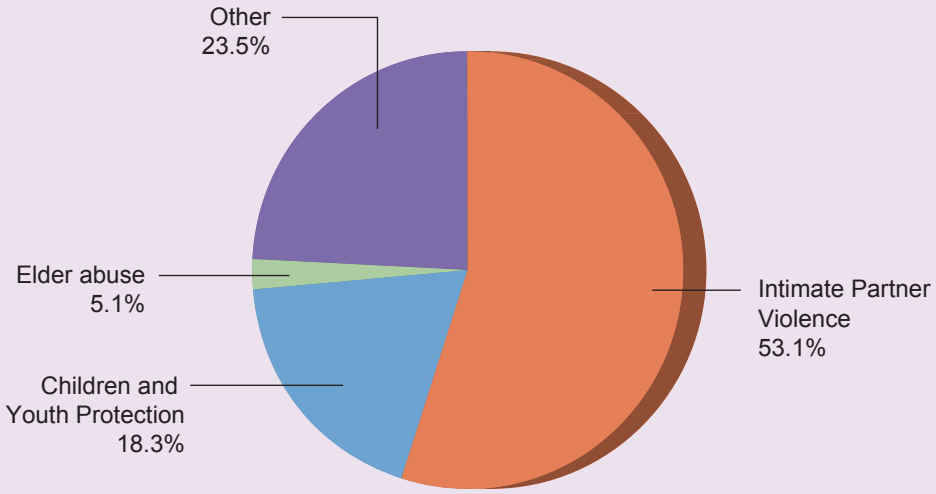
Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Figure 2-11 Victims of Domestic Violence Population Rate, by Year



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)
Note: Reported victims/mid-year population x 100,000.

Figure 2-12 Domestic Violence Reported Cases by type, 2015



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

By type of case, "intimate partner violence" accounted for 53.1%;"children and youth protection" accounted for 18.3% ; and "elder abuse" accounted for 5.1% (Figure 2-12).

Chapter 5 International Comparisons

Section 1 Life Expectancy

According to the data of WHO in 2013, it presented the life expectancy at birth of 80 and 87 years for male and female in Japan, respectively. The life expectancy at birth of both male and female in Japan was the highest among all. On the other hand, in Taiwan the life expectancy at birth was separately 77 years for male and 83 years for female, and they have increased by six years over the past two decades. (Table 2-4).

Section 2 Natural Increase Rate

According to the data of WHO Statistical Information System in 2015, it showed the global population was 7.13 billion and the global natural increase rate was 1.5%. Japan and Germany had a negative natural increase rate. At the same time, the natural increase rate of Taiwan was 0.2% (Table 2-5).

In 2013, the globe of total fertility rate (it means each woman may give birth to the children and they survive in her lifetime) was 2.5 persons and those countries listed the table 2-5 were lower than the average fertility rate of the global. Thereof, countries in Asia were significantly lower than else, in other words, Asia was region of low fertility. During the same period, the fertility rate was 1.1 persons in Taiwan. Furthermore, the global of birth rate was 23‰ and the mortality rate was 8‰. Only Japan and Germany' birth rate were lower than mortality rate.The summary of that year, the demographic structure had tended to low birth rate and mortality rate in the developed country (Table 2-5).

Section 3 Dependency Ratio

Based on the data from the World Bank, the global dependency ratio in 2014 was 53.9%. Among major nations, the dependency ratio of Japan was the highest , at 63.0%, in sequence, France at 59.2%, and the United Kingdom at 54.3%. The dependency ratio of Taiwan was 35.1% and it was below the global average as well as on the low side in the major nations. The dependency

Table 2-4 Life Expectancy at Birth in Major Countries

Unit: Years

	Total		Maie		Female	
	1990	2013	1990	2013	1990	2013
R.O.C. (Taiwan)	74	80	71	77	77	83
Japan	79	84	76	80	82	87
South Korea	72	82	68	78	76	85
United States	75	79	72	76	79	81
Canada	77	82	74	80	81	84
United Kingdom	76	81	73	79	79	83
Germany	76	81	72	79	79	83
France	78	82	73	79	82	85
Australia	77	83	74	80	80	85
New Zealand	76	82	73	80	78	84

Source: Department of Statistics, MOI, R.O.C. (Taiwan), 2015 WHO Statistical Information System.

Table 2-5 Population Status of the world

	2013 Mid-year population	2013 Total fertility rate	2013 Crude birth rate	2013 Crude death rate	2013 Rate of natural increase
	Millions	Per Woman	‰	‰	%
Global	7126.1	2.5	23	8	1.5
R.O.C. (Taiwan)	23.4	1.1	9	7	0.2
Japan	127.1	1.4	8	10	-0.2
South Korea	49.3	1.3	10	6	0.4
United States	320.1	2.0	13	8	0.5
Canada	35.2	1.7	11	7	0.4
United Kingdom	63.1	1.9	12	9	0.3
Germany	82.7	1.4	9	11	-0.2
France	64.3	2.0	12	9	0.3
Australia	23.3	1.9	13	6	0.7
New Zealand	4.5	2.1	14	6	0.8

Source: Department of Statistics, MOI, R.O.C. (Taiwan), 2015 WHO Statistical Information System.

ratio of Taiwan has been reduced 56.9%, nearly five decades, the result can attributed to a large decrease in the young age (Table 2-6).

Section 4 Mortality Rate

According to the data of WHO, the rate of standardized cancer mortality in Japan was 101.3 deaths per 100,000 population among the major nations that was the lowest, compared with deaths of 130.4 in Taiwa; The death from transport accidents, the United Kingdom was the lowest, at 2.6 deaths per 100,000 population, compared to the deaths of 11.8 persons in Taiwan; For suicides, the mortality of the United Kingdom also was lowest, with 6.5 deaths per 100,000 population, compared to 12.0 deaths in Taiwan; Japan's infant mortality rate was 2‰, that was the lowest, by contrast, the deaths of 4‰ infants in Taiwan (Table 2-7).

Table 2-6 Dependency Ratios of Major Countries

Unit: %

	1960	1970	1980	1990	2000	2005	2010	2014
Global	73.6	76.3	71.5	65.5	60.2	56.3	54.1	53.9
R.O.C. (Taiwan)	92.0	74.2	57.3	49.9	42.3	39.7	35.8	35.1
Japan	56.0	45.3	48.4	43.4	46.6	50.7	56.8	63.0
South Korea	80.7	83.3	60.7	44.1	39.5	38.4	37.6	37.0
United States	66.5	61.1	51.7	51.8	50.5	48.7	48.7	50.3
Canada	70.7	61.6	47.4	46.9	46.4	44.5	44.1	46.5
United Kingdom	53.6	59.2	56.2	53.1	53.6	51.5	51.2	54.3
Germany	49.1	58.7	52.2	44.5	46.2	49.5	51.8	51.6
France	60.9	60.2	56.3	51.2	53.6	54.0	55.0	59.2
Australia	63.4	59.4	53.6	49.5	49.7	48.6	48.2	50.2
New Zealand	71.0	67.3	58.6	52.3	52.7	50.6	50.4	53.2

Source: Department of Statistics, MOI, R.O.C. (Taiwan), World Development Indicators, The World Bank.

Note: Dependency ratio = (Population aged 14 and younger + Population aged 65 and above)/Population aged 15-64 * 100

Table 2-7 Standardized Mortality Rates of Major Countries

	Year	Malignant neoplasms	Transport accidents	Intentional Self-Harm (Suicide)	Infant mortality
		per 100,000 population	per 100,000 population	per 100,000 population	per 1,000 live births
R.O.C. (Taiwan)	2013	130.4	11.8	12.0	4
Japan	2013	101.3	3.2	16.2	2
South Korea	2013	102.9	9.5	22.4	3
United States	2013	110.6	11.1	11.5	6
Canada	2011	118.9	6.2	9.5	5
United Kingdom	2013	125.5	2.6	6.5	4
Germany	2013	119.1	4.0	8.5	3
France	2011	121.3	5.9	12.9	4
Australia	2011	111.8	6.3	9.1	3
New Zealand	2011	124.5	7.5	10.9	5

Source: Ministry of Health and Welfare, R.O.C.(Taiwan). WHO Mortality Database. WHOSIS2015.

Note: Infant mortality rate data for all countries is from 2013

Section 5 Health Expenditure

Taiwan's per capita current expenditure on health (CEH) at purchasing power parity (PPP) were US$2,621 in 2013, lower than the Organization for Economic Co-operation and Development (OECD) median of US$3,385. If ranked among OECD member states, Taiwan would have been 22nd. GDP per capita in Taiwan was US$43,813, which was higher than the OECD median of US$36,953 and ranked 11th when compared to OECD member states. Generally, higher GDP per capita is accompanied by higher CEH per capita. In 2013, CEH accounted for a 6.0% share of Taiwan's GDP, a relatively low amount that was 2.8 percentage points below the OECD median (Table 2-8).

Table 2-8 Comparisons of CEH Per Capita and GDP Per Capita Between R.O.C. (Taiwan) and OECD Member States, 2013

Ranking	Country-Ranked by CEH per capita	CEH per capita (USD PPs)	GDP per capita (USD PPs)	CEH/GDP (%)
Median		3,385	36,953	8.8
1	United States	8,713	53,042	16.4
2	Switzerland	6,325	56,940	11.1
3	Norway	5,862	65,640	8.9
4	Netherlands	5,131	46,162	11.1
5	Sweden	4,904	44,646	11.0
6	Germany	4,819	43,887	11.0
7	Denmark	4,553	43,782	10.4
8	Austria	4,553	45,082	10.1
9	Luxembourg[2012]	4,371	91,850	6.6
10	Canada	4,351	42,839	10.2
11	Belgium	4,256	41,573	10.2
12	France	4,124	37,671	10.9
13	Australia[2012]	3,866	43,971	8.8
14	Japan	3,713	36,236	10.2
15	Iceland	3,677	42,035	8.7
16	Ireland[2012]	3,663	45,242	8.1
17	Finland	3,442	39,869	8.6
18	New Zealand	3,328	34,899	9.5
19	United Kingdom	3,235	38,255	8.5
20	Italy	3,077	35,075	8.8
21	Spain	2,898	33,092	8.8
22	R.O.C. (Taiwan)	2,621	43,813	6.0
23	Portugal	2,514	27,509	9.1
24	Slovenia	2,511	28,859	8.7
25	Israel	2,428	32,502	7.5
26	Greece	2,366	25,854	9.2
27	South Korea	2,275	33,089	6.9
28	Czech Republic	2,040	28,739	7.1
29	Slovak Republic	2,010	26,497	7.6
30	Hungary	1,720	23,336	7.4
31	Chile	1,606	22,178	7.3
32	Estonia	1,542	25,823	6.0
33	Poland	1,530	23,985	6.4
34	Mexico	1,049	16,891	6.2
35	Turkey	941	18,508	5.1

Source: Ministry of Health and Welfare, R.O.C.(Taiwan). 2015 OECD Health Data.

Note: A System of Health Accounts released by OECD recently, health expenditure and financing are based on current expenditure on health care to compile health care indicators.

3 Friendly Environments Supportive to Health

In order to achieve the "Health for All" policy goal advocated by the WHO, the MOHW has planned health promotion policies to benefit people of all types and all life stages, including pregnant women, infants and toddlers, children, adolescents, middle-aged adults, and the elderly (Figure 3-1). In response to the challenges posed by unhealthy lifestyles, we have gathered empirical data from health monitoring (surveillance) and research, along with human rights, gender, and health equality perspectives, as outlined in the UN "Health in All Policies" initiative. Health implications are systematically incorporated into cross-departmental policy-making decisions in order to locate synergies and reduce negative impact. By taking greater responsibility for health considerations in all aspects and levels of each decision, policy makers improve health and reduce health inequality. Also, in accordance with the 2012 World Health Assembly (WHA) "25 by 25." objective (to reduce preventable deaths due to noncommunicable diseases by 25% by 2025), the MOHW incorporated the nine global targets and 25 indicators contained in the objective into its policies. Taking "whole-of-government, whole-of-society." actions and a "life course approach," strategies are formulated to improve health at the individual, populace, community, national, and global levels.

Chapter 1 Healthy Childbirth and Growth

In order to aid healthy growth of infants and children, the MOHW promotes health among pregnant women, infants, children, and adolescents while seeking to detect and correct abnormalities at an early stage.

Section 1 Maternal Health

1. Prenatal Care

(1) 10 prenatal checks and 1 ultrasound were offered to pregnant women, the average usage rate of the 10 prenatal checks was 94.8% in 2015. Also, 90.1% of pregnant women took advantage of the two prenatal health assessment and guidance sessions offered.

(2) Subsidized Group B Streptococcus Screenings (GBS): In 2015, there were 186,787 GBS

Figure 3-1 From Womb to Tomb, from Households to the Community – Policies That Promote Health for All

Enhance health literacy, build healthy lifestyles
Spread preventive healthcare, Promote effective prevention and screening
Upgrade healthcare quality, improve chronic disease control and prognosis
Create a friendly supportive environment, bolster health options and equality

Womb

★ Birth control guidance	★ Newlywed Health manuals
★ Prenatal Examination & guidance	★ Nutrition and healthcare guidance for pregnant women and babies
★ Breastfeeding	★ Newborn screening
★ Preventive Healthcare for Newborns and Children	★ Screening of Preschool Children for Visual Impairment
★ Screening for Strabismus and amblyopia	★ Health Check-up for Students
★ Preventive Healthcare for Adults	★ Screening for Cancer
★ Smoking cessation services	★ Diabetes management
★ Chronic Kidney disease management	★ Quality Accreditation of Cancer diagnosis and treatment
★ Services for Cancer patients	★ Palliative Care

Tomb

Well-rounded infrastructure; Bolstered legal framework; surveillance and research; Education and training; Domestic and international cooperation

screenings, with a coverage rate of 87.2% and 20.8% of those screenings positive.

(3) Subsidized prenatal genetic testing was offered to those at high risk of passing on a genetic disease. In 2015, of 57,471 people tested, abnormalities were detected in 1,645 cases, all of which were offered follow-up consultation.

2. Sex Ratio at Birth

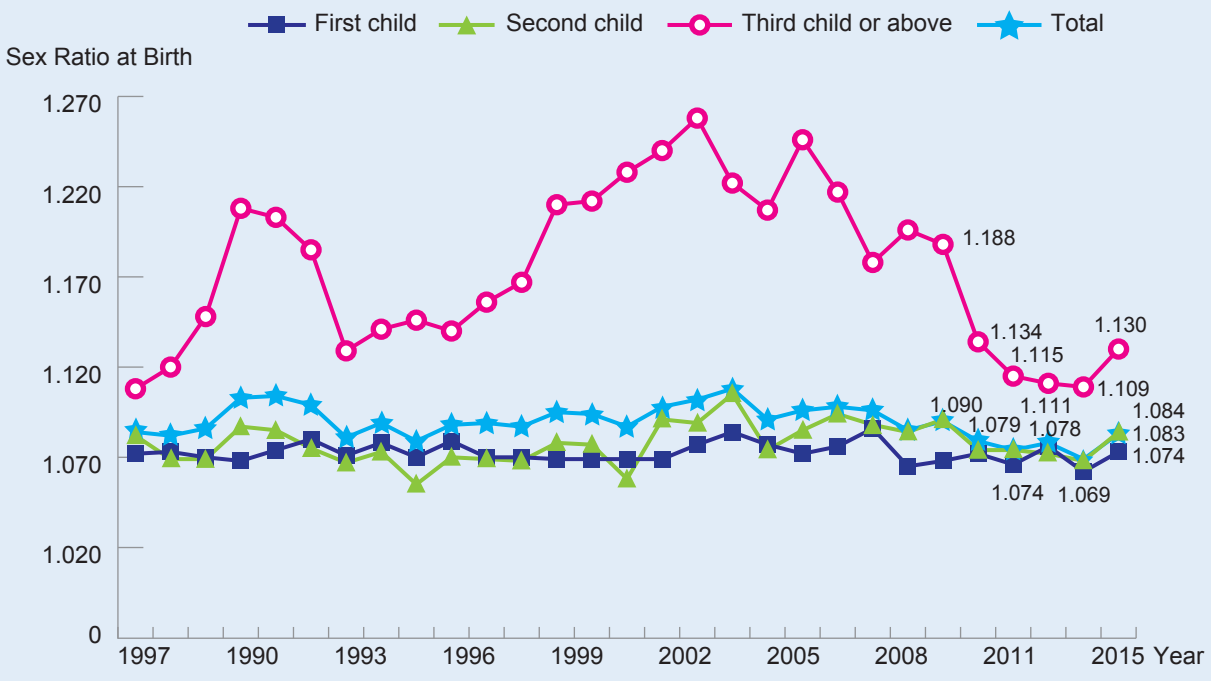
The Health Promotion Administration (HPA), the Department of Medical Affairs, and the Taiwan Food and Drug Administration (TFDA) established a ministry task force to monitor the sex ratio at birth. Besides using monitoring mechanisms, the legal framework, and management of reagent sources and testings, the task force worked in conjunction with local health departments, checked local censuses, and provided guidance to institutions offering birth and prenatal checkup services. Also, it has strengthened gender equality education and medical ethics trainings among health workers and used publicity targeting the general public to ensure female babies the opportunity to be born. Taiwan's sex ratio at birth dropped to 1.069 in 2014, then rose in 2015 to 1.083, showing that more efforts were needed to achieve the natural ratio of 1.06 (Figure 3-2).

3. A free hotline (0800-870-870), app, and website (http://mammy.hpa.gov.tw) were established to provide obstetric care information to expectant mothers. In 2015, there were 18,761 calls to the hotline, there were 2,324,461 visits to the website, and the app was downloaded 5,169 times.

4. In accordance with the Public Breastfeeding Act, by the end of 2015 a total of 2,135 public breastfeeding rooms had been established, and another 781 breastfeeding rooms had been established by county and city.

5. In line with the WHO policy on breastfeeding, the MOHW has implemented Baby-Friendly Hospital accreditation to promote breastfeeding. In 2015, there were 182 hospitals accredited as Baby-Friendly hospital, with total coverage reaching 80.7% of all births in Taiwan. The exclusive breastfeeding rate under 6 months of age was 45.4%, beating the world average of 38% and bringing Taiwan closer to the WHO global target of 50% by 2025.

Figure 3-2 Sex Ratio of Live Births in Taiwan, by Year



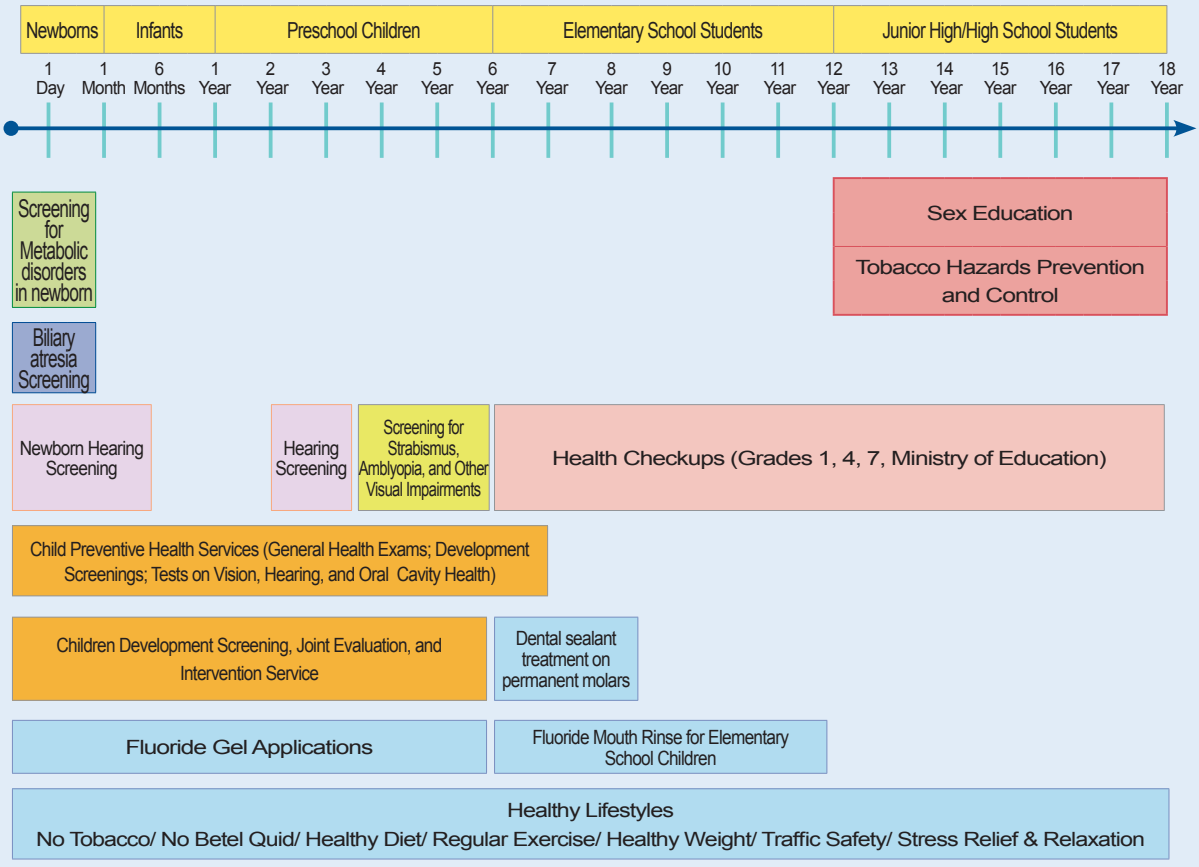
Source: Birth Reporting Statistics, HPA

Section 2 Health for Infants, Children, and Adolescents

Besides providing screenings for newborns and guidance for parents, the Child Development Assessment Centers were established to provide early assessment and intervention to children suspected of developmental delays. Other measures include seven rounds of pediatric preventive health care and health education; oral, visual and auditory health exams for children; and a program to promote sexual health among adolescents (Figure 3-3). Achievements include the following:

1. Screening of infants for inborn metabolic disorders: At 48 hours after birth, newborns in Taiwan are screened for 11 genetic metabolic disorders, with follow-up referrals, diagnosis, and treatment provided in all atypical cases. In 2015, there were 213,251 newborns screened, for a coverage rate of over 99%.
2. Fully subsidized hearing screenings are provided to newborns below 3 months of age. In 2015, 208,722 newborns were screened with a screening coverage rate of 97.8%, where 795 newborns had hearing loss and were referred for follow-up care.
3. Preventive health care services are provided for children under 7 years of age. About 1.12 million rounds of preventive health care services were provided in 2015, with an average estimated usage rate of 78.3% of the target value, and 96.2% of children under 1 year old received at least one round of service. Seven rounds of health education and guidance are offered for children under 7 years of age, where in 2015, 898,825 rounds of services were provided, with 63% of people using all seven rounds of services.
4. Every city and county have one to four Child Development Assessment Center(s). In 2015,

Figure 3-3 Health Policies for Infants, Children, and Adolescents



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

46 such centers nationwide had diagnosed developmental delays in a total of 16,598 children. In order to raise the service quality, the MOHW formulated the "Child Development Assessment Center Investigation Criteria", and enacted on-site inspections and visits.

5. Inter-ministerial units continued to encourage strabismus, amblyopia, and eyesight screenings for preschool children 4 and 5 years of age. In 2015, the screening rate was 99.8%, with 99.3% of suspected abnormalities referred for treatment.
6. A reduction in unplanned pregnancies was achieved through adolescent sex education covering preventive care and reproductive health. Instructional channels included websites, online video consultations, school-based promotions, and Youth-Friendly Clinics. In 2015, website traffic reached 84,104 visits, there were 2,364 video consultations, and total attendance at 85 sexual health school lectures and parental education lectures was 21,346. There were also 70 Youth-Friendly Clinics, with coverage extending to each of the nation's cities and counties and visits totaling 30,297.

Chapter 2 Healthy Living

Major everyday hazards include personal unhealthy habits such as smoking chewing betel quid, poor diet, and lack of exercise, as well as environmental factors such as accidents "remove space.". Among these, smoking and betel quid are both group 1 carcinogens and accidents are among the 10 leading causes of death, underscoring how rejecting tobacco and betel quid while building a safe environment to create a healthy life for people.

Section 1 Tobacco and Betel Quid Hazards Control

1. Tobacco Hazards Prevention

The launch of new regulations under the "Tobacco Hazards Prevention Act" in 2009 was followed by a sharp decline in the smoking rate, with the rate among adults 18 years old and above falling from 21.9% in 2008 to 17.1% in 2015, a decline of nearly a quarter, equal to about 760,000 smokers (Figure 3-4). The rate among junior high school students fell from 7.8% in 2008 to 3.5% in 2015 and the rate among high school and vocational school students fell from 14.8% in 2009 to 10.4% in 2015 (Figure 3-5). The secondhand smoke exposure rate in public places fell from 23.7% in 2008 to 7.7% in 2015. Keeping pace with international advances, Taiwan also implemented the Framework Convention on Tobacco Control as well as the MPOWER measures: Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship; and Raise taxes on tobacco. Major projects and achievements are as follows:

(1) Building a Smoke-Free Environment through the Tobacco Hazards Prevention Act.

a. In conjunction with promulgation of the Long-Term Care Services Act, and due to challenges posed by an aging society and a low birth rate, an amendment to the Regulations of the Tobacco Health and Welfare Surcharge Distribution and Utilization was amended and implemented on September 1, 2015. Changes to the distribution rates ensured that the surcharge will be used on the most imperative health and welfare initiatives to achieve the greatest benefit.

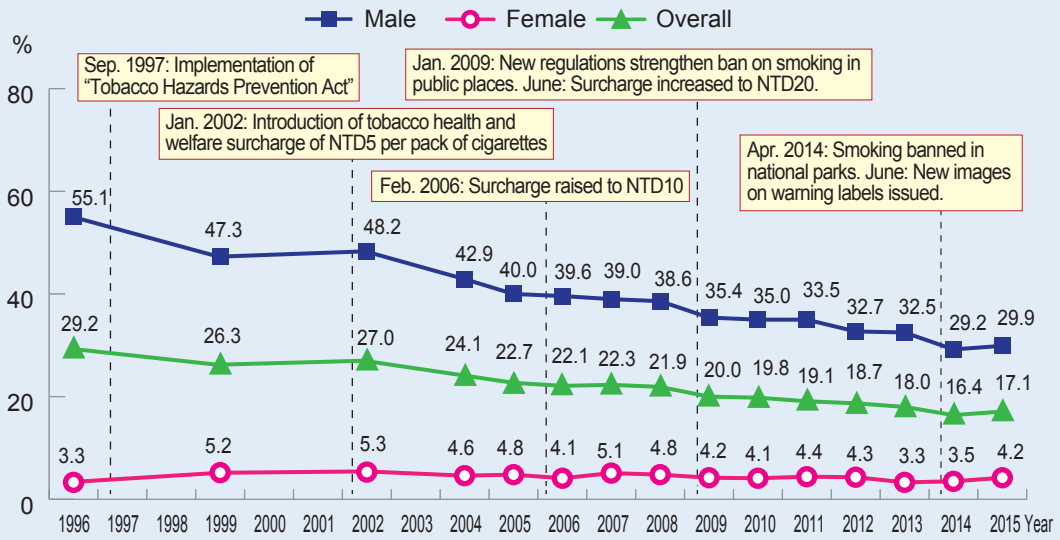
b. On April 1, 2014, Taiwan became the second nation in the world to ban smoking in designated areas of parks and green lawns by local governments (apart from specially marked smoking zones). Smoking was banned at 47 areas in national parks, 174 scenic spots, and 3,790 parks and green areas.

c. Local health departments carry out inspections and provide guidance. In 2015, more than 4.27 million inspections were conducted at over 630,000 businesses, with violations recorded in 8,771 cases and total fines of NTD31.99 million.

(2) Providing Diverse Smoking Cessation Services

a. Second-generation Smoking cessation services introduced a diverse new range of cessation services that were used by more than 430,000 people in 2015. Between implementation in March 2012 and December 2015, services were provided approximately 1.15 million

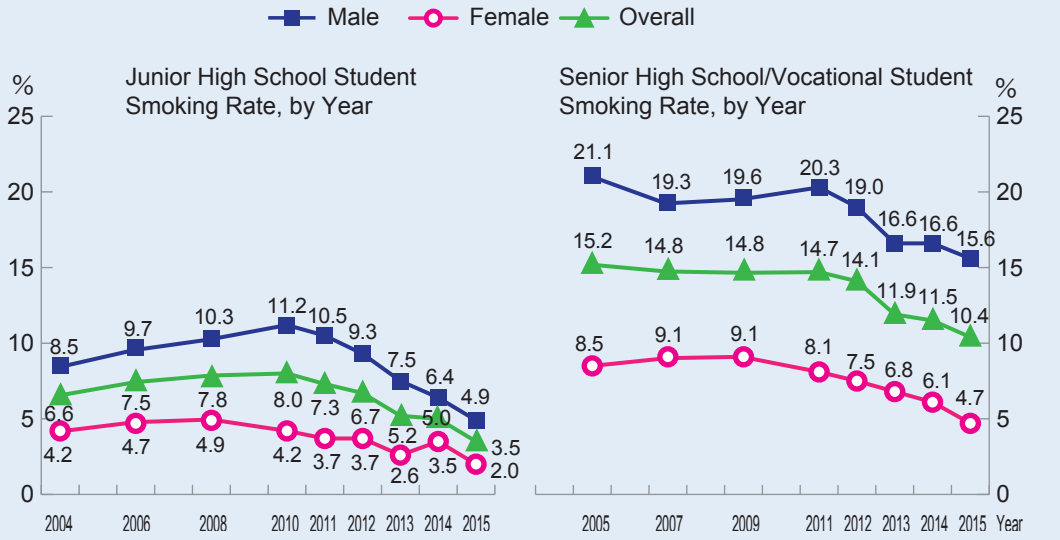
Figure 3-4 Smoking Rates of Adults over 18 Years Old in Taiwan, by Year



Sources:

1. 1996 survey data from the Taiwan Tobacco & Liquor Corporation.
2. 1999 survey data provided by Professor Li Lan.
3. 2002 data obtained from the HPA's "2002 National Health Interview Survey".
4. 2004-2015 data obtained from the HPA's" Adult Smoking Behavior Survey".
5. From 1999 to 2015, adult smoker was defined as anyone who had smoked more than 100 cigarettes (five packs) and had smoked within the past 30 days.
6. Data from 2004 to 2015 were weighted and standardized by gender, age, education, and area of residence using data collected by the Directorate-General of Budget, Accounting and Statistics (DGBAS) in 2000.

Figure 3-5 Taiwan Adolescent Smoking Rates, by Year



Notes:

1. Data obtained from the MOHW HPA's Global Youth Tobacco Survey.
2. Adolescent smoking rate was defined as anyone who attempts to smoke within the past 30 days, even if was limited to one or two puffs.

times, helping more than 98,000 people to quit smoking and offering short-term savings on NHI fees of more than NTD530 million.

b. In 2015, there were 90,623 calls to the free Smoking Cessation Helpline (0800-636363).

(3) To revise the law to increase the Tobacco Health and Welfare Surcharge: The WHO recommends increasing tobacco prices through taxation. Such forms of price control discourage adolescents from smoking and cause adults to smoke less.

(4) Achievements in Adolescent Tobacco Hazards Prevention.

a. The MOHW cooperates with local health departments to carry out inspections of tobacco sellers. In 2015, more than 350,000 such inspections uncovered 570 cases of tobacco being sold to minors, leading to total fines of over NTD5.43 million. Another 380,000 inspections uncovered 3,795 cases of minors smoking, with smoking cessation classes completed in 3,713 of these cases.

b. In order to create a smoke-free culture and environment, cases violating the ban in the Tobacco Hazards Prevention Act on providing tobacco products to children under 18 years of age have been included as part of evaluations of local health departments and effectiveness assessments of the Youth Project since 2014.

2. Betel Quid Hazards Prevention and Control

(1) Besides using media channels to spread the message of preventing betel quid hazards, the MOHW worked with the Ministry of Education (MOE), the MOI, the Ministry of National Defense, the Environmental Protection Administration, the Council of Agriculture, and NGOs to build betel quid free environments and offer cessation services. In 2015, these cessation services were provided to more than 20,000 people, helping nearly 5,000 of them quit.

(2) Oral cancer screenings are offered to betel quid chewers and smokers aged 30 and older as well as indigenous people aged 18 and older who chew betel quid. The recognition rate of betel quid carcinogenic effects rose from 39.9% in 2007 to 54.2% in 2015, as the betel quid chewing rate among males 18 years old and above dropped from 17.2% in 2007 to 8.8% in 2015, a decline of 48.8%. With a reduction by half in less than a decade, approximately 700,000 people were able to quit chewing betel quid.

(3) In order to reinforce source control and help determine whether the area used for growing betel quid continues to fall, the MOHW monitors the conversion of abandoned betel quid farms into other crops. From 2014 - 2015, subsidies were provided to assist in converting 58.7 hectares of land.

Section 2 Promotion of Physical Activity

According to a survey by the Sports Administration (SA), MOE, population ages 13 and above who engaged in regular exercise rose from 20.2% in 2007 to 33.4% in 2015, an increase of 65%. A key element of regular exercise, walking, was named by the WHO as the easiest form of exercise to put into practice and as the physical activity it most recommends. Since 2002, the MOHW promoted the "10,000 Steps a Day, Health is Here to Stay" campaign, and in 2006, we designated November 11 as National Walking Day. Key achievements in 2015 were as follows:

1. The "Running Kids – Exercise for Healthy, Happy Lives" activity, which encouraged students to adopt healthy exercise habits, was held at four elementary schools. There was also a National Healthy Exercise Competition attended by 32 teams, with 19 teams passing local preliminaries and 16 teams winning awards in the finals.

2. Building Health-Promoting Schools, Workplaces, and Hospitals

   On December 30, 2015, the HPA, MOHW and the SA, MOE jointly held a seminar on sports and health, which served as a basis for future cooperation regarding exercise. Among the approximately 130 people in attendance were invited representatives from local health departments, sports departments, schools, workplaces, hospitals, academics and other experts.

The New Taipei City Taishan Gymnasiun conducts the national contest of exercises

3. To build health, we encouraged schools, workplaces, and hospitals to increase time spent doing physical activity and to create environments supportive to exercise. Information relating to physical activity was provided through diverse means such as handbooks, broadcasts, and press releases.

Section 3 Nutrition and Obesity Control

As part of its commitment to promoting active lifestyles, the MOHW educates people about calories and nutrition, maintaining a healthy body weight, improving physical/mental and social health, and preventing chronic diseases. Key strategies and achievements in 2015 were as follows:

1. The MOHW launched a model plan to promote healthy food and beverages to catering industries and restaurants that around campuses within 500 meters. In 2015, local health departments gave advice to 98 schools, community health-promoting units gave advice to 183 schools, and health-promoting hospitals gave advice to 108 schools.
2. Healthy Weight Management Plan: By the end of 2015, participants shed a total of 1.19 million kg, or an average of 1.66 kg per person, and dropped the rates of overweight and obesity from 63.7% to 56.3%.
3. The Nutrition and Health Survey in Taiwan (NAHSIT) included the following data on the prevalence of overweight and obesity. (Figure 3-6)

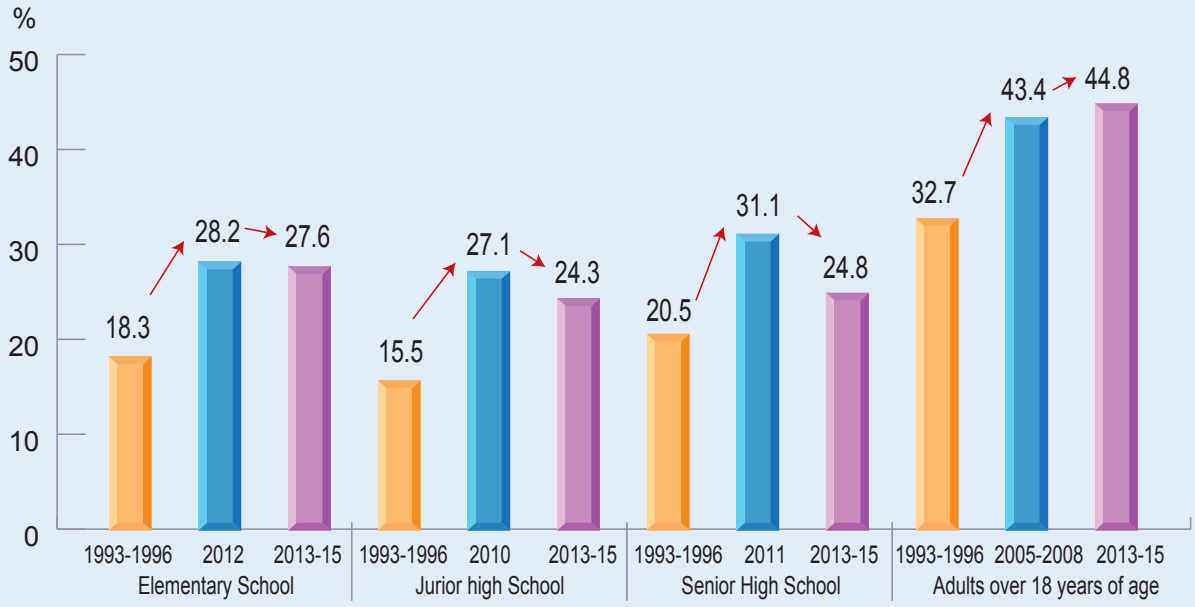
(1) The rate of overweight and obese adults increased from 32.7% in 1993 and 1996 to 43.4% between 2005 and 2008, a rise of 10.7% (or 32.7% of the previous value). In the latest preliminary data for 2013 to 2015, the rate was 44.8%, showing that the rise in overweight and obesity slowed greatly.

(2) The rate of overweight and obese elementary school students decreased from 28.2% in 2012 to 27.6% in 2013 - 2015; the rate among junior high school students decreased from 27.1% in 2010 to 24.3% in 2013 - 2015; and the rate among high school students decreased from 31.1% in 2011 to 24.8% in 2013 - 2015, showing a decrease in the overweight and obese prevalent of elementary school, junior high school, and senior high school students.

Section 4 Prevention of Accidents and Injuries

1. In order to build safe household environments for toddler, local health departments (centers) conducted home safety inspections and improvements. In 2015, there were 22,675 homes inspected.

Figure 3-6 Overweight and Obese Rate in Taiwan



Source: Nutrition and Health Survey in Taiwan

Notes: 1. Sample size means effective sample size for indicators and all results were weighted.
2. Overweight and obese indicators for elementary, junior high, and senior high school students were based on the BMI recommended from MOHW in 2013.
3. Adults age 18 and above with a BMI ≥ 24 kg/m^2 were considered as overweight or obese.

2. The Children's Health Manual provides the "Table for Assessing Children's Accidents and Injuries" and "Prevent Accidents and Injuries", in order to increase understanding among parents and caregivers about how to prevent such harms.
3. Exercises to prevent falls were promoted at locations frequented by senior citizens. We published the Tips for Elderly Falls Prevention handbook, which local health departments (centers) contributed by distributing or supplying to the elderly for their reference.

Chapter 3 Healthy Environments

In accordance with the 1997 Jakarta Declaration (WHO), the MOHW continues to promote healthy cities, healthy communities, health-promoting workplaces, health-promoting schools, and health-promoting hospitals. Using public and private resources, it encourages greater participation among the general public and cultivation of health knowledge and capacity. We build friendly support environments in order to achieve physical, mental, and social health.

Section 1 Healthy Cities, Communities, Schools, and Workplaces

1. Healthy Cities

(1) By 2015, there were 21 cities and counties in Taiwan that had launched Healthy City plans, as well as 12 cities and counties and 11 townships had joined the Alliance for Healthy Cities, an organization supported by the WHO Regional Office for the Western Pacific.

(2) In 2015, the MOHW cooperated with the Alliance for Healthy Cities, Taiwan in hosting the 7th Annual Taiwan Healthy Cities and Friendly Cities Awards Nomination Ceremony. A total of 54 awards in categories ranging

from excellence and innovation to outstanding contributions in the area of healthy cities were presented.

2. Healthy Communities

In 2015, the MOHW subsidized building healthy communities in 156 cities and townships by 19 local health departments. Achievements included the following: 4,965 volunteers and then participated in community building work; 86,039 people participated in oral cancer screening; 4,931 people used betel quid cessation services; 162,661 senior citizens joined health promotion activities; 1,429 restaurants were guided in providing low-sodium meals; total healthy weight loss by the general public was 576,398 kg; 590 healthy purchasing advocacy events were held; 199 walking groups were established; and 306 safe, healthy walking trails with calorie labeling were constructed.

3. Health-Promoting Schools

(1) Since 2002, the MOHW and MOE have integrated cross-departmental resources toward implementation of health-promoting school plans, including the 2008 establishment of the Health-Promoting Schools Support Center, which publicizes oral and visual health, healthy BMI, and tobacco hazards prevention. By 2015, Taiwan had 3,885 health-promoting schools at the high school/vocational school level or lower and 159 health-promoting universities and colleges.

(2) The MOHW hosted the 2015 International Health Promotion Conference. Fourteen experts from the United States, Canada, France, Thailand, and Taiwan were invited to share health promotion ideas, evaluation of health promotion core capabilities, and other experiences.

4. Health-Promoting Workplaces

The MOHW has undertaken several initiatives to promote health in the workplace. Since 2007 it has offered healthy workplace certification, with 14,287 workplaces qualified by the end of 2015. In 2015, there were 31 workplaces awarded for excellence in health promotion and four individuals recognized for outstanding contributions.

Section 2 Health-Promoting Hospitals

1. The MOHW has been an active participant in the WHO International Network of Health-Promoting Hospitals & Health Services (HPH).

(1) In June 2015, the 23rd International HPH Conference took place in Oslo, Norway. Taiwan Adventist Hospital won the fourth Outstanding Fulfillment of WHO HPH Standards Award; Taiwanese hospitals have won the award four years in a row.

(2) By the end of 2015, Taiwan had 160 institutions (146 hospitals, one Long Term Care institution, and 13 health centers) that were certified by the WHO HPH. This makes Taiwan's the largest network within that international network.

(3) Subsidies were provided to 19 local health departments and 131 health care institutions to implement the "Plan to Encourage Health Care Institution Participation in Health-Promotion Work".

(4) In November 2015, at the 2015 HPH Conference, there were 13 institutions welcomed to the ranks of health-promoting hospitals. Another seven institutions were recognized as models of HPH fulfillment and for overall excellence and organizational restructuring, and 34 institutions were recognized for having introduced 47 innovative plans.

2. Promotion of Low Carbon Hospitals

(1) In 2015, the MOHW held two Workshops on Environmental Friendliness to assist hospitals in implementing measures to save energy and reduce carbon emissions.

(2) Teams of experts allocated to specific regions conducted onsite visits to 30 hospitals and provided professional guidance on saving energy and reducing carbon emissions. The Hospital Energy Saving and Carbon Reduction Reporting System was built to gather related data from hospitals.

(3) Low carbon hospitals were encouraged to fill out Hospital Environmental Friendliness Self-Estimate report and assessment forms. The MOHW also issued the publications Reducing Carbon to Save the Earth: Hospitals at the Forefront – A Results Report on Taiwan's Low-

Carbon Hospitals and the Health Promotion and Environmentally-Friendly Hospital Strategy Manual.

(4) Seven domestic and two international health care institutions attended the 2015 International Environment-Friendly Hospital Team Work Best Practice Awards.

(5) By the end of 2015, there were 174 hospitals in Taiwan that had undertaken energy saving and carbon reduction actions.

Chapter 4 Healthy Aging

By 2018, Taiwan is expected to meet the criteria for an aged society. The older population, together with more sedentary lifestyles and Western eating habits, has increased the number of people afflicted by chronic diseases. In order to raise the quality of life of older people and reduce the threat posed by chronic diseases, the MOHW promotes age-friendly cities, age-friendly health care, health promotion among elderly persons, and control of major chronic diseases and cancer.

Section 1 Health Promotion for Middle-Aged and Older People

1. A preventive adult health examination is provided every three years for people aged 40 to 64, and annually for people aged 65 and older. As shown by the 2013 National Health Interview Survey (NHIS), nearly 60% of respondents aged 40 and older said they had at least one health exam within the past year. Of these, 32.5% had the preventive adult health exam; others had a health exam for laborers (21%), civil servants (4%), or the school or military (1%), an exam through an insurance company (20%), or undisclosed exam type (7%).
2. Eight factors were selected to use as a basis for ensuring health among the elderly and preventing functional decline. Local health institutions and health departments were also encouraged to support work by community care centers, with support given to 1,921 of 2,007 care centers nationwide, for 96% integration.
3. Older people were encouraged to join local township or village teams to compete in a national competition for elderly health promotion. In 2015, there were 2,484 teams and more than 104,000 seniors who participated, and over 4% of the total senior population.

Section 2 Age-Friendly Environments

1. In 2013, Taiwan achieved the highest coverage rate of age-friendly cities in the world when each of its 22 cities and counties promoted the age-friendly cities program. Drawing on this foundation, there were 386 entries to the 2015 Healthy City and Age-Friendly City Awards, 96 of which won awards.

A performance by a team from Guandu, Taipei in the 2015 national Dancing at a Happy Age: Go Go Grandpa & Grandma competition for elderly health promotion.

2. In 2014, the MOHW launched the Project for Universal Age-Friendly Health Care Organizations. By 2015, there was a total of 206 health care institutions certified as age friendly (including 25 public health centers and 28 Long Term Care institutions).

Section 3 Control of Major Chronic Diseases

1. Control of Major Chronic Diseases

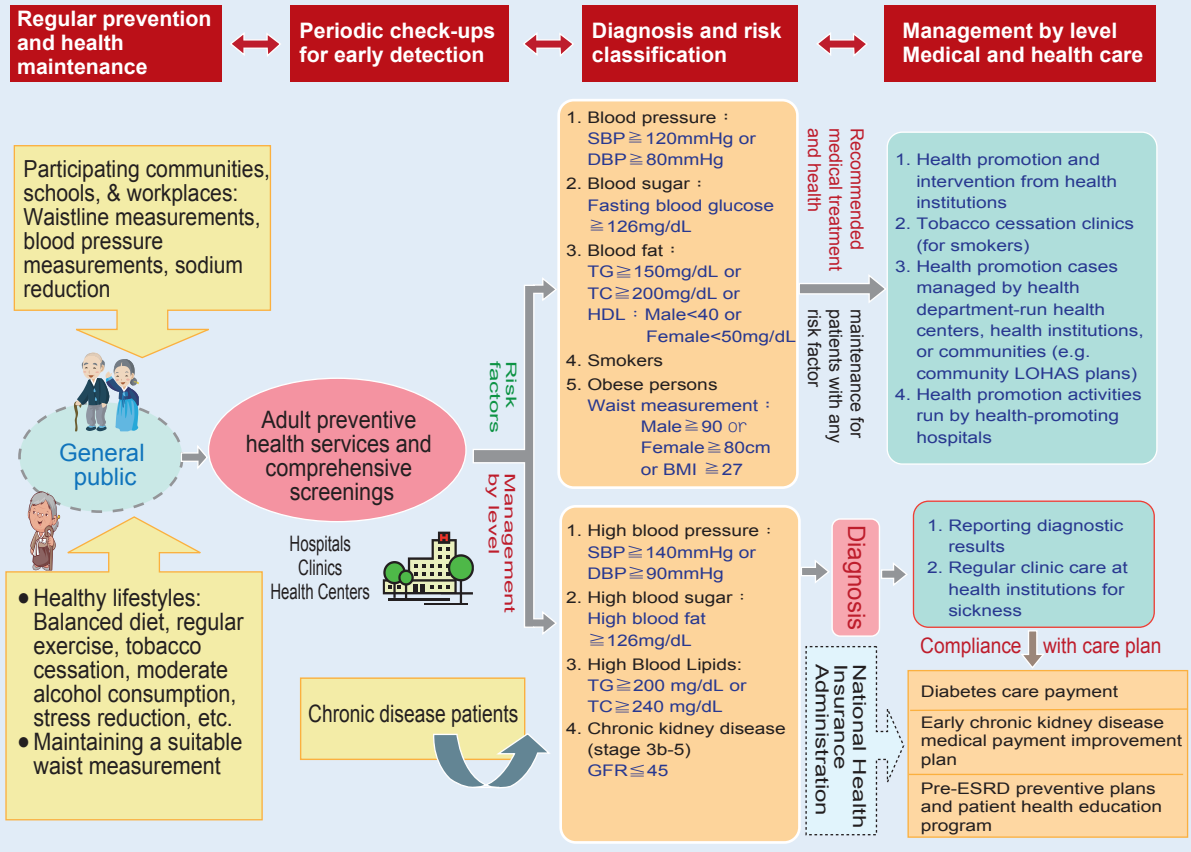
(1) By using multiple channels to educate members of the general public on control of metabolic syndrome, the rate of public recognition of waist warning values rose from 3% in 2006 to 47.6% in 2015. Local health departments and NGOs cooperated in a campaign to increase awareness of and to prevent the "Three Highs" (high blood pressure, high blood sugar, high blood fat/lipids) and other chronic disease prevention information. Also, the establishment of a chronic disease control framework (Figure 3-7) encouraged cities and counties to work with local health institutions to provide integrated screenings.

(2) In order to enhance care quality for diabetes patients, the MOHW promoted a diabetes shared care network comprising 213 diabetes health promotion institutions. It also established 514 diabetes support groups.

(3) For kidney disease control, the MOHW strengthened publicity and educational campaigns. It also established 166 kidney disease health promotion institutions that provided better case management and strengthened disease control.

(4) In order to help prevent the "Three Highs" and cardiovascular diseases, the MOHW (HPA) contracted for the Cardiovascular Health Management Pilot Study (abbr. CVHMPS). Six hospitals joined in planning a cross-departmental task force and appointing special care managers. Through intervention and

Figure 3-7 Chronic Disease Control Framework



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

tracking, including good control of the "Three Highs", smoking cessation, regular exercise, and following doctor's prescription orders, the study sought to establish quality indicators and promote the control and management of cardiovascular diseases.

(5) To extend access to blood pressure monitoring, besides health institutions, blood pressure monitoring stations are provided at 1,852 other public locations. The MOHW also contracted for developing the CVHM models for cardiovascular disease patients to strengthen control over the Three Highs and minimize functional loss and death.

2. Menopause Health

In order to provide accurate health information to women undergoing menopause, the MOHW established a special toll-free hotline. In 2015, the service was used 8,158 times, and the satisfaction rate among callers was 95.9%. Other services offered by combining community and medical resources included a menopause camp, health lectures, colored drawing or pattern classes, and train qualified counselors. There were 42 such activities in 2015 with total attendance of 2,644.

Section 4 Cancer Control

In order to reduce the cancer mortality rate, from 2014 to 2018 the MOHW is implementing the 3rd Phase National Cancer Prevention and Control Program. The program features three new major points to root the problems out at the source: (1) apart from preventing smoking and chewing of betel quid, paying greater attention to emerging risk for cancer such as obesity, poor diet, and insufficient exercise; (2) continuing to promote cancer screenings with preventive effect, especially for oral, colorectal, and cervical cancer, as well as the detection and elimination of premalignant lesions to stop cancer before it starts; (3) implementation of the Cancer Navigation Plan to avoid losing any cancer patient who could be saved.

1. Cancer Incidence and Mortality, by Year

Population aging, the adoption of Western lifestyle habits, and better detection through screenings of the four major types of cancer led the age standardized incidence rate of cancer rose from 111 per 100,000 population in 1982 to 299.7 per 100,000 population in 2013. In addition cancer has been the leading cause of death in Taiwan in 1982, the age standardized mortality rate continued to rise, until gradually falling in 2014 to 130.2 per 100,000 population.

2. Control of Cancer Risk Factors

There are four major risk factors associated with cancer: smoking, insufficient exercise, poor eating habits, and harmful alcohol use. The MOHW advocates healthy lifestyles by encouraging people to quit smoking, chewing betel quit, and drinking, as well as to manage a healthy weight and change dietary habits.

3. Cancer Screenings

(1) In 2010, Taiwan became the first country in the world to fully subsidize screenings for cancers of the cervix, breast, colon, and oral cavity. In 2015, 5.064 million screenings for these four types of cancer detected precancerous lesions in 48,118 patients and cancerous tumors in 11,429 patients. The screening rate, cancer detection rate, and five-year survival rate for these four types of cancer are shown in Tables 3-1 to 3-3.

(2) In 2015, there were 231 health institutions that implemented the Plan to Enhance the Quality of Cancer Screenings, Diagnosis, and Treatment in Hospitals, including 132 that offered outpatient screenings for the four major cancer types. A notification system in clinics alerted patients to the screenings and there was a single channel for referrals of positive cases. The institutions also cooperated with local health departments in conducting community-based screenings and hospital-based health education and betel quit cessation classes.

(3) In order to raise the quality of cancer screenings, quality reviews are made of health institutions that conduct such screenings. In 2015, accreditations were given to 117 institutions that conduct cervical cancer screenings, 204 that conduct mammograms, and 135 that conduct fecal occult blood tests. The Plan to Improve the Quality of Oral Mucosa Exams trained dentists and ENT physicians to join in the work of screening for oral cancer.

4. Improving the Quality of Cancer Care

(1) Since 2008, accreditation for cancer care quality has been offered to hospitals that treat at least 500 new cancer cases each year. By the end of 2015, a total of 55 hospitals had qualified.

(2) In 2015, the MOHW subsidized direct service plans for people with cancer by seven NGOs, so people with cancer and their families could receive comprehensive care and support.

(3) In 2015, there were 67 hospitals that took advantage of subsidies to operate Cancer Resource Centers with single-channel service. By combining resources from both inside and outside the hospital, they offered comprehensive services to patients and their families, for a total of approximately 160,000 visits.

(4) The MOHW commissioned 87 hospitals to conduct the Cancer Navigation Plan. Once a patient is diagnosed with cancer, they are contacted by a nurse navigator. Besides providing medical consultations, they encourage patients to receive treatment within three months and follow-up and care for each case for at least one year. In 2014, there were 98,000 patients newly diagnosed with cancer who were served by the plan about 90% of

Table 3-1 Screening Volume and Rate, Precancerous Lesions, and Cancer Cases for the Four Major Types of Cancer, 2015

Cancer Type	Screening Volume (Millions)	Screening Rate (%)	Precancerous Lesions	Cancer Cases
Cervical cancer	2.17	74.5	10,474	4,014
Breast cancer	0.774	39.5	-	3,701
Colon cancer	1.181	42.0	33,529	2,352
Oral cavity cancer	0.939	56.1	4,115	1,362
Total	5.064	-	48,118	11,429

Source:

Notes: Basis for Screening Rates

1. Cervical Cancer: The rate of women aged 30 - 69 who had received a screening for cervical cancer within the past three years (telephone survey).
2. Breast Cancer: The rate of women aged 45 - 69 who had received a screening for breast cancer within the past two years.
3. Colon Cancer: The rate of people aged 50 - 69 who had received a screening for colon cancer within the past two years.
4. Oral Cavity Cancer: The rate of betel quit chewers (including those who quit) or smokers aged 30 and older who had received a screening for oral cavity cancer within the past two years.
5. Precancerous Lesions: Morphologically atypical tissues that are benign but more likely to develop into cancer.

Table 3-2 Cancer Detection Rates for the Four Major Types of Cancer, 2015

Cancer Type	Cancer detection rate (Estimates based on 100% follow-up of positive cases)		
	Precancerous Lesions	Cancer	Total
Cervical cancer	1/90	1/347	1/71
Breast cancer	-	1/179	1/179
Colon cancer	1/24	1/347	1/23
Oral cavity cancer	1/181	1/546	1/136

Source:

Notes: Basis for Detection Rates

1. Precancerous Lesion Detection Rate (Based on 100% Follow Up): Defined as precancerous lesion cases/number of screenings
2. Cancer Detection Rate (Based on 100% Follow Up): Cancer cases/number of screenings
3. Overall Detection Rate (Based on 100% Follow Up): (Precancerous lesions + cancer cases)/number of screenings
4. 1/Detection Rate = Number of people who must be screened on average to detect one positive case

Table 3-3 Five-Year Survival Rate for Four Major Types of Cancers, 2015, by Stage

Unit: %

Stage	Female Breast Cancer	Cervical Cancer	Colon Cancer	Oral Cavity, Oropharynx and Hypopharynx Cancer
Stage 0	97.5	97.0	86.1	77.1
Stage 1	95.5	87.8	80.9	79.4
Stage 2	89.4	69.4	71.2	69.6
Stage 3	73.6	56.9	59.9	54.8
Stage 4	27.8	17.5	12.3	33.5

Source: Taiwan Cancer Registry database (includes carcinoma in situ)

Notes: Analyzed hospital-reported data on the five-year survival rate for four major types of cancers, by stage, from 2009 to 2013 (patient tracking through 2014)

whom underwent treatment within one month of diagnosis. Another 5,000 who refused treatment were urged to reconsider, leading the number of patients who had not undergone treatment within three months of diagnosis to fall to 9%.

Chapter 5 Health Communication, Information, and Surveillance

Section 1 Health Communication and Empowerment

We have pooled health education resources in order to implement health education, raise public awareness of health issues and help us reach the goals of promoting health knowledge.

1. Health Communication

(1) Setting Health Education Themes: The health promotion policy combined multiple important themes including Drug Abuse Prevention, Food Safety Education, Elder-Friendly Environments and Disease Prevention in 2015. Integrated marketing strategies are used to enhance people's understanding of health issues and improve their ability of self-management.

(2) Using websites, social networks and all varieties of communication media to spread out public health information. Propagating knowledge of Maternal Health, Tobacco Hazards Prevention, Healthy Cities and Locales, Weight Management, Chronic Disease Control, Cancer Control and other health issues to improve people's health.

2. In order to advance health educators' executive ability in practice. In 2015, The Ministry of Health and Welfare (MOHW) held four workshops based on two themes: Advocacy Experience Sharing & Reviews, and Improving Professional Capabilities. Up to 200 attendants were participated in the workshops.

Section 2 Health Information

By using information and communications cloud technology, the HPA has closely integrated national health management and mobile services. Through the launch of its " Wellness Cloud," it has become possible for more people to use mobile channels to obtain accurate health information and preventive health services, leading to better health.

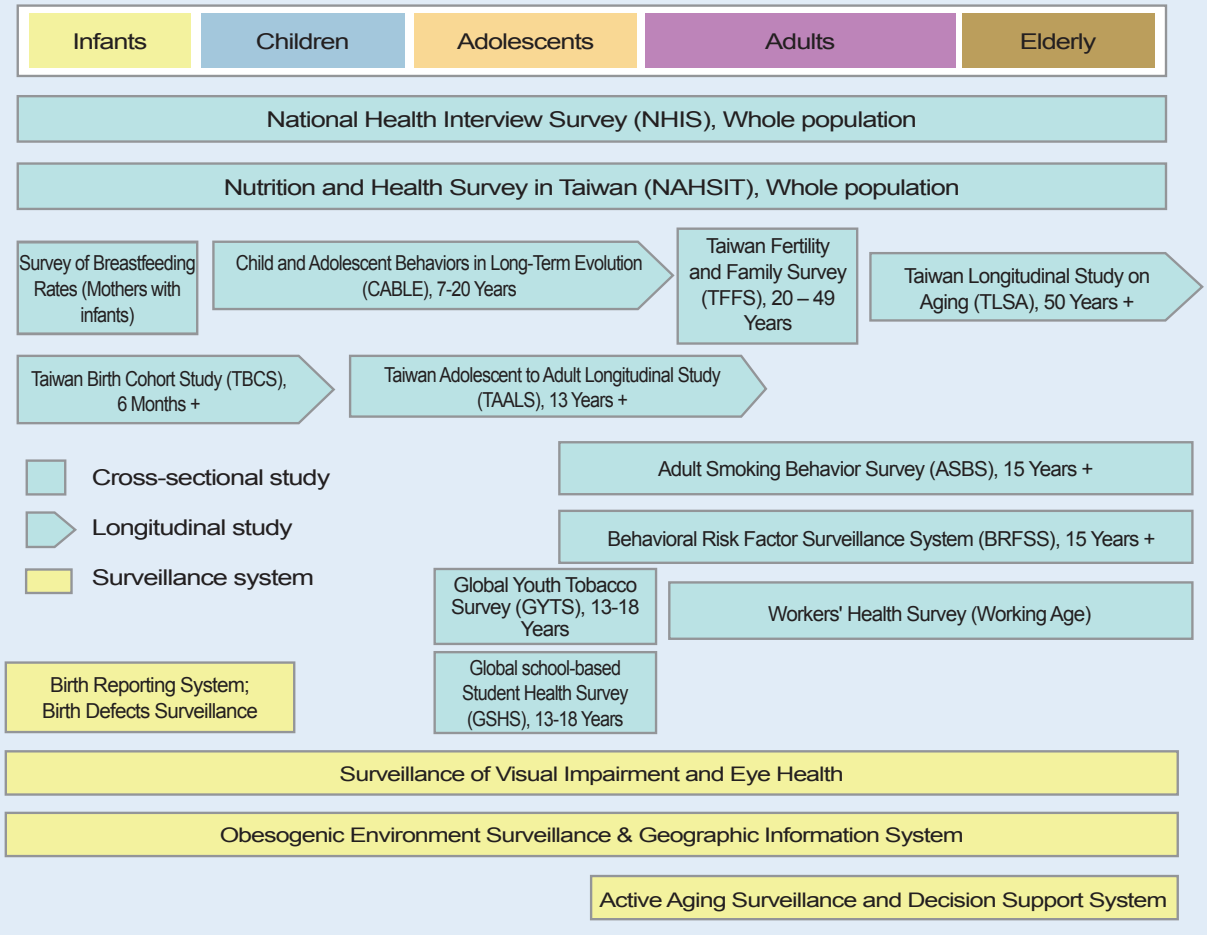
1. The Wellness platform and app provide the public with convenient tools for management of a healthy lifestyle and health examination records, health risk assessments and recommendations, and health alerts.
2. At the end of 2015, there were 178 sets of health data available on the government's Open Data Platform and 89 value-added applications had been commended.

Section 3 Health Surveillance

To inform adequate policy making for health promotion of the people, the MOHW developed the surveillance system and conducted health surveys to collect, analyze and disseminate policy relevant data continuously. The surveillance system for non-communicable diseases has been established and expanded gradually over the years.

1. To understand the current status and trends in the health of the whole population and people of different age groups, national health surveys are conducted regularly. Using data from the Nutrition and Health Survey in Taiwan, the MOHW was able to update data of nutritional status and noncommunicable disease of the people. Besides continued longitudinal studies of children, middle-aged people, and senior citizens, a longitudinal study aims to investigate health behavior changes from adolescence to adulthood was initiated and baseline survey was completed in 2015 (Figure 3-8).
2. To improve the framework and efficacy of reporting, registration, and monitoring systems, we referred to the system implemented by the European Surveillance of Congenital Anomalies (EUROCAT) and enhanced the birth defects recording of the birth reporting system by adopting the International Classification of Diseases codes. Statistical analysis of unintentional injuries was strengthened by better utilization of the existing data, e.g. cause of death statistics, NHI utilization, health surveys.
3. The MOHW developed multiple and diverse mechanisms to disseminate the surveillance and survey results, including a convenient and user-friendly online query system based on data from health surveys and birth reporting. More than 700 health indicators are available from the website (URL: https://olap.hpa.gov.tw/).

Figure 3-8 Major Health Surveillance and Surveys



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

4 Health Care

The rapid pace of change in the medical, social and economic environments presents significant challenges for Taiwan's health system and health providers. The key tasks that need to be addressed include: providing a holistic health care system for all, strengthening doctor-patient relations, implementing community health care and preventive medicine, and improving the overall health and quality of life of Taiwan's citizens.

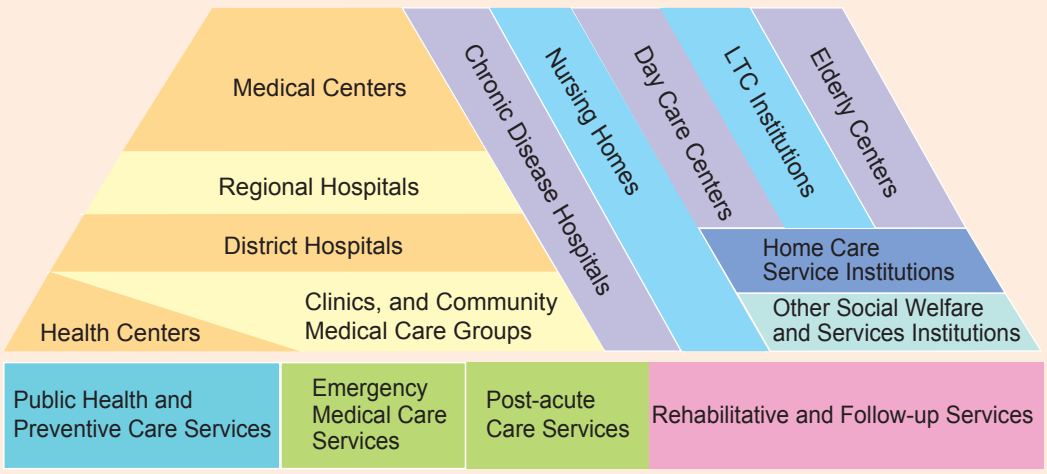
Chapter 1 Health Care Systems

Following the enactment of the Medical Care Act in 1985, the government implemented a medical facilities network project, whereby Taiwan was divided into 17 medical care regions; planning was undertaken for the allocation of medical human resources and facilities to each region, to ensure that medical resources were evenly distributed throughout the country and to enhance the standard of medical care provision in each region. This project was implemented in four stages over a 20-year period, and has now been successfully completed. The number of beds available in hospitals has grown steadily, and the overall quality of medical care has been significantly enhanced. Following the Severe Acute Respiratory Syndrome (SARS) the epidemic of 2003, the medical system in Taiwan was overhauled. The Holistic Health Care Plan, which was implemented over the period 2005 – 2008, emphasized patient safety and a patient-centric approach to medical service provision, while also promoting the development of a community-based healthcare system. In 2009 – 2012, in response to the aging of the population, the trend towards smaller families, and changing patterns of disease occurrence, Taiwan implemented the New Generation Health Navigation Project, intended to strengthen the provision of user-friendly, accessible, sustainable, integrated holistic healthcare services to all of Taiwan's citizens. This was followed in 2013 – 2016 by the Equitable Healthcare Provision Plan, which sought to enhance the level of coordination in the healthcare delivery system (in line with the changes made in the structure of the Executive Yuan), with the establishment of an integrated, sustainable public health and medical service network that is rooted in the local community. The overall structure of Taiwan's current healthcare system is shown in Figure 4-1 below.

Section 1 Medical Care Resources

With the aim of promoting balanced development of medical care resources, the Ministry of Health and Welfare (MOHW) has established a regional medical care system in accordance with the Medical Care Act and the Medical Care Network Project. Making use of regional guidance and the operation of related organizations, the MOHW assessed the health needs of citizens in each area, and implemented various projects to ensure

Figure 4-1 Current Health Care Systems



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

the equitable allocation of medical care resources between regions and to enhance the overall quality of care in all regions. The main results achieved in 2015 were as follows:

1. Current Status of Medical Institutions

   As of 2014, there were 22,177 medical institutions in Taiwan, along with 7,922 pharmacies, 1,251 nursing institutions, 18 blood donation institutions, 10 pathology institutions, and 1,549 other medical institutions (such as midwifery practices and medical laboratories, etc.) (Table 4-1).

2. Current Status of Hospital Beds

   In 2015, there were 133,335 beds in medical care institutions (including general beds, special beds, specially designated beds and beds in clinics), with general beds for acute care, general beds for chronic care, beds for psychiatric acute care, and beds for psychiatric chronic care included among general beds in hospitals. There were an average of 56.8 beds for every 10,000 people in Taiwan (Figure 4-2).

Section 2 Emergency Health Care and Rescue

The MOHW has been working to strengthen the national emergency medical care and rescue network, actively promoting the development of integrated emergency response mechanisms.

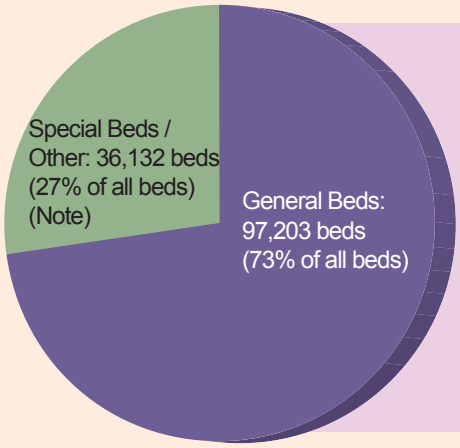
1. The MOHW has continued to strengthen the capabilities of Taiwan's six Regional Emergency Medical Operation Centers (REMOCs), with timely monitoring of intra-regional emergency situations and resource utilization status, and the provision of assistance to support coordinated disaster response across county and city boundaries.

Table 4-1 Status of Medical Institutions, 2015

Type of Medical Institution		No. of Institutions
Medical Care Institutions	Hospitals	494
	Clinics	21,683
Pharmacies		7,922
Nursing Institutions	General Nursing Homes	500
	Psychiatric Nursing Homes	37
	Home Care Practices	513
	Post-Natal Nursing Institutions	201
Blood Donation Institutions	Blood Donation Centers	6
	Blood Donation Stations	12
Pathology Institutions		10
Other Medical Institutions	Midwifery Practices	25
	Medical Laboratories	407
	Medical Radiological Institutions	58
	Physical Therapy Practices	92
	Occupational Therapy Practices	14
	Denture Clinics	49
	Mental Counseling Clinics	52
	Psychotherapy Clinics	30
	Speech Therapy Centers	19
	Dental Technology Centers	771
	Hearing Centers	10
	Home Respiratory Care Practices	1
	Nutrition Advisory Organizations	21

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Figure 4-2 Status of Hospital Beds in Medical Care Institutions, 2014



- General Beds for Acute Care: 72,255 beds
- General Beds for Chronic Care: 3,527 beds
- General Beds for Psychiatric Acute Care: 7,408 beds
- General Beds for Psychiatric Chronic Care: 13,810 beds
- Beds for Hansen's Disease Patients: 201
- Beds for Chronic Tuberculosis: 2

Note: Includes intensive care beds, intensive care beds for psychiatric patients, intensive care beds for burn patients, general beds for burn patients, subacute respiratory care beds, chronic respiratory care beds, isolation beds, beds for bone marrow transplant patients, hospice beds, infant sickbeds, infant beds, hemodialysis beds, peritoneal dialysis beds, surgery recovery beds, emergency observation beds, and beds for sex offenders undergoing compulsory treatment.

2. As of 2015, a total of 36 hospitals had been designated as capable of handling severe emergency situations, and 82 hospitals had qualified as being able to handle moderate-severity emergency situations; 43 of Taiwan's sub-regions had at least one hospital designated as being capable of handling at least moderate-severity emergency situations. These figures reflect the steady improvement in Taiwanese hospitals' emergency and acute care capabilities, which ensures that people throughout the country can rely on receiving high-quality emergency care.
3. The MOHW has been implementing an improvement project targeting districts with inadequate emergency medical care resources, involving the establishment of three treatment models: emergency medical stations in areas that receive large numbers of tourists; first-aid stations that are open at night, on weekends and on public holidays; strengthening the emergency medical care capabilities of hospitals located in districts with limited emergency medical care resources. In 2015, special incentives were used to promote the development of these treatment models in 19 districts.
4. The MOHW has continued to implement an incentive program which encourages medical centers to provide emergency care support on outlying islands and in areas with insufficient medical care resources. Nineteen medical centers have been participating in this program, providing a combined total of 72 acute and critical care doctors to assist in 18 outlying islands and areas with insufficient medical care resources. This program is helping to strengthen medical care resources and enhance the quality of care provided, making it easier for people in these communities to receive the medical assistance they need.
5. As of the end of 2015, there were approximately 10,235 automated external defibrillators (AEDs) in Taiwan, equivalent to 44.5 AEDs for every 100,000 people. A total of 6,575 AEDs were registered on a network of AEDs located in public places, with 2,672 locations designated as "safe locations" (denoting that there is an AED available in that location, and that at least 70% of employees working in that location have completed CPR and AED training). In all, around 30,000 people had undergone training in AED use.

6. When the Formosa Fun Coast explosion incident occurred on June 27, 2015, the MOHW immediately activated its large-scale incident response mechanism, allocating extensive medical resources to treat the burn victims. A total of 499 people were injured in the incident; on average, the victims suffered burns over 41% of the body. The victims were treated at 53 hospitals throughout Taiwan. As of the end of 2015, 461 of the victims (92.4%) had been released from hospital, 23 (4.6%) were still receiving treatment in hospital, and 15 (3%) had died from their injuries. To provide recognition for the efforts made by so many medical personnel, involving effective team-based care and close collaboration with the public health authorities and with local communities, the MOHW organized the "2015 MOHW Emergency Care Provision Awards and Ceremony for Honoring Personnel Who Made a Significant Contribution in the Aftermath of the Formosa Fun Coast Explosion Incident", to express the government's thanks for the selfless dedication of the nation's emergency health care providers.

Section 3 Post-acute Care Services

Post-acute care is intermediary between intensive care and long-term basic care. It combines several professional teams - including those offering acute care, nursing home services, geriatric day care, and home care - to offer patients a seamless chain of health care services. After a patient who has completed acute care has been evaluated to determine suitability, and either the patient or his or her family grants approval, a period of post-acute care lasting 3 - 6 weeks may begin. During the post-acute care period, guidance is offered on returning home, and arrangements are made for home care. After post-acute care services have ended, a case manager handles follow-up procedures.

As of the end of 2015, the National Health Insurance Administration (NHIA), MOHW was continuing to implement a "Post-acute Care Pilot Program", focusing initially on stroke patients. A total of 157 hospitals were participating in the program, with 23 hospitals providing post-acute care services through 39 medical teams. In 2015, a total of 3,302 patients were admitted to the program. 87.4% of these patients experienced an improvement in body function, 85.4% were able to return home, and 86.9% expressed satisfaction with the post-acute care service that they had received. The Post-acute Care Plan for Burns (BPAC), implementation of which began on September 9, 2015, expands the scope of post-acute care to include burn victims, providing community-based post-acute care and rehabilitation services for burn victims.

Section 4 Hospice and Palliative Care

Implementation of the Hospice Palliative Care Act on June 7, 2000 paved the way for doctors to focus on relieving symptoms, eliminating suffering, and offering support to terminally ill patients who are near death, in lieu of curative- and rescue-oriented care; patient consent is a prerequisite.

The "2015 MOHW Emergency Care Provision Awards and Ceremony for Honoring Personnel Who Made a Significant Contribution in the Aftermath of the Formosa Fun Coast Explosion Incident", held on December 30, 2015

Starting form 2006, a special project has sought to raise the willingness of medical care institutions and the general public to participate in hospice and palliative care, while encouraging NHI-enrolled persons to record consent on their NHI IC cards. As of the end of 2015, a total of 310,182 people had signed a document expressing their willingness to undergo hospital and palliative care, along with their wishes in relation to life-sustaining treatment. Each person's choices were recorded on his or her NHI IC card (Figure 4-3).

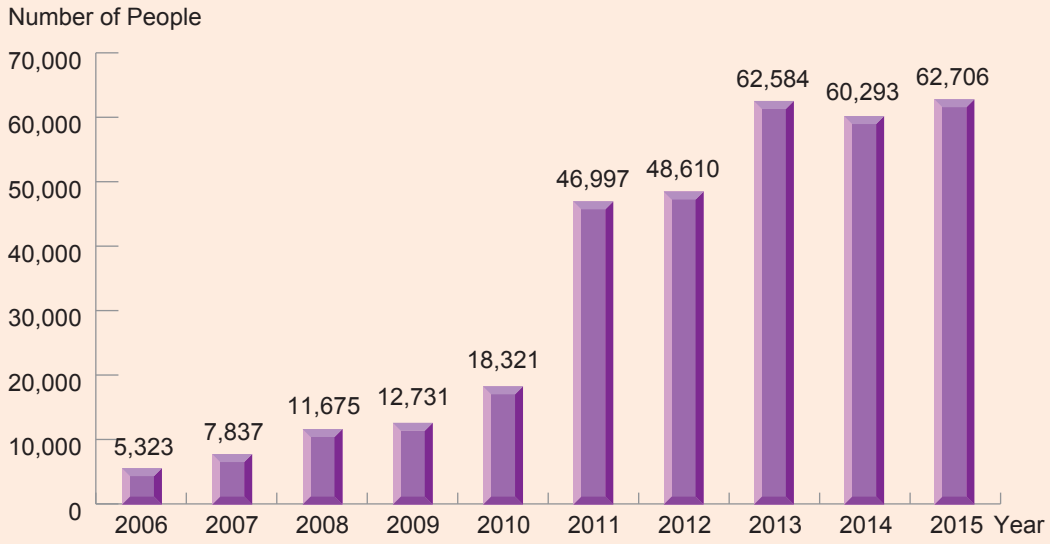
As of 2015, there were 53 hospitals in Taiwan that provided hospice services to inpatients, 135 hospitals that were participating in a collaborative hospice care provision program, 88 that provided hospice care to patients in their own homes, and 107 that were involved in community-based hospice care services. In accordance with the needs of individual terminally-ill patients, medical teams provide an interconnected network of hospice and palliative care services for patients in hospital, after leaving hospital, in the community and at home. Both collaborative hospice care provision service and community-based hospice care service were brought within the scope of NHI coverage, in April 2011 and January 2014 respectively. In 2015, approximately 37,000 people in Taiwan received end-of-life care, representing a 23% increase compared to 2014. The percentage of cancer patients who received hospice care in the year prior to their deaths rose from 23% in 2010 to 49% in 2014.

Section 5 Oral Health Care

1. Better Dental Care for the Disabled

(1) The MOHW has continued to promote "Dental Care Services for People with Special Requirements." In 2015, the "Coordinated Dental Care Plan for People with Special Requirements" was implemented with the provision of subsidies for seven model centers (National Taiwan University Hospital, Shuang Ho Hospital, Chung Shan Medical University Hospital, National Cheng Kung University Hospital, Kaohsiung Medical University Hospital, National Yang-Ming University Hospital, and Mennonite Christian Hospital) and 23 hospitals. The Plan involves encouraging hospitals to establish special dental outpatient services for patients with special needs, building support and transfer networks between hospitals and social welfare organizations, and offering special training for dentists and caregivers, so as to enhance the overall quality of care received by patients with special requirements. In 2015, services were provided under this Plan on 29,240 occasions.

Figure 4-3 Number of People Who Have Had Their Hospice and Palliative Care Intentions Recorded on Their NHI IC Cards



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

(2) A total of 89 hospitals in counties and cities throughout Taiwan have been designated to provide special dental outpatient service for the disabled in accordance with the provisions of the Act for the Management of Special Outpatient Services for the Disabled.

2. Continued Implementation of Dental Health Services for Young Children

(1) The MOHW has continued to provide topical fluoride application service every six months for young children under the age of six, and every three months for children under the age of 12 in low-income households, disabled children, children living in aboriginal (indigenous) districts, and children living on outlying islands or in remote areas. In 2015, topical fluoride application service was provided on 1.07 million occasions, with 77.3% of children aged 3 - 6 receiving the service at least once over the course of the year.

(2) Starting from September 2014, the MOHW has been providing cavity filling service for permanent molars for all first-grade elementary school students and for both first- and second-grade students in the case of members of aboriginal (indigenous) communities, children living on outlying islands, disabled children, and children in low-income and medium-to-low-income households. In 2015, this service was provided on 260,000 occasions.

(3) The MOHW has also continued to promote the administration of anti-plaque fluoride mouthwash for elementary school students throughout Taiwan. In 2015, this service was provided to 1.15 million children, representing a coverage rate of around 90%.

3. Provision of Subsidized Dentures for Medium-to-Low-Income Senior Citizens

A plan to provide subsidized dentures for medium-to-low income senior citizens that was launched on January 1, 2009 offers subsidized dentures to: senior citizens living in low-income or medium-to-low-income households; recipients of living allowances for medium-to-low-income senior citizens; senior citizens who are recipients of living subsidies for medium-to-low income disabled persons; senior citizens who are recipients of full-placement subsidies from any level of government; and senior citizens who quality for at least 50% subsidized daily care and living care expenses from any level of government. From 2009 to the end of 2015, more than 41,520 people had benefited from this program. In addition, starting from 2013 the amount of subsidy available for denture repair was increased, so as to help improve chewing function for medium-to-low-income senior citizens.

Chapter 2 Mental Health and Psychiatric Care

Section 1 Mental Health Promotion Strategies

1. In order to enhance awareness and understanding of mental health issues among the general public, in 2015 the MOHW produced four promotional posters (and leaflets), on the following topics: "Mental Health and Happiness," "Mental Health in the Workplace," "Promoting the Mental Health of Home Caregivers," and "Mental Health for Senior Citizens (Staying Cheerful and Healthy)." These leaflets were distributed to county and city government Public Health Bureaus, to the Ministry of the Interior, and to the Ministry of Labor, as part of a concerted effort to spread awareness of important mental health concepts. In all, a total of 3,200 posters and 40,000 leaflets were distributed. Additional exposure was achieved through other media, including the use of Taipei Metro advertising light boxes, public address system announcements, the Upaper (a free newspaper distributed in Taipei Metro stations), online banner advertising, etc. In addition, a special "Love, Care, Mental Health and Happiness" press conference was held on World Mental Health Day, to spread awareness of the importance of mental health.

2. To promote primary mental health preventive work and realize the vision of enhanced wellbeing and mental health for all, the MOHW has been promoting the establishment of mental health networks in each of Taiwan's counties and cities. In 2015, the MOHW commissioned 21 county and city government

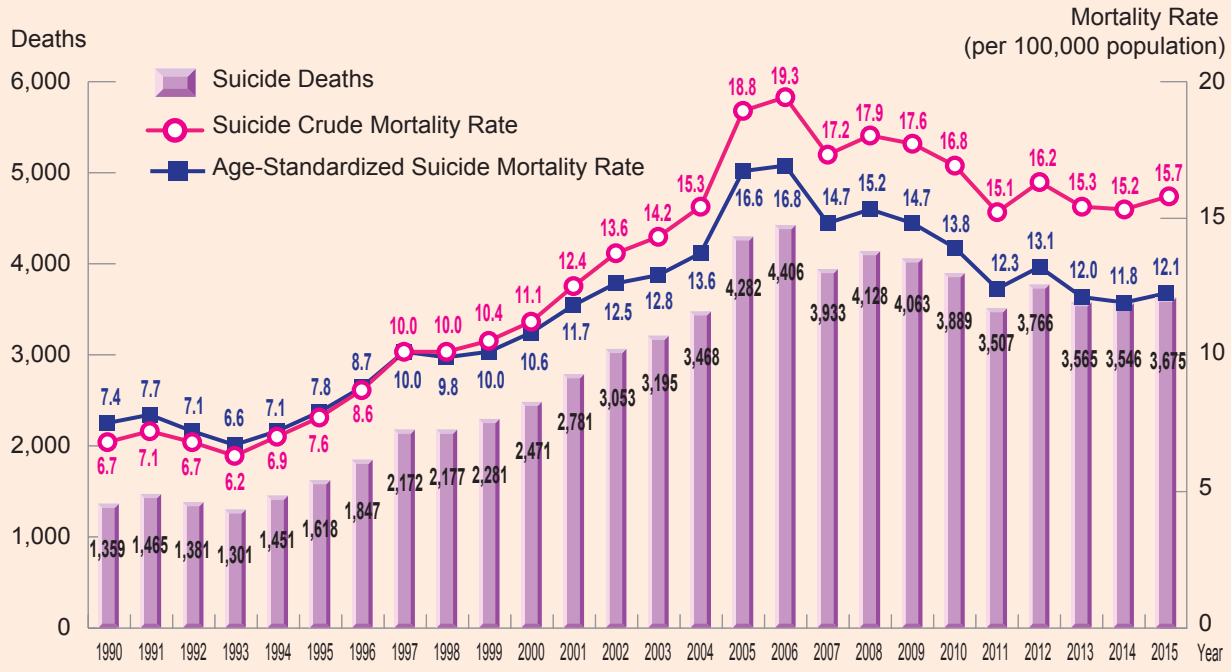
Public Health Bureaus to implement the "Mental Health Network Promotion Pilot Project." The results achieved by the counties and cities participating in the pilot project were very impressive, and included the following: Mental health promotion task-forces were established in each county and city, and network coordination meetings were held, as well as 1,668 spotlight activities, which were attended by 121,393 people; the average level of satisfaction expressed by ordinary citizens participating in these activities was 93%. In addition, maps of county and city mental health networks were compiled, and various types of mental health education resources were put in place.

3. The MOHW implemented the "Mental Health Promotion Policy White Paper Compilation Plan," addressing seven mental health promotion core issues: infants, children and teenagers; middle-aged people; senior citizens; members of aboriginal (indigenous) communities; the disabled; care-givers; and the media. Short-term (2016 - 2018), medium-term (2019 - 2021) and long-term (2022 - 2025) objectives, strategies and measures were formulated, taking into account multiple perspectives: the individual; families and households; schools, institutions and organizations; communities, neighborhoods and districts; social, cultural and religious aspects; national-level and policy aspects, etc.
4. In 2015, the MOHW provided funding support for 18 Mental Health Promotion Plans, falling into eight categories: mental health for preschool children; mental health for schoolchildren; workplace and labor mental health; premarital education and family mental health; mental health in aboriginal (indigenous) communities; mental health for long-term care providers; training of mental health education volunteers; and mental health promotion targeting ordinary members of the public. The overall goal of this funding support provision was to help put in place relevant health education resources and to cultivate the necessary specialist human resources, thereby helping to strengthen Taiwan's mental health promotion infrastructure in its various aspects.
5. The MOHW has established a toll-free, 24-hour suicide prevention hot-line (0800-788995), which provided expert counseling on 70,574 occasions in 2015, helping 12,152 people who had been considering suicide, and directly preventing 464 suicide attempts.
6. In order to strengthen suicide prevention, the MOHW has continued to implement reporting of all suicide-related cases, arrange outreach visits, and implement work aimed at helping people overcome crises that have led to thoughts of suicide; the MOHW has also worked to coordinate suicide prevention resources and promote diversified suicide prevention services. In 2015, there were 29,914 reported suicide attempts in Taiwan, and a total of 208,988 outreach visits were made.
7. In 2015, there were 3,675 deaths by suicide in Taiwan, representing a decrease of 731 compared to the 2006 total of 4,406 deaths (Figure 4-4). Nevertheless, with more than 3,000 people killing themselves every year, in the future the MOHW will continue its efforts to have both central government and local government authorities strengthen the social safety net, promoting the implementation of outreach visits, suicide prevention counseling, suicide prevention hot-line provision and other suicide prevention strategies.
8. The MOHW provided funding support to help Tsaotun Psychiatric Center, MOHW expand and revise the "Disaster-related Mental Health Handbook", and implement "train the trainers" training programs; a total of 254 trainers received training through this program.

Section 2 Psychiatric Health Services

1. In order to further enhance the health care services provided to psychiatric patients, the MOHW has been implementing a plan to develop seven regional psychiatric care networks. Within these networks, designated core hospitals play the following roles: (1) Serving as regional psychiatric care units, promoting mental health within the region and leading the development of the regional psychiatric care network. (2) Cooperating with local Public Health Bureaus to help improve the quality of care provided by psychiatric care institutions within the regional psychiatric care

Figure 4-4 Suicide Deaths and the Suicide Mortality Rate in Taiwan, 1990 - 2015



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

network. (3) Developing specialist mental health and psychiatric care services. (4) Arranging education and training programs for health professionals within the regional network.

2. In 2015, there were 461 psychiatric care institutions in Taiwan, equipped with a total of 21,218 beds (including 7,408 beds for emergency psychiatric patients and 13,810 beds for chronic psychiatric patients), equivalent to approximately 9.04 beds for every 10,000 people in the population. There were also 67 daytime psychiatric rehabilitation institutions (capable of serving 3,281 persons), 132 psychiatric rehabilitation institutions that offered accommodation (with 5,519 beds), a number of psychiatric day care centers (capable of serving 6,333 persons), and 37 nursing care institutions (with 3,494 beds).
3. In order to demonstrate effective concern for mental patients in the community, the MOHW provided subsidies to help county and city governments recruit a total of 96 outreach associates. Periodic outreach visits are made according to a system of categories based on the severity of the patient's condition. In 2015, a total of 699,815 outreach visits were made to 142,416 patients.
4. The MOHW commissioned the Taiwanese Society of Psychiatry to implement screening review with respect to patients with serious mental illnesses requiring mandatory hospitalization or mandatory community care. In 2015, there were 747 applications approved (including 677 applications for mandatory hospitalization and 70 for mandatory community care).
5. In 2015, the MOHW carried out evaluation inspections of 11 psychiatric medical care institutions (including psychiatric teaching hospitals), 63 psychiatric rehabilitation institutions, and 17 psychiatric nursing care institutions; in addition, occasional follow-up and guidance was conducted for 22 institutions. (Table 4-2)
6. The MOHW has published a series of "Mental Health Guides" that take into account the mental health care needs of the general public and the importance of holistic care planning. There were 13 such guides published in 2015: "Learn About Mental Illness," "Dealing

Table 4-2 The Number of Psychiatric Care Institutions in Taiwan in 2015, and Evaluation Results

Psychiatric Care Institution Category		No. of Institutions	Total No. of Beds	No. of Institutions Evaluated in 2015	Evaluation Results		
					Outstanding	Acceptable	Not acceptable
Psychiatric hospitals	Teaching hospitals	11	21,218	3	-	3	0
	Non-teaching hospitals	35		8	1	7	0
General hospitals with a psychiatric care department		151		-			
Clinics with a psychiatric care department		264					
Psychiatric rehabilitation institutions	Daytime only	67	3,281	14	-	14	0
	With residential accommodation	132	5,519	49	-	46	3
Psychiatric nursing homes		37	3,494	17	-	15	2

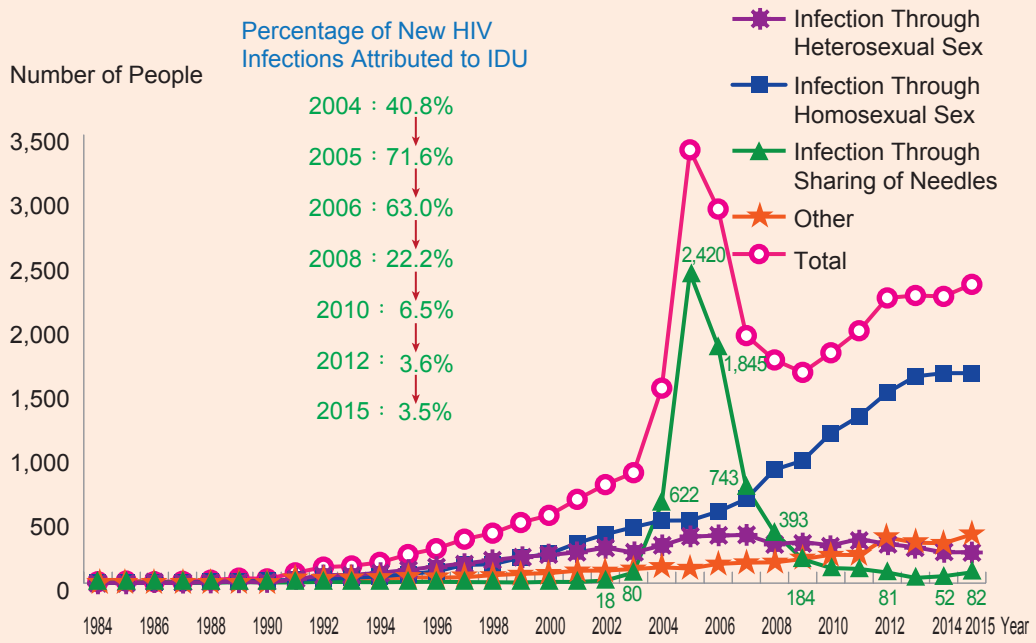
Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

with Autism," "Attention Deficit Disorder," "Learning and Mental Health," "Gender Identity Disorder," "Sleep and Mental Health," "Drug Addiction and Mental Health," "Learn About Schizophrenia," "Recognize Depression, Face Up to Depression, and Say Goodbye to Depression - The Depression Self-help Manual," "How to Overcome Anxiety Disorder," "Physical Symptoms and Mental Health," "Trauma/Pressure and Mental Health," and "Overcoming Internet Addiction - A Comprehensive Handbook for Smartphone Users and Other Internet Users," Copies of these guides have been distributed to relevant institutions for their reference, and the guides are also available to the general public on the MOHW website.

Section 3 Control of Drug Addiction

1. Subsidized alternative therapy for drug addiction was introduced in 2006. As of the end of 2015, a total of 162 institutions throughout Taiwan were providing alternative therapy, with a cumulative total of 41,762 patients treated. In 2015, on average, 8,789 patients received treatment every day. The number of new HIV cases among drug addicts per year has fallen from 2,420 in 2005 to 82 in 2015 (Figure 4-5).
2. As of the end of 2015, there were 162 designated drug addiction treatment institutions in Taiwan, with a combined staff of 1,849 (including psychiatrists, pharmacists, nurses, clinical psychologists, occupational therapy specialists, social workers, etc.), providing addiction treatment emergency services, hospitalization, and post-discharge follow-up in the community for drug addicts who voluntarily seek help. The regional psychiatric care networks' core hospitals were responsible for providing continuing education and training to these personnel, in order to strengthen their professional competence.
3. Under the "Subsidy Program for the Treatment of Non-Opiate Addicts," which was launched in July 2014, the provision of financial assistance to help addicts receive treatment for their addiction has significantly reduced the financial burden on addicts, and has substantially enhanced the willingness of addicts who had previously been keeping a low profile within the community to seek help in dealing with their addiction. In 2015, the maximum amount of subsidy available per person per year was increased to NT$25,000, with a total of 441 people benefiting from the program.
4. Tsaotun Psychiatric Center, MOHW received funding support to develop a "Community Treatment and Rehabilitation Model for Users of Schedule III and Schedule IV Drugs." A total of 59 users of Schedule III and Schedule IV drugs have received treatment under this program, with a total of 8,259 person-days of treatment provided. Details of the model uses have been combined in the form of guidelines,

Figure 4-5 No. of HIV Infections by Route of Transmission, 1993 - 2015



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

with the aim of promoting widespread adoption of the "drug addict treatment community" model. The MOHW provided subsidies to help eight civic organizations implement the "Drug Addict Psychological Counseling and Social Rehabilitation Work Plan." Living support was provided for 54 addicts, 6 were helped to secure rental accommodation, and various other forms of assistance (including living guidance, psychological support, household support, vocational skills training, guidance for securing employment, and job matching services, etc.) were provided on a total of 4,898 occasions.

5. The MOHW implemented the "Alcohol Addiction Treatment Plan," which involved the provision of funding support for treatment targeting specific groups, including people who voluntarily asked for assistance, domestic violence offenders, high-risk family members etc. The subsidies covered the cost of hospitalization, clinical reatment, psychotherapy and family therapy. In 2015, subsidies were provided to help a total of 1,193 people. In addition, the MOHW provided subsidies to help four hospitals implement the "Project for the Establishment of a Treatment and Social Rehabilitation Service Model for Problem Drinkers and Alcohol Addicts, which brought together a network of agencies (including the public health authorities, social affairs agencies, district prosecutors offices, motor vehicle registration offices etc.) to establish a mechanism for the medical referral of problem drinkers and alcohol addicts; a wide range of harm mitigation and addiction treatment and social rehabilitation methods have been developed to meet individual needs, with the aim of facilitating early identification and early-stage treatment.

6. Funds from Taiwan's national lottery have been used to subsidize the recruitment of social workers by local governments and NGOs, to provide family support services for drug addicts, including outreach visits, daily living support, family activities, and resource referral, etc., so as to improve the lives and social functioning of drug addicts and their family members, and help reintegrate drug addicts back into society. In 2015, subsidies were provided to 19 county and city governments and 1 NGO, with services being provided on a total of 197,462 occasions.

Chapter 3 Long-Term Care Service Systems

Taiwan's population structure is rapidly becoming an aging society. Therefore, the establishment of sound long-term care service systems has become a key issue for Taiwan's social security. Since 2008, the MOHW has been establishing long-term care service policies in several stages. The first stage is the National Ten-year Long-Term Care Plan. The second stage is the Long-term Care Service Network Plan and the Long-term Care Services Act. In November 2015, the Long-term Care Capacity and Capability Plan was put into motion, to provide a bridging plan for long-term care. The Long-term Care Services Act was announced in June of the same year, and will be fully implemented in 2017. The MOHW is currently working on the establishment of relevant regulations and planning related supporting measures. (Figure 4-6)

Section 1 Universal Long-Term Care Services

In order to build a comprehensive long-term care (LTC) system in Taiwan, a three-stage program has been established as follows:

1. Stage 1: Implementation of the "National Ten-year Long-term Care Plan"

(1) Continued implementation of the "National Ten-year Long-term Care Plan": Development of a community-based aging-in-place network.

a. Raising the service usage rate: Usage among senior citizens who had lost functional ability rose from 2.3% in 2008 to 35% in late 2015, representing a 15-fold increase.

b. Accelerating resource expansion:

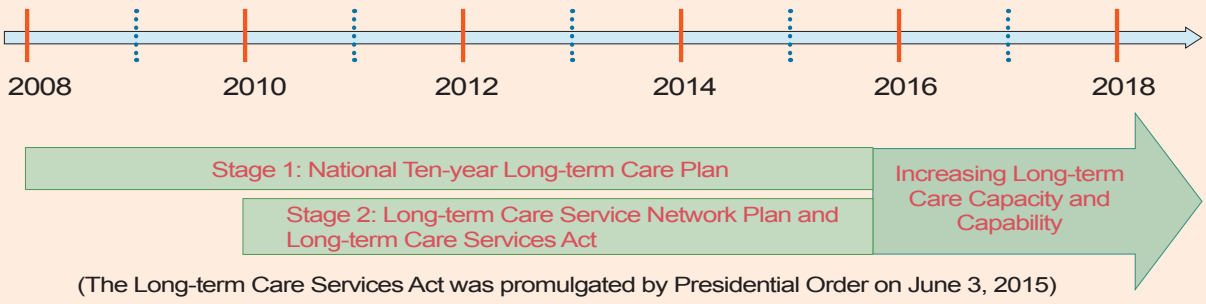
a) In areas with insufficient elderly welfare institutions, the main focus has been placed on subsidizing the establishment of such institutions by private organizations. In areas with sufficient resources, emphasis has been placed on providing the guidance and improvements needed to enhance institutions' service quality.

b) Overall service capacity has risen by 84%, with the biggest gains being seen in day care service, where the number of institutions providing this kind of service has increased from 31 in late 2008 to 178 in 2015, a nearly six-fold increase (Tables 4-3 and 4-4).

c) As of December 2015, there were 104,742 beds available at institutions providing residential care, comprising 37,032 beds (with 85.8% occupancy) at general nursing homes, 59,869 beds (with 77.3% occupancy) at LTC and elderly centers, and 8,200 beds at veterans' homes.

(2) Making LTC a more feasible option for the economically disadvantaged: Analysis of socioeconomic data for LTC cases throughout Taiwan over a five-year period shows that medium- to low-income households accounted for 12% of all households receiving assistance (and 4% of all medium- to low-income households in Taiwan), while low-income households accounted for 14% (and 1% of all

Figure 4-6 Long-Term Care Planning Chart



(The Long-term Care Services Act was promulgated by Presidential Order on June 3, 2015)

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 4-3 Services Provided by Institutions Offering LTC Home-Care and Community-Based Care

Unit: Institutions

Item / Year	2008	2009	2010	2011	2012	2013	2014	2015
Home Care Service	124	127	133	144	149	160	168	173
Day Care Center (including day care centers for senior citizens suffering from Alzheimer's)	31	39	66	78	90	120	150	178
Household Entrusted Services	4	16	23	16	17	20	22	21
Nutrition Meals for the Elderly	166	204	201	159	169	190	209	197
Transportation Service	31	42	43	39	43	42	41	41
Home Nursing Care	487	495	489	451	498	478	486	494
Home/Community Rehabilitation	62	88	113	112	111	191	143	143
Respite Care Services	102	114	311	474	527	651	1,549	1,565
Total	1,007	1,125	1,379	1,473	1,604	1,852	2,768	2,812

Notes: Declines in elderly nutrition meals and transportation services in 2011 were attributable to adjustments in local government planning and implementation. There was no impact on overall service capacity.

Table 4-4 No. of Persons Receiving LTC Services

Unit: Persons

Item / Year		2008	2009	2010	2011	2012	2013	2014	2015
Care Services	Home Care Service	22,305	22,017	27,800	33,188	37,985	40,677	43,331	45,173
	Day Care	339	618	785	1,213	1,483	1,832	2,344	3,002
Household Entrusted Services		1	11	35	62	110	131	146	200
Assistive Device Purchases/ Rentals and Handicap-Friendly Improvements to Residences (Instances)		2,734	4,184	6,112	6,845	6,240	6,817	6,773	7,016
Nutrition Meals for the Elderly		5,356	4,695	5,267	6,048	5,824	5,714	5,074	5,520
Transportation Services (Instances)		7,232	18,685	21,916	37,436	46,171	51,137	54,284	57,618
LTC Institutions		1,875	2,370	2,405	2,755	2,720	2,850	3,127	3,426
Home Nursing		1,690	5,249	9,443	15,194	20,882	21,258	23,933	24,547
Home/Community Rehabilitation		1,765	5,523	9,511	15,439	16,303	21,209	25,583	27,417
Respite Care Services		2,250	6,351	9,267	12,296	17,471	32,629	33,356	39,135

Notes: 1. Figures for assistive device purchase/rental and handicap-friendly improvements to residences, as well as for transportation services, refer to to cumulative total number of people who received service over the year. Figures for other items indicate the number of people receiving service as of the end of December.
2. Implementation of assistive device purchase/rental and handicap-friendly improvements to residences, as well as elderly meals and LTC institutions, are dependent on the amount of the budget allocated by individual county and city governments.

low-income households in Taiwan); overall, economically-disadvantaged households could be said to be receiving more support than the population as a whole.

2. Stage 2: Implementation of the Long-term Care Service Network Plan and Enactment of the Long-term Care Services Act

(1) Implementation of the Long-term Care Service Network Plan

An LTC service network plan, drafted with the intent of promoting the development of diversified, balanced LTC resources, has fostered a universal service network that brings LTC services to communities throughout Taiwan (including remote areas). The plan divides the nation into large (22), medium-sized (63) and small (368) LTC regions based on service requirements; it includes incentives for resource development, and is focused on

community-based resources that meet local needs. As of December 2015, the following items had already been completed:

a. A total of 233 day care institutions of various types have been established (including 178 day care centers, 52 day care stations, and 3 aboriginal community cultural and health facilities), as well as 27 dementia-focused community service centers. Eighty-nine regions that had previously lacked LTC resources have had service locations established, along with the allocation of other resources, and approval has been given for the provision of subsidies to support the establishment of facilities with accommodation in two regions that previously lacked them.

b. Promotion of telecare

a) As part of the efforts to build a comprehensive, "smart" care service system that will increase usage of LTC and spur the development of the health care industry, as of the end of 2015 a total of 966 community-based biometric measurement service locations had been established in 12 counties and cities (Kaohsiung City, Tainan City, Taoyuan City, Chiayi County, Pingtung County, Changhua County, Yilan County, Hsinchu County, Hsinchu City, Taitung County, Hualien County, and Penghu County). The government has also provided biometric measurement services for 1,903 senior citizens living alone. In all, the number of registered users of biometric measurement services has reached 41,021, with a cumulative total of 392,485 sets of measurements made to date.

b) In order to ensure that the security of citizens' health care data is protected, the "Guidelines for Maintaining the Security of Telecare Personal Data" were promulgated on November 10, 2014.

c) A group of companies from various industries has been brought together to form a biometric measurement and data transmission equipment alliance, with the MOHW providing measurement standards and procedures, etc.; to date, a total of 23 firms have been involved in the completion of 104 individual projects, and eight firms have applied for licensing of related official applications.

(2) Enactment of the Long-Term Care Services Act:

The Long-Term Care Services Act passed its third reading in the Legislative Yuan on May 15, 2015, and was promulgated by Presidential Order on June 3, 2015; implementation was scheduled to begin in June 2017. The Act contains seven chapters and a total of 66 articles, with content covering long-term care services, personnel management, institutions management, protection of interest of service receivers, and incentives for continued service development. The Act represents a solid foundation for the ongoing development of long-term care services and systems in Taiwan.

Section 2 LTC Human Resources

1. Results achieved in the cultivation of specialist LTC human resources

(1) A three-stage training and development program has been implemented for the cultivation of specialist LTC human resources, with a cumulative total of 35,091 people undergoing training by December 2015. The overall total of trained care service personnel is now 110,263 personnel.

(2) As regards efforts to strengthen localized training of specialist LTC personnel, the MOHW has been working to cultivate local assessment specialists and other specialist LTC staff, with the aim of enhancing LTC human resources availability at the local level. As of the end of 2015, a total of 1,040 specialist personnel had been cultivated, including 165 care management specialists and 875 LTC-related medical specialists; the trainee retention rate was 74%.

(3) In order to make it easier and more convenient for LTC personnel to receive training, an LTC specialist training e-learning program was launched; the new training system was scheduled to come on-line in 2017.

2. Expansion and retention of the care service workforce

(1) Strengthened cultivation of care workers, and improved salaries and working conditions: A

vocational training system has been used to encourage more middle-aged workers and people seeking a second career to join the LTC service sector. Starting from July 1, 2014, the standard hourly wage for LTC workers was raised to NT$200 per hour, with the minimum hourly wage set at NT$170. Also, to help care service providers defray costs, subsidies are provided for operational expenses, including overtime, vacation pay, on-the-job training, and other benefits that employers are required to provide in accordance with labor regulations. By providing an incentive to hire more care workers, these measures are helping to pave the way for growth in overall LTC service capacity.

(2) Measures to increase personnel retention in the home care service sector, and encourage more people to seek employment in this sector: To encourage more Taiwanese citizens to seek employment in the home care service sector, and to improve employee retention rates within the sector, starting from July 2015 an additional monthly payment of NT$350 per patient with dementia has been provided to home care service workers engaged in providing home care to persons with dementia (in recognition of the special difficulties involved). By ensuring that payment structures take account of the types of patient served, this new measure is helping to boost real income levels for home care service personnel. In addition, in order to enhance the professional image of care service personnel and create a clearer career structure, all care workers (employed by home service service operators) who hold a care service technical specialist certificate are entitled to a supplementary payment of NT$1,000 for each month in which they work for at least 130 hours.

(3) Raising the service quality and effectiveness of workers in elderly welfare institutions: In 2015, two on-the-job training sessions were provided for presidents (or directors) of elderly welfare institutions and social workers; these training sessions were attended by a total of 102 elderly welfare institution presidents (or directors) and 73 social workers. In addition, public and private-sector resources were combined to hold four specialists training sessions for persons involved in caring for senior citizens suffering from dementia; these four sessions were attended by a combined total of 140 persons.

Section 3 Integration of LTC Institutional Management

In order to enhance the quality of service provided at nursing homes and elderly welfare institutions, accreditation is performed in accordance with the provisions of the Nursing Personnel Act and the Senior Citizens Welfare Act. In 2013, the Ministry of the Interior and the Veterans Affairs Commission were invited to participate in the process of integrating LTC institution accreditation standards, and in 2014 the MOHW reviewed and revised these standards on the basis of the implementation status.

As of 2015, a total of 479 general nursing homes had been evaluated (of which 293 were evaluated in 2015), with 454 (94.8%) found to be in accreditation with requirements, and 25 (5.2%) found to be non-accredited (Table 4-5). In addition, there are a total of 1,067 elderly welfare institutions which are required to undergo review by the competent authorities on an annual basis, and full-scale assessment every three years. A total of 127 institutions were assessed by the MOHW in 2013; the assessment results are shown in Table 4-6. A total of 1,016 institutions were assessed by local government authorities over the period 2012 - 2014.

Chapter 4 Medical Manpower

Section 1 Current Status of Medical Manpower

1. In accordance with the licensing system for professional medical workers, there are 14 laws and regulations governing the management of medical personnel: the Physicians Act, the Pharmacists Act, the Midwives Act, the Dietitian Act, the Nursing Personnel Act, the Physical Therapists Act, the Occupational Therapist Act, the Medical Technologists Act, the Medical Radiological Technologists Act, the Psychologists Act, the Respiratory Therapists Act, the Hearing Specialists Act, the Speech Therapists Act, and the Dental Technicians Act.

Table 4-5 Results of Accreditation Evaluation of General Nursing Homes by the MOHW (as of 2015)

Grade	No. of Institutions	Percentage of Total	Percentage of Institutions accredited to Requirements
Excellent	98	20.5%	94.8%
Good	168	35.1%	
Average	188	39.2%	
Not accredited	25	5.2%	5.2%
Total	479	100%	100%

Table 4-6 Results of Assessment of Elderly Welfare Institutions by the MOHW (2004 - 2013)

Unit: No. of Institution (%)

Year	Excellent (Percentage of Total)	A (Percentage of Total)	B (Percentage of Total)	C (Percentage of Total)	D (Percentage of Total)	Total
2004	30 (22.9)	49 (37.4)	49 (37.4)	3 (2.3)	0 (0.0)	131
2007	24 (19.7)	41 (33.6)	39 (32.0)	12 (9.8)	6 (4.9)	122
2010	14 (10.9)	59 (46.1)	39 (30.5)	14 (10.9)	2 (1.6)	128
2013	17 (13.4)	63 (49.6)	40 (31.5)	6 (4.7)	1 (0.8)	127

2. As of 2015, there were 280,508 practicing medical workers in Taiwan, including 63,806 physicians (including both Western and Chinese medicine doctors and dentists), 33,516 pharmacists, 9,261 medical technologists, 5,952 medical radiological technologists, 148,223 registered nurses, 150 midwives, and 2,392 dietitians. By comparison with the situation in 2005, the number of physicians has increased by 15,009, the number of pharmacists by 21,226, the number of medical technologists by 3,109, the number of medical radiological technologists by 2,260, the number of registered nurses by 55,776, and the number of dietitians by 1,424, while the number of midwives has fallen by 69. The number of practicing medical workers in each category and the number of practicing medical workers for every 10,000 people in the population, as of the end of December 2015, are shown in Table 4-3 in Appendix 1.

Section 2 Training of Medical Workers

In order to raise the quality of the medical workforce, every year the MOHW carries out training plans, cultivation plans, and workplace training. The results achieved have been as follows:

1. Mechanisms put in place to regulate the training of medical workers includes, in regard to the cultivation of physicians (Western medicine), a general quota of 1,300 medical students to be enrolled each year, and special channels for the cultivation of other categories of medical workers (which are subject to the requirement that The Ministry of Education must approve the establishment of new medical training programs). Future planning of the physician workforce will focus on balanced distribution of resources, and the establishment of mechanisms for periodic evaluation.
2. With the government-sponsored physician system having been in place for over 30 years, the policy goals that the system was set up to address had gradually been achieved. Starting from 2006, The annual quota of 40 government-sponsored medical students was gradually reduced, before being eliminated entirely in 2009, while at the same time the annual number of locally-sponsored physicians was increased by 6 - 9 each year, to 27.

3. Post-graduate general medical training is offered to strengthen holistic care awareness and capabilities, while also improving the overall quality of training received by physicians. In 2015, a total of 128 hospitals (including 40 training provider hospitals and 88 collaborating hospitals) were approved to participate in post-graduate year (PGY) training programs; a total of 1,386 medical school graduates received training under this scheme.
4. A system of postgraduate clinical training for dentists have been put in place to enhance the quality of the training that is required to ensure a high standard of oral health care, integrating medical school education and clinical practice to ensure patient safety. As of 2015, a total of 374 institutions were certified to provide this training, including 83 hospitals and 291 clinics; a cumulative total of 759 dentists had received training under this project.
5. Specialist nursing training has been provided since 2006 to enhance the professionalism of, and quality of care provided by, nursing practitioners. The program is divided into internal medicine and surgery tracks, with the internal track further subdivided into internal, pediatric and neurologic groups since 2012; in 2012, an OB/GYN group was added to the surgery track. As of 2015, a total of 5,702 specialist nursing practitioners had been accredited under this program (including 3,011 internal medicine nursing practitioners and 2,691 surgical nursing practitioners).
6. To ensure that newly-qualified medical professionals can receive first-class clinical training, thereby enhancing the overall quality of service provision by medical professionals, in 2007 the MOHW launched the "Clinical Practitioner Training Program." As of 2015, a total of 2,187 individual training plans had been approved at 138 participating hospitals, with a cumulative total of 26,889 medical workers trained; 83.95% of medical workers received training within two years of receiving their professional certification.
7. A continuing education system for 14 categories of medical worker mandates a certain number of hours of continuing education every six years as a prerequisite for license renewal, to ensure that medical workers' skills remain up-to-date. In addition, to realize improvements in the assessment of medical students' clinical skills and in the overall quality of clinical education, since 2013 medical school graduates have been required to pass the Objective Structured Clinical Examination (OSCE), which tests doctor-patient communication, the ability to perform physical examinations, and other health care techniques, before they can advance to the second stage of the physician licensing examination.
8. In order to put in place an effective clinical training system for Chinese medicine doctors and further the cultivation of Chinese medicine talent, the MOHW has launched the Scheme for the Training of Responsible Physicians in Chinese Medical Care Institutes. In 2015, this scheme assisted 35 eligible training hospitals, which accepted a total of 188 new Chinese medicine doctors for a two-year training period. The MOHW has also promulgated the "Certification Guidelines in Relation to the Training of Responsible Physicians in Chinese Medical Care Institutions." In 2015, training was provided for 625 instructor physicians and 218 instructor pharmacists.
9. Regarding the implementation of the "Project to Enhance the Professional Competence of Chinese Medicine Practitioners," in 2015 a total of 11 Chinese medicine related academic conferences were held. In addition, a total of 387 nursing practitioners completed a Chinese medicine basic nursing training program, the content of which included seven classes worth nine credits. The MOHW has also been promoting a Chinese medicine diversified care model, providing guidance to three teaching hospitals to help them establish combined Chinese-Western treatment programs and a Chinese medicine based day care provision model, with the aim of expanding the scope of Chinese medicine based health care provision.

Section 3 Nursing Reform

To address shortages in nursing manpower, in May 2012 the MOHW started promotion of the Plan for Nursing Improvement to actively implement relevant reforms. These include reducing the workload of nurses, improving nurse salaries and benefits, improving work environments for nurses,

and implementing the Elite Nurses Plan for Remote Regions. These measures are aimed at retaining nurses and increasing the number of returning nurses. The results as of 2015 are as follows:

1. Increasing the Number of Nurses and Reducing the Turnover Rate and Vacancy Rate:

(1) Increasing the number of nurses: As of the end of 2015, there were a total of 153,336 registered nurses in Taiwan, representing an increase of 16,921 compared to the situation before the reforms began (end of April 2012).

(2) Reducing turnover and vacancy rates: The total turnover rate has dropped from 13.14% in 2012 to 10.5% in 2015 (a fall of 2.6%), representing the lowest since 2010. The total vacancy rate has dropped from 7.2% in 2012 to 5.6% in 2015 (a fall of 1.6%).

(3) Increase in the number of nurses per 10,000 people: Increased from 60.48 in 2012 to 65.27 in 2015.

2. Reducing Nurses' Workload, Improving Nurse-Patient Ratios and Work Conditions

(1) Amendment of the Establishment Standards for Medical Institutions: On January 1, 2013, the Establishment Standards for Medical Institutions was amended to raise the standards for nursing personnel in medical institutions. The ratio for hospitals with 50 beds or more was raised from 1 nurse per 4 beds to 1 nurse per 3 beds.

(2) Nurse-patient ratios included in hospital evaluations:

In 2015, nurse-patient ratios were officially added to the criteria for hospital evaluations. The standard for evaluation is the "average whole-day nurse-patient ratio" for emergency and general beds in hospitals; the ratio for medical centers is≦9, including≦7 for daytime nurses; the ratio for regional hospitals is≦12; the ratio for local hospitals is≦15. In 2015, the "average whole-day nurse-patient ratios" for all 114 hospitals evaluated were in line with requirements.

(3) Expansion of the Mechanism to Link Inpatient Insurance Payments to the Nurse-Patient Ratio

a. the National Health Insurance Administration of MOHW has announced and implemented the policy on August 13, 2014 and allocated NT$4 billion for implementation of the payment item of Monthly Three-Shift Average Nurse Staffing in Acute General Medical Wards from the NT$20 billion budget of the National Health Insurance Hospitalization Care Quality Improvement Program and integrated the concept of the linkage system for nurse-to-patient ratio, so as to implement the linkage of the medical service fees and the nurse-to-patient ratio for hospitalization insurance for a trial.

b.In 2015, a budget of NT$2 billion was allocated within the general service segment for hospitals, for use in boosting inpatient nursing payments and linking inpatient insurance payment to the nurse-patient ratio. Using the nurse-patient ratio verified during hospital assessment as the baseline, the average whole-day nurse-patient ratio is determined, and an additional 9% to 11% provided accordingly. The implementation results in 2015, based on monthly nurse-patient ratios reported by individual hospitals, showed that on average the necessary threshold was achieved in 95% of the months, making this program eligible for expansion. (Table 4-7)

(4) Abolishment of the responsibility system: To protect the labor rights of nurses, on March 30, 2012, the Ministry of Labor (previously the Council for Labor Affairs, Executive Yuan) announced that the medical and healthcare service industries (including military hospitals and civilian clinics) would no longer be applicable to Article 84-1 of the Labor Standards Act starting from March 30, 2012 and January 1, 2014 respectively. Their legal

Table 4-7 The markup percentages of the nurse-to-patient ratio in hospitals

Range of the nurse-to-patient ratio			Markup Percentage Metropolitan Hospitals
Medical Centers	Regional Hospitals	District Hospitals	
8.5-8.9	11.5-11.9	14.5-14.9	9%
8.0-8.4	11.0-11.4	14.0-14.4	10%
< 8.0	< 11.0	< 14.0	11%

working hours would no longer include the responsibility system (commonly referred to as the abolishment of the responsibility system).

(5) Violations of the Labor Standards Act included in evaluations: Hospitals' violations of the Labor Standards Act will be included in the key points for evaluations and future guidance. The various Departments of Health at county and city level are asked to include the results of labor inspections at hospitals in the key areas of focus for oversight and evaluation.

(6) Prevention and addressing violence in hospitals: On January 29, 2014, amendments to Articles 24 and 106 of the Medical Care Act were announced, establishing the measures that medical institutions must take if medical personnel are subject to violence or harm. If criminal responsibility is involved, then the police shall refer the offenders to prosecutors for investigation. Penalties were also established for the destruction of equipment, obstructing medical procedures, and if such actions lead to more severe consequences.

3. Raising Salaries and Benefits:

(1) Ministry of Labor surveys have shown that, in the last four years, nurse salaries rose by approximately 8.08% on average.

(2) Increases to night shift salaries: Surveys of hospitals in Taiwan (including military hospitals) up to 2015 have shown that 96.9% have offered raises for night shifts (at 100% of public hospitals and 96.2% of private hospitals).

4. Implementation of the Elite Nurses Plan for Remote Regions:

(1) In order to overcome nursing shortages and strengthen health care resources in remote regions, on June 19, 2014 the Executive Yuan approved the "Elite Nurses Plan for Remote Regions"; recruitment under this Plan began in 2015. It is anticipated that, over a four-year period, 200 nursing staff will be trained under this Plan. After graduation, they will be assigned to hospitals in remote areas to serve as clinical nurses for at least 4 years.

(2) For the 2015 academic year, 36 students on this government scholarship have been enrolled (including 25 trainees studying nursing at university and 11 studying at a vocational college).

Section 4 Medical Specialist System

1. Following a June 9, 2010 amendment, Article 3 of the Rules of Specialization and Examination for Medical Specialists designates 23 physician specializations: family medicine, internal medicine, surgery, pediatrics, OB/GYN, orthopedics, neurosurgery, urology, otolaryngology, ophthamology, dermatology, neurology, psychiatry, rehabilitation medicine, anethesiology, diagnostic radiology, radiological oncology, anatomical pathology, clinical pathology, nuclear medicine, emergency medicine, occupational medicine, and plastic surgery. Article 4 designates three dentist specializations: oral and maxillofacial surgery, oral pathology, and orthodontics. As of the end of 2015, the specialist examinations for physicians had been passed a cumulative total of 50,060 times.

2. In order to achieve a more balanced distribution of medical specialists, while also strengthening the medical specialist training environment and training quality, full implementation of a plan that restricts the number of trainees in each medical specialty began in 2001. The plan started with an annual limit of 1,948 trainees and a flexible cap that permitted up to 20% additional trainees (giving a figure of up to 2,339 trainees in total). Medical specialization associations were entrusted with the task of designating hospitals that offer appropriate specialist training, and to manage enrollment capacity. Over time, however, it became apparent that there was too great a disparity between the quota referred to above and the number of resident physicians in Taiwan (1,300), which was likely to negatively impact the distribution of specialists. After careful consideration, the annual limit was reduced from 1,948 to 1,550 in 2015.

Chapter 5 Health Care Quality

Section 1 Quality of Medical Care Services

With a view to strengthening the overall quality of medical care service provision, the MOHW has established a patient-centered, safe treatment environment, a hospital evaluation and accreditation system, annual objectives for medical

care quality and patient safety, and a patient safety incident reporting mechanism. Significant achievements in 2015 were as follows:

1. Patient Safety and Quality of Medical Care

(1) The MOHW drew up the "2016 - 2017 Taiwan Treatment Quality and Patient Safety Goals for Hospitals" (Table 4-8)

(2) The Taiwan Patient Safety Reporting System (TPR) has been used to foster an effective patient safety culture. In 2015, 6,788 medical and healthcare organizations were participating in the TPR, and preliminary statistics indicate that a total of around 62,000 cases were reported.

(3) The Hospital Accreditation Standards include environmental and equipment safety, patient oriented services, care quality, medication safety, anesthesia and operations, and infection control. All of them are aimed at the creation of a safe hospital environment for patients.

2. The Hospital Accreditation System

In accordance with the core values of providing patient-centered care and prioritizing patient safety, reforms have been made to the hospital accreditation and teaching hospital accreditation systems.

(1) As of 2015, accreditation had been granted to a total of 424 hospitals and 124 teaching hospitals (Tables 4-9 and 4-10).

(2) In order to further the development and reform of the accreditation system, a "Hospital Accreditation System Planning Team" was established in 2013, and goals were set for the revision of the hospital accreditation standards by 2015. Evaluation of the prepublication standards took place in 2014 and formal implementation in 2015; the new standards help improve patient flow and optimize hospital performance.

(3) The "Operational Procedures for the Accreditation of Chinese Medicine Hospitals" and the "Accreditation Standards for Chinese Medicine Hospitals" were promulgated in April 2014. Also, in accordance with the consolidation of hospital accreditation mechanisms, starting from 2015, Chinese medicine departments affiliated with regular hospitals have been included with the main hospital for the purpose of hospital accreditation; Chinese medicine departments attached to teaching hospitals and independent Chinese medicine hospitals continue to be accredited separately. In 2014, a total of three Chinese medicine hospitals attached to regular hospitals and one independent Chinese medicine hospital received accreditation.

(4) Survey processes of hospital accreditation, health facilities inspection and accreditation of medical specialist training programs have been integrated. By the end of 2015, the total number of required evaluations had reduced from 621 to 371, significantly reducing operation disruption caused by site visits.

Section 2 Improving the Quality of Blood Supply/Transfusion and Medical Radiological Services

Taiwan has promoted voluntary, non-remunerated blood donation since 1974. It has consistently maintained a voluntary, unpaid donation rate of at least 5%, with 100% of national blood bank supplies deriving from strictly altruistic donations, putting Taiwan among the ranks of the world's most advanced nations when it comes to blood bank supplies.

To enhance the safety of blood products and blood preparations, Taiwan tests donations for pathogens, including HIV, hepatitis B, hepatitis C, and syphilis. While these tests traditionally used the Enzyme ImmunoAssay (EIA) method, the NHI is now providing funding to switch over completely to Nucleic Acid Amplification Testing (NAT); this has brought Taiwan's blood testing into line with international standards, while also ensuring the safety of blood products.

Since 2009, inspections made to primary care institutions have contributed to improve management, safety and image quality of equipment capable of producing ionizing radiation. According to data compiled by the Atomic Energy Council, as of June 2013, there were 7,262 primary care institutions with equipment capable of producing ionizing radiation; by December 2015, on-site guidance and inspections had been completed at nearly 1,700 of these institutions.

Table 4-8 2016 - 2017 Taiwan Treatment Quality and Patient Safety Goals for Hospitals

Item	Eight Major Performance Objectives	Implementation Strategy
1.	Improving communication between health care workers	1. Ensuring accurate, comprehensive, and timely transmission of information 2. Implementing effective risk management and standard operating procedures for patient transportation 3. Implementing timely notification and processing of medical radiation, examination, test and pathology report critical values and other important results 4. Strengthening team communication skills
2.	Managing patient safety in the event of abnormal situations	1. Building an effective patient safety culture, and promoting participation in the Taiwan Patient Safety Reporting System (TPR) 2. Analysis of patient safety incidents and implementation of improvement strategies 3. Formulation of patient safety management plans
3.	Improving surgical safety	1. Implementation of surgical identification procedures and safety auditing operations 2. Enhancement of anesthesia care quality 3. Implementation of surgical instruments and equipment inspection and testing operations 4. Prevention of unnecessary harm to patients during surgical procedures 5. Establishment of suitable mechanisms for reviewing unnecessary operations
4.	Preventing patient falls and reducing the severity of injury	1. Implementing fall risk evaluation and preventive measures 2. Providing a safe care environment and reducing the severity of injury from falls 3. Implementation of post-fall examination and care adjustment planning
5.	Improving safe use of pharmaceuticals	1. Promoting coordinated pharmaceutical use 2. Transmission of patient histories of allergic reactions to pharmaceutical drugs and adverse drug reactions 3. Improving the safety of high-risk pharmaceuticals and infusion pump use
6.	Implementing infection control	1. Ensuring consistent, correct hand hygiene 2. Implementing mechanisms for the effective management of antibiotics use 3. Implementing bundled care measures to reduce health care related infection 4. Regular implementation of environmental sanitation, monitoring, establishment of disinfection and sterilization management mechanisms
7.	Improving tube safety	1. Implementing tube use evaluation and related care provision 2. Enhancing tube insertion safety and reducing related trauma 3. Strengthening team collaboration and enhancing coordinated care provision
8.	Encouraging patients and family members to carry out patient safety tasks	1. Encouraging medical personnel to proactively establish a collaborative partnership with patients and their family 2. Providing the public with diversified channels for participation 3. Encouraging the public to report safety issues relating to patients 4. Proactively providing patients with medical safety information, and encouraging patient participation in decision making

Table 4-9 Hospital Accreditation Results

Accreditation Results	Hospital Accreditation - Excellent			Hospital Accreditation - Qualified	
	Medical Centers	Regional Hospitals	District Hospitals	Regional Hospitals	District Hospitals
No. of Institutions	19	78	49	3	275

Table 4-10 Teaching Hospital Accreditation Results

Accreditation Results	Doctors and Medical Personnel Teaching Hospital Accreditation - Qualified (Medical Centers)	Doctors and Medical Personnel Teaching Hospital Accreditation - Qualified	Medical Personnel (Excluding Doctors) Teaching Hospital Accreditation - Qualified
No. of Institutions	19	98	7

Section 3 Improving the Efficiency and Quality of Organ Donation and Transplantation

Countries throughout the world are facing a shortfall in the availability of organs for transplantation. As of the end of 2015, there were more than 8,000 patients in Taiwan awaiting organs; on average, only 700 - 800 patients a year are able to receive an organ transplant (Figure 4-7). To promote organ donation, expand organ sources and aid distribution, in 2002 the MOHW established the Taiwan Organ Repository and Sharing System. Measures such as this have given Taiwan the second highest organ donation rate in Asia, and an organ transplant success rate comparable with that of Europe and North America. Important measures implemented in 2015 included the following:

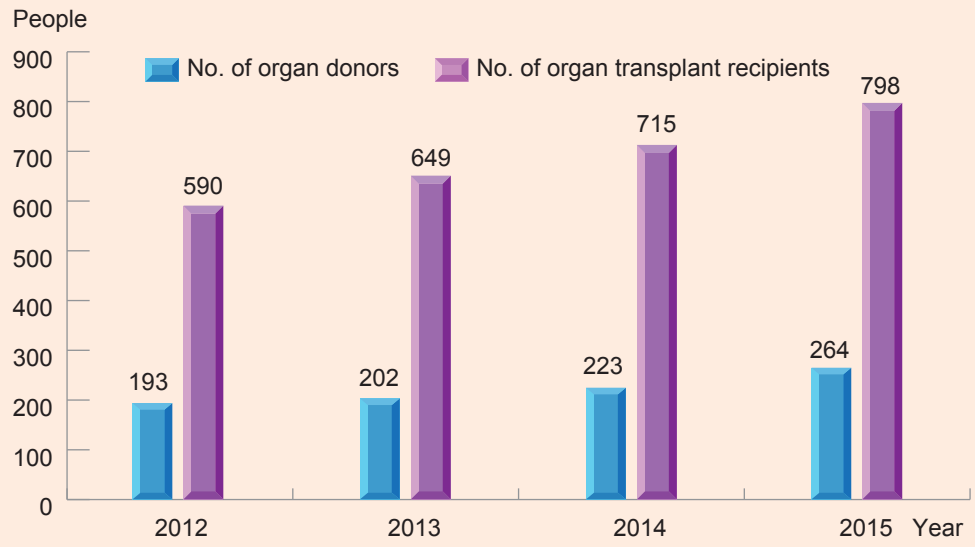
1. In July 2015, Article 8 of the Human Organ Transplantation Act was revised so that, in cases where a person wishes to donate an organ to a family member but they are medically incompatible, they can be matched with another pair of relatives so that the transplants can go ahead, thereby enhancing the likelihood that a person in need of organ transplantation can obtain the transplant they need.
2. To provide recognition for the compassion shown by organ donors, in August 2015 the MOHW designated June 19 each year as Organ Donation Day, helping to ensure that the kindness and bravery of organ donors will not be forgotten.

Section 4 Smart Health Care

In line with the Executive Yuan's Cloud Computing Applications and Industry Development Policy, the MOHW has launched the Taiwan Health Cloud program since 2014. The program, which will be implemented fully before 2017, is comprised by four sub-programs: the Medical Cloud, Care Cloud, Health Promotion Cloud, and Communicable Disease Control Cloud. By effectively applying Taiwan's information and communications technology (ICT), this program aims to provide customized, convenient, and efficient cloud-based health services that promote overall health of Taiwan's citizens. The following are the main accomplishments in 2015:

1. Continued implementation of electronic medical records (EMR) has resulted in a cumulative total of 406 hospitals, 152 health centers and over 3,700 clinics being connected with the EMR Exchange Center.

Figure 4-7 Organ Donation and Organ Transplant Recipients in Taiwan, 2012 - 2015



Source: Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

2. The NHIA has continued to implement the "My Health Bank" system. Besides introducing a new way to register for the service and download information using National Health Insurance (NHI) cards, the NHIA has also launched a new "My Health Bank" mobile app, which makes the system even easier and more convenient for people to use, and facilitates effective health self-management. As of the end of 2015, the cumulative number of times that people had logged on to check their "My Health Bank" data had reached 332,517, and the number of times that people had downloaded "My Health Bank" data had reached 294,589. By enabling people to monitor their medical situation and overall health, the "My Health Bank" system ultimately makes medical care safer, better and more effective.
3. The NHIA has continued to enhance the functionality of the NHI PharmaCloud System. Physicians and pharmacists who use the system to check patients' medication records can improve the quality of care and prevent duplicated prescriptions, which help saving the spending on drugs. As of the end of 2015, a total of 18,690 health care-related providers had used the system to check patients' medication records 165.62 million times.
4. In cooperation with the Public 12 local Health Bureaus, the MOHW has established 966 community-based service stands for biometric measurements. Biometric measurement service has also been provided for 1,903 elderly people living alone. Overall, the total number of registered users for the biometric measurements service has reached 41,021 people, with a cumulative total of 392,485 sets of measurements made.
5. The MOHW has established the Health Promotion Helper platform, which serves as a foundation for holistic health management mobile cloud-based services. In 2015, the platform was expanded with the addition of a decision-making support system function. At the same time, the MOHW has been working actively to encourage people to register with the platform.As of December 2015, the number of registered members has reached 11,014, up 7,896 from the 2014 total of 3,118 registered members.
6. Over 40 hospitals are participating in the system for automatic infectious disease notification and laboratory data submission. Of all reported records nationwide, 35% are attributed to automatic reporting. These systems simplify the infectious disease reporting flow and reduce the time needed for reporting.

Chapter 6 Health Care in Remote Regions

Section 1 Strengthening the Provision of Health Care Tailored to Local Needs

To protect the right of people living on outlying islands or in remote regions to receive proper medical care, the MOHW continues its efforts to provide seamless care. Measures taken to strengthen local medical care functions include the following:

1. An Integrated Delivery System (IDS) has been launched to improve NHI effectiveness in mountainous regions and on outlying islands. Hospitals formulate plans and dispatch manpower and resources to remote regions to provide specialized and emergency care, evening clinics at fixed locations, and mobile medical service points. These measures have contributed towards effective implementation of the "doctors move, patients stay put" principle, thereby providing a further strengthening of local medical care.
2. The construction of the Kinmen County Comprehensive Medical Building and of a new medical building for Lienchiang County Hospital, as well as the opening of new cardiac catheterization rooms at Penghu Hospital and Kinmen Hospital in 2013 and 2015 respectively, have helped to enhance the overall quality of medical service provision in these areas, with a particularly improvement in the ability to effectively treat patients with cardiac problems.
3. The MOHW has continued to build and renovate health centers in remote regions and on outlying islands. In 2015, the health centers in Wenlo Village and Wangchia Village in Laiyi Township, Pingtung County were rebuilt, and the health center in Lieyu Township, Kinmen County was reopened after renovation. Work

was also completed on renovating the air conditioning systems in the old medical building at Lienchiang County Hospital. The MOHW has also been implementing the Plan to Enhance the Quality of Care at Dawu Township Health Center and Emergency Medical Care Provision on the South Link Rail Line, involving plans to establish a South Link Emergency Medical Care Center in Dawu Township, Taitung County. It is anticipated that these projects to upgrade medical facilities will help to provide a better medical treatment environment and enhanced quality of medical care service for people living in remote communities.

Section 2 Health Information Networks

1. Building Health Information Networks for Remote Regions

   To ensure effective medical care provision in remote districts and to enhance the overall quality of medical care available to members of aboriginal (indigenous) communities and inhabitants of outlying islands, the MOHW has been promoting the implementation of mobile clinics that bring medical care to remote communities, making it easier and more convenient for people in these communities to access the medical services they need. As of the end of 2015, medical information systems had been established at 64 health centers in Hsinchu County and 14 other counties, along with 342 mobile medical stations. In addition, to enable residents of remote communities to benefit from teaching hospitals' diagnostic expertise and related advisory services, the MOHW has been making effective use of the Picture Archiving and Communication System (PACS), with Taoyuan Hospital assisting with medical image analysis; in 2015, support was provided in 7,718cases.

2. EMR Interoperability Plans for 48 Remote Districts and Outlying Islands

   In order to improve medical information service quality in remote districts, while developing cloud service architecture, electronic medical record (EMR) reading systems have been installed in 48 health centers located in remote districts.

Section 3 Emergency Medical Evacuations

To ensure that residents of outlying islands requiring emergency medical treatment can receive proper care, the MOHW has followed the principles of "doctors move, patients stay put" and of seamless medical care, working to strengthen the provision of medical care locally, supplemented by aeromedical services. Since 2013, the MOHW has been implementing the "Plan to Provide Incentives to Encourage Medical Centers to Support Emergency Treatment and Care Services on Outlying Islands and Districts with Insufficient Medical Resources." Taipei Veterans' General Hospital has been supporting Kinmen Hospital, Kaohsiung Chang Gung Memorial Hospital and Chi Mei Medical Center have been supporting Penghu Hospital, and Far Eastern Memorial Hospital and Wan Fang Hospital have been supporting critical care physician resources at Lienchiang County Hospital.

1. In order to establish an effective aeromedical review mechanism and enhance the quality of aeromedical service provision, in 2012 the MOHW established the Aeromedical Service Review Mechanism, with the assignment of specialist physicians. In accordance with the "National Aeromedical Approval Center Standard Operating Procedures for Emergency Medical Evacuation from Outlying Islands," emergency medical consultations are provided on a 24-hours-a-day basis, as well as evaluation of the necessity of aeromedical service provision and related coordination of aircraft and Coast Guard Administration vessels. Prior to the establishment of the National Aeromedical Approval Center, the average number of instances of aeromedical service provision per month was 43.18. Since the Center's establishment, this figure has fallen steadily; in 2015, the monthly average was 22.36 instances of service provision, representing a decline of 48.22%.

2. In accordance with the provisions of the Emergency Medical Care Law, the Regulations Governing Management of Emergency Helicopters, and the "National Aeromedical Approval Center Standard Operating

Procedures for Emergency Medical Evacuation from Outlying Islands," when an attending physician on an outlying island submits an application for air evacuation, the National Aeromedical Approval Center must complete their review of the application within 20 minutes. If the case is deemed to meet the requirements of the Regulations Governing Management of Emergency Helicopters, then assistance will immediately be provided to implement emergency evacuation to the main island of Taiwan for treatment. If sufficient aircraft are not available due to time or other constraints, then assistance is obtained from the National Airborne Service Corps or from the Ministry of National Defense. In 2015, there were 236 air evacuations, representing a decrease of 1.67% compared to 2013. The opening of a cardiac catheterization room at Penghu Hospital on December 4, 2013 reduced the percentage of patients requiring aeromedical services from 51% of cardiac emergency patients to 1%, which has contributed to a significant improvement in overall care quality.

3. In accordance with the provisions of the "Regulations Governing the Subsidization of Transportation Expenses for Inhabitants of Mountainous Districts and Outlying Islands Requiring Treatment for Serious or Emergency Illnesses or Injuries," in the case of persons who are in a stable enough condition to arrange their own travel, subsidies are provided to cover half of the cost of air (or sea) transportation; where a physician confirms the necessity for continued treatment, such subsidies can now be provided for up to six journeys. Subsidies are also available to cover the transportation expenses for accompanying medical personnel in cases of aeromedical evacuation.

Section 4 Health Care Quality

1. Guaranteed Funding for Areas with Insufficient Medical Resources

   The NHIA launched the "Plan to Enhance the Quality of Medical Service in Districts with Inadequate NHI Resources" in May 2012. In 2015, a budget of NTD800 million was allocated to support community hospitals that play a primary role in providing urgent medical care to mountain districts, outlying islands and remote areas. This funding support has helped to strengthen the provision of 24-hour emergency care and inpatient services in four main departments: internal medicine, surgery, OB/GYN, and pediatrics.

2. Increased, Guaranteed NHI Payments for Emergency Care:

   In 2015, there were 41 hospitals designated to handle emergency and rescue services in areas with insufficient resources. By offering a 30 - 80% increase in emergency diagnosis and examination fees and guaranteeing a full NTD1 payment per point for emergency cases under the NHI's pay-for-points system, these hospitals were encouraged to expand and improve emergency care provision.

3. The NHIA has been working actively to implement the "Plan for Improving NHI Dental Resources in Under-served Areas." In 2015, a NTD280 million special fund was allocated provide fixed-location clinics and mobile dental services in under-served areas, thereby helping to bridge the dental treatment gap that exists between urban and rural areas. In 2015, there were 33 dental clinics operating under the plan in 33 townships with inadequate dental resources, and 18 medical teams (with staff from 280 hospitals and clinics) were offering mobile dental services in 124 townships.

4. The NHIA has also been implementing the "Plan for Improving NHI Western Medicine Resources in Under-served Areas," encouraging primary care clinics and district hospitals (as well as larger hospitals) to provide health care and health maintenance services in areas with inadequate Western medicine resources, thereby protecting the right to medical care of residents in remote areas. In 2015, a total of 170 medical care institutions offered mobile services in 116 townships (including 130 primary care clinics that served 86 townships, and 40 hospitals that served 30 townships).

5. In addition, the NHIA has been implementing the "Plan for Improving NHI Chinese Medicine Resources in Under-served Areas." In 2015,

a special fund amounting to nearly NTD100 million was allocated provide Chinese medicine services in under-served areas, thereby helping to protect the right to medical care of residents in remote areas. In 2015, a total of 91 medical care institutions offered mobile Chinese medicine services in 86 townships.

Section 5 Training and Retaining Staff

In order to ensure a more equitable allocation of medical resources in remote districts, the MOHW has been working actively to cultivate health workers for these communities. The "Plan for the Cultivation of Medical Personnel for Aboriginal Communities and Outlying Islands" was launched in 1969. As of 2015, a cumulative total of 910 health workers had been trained under this program, including 486 doctors and 424 other medical personnel. The historic retention rate of government-sponsored physicians who, after completing their required period of service in aboriginal (indigenous) communities or on outlying islands, continue to work in these communities, has been approximately 70%. In addition, to help overcome the difficulties in recruiting nursing staff to work in remote districts, in 2013 a plan was formulated to train 200 "elite nurses" to serve in remote districts; recruitment began in 2015, and currently 36 government-sponsored nursing students are undergoing training. Furthermore, to encourage medical personnel to continue working in remote districts, and realize community-centric medical services in these areas, the MOHW continues to provide subsidies to help health workers in these districts to open practices and undergo further training. In 2015, these subsidies contributed to the opening of eight new practices and to the provision of advanced training for one health center employee.

Chapter 7 Health Care Provision for Specially Targeted Groups

Section 1 Health Care for New Immigrants

1. In line with the prenatal standards for citizens, new immigrants who have not yet joined the NHI system can receive subsidies for 10 prenatal checkups, Group B Streptococcus screenings, 1 ultrasound, and 2 health education guidance consultations. New immigrants and their children are provided with health management cards, which offer guidance in the areas of family plannings, breastfeeding, prenatal health, prenatal checkups, and prenatal nutrition. In 2015, the usage rate for these cards was 100%.
2. In order to protect the reproductive health of new immigrants who have not yet joined the NHI system, since 2011 subsidies for prenatal checkups have been provided to foreign spouses of Taiwanese citizens. In 2015, a total of approximately 13,810 such subsidies were offered, with a combined value of around NT$6,250,336.
3. The MOHW has been implementing the "Plan for the Provision of Reproductive Health Interpreters for Foreign Spouses of Taiwanese Citizens," which involves local government Public Health Bureaus (at the county and city level) training interpreters to assist in the provision of reproductive health information. In 2015, 211 health centers in 19 counties and cities participated in this program, with a combined total of 389 interpreters.
4. In order to provide reproductive health information more effectively to people from a wide range of backgrounds, in 2015 the MOHW commissioned the publication of the "Children's Health Booklet" and "Maternal Health Booklet" in five language pairings: Chinese-English, Chinese-Vietnamese, Chinese-Indonesian, Chinese-Khmer, and Chinese-Thai. Besides having local government Public Health Bureaus distribute the booklets to medical institutions, PDF versions of the booklets have also been made available for downloading from the publications section of the Health Promotion Administration website, so that new immigrants and their family members can make effective use of them.

Section 2 Health Care for Rare Disease Patients

1. As of 2015, a total of 207 rare diseases had been officially announced, along with 92 drugs for treating rare diseases and 40 special

nutrient foods essential to the maintenance of life. Rare diseases have also been formally included on a list of " Major Illness/Injury" under the National Health Insurance program, thereby patients can receive treatment without making a co-payment .

2. A logistics center for nutritional supplements and drugs for treating patients with rare diseases has been established; in 2015, the center supplied drugs and nutritional supplements to rare disease patients on 1,331 occasions. The MOHW also provides subsidies to cover rare disease related expenses not covered by the NHI, including rare disease diagnosis, treatment, examinations (both in Taiwan and overseas), and home medical care equipment. In 2015, subsidies were provided on 1,192 occasions.
3. Besides providing reproductive genetics services (including prenatal genetics testing, neonatal screenings, hereditary disease examinations, and genetics counseling), genetics counseling centers which specialize in hereditary and rare diseases have been established at 14 medical centers. In addition, a genetics counseling website has been established to provide information about hereditary and rare diseases.
4. Strengthening rare disease prevention education and advocacy: In 2015, a total of 21 explanatory meetings were held for patients, patient groups, businesses, and medical care institutions.
5. On January 14, 2015 the revised Prevention of Rare Diseases and Orphan Drug Act was promulgated and came into effect. The main amendments to the Act include: the inclusion of a requirement for professional staff outreach visits to provide rare disease patients and their families with psychological support, reproductive and childrearing care, and consultations. Subsidies will be provided for supportive care and palliative care not covered by the NHI. When rare disease patients need schooling or home care, assistance from related organizations will be arranged. The views of The views of the Review Committee for Rare Diseases and Orphan Drug will be taken into account when making decisions on NHI reimbursements for rare disease medications. Pharmaceutical companies will be required to continue providing rare disease drugs for the duration of the drug sale permit period, unless circumstances beyond their control prevent them from doing so. If a drug company fails to continue supply as required by law, it will be required to pay a fine of between NTD100,000 and NTD500,000; if necessary, the drug sale permit granted to the company may be revoked.

Section 3 Groups With Special Health Needs

1. Health Care for Patients Affected by Polychlorinated Biphenyl (PCB) Poisoning

(1) Contaminated rice bran oil led to a PCB poisoning outbreak in Taiwan in 1979. As research has shown that PCB poisoning can be passed on to the next generation through the placenta or breast milk, since 2005 health care services provided to PCB poisoning patients has also been furnished to children of female PCB poisoning patients born after January 1, 1980 (these children are referred to as "second-generation PCB poisoning patients").

(2) In order to guarantee the health care rights of patients affected by PCB contamination, the Yu Cheng Patients Health Care Services Act was promulgated by presidential order on February 4, 2015. Under the provisions of the Act, both first-generation and second-generation PCB poisoning patients will continue to be exempt from NHI co-payments for outpatient (and emergency) services, and first-generation PCB poisoning patients will also continue to be exempt from NHI co-payments for inpatient expenses, and to be entitled to free annual health checkups, special clinics for PCB poisoning patients, outreach visits and health education support. The Act also includes new provisions guaranteeing that the human and legal rights of PCB poisoning patients must be respected, and prohibiting discrimination against them in regard to education, employment, medical treatment, etc.; the Act further guarantees that, if a PCB poisoning patient's rights are infringed upon, resulting in legal action, the government will provide

all necessary legal support. Where a PCB poisoning patient dies before the Act comes into effect, the patient's spouse and direct lineal descendants will be entitled to receive a solatium payment of NTD200,000 (applications for which must be received between August 10, 2015 and August 9, 2017).

(3) As of the end of 2015, there were a total of 1,817 registered PCB poisoning patients, including 1,272 first-generation patients and 545 second-generation patients. In 2015, there were a total of 18,125 instances of subsidies being provided to cover PCB poisoning patient outpatient (and emergency) service co-payments, and 106 instances of subsidies being provided to cover inpatient co-payments. There were also 690 instances of free health examinations being provided to PCB poisoning patients, and 39 applications for the payment of solatiums to the family members of deceased PCB poisoning patients were approved.

2. Human rights Protection and Care for Hansen's Disease Patients

(1) The MOHW has continued the implementation of the Directly Observed Treatment Short-Course (DOTS) program for Hansen's disease patients, in order to provide high-quality care for these patients.

(2) As of the end of December 2015, 5 hospitals had been designated to diagnose and treat Hansen's disease: National Taiwan University Hospital, MacKay Memorial Hospital, Taichung Veterans General Hospital, National Cheng Kung University Hospital, and Lo-Sheng Sanitarium, thus making it more convenient for Hansen's patients to seek medical treatment.

3. Human Rights Protection and Care for HIV Patients

The MOHW's continuing commitment to safeguard the human rights and health care of HIV patients is reflected in the MOHW's introduction of Zidovudine (ZDV/AZT) medication in 1988, and free provision of highly active antiretroviral therapy (HAART) since 1997. Highlights of the MOHW's efforts in 2015 are as follows:

(1) Human Rights Protection

Following the promulgation of the "Regulations Governing the Protection of the Rights of HIV Patients" in 2007, a system was established for HIV patients to file rights violation complaints and related complaints. As of 2015, a cumulative total of 1 rights violations had been confirmed. In 2015, the MOHW assisted with the handling of 4 complaints from members of the public. Additionally, to protect the educational rights of HIV patients, in 2014 National Defense University disputed the MOHW's measures (restoring students' enrollment or settling the case), and filed an administrative litigation with the High Administrative Court. The litigation with National Defense University is ongoing.

(2) Health Care

a. As of the end of 2015, a total of 59 hospitals in Taiwan had been designated for the treatment of HIV/AIDS. 90% of new HIV patients seek treatment within three months of diagnosis, 78% adhere to treatment, and 67% of infected patients have an undetectable viral load.

b. In order to strengthen health self-management among those infected with HIV/AIDS, in 2007 the MOHW launched an HIV case management plan. In 2015, 57 hospitals were designated for the treatment of HIV/AIDS participated under this plan by providing health education and consultation services. The cumulative total of cases is 20,252, and 13,412 patients are currently enrolled in the plan.

c. Local health bureaus and health centers track and manage cases, and case managers encouraged patients to seek regular treatment to improve their quality of life. It has also strengthened the provision of consultation, examination and tracking services for the partners of HIV/AIDS patients.

d. Subsidies are provided to NGOs that assist with HIV patient acceptance and care, treatment arrangements, emergency placement, and provision of case management services. In 2015, 202 cases were offered placement, and case management services were provide to 368 patients.

5 Communicable Disease Control

The prevention, management, and control of communicable diseases require disease surveillance and outbreak investigation, preparedness and response efforts, research, and immunization. In addition, appropriate changes must be made as needed to relevant regulations in order to be align with global trends and construct a solid framework for communicable disease control that can ensure the health and wellbeing of the people in Taiwan.

Chapter 1 Overview of the Communicable Disease Control System

In order to prevent the occurrence, transmission and spread of communicable diseases, the Communicable Disease Control Act and related regulations have been formulated. The Act specifies the obligations and rights associated with the control of communicable diseases among government agencies, medical care institutions, health care workers, and members of the general public. It also provides the legal basis for health care workers to undertake disease control activities.

Section 1 Laws, Regulations, and Framework for Communicable Disease Control

1. Laws and Regulations Governing Communicable Disease Control

   The Communicable Disease Control Act and the HIV Infection Control and Patient Rights Protection Act serve as the two main sets of regulations governing communicable disease prevention and control. In 2015, to strengthen prevention and control efforts, a total of 12 amendments were made to nine related regulations and legal orders including legally binding announcements, as shown in Table 5-1.

2. Administrative Communicable Disease Control Framework

   The Centers for Disease Control, Ministry of Health and Welfare are responsible for the formulation and review of communicable disease control policy, and have established six regional control centers that provide local government authorities with guidance regarding disease control and quarantine operations; individual local government authorities are responsible for formulating and implementing disease control plans.

3. Laboratory Technical Framework

   The Centers for Disease Control (CDC) are responsible for laboratory testing and research in relation to communicable diseases in Taiwan and have established a comprehensive service network for the inspection of communicable diseases. In addition to the CDC laboratories, there are 272 certified institutions and 1 appointed RG4 institution for communicable disease testing, 8 contracted laboratories for enterovirus and influenza testing, and 8 contracted laboratories for tuberculosis testing. Furthermore, the provisional institutions will be designated in response to the emerging communicable diseases outbreaks. For example, 6 institutions are designated as the testing centers for Middle East Respiratory Syndrome Coronavirus (MERS-CoV) during July to December 2015. Meanwhile, the "Guidelines for the collection of specimens

Table 5-1 List of Revised Regulations Issued in Relation to Communicable Diseases, 2015

Date of Amendment	Name of Regulation / Legal Order	Objective of Amendment
Feb. 4	HIV Infection Control and Patient Rights Protection Act	1. Revision of the way in which HIV patients pay for medical expenses. 2. Addition of a provision allowing testing without patient consent in cases of medical necessity or extreme urgency. 3. Lifting of the restrictions on foreign nationals with HIV entering, staying in or residing in Taiwan, in line with the recent international trends in terms of human rights protection.

Date of Amendment	Name of Regulation / Legal Order	Objective of Amendment
Feb. 25	Scope of Persons Requiring Testing for HIV	In accordance with the revisions made to the HIV Infection Control and Patient Rights Protection Act, the category of foreign nationals infected with HIV was removed from the scope of this regulation.
Mar. 23	Regulations on Implementation of Communicable Disease Surveillance and Alert Systems	Revision of the provisions regarding laboratory monitoring and alert system pathogen testing.
Jun. 17, Dec. 30	Communicable Disease Control Act	1. Addition of a legal basis for the granting of official leave (leave for statutory reasons) to members of the public when required for the purposes of disease control work, and addition of provision for heavy penalties for persons responsible for major sources of infection who fail to remedy the situation when instructed to do so. 2. Revision of regulations and penalties relating to communicable disease control, in line with actual needs; the key revisions are as follows: (1) Replacement of the phrase "infection control" with the phrase "infection management and control." (2) Strengthening of infectious disease control work in medical institutions and other similar institutions, and authorization of the central government regulatory authorities to formulate infectious disease control auditing regulations. (3) Granting the regulatory authorities the authority to imposed suitable punishments (in light of the severity of the violation) for violations of infectious disease control regulations by medical institutions and by long-term care institutions etc.
July 31	Regulations Governing Management of the Health Examination of Employed Aliens	In accordance with the revision of the HIV Infection Control and Patient Rights Protection Act, the restrictions on the right of foreign nationals with HIV to reside and work in Taiwan were lifted, and the Regulations were amended in accordance with the needs of employed alien health examination management.
Jul. 31, Dec. 24	Regulations on the Designated Labor Health Examination Medical Institutes	1. In accordance with the revision of the HIV Infection Control and Patient Rights Protection Act, the documents that hospitals are required to submit when applying for designation as a designated labor health examination medical institute were amended. 2. The criteria that must be met in order to apply for designation as a designated labor health examination medical institute were relaxed, and the relevant regulations were amended in line with the revisions being made to health examination data processing operations.
Oct. 12, Dec. 18	Regulations Governing Operation of the Communicable Disease Control Medical Network	1. Granting to regulatory authorities at the local government level the right to specify the scope of responsibility of hospitals charged with responding to communicable disease outbreaks, and provision of a legal basis for the allocation of budgets and subsidies. 2. Replacement of references to "Taoyuan County" by "Taoyuan City," following Taoyuan County's upgrading to special municipality status.
Dec. 7	Regulations Governing the Management of Testing Institutions and Laboratory Testing for Communicable Diseases	1. Deletion of the appended tables specifying infectious disease testing items, testing schedules, and testing methods, with these items to be announced separately by the regulatory authorities instead. 2. Granting to regulatory authorities at the local government level the right to audit testing institutions falling within their jurisdiction.
Dec. 14	Regulations Governing Payments for Expenses for Laboratory Testing, Prevention and Treatment of HIV	In line with the revision of the HIV Infection Control and Patient Rights Protection Act, the Regulations Governing Payments for Expenses for Laboratory Testing, Prevention and Treatment of HIV have been renamed as the Regulations Governing Subsidies for Treatment Expenses of HIV Patients.

for the communicable diseases" and the "Quality management plan for transportation of specimens of general communicable diseases" have been formulated to ensure the quality, effectiveness and safety of the specimen collection and transportation.

4. Command Framework

   The National Health Command Center was established in 2005, with responsibility for gathering health-related information from central and local government agencies and other institutions. This information is then made available for use in supporting comprehensive outbreak response, and for command officials to use as a reference for decision-making. Taiwan has also established a Single Window system for communication and liaison with other countries, which facilitates reporting and responding to major outbreaks and public health emergencies.

Section 2 Disease Surveillance and Investigation Mechanisms

The number of notifiable disease cases in 2015 is shown in Appendix II. The status of disease surveillance and outbreak investigation is as follows:

1. Diversified Surveillance Systems for Communicable Diseases

   Besides the diversified communicable disease reporting and surveillance system that have been established (including the School-based Disease Surveillance System, Surveillance System for Populous Institutions, Real-time Outbreak and Disease Surveillance System, and automated reporting of infectious diseases from laboratories), data are also collected from NHI databases and from death records. A variety of systems is used to gather and analyze information relating to domestic and international outbreak situations, so as to facilitate effective outbreak monitoring.

2. Integration of Disease Reporting Systems

   Since 2015, efforts have been underway to promote inter-ministerial cross-checking of data, with integration of disease data from three organizations - the Council of Agriculture (Executive Yuan), and the Ministry of Health and Welfare's Food and Drug Administration and Centers for Disease Control - with the aim of enhancing the accuracy and integrated, value-added utilization of disease control surveillance data, thereby enhancing the overall effectiveness of disease surveillance.

3. Investigation of Outbreaks

   The investigation is needed when sudden communicable disease outbreaks of unidentified origin occur. In 2015, the MOHW investigated 620 suspected cluster outbreaks, including a Norovirus cluster outbreak caused by consumption of tainted ice at a holiday resort in Pingtung County, a Norovirus cluster outbreak on Green Island in Taitung County caused by consuming raw oysters, and a Vibrio parahaemolyticus cluster outbreak caused by consuming tainted seafood at a wedding reception in Yilan County.

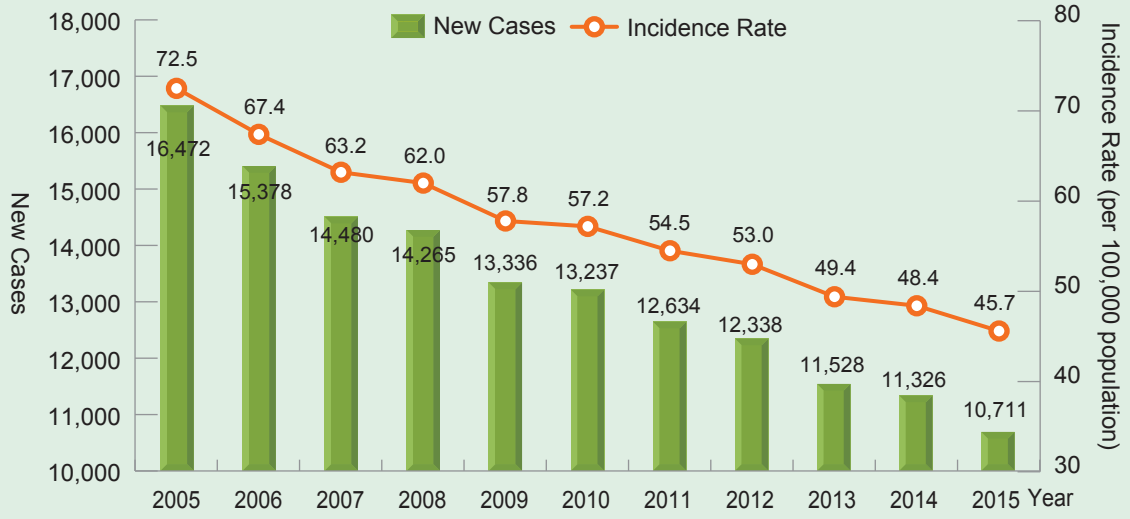
Chapter 2 Control of Major/Emerging Communicable Diseases

Section 1 Tuberculosis

In 2015, there were 10,711 confirmed tuberculosis (TB) cases in Taiwan (Figure 5-1). Taiwan has been implementing a National Mobilization Plan to Halve TB in 10 Years. The results achieved in the implementation of this Plan in 2015 were as follows:

1. The TB incidence rate fell from 72.5 cases per 100,000 people in the population (16,472 cases in absolute terms) in 2005 to 45.7 cases per 100,000 people (10,711 cases) in 2015, a fall of 37%, and indicating that the TB control strategy has been effective
2. More than 90% of the patients who tested positive on TB smears or culture tests have participated in the Directly Observed Treatment, Short-course (DOTS) program.
3. From 2013, patients treated under a dedicated medical treatment and care system for multidrug-resistant TB (MDR-TB) had a 24-month treatment success rate of 76.4%.
4. Improved contact investigation has led to an average of 10 contacts investigated for each confirmed TB case in 2015.

Figure 5-1 Reported TB Cases, 2005 - 2015



Source: Centers for Disease Control, MOHW

5. A Latent TB Infection Treatment Program has been implemented in conjunction with the Directly Observed Preventive Therapy (DOPT) program; in 2015, a total of 4,706 people have participated in the Latent TB Infection Treatment Program.
6. To actively identify TB cases, the MOHW has been conducting nationwide TB screening via mobile chest X-ray vans. In 2015, a total of 347,264 screenings were implemented, leading to 363 diagnosed cases.
7. By offering subsidized hospitalization and living expenses for patients with chronic TB infection, the MOHW encourages long-term isolated care to prevent further transmission.
8. Routine HIV screening is provided for TB patients aged between 15 and 49. In 2015, the HIV detection rate among this target group is 94%.

Section 2 Communicable Diseases of the Enteric Tract

1. Enterovirus

   There were six cases of severe enterovirus infection in 2015, including two deaths; all of these cases involved direct mother-child infection, which cannot as yet be effectively prevented. The main prevention and control strategies implemented included disease surveillance, enhanced environmental sanitation and hygiene inspection activities at schools/nurseries and public locations frequented by children, collaboration with local government authorities on the implementation of an "Enterovirus Control Plan," extended community health education, the establishment of a medical care network for severe infections to speed up transfers between responsible hospitals, and measures to enhance the clinical diagnosis capabilities of medical personnel and the quality of care provided.

2. Hepatitis A

   Since June 1995, the MOHW has been providing hepatitis A immunization to preschool children in 30 mountain villages and in 9 villages in lowland areas adjacent to mountain regions. This has caused the incidence rate of hepatitis A in mountain villages to fall from 90.7 per 100,000 population to less than 0.5 per 100,000 population, representing an example of successful disease control policy implementation.

Section 3 Vector-borne Communicable Diseases

1. Dengue Fever

In 2015, there were 43,784 confirmed cases of dengue fever, comprising 365 imported cases and 43,419 indigenous cases (including 228 deaths). It was the worst indigenous dengue outbreak in years, due to a combination of factors, including an increase in global dengue incidence, rising temperatures, and increased precipitation. In addition, there were 647 severe cases of dengue fever, all of which were indigenous. The case number of dengue fever by year is shown in Figure 5-2.

In 2015, the new strategies for dengue prevention and control included:

(1) The Communicable Disease Control Act was revised, with the addition of more severe penalties for persons who fail to remove potential sources of infection, and with the addition of new provisions enabling citizens subject to emergency preventive measures to apply for statutory leave.

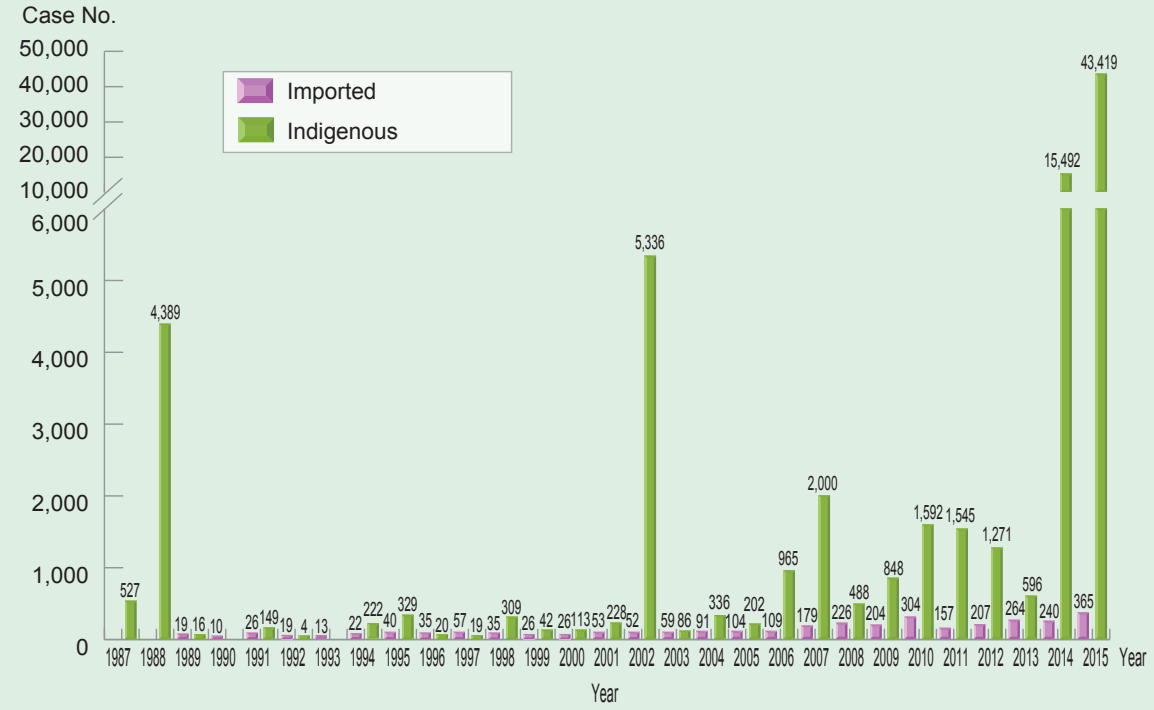
(2) The case reporting definitions were revised, with physicians being reminded to pay particular attention to severe cases of dengue fever, so as to reduce the mortality rate.

(3) The guidelines for the prevention and control of dengue fever were revised, giving local government authorities more flexibility when dealing with large-scale outbreaks.

(4) An outside body was commissioned to compile a "Dengue Fever Prevention Research Center Integration Plan," which seeks to bring together experts from various disciplines to develop or introduce effective disease vector prevention techniques, in line with future prevention needs.

As the summer of 2015 saw a large-scale outbreak of dengue fever, on September 15, 2015 the Executive Yuan established the Central Epidemic Command Center (CECC) for Dengue Fever. Weekly meetings were held to integrate the utilization of central and local government disease prevention resources, exercise overall control and coordination,

Figure 5-2 Case No. of Dengue Fever, by Year



Source: Centers for Disease Control, MOHW

and provide guidance. The incidence of new infections began to slow in November, and the CECC was stood down on January 11, 2016.

2. Japanese Encephalitis

   In Taiwan, Japanese Encephalitis is prevalent between May and October, and peaks in July and July. In 2015, there were 30 confirmed cases.

3. Malaria

   The MOHW has continued to implement monitoring of malaria cases and the Anopheles minimums mosquito, strengthened health education and warned citizens to take precautions against being bitten by mosquitoes when traveling overseas. In 2015, there were 8 imported cases.

Section 4 Communicable Diseases Transmitted by Blood or Body Fluids

1. HIV/AIDS

   Between 1984 and the end of 2015, there was a cumulative total of 31,030 reported cases of HIV among Taiwanese nationals. Of those infected, 14,003 developed full-blown AIDS, and there were 5,085 deaths. In 2015, there were 2,327 new infections, with 93.9% of the new patients having contracted the disease through sex, 82.6% of whom were men who had sex with men. The main prevention control strategies implemented in 2015, and the results achieved, are outlined below:

(1) To promote HIV prevention strategies targeting men who have sex with men(MSM), the MOHW has continued commissioning five LGBT's community centers, which providing health talks, health education, free telephone consulting, specialized clinics, as well as testing and referral services, etc. for all genders. Also, social media such as Line and Facebook are being used to provide health advice, and some dating apps disseminated health promotion messages; on average, these messages reach around 10,000 people every month.

(2) There has been close collaboration between central and local government agencies on the implementation of awareness-raising efforts, using a broad range of innovative communication channels - including Facebook, Twitter, Instagram, and dating apps, etc. - to strengthen citizens' HIV prevention knowledge. Public opinion surveys have shown that over 80% of people in the 15 - 49 age range now have an accurate understanding of HIV prevention.

(3) The MOHW has been implementing the "Intravenous Drug User HIV Prevention Plan." 159 medical care institutions throughout Taiwan have been providing substitution therapy, 834 have established clean needle and health consultation service stations, and 417 have installed needle syringe vending machines; the needle and syringe return rate is over 92%.

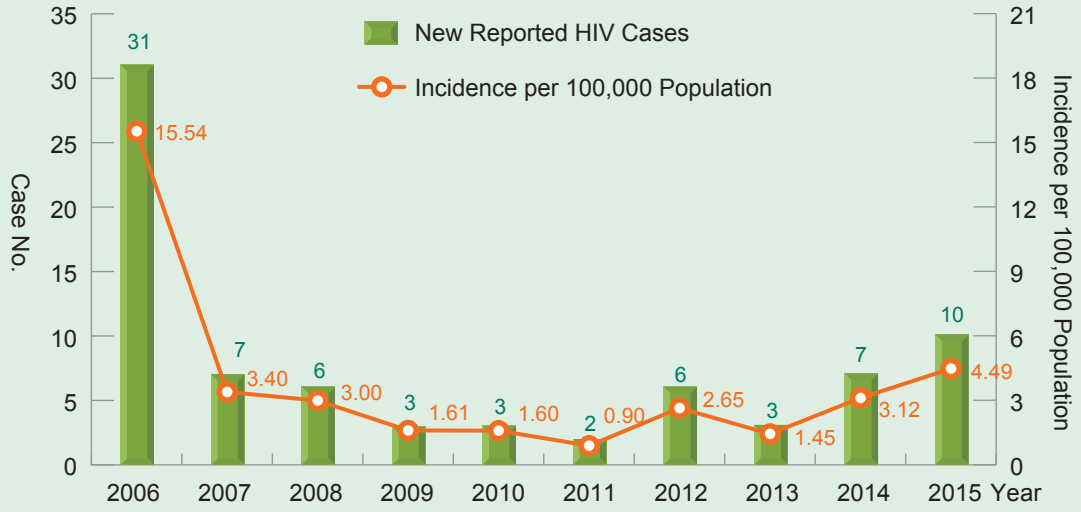
(4) The MOHW has commissioned 43 medical care institutions to implement the "Free, Anonymous HIV Screening and Consultation Plan." In 2015, a total of 38,599 people were screened, with a positive rate of 2%.

(5) To prevent mother-to-child transmission of HIV, the MOHW implements a universal HIV screening program for pregnant women, and provides prophylaxis. As of 2015, there had been 105 new cases of HIV detected in pregnant women (including 24 foreign nationals), of which 10 cases were detected in 2015. The positive rate was 4.49 per 100,000 population. The trend in annual reported HIV cases shows in Figure 5-3.

2. Sexually Transmitted Diseases

   The MOHW has been implementing the "Program for Improving and Evaluating the Quality of Clinical Treatments for HIV and Sexually Transmitted Diseases." Measures to raise the willingness of patients with STDs to receive treatment include the training of specialized physicians in each specialty association and the recommendation of physicians who run STD-friendly clinics. A total of 1,371 physicians had been recommended at the end of 2015. An additional program to promote HIV screening among patients with STDs has resulted in 103,241 patients being screened in 2015, 0.37% of whom tested positive.

Figure 5-3 New HIV Cases and Incidence under the Universal Screening Program for Pregnant Women, by Year



Source: Centers for Disease Control, MOHW

3. Hepatitis B and C

(1) There are currently approximately 2.5 million adult carriers of hepatitis B in Taiwan and 400,000 - 700,000 adult carriers of hepatitis C. Implementation of the "Pilot Program to Improve NHI Services for Chronic Hepatitis B and C Patients" began in October 2003. As of the end of 2015, a cumulative total of 187,243 hepatitis B patients and 87,045 hepatitis C patients had participated in this program.

(2) The continuing screening of hepatitis B during prenatal care visits for pregnant women and the prophylactic vaccination for newborns against hepatitis B had significant lower the carrier rate of children at age 6 to fall from 10.5% (before implemented these measures) to around 0.8% today.

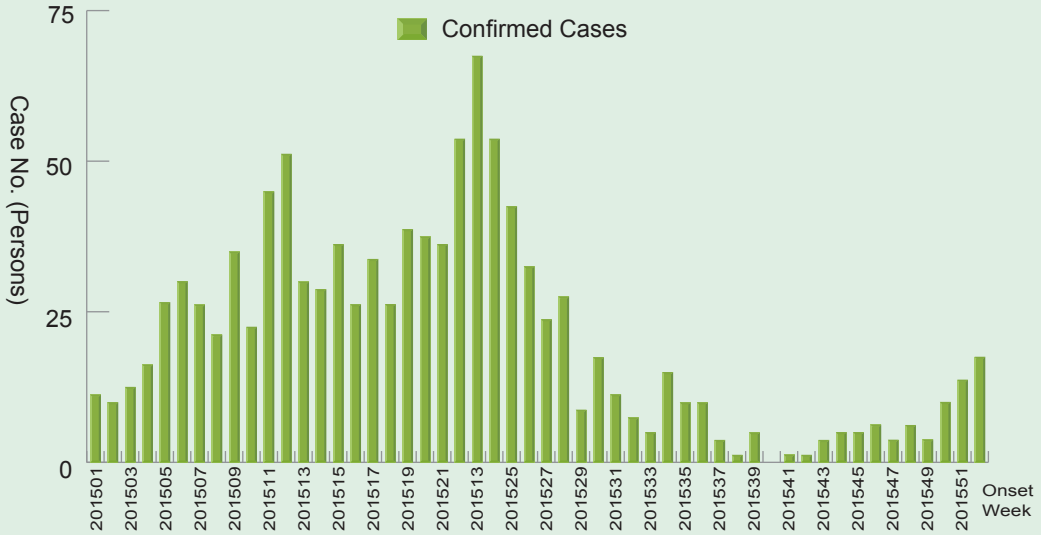
Section 5 Seasonal Influenza Prevention and Control

1. In 2015, there were 857 confirmed cases of influenza-related complications, including 147 deaths, giving a mortality rate of 17.2%. The change in the number of flu cases over time is shown in Figure 5-4.

2. An annual influenza vaccination program is launched in October every year. As of 2015, the following groups of people were eligible for government-funded vaccinations: people over the age of 65; children between the age of 6 months and the sixth year of elementary school; patients with severe injury or illness; residents and front-line caregivers in care/nursing institutions; health and disease prevention workers; patients aged between 50 and 64 with diabetes or cardiovascular, pulmonary, vascular, liver or kidney ailments; HIV patients, and pregnant women. The diagnosis fees for seasonal influenza vaccination are subsidized for infants, toddlers, senior citizens aged 65 or above, residents of care/nursing institutions, and patients with rare diseases.

3. To address the medical demand during peak influenza periods, the eligibility for subsidized influenza immunizations was expanded from December 1, 2014, to April 30, 2015, and the number of locations that offered subsidized antivirals was also expanded, to more than 3,200.

Figure 5-4 Confirmed Cases of Severe Complicated Influenza in 2015



Source: National Infectious Disease Statistics System, Centers for Disease Control

4. In 2015, to facilitate the handling of incidents involving clusters of flu-like symptoms, the MOHW made a number of adjustments, including the following: (1) The medical officers at the 6 Regional centers under the Centers for Disease Control (CDC) were authorized to decide on the usage of subsidized influenza antivirals. (2) Changes were made to symptom monitoring procedures. (3) Adjustments were made to the reporting process and content used for school-based infectious disease surveillance systems, and the "Influenza Prevention and control Guideline " was revised accordingly. The goal of these adjustments was to make it easier for medical and disease prevention personnel to take appropriate measures in light of the severity of the situation and to facilitate collaborative preventive work.
5. To help relevant personnel cope more effectively with the annual peak periods of demand for preventive measures (on seasonal influenza and the novel influenza A virus) the MOHW has formulated the "Strategic Plan for Responding to Peak Periods for Influenza." The Plan's main strategies include: Improving the effectiveness of influenza monitoring; expanding the range of categories of people eligible for subsidized influenza antivirals and increasing the number of locations at which subsidized immunization is available; establishment of special clinics for the treatment of flu-like symptoms; measures to reduce congestion in clinics and enhance the quality of service provided; improving communication with the public regarding influenza risks and strengthening health education, etc.
6. To address the medical demands during peak influenza periods and provide influenza patients with timely and appropriate treatment, during the weekends and holidays from February 14 to March 1, 2015 (including the Lunar New Year extended holiday), a total of 145 medical institutions throughout Taiwan ran special influenza clinics. The total number of the clinics operated was 1,617, with 18,758 patients seen; these clinics are estimated to have diverted 30.3% of influenza patients away from emergency rooms during weekends and holidays.

The International Training Course on Molecular Diagnosis for MERS-CoV, a collaborative project between Taiwan and the U.S.

Section 6 Control of Emerging Communicable Diseases

1. In response to the emergence of new communicable diseases such as Ebola, Middle East respiratory syndrome coronavirus (MERS-CoV) and the Zika virus in recent years, and in line with the MOHW vision of realizing "One Health" coordinated communicable disease prevention, Taiwan has been working actively to secure participation in the Global Health Security Agenda (GHSA). Over the period September 6 - 9, 2015, officials from the Centers for Disease Control (MOHW) represented Taiwan (which is a member of APEC under the name "Chinese Taipei") at the APEC-GHSA Policy Forum on Partnering to Establish Basic Infrastructure for Infection Prevention and Control in South Korea.
2. Preventive measures were taken by Taiwan in response to the continued global spread of the Ebola virus in 2015 included the following:

(1) Issuing "Ebola Travel History Declaration Cards" to passengers on flights arriving in Taiwan from Europe or Dubai, so as to reduce the risk of Ebola being spread to Taiwan. Over the period from February to June 2015, the MOHW held 20 "Emerging Contagious Disease (Ebola Virus) Infection Prevention Readiness Training" sessions, with the aim of strengthening the readiness of frontline medical personnel to deal with emerging communicable diseases such as Ebola, including the ability to put on and remove protective clothing safely.

(2) In March 2015, the MOHW collaborated with the U.S. on the establishment of the "Ebola Prevention Training Center," and held the first tranche of training sessions. In all, a total of 16 medical personnel from six countries, including the Philippines, Malaysia, Indonesia, Singapore, Cambodia and Vietnam, participate in the training sessions, which will help to further a network of international collaboration in the region.

3. Following the spread of MERS-CoV to South Korea in May 2015, the following preventive measures have been implemented in Taiwan:

(1) On May 21, 2015, the MOHW issued a press release and sent notifications to medical personnel, providing information about the current international status of the MERS-CoV epidemic, and warning both doctors and members of the public to be on their guard.

(2) On May 22, the MOHW established a "MERS Emergency Response Team," and formulated response strategies for dealing with three possible scenarios involving the spread of MERS to Taiwan, while working actively to strengthen disease monitoring capabilities, enhance testing capabilities, strengthen border quarantine measures, improve infection management in hospitals, enhance international collaboration, and step up communication efforts with the risks posed by MERS.

(3) Also in May, the MOHW dispatched medical officer to visit the health authorities and leading doctors in South Korea, and to provide health advice to Taiwanese citizens resident in South Korea, with the aim of preventing the further spread of MERS-CoV.

(4) In August 2015, the MOHW collaborated with the U.S. on the implementation of the International Training Course on Molecular Diagnosis for MERS-CoV. A total of 17 senior molecular virology specialists from nine countries (Japan, the Philippines, Indonesia, Cambodia, Malaysia, Vietnam, Thailand, India, and Papua New Guinea) took part in the training sessions. This program also involved the establishment of a communication network linking laboratories in countries and regions throughout Southeast Asia and the Asia Pacific region as a whole, creating new opportunities for expanded inter-regional collaboration, and contributing to the enhancement of regional contagious disease prevention capabilities.

Section 7 Control of Imported Communicable Diseases

Taiwan implements all necessary quarantine measures with regard to ships, aircraft, and people; port and airport authorities are required to establish health and safety work teams to prevent the importation and exportation of communicable diseases. The measures implemented in 2015 included:

1. Quarantine

   In 2015, a total of 23,601,215 people entered Taiwan. Of these, 17,779 were identified as symptomatic by the non-contact infrared thermometer diagnostic stations run by the Centers for Disease Control (MOHW) at Taiwan's airports and ports, and 161 people were later confirmed to be infected with notifiable communicable diseases.

2. Control and Prevention of Communicable Disease Related to Travel

   Special travel clinics provide counseling to travelers regarding appropriate vaccines and preventive medication. In 2015, travel clinics at 26 contracted hospitals provided services on 17,316 occasions.

Chapter 3 Communicable Disease Preparedness and Response, and Infection Control

The disease outbreaks that have occurred in recent years have demonstrated the importance of pandemic-related preparedness, stockpile supply management, nosocomial infection control, and response mechanisms for bioterrorism events. The MOHW's Centers for Disease Control (CDC) continues to maintain the Communicable Disease Control Medical Network (Figure 5-5) and implements regular inspections and audits of isolation beds at hospitals responsible for pandemic responses. Training and drills are implemented following response planning; in 2015, a total of 194 training sessions and 23 excercise were held.

Section 1 Pandemic Influenza Preparedness and Response

1. Pandemic influenza preparedness operations are carried under the National Influenza Pandemic Preparedness Plan Phase II. These operations are based on the "Four Major Strategies and Five Lines of Defense" as outlined in the Plan. On May 26, 2015, the MOHW received the approval from the Executive Yuan to implement the National Influenza Pandemic Preparedness Plan Phase III, with the aim of ensuring continued seamless implementation of preparedness operations.
2. To address the need for the prevention and control of novel influenza A virus infections, a stockpile of influenza antiviral agents equivalent to 10-15% of the population is maintained.
3. A suitable stockpile of human A/H5N1 vaccines are maintained, and a voluntary A/H5NI vaccination program has been created for at-risk individuals as identified by WHO, ensuring the health of the public.
4. The MOHW responded to the outbreak of H5 avian influenza at poultry farms in Taiwan in 2015 by taking measures for prevention as below:

(1) The MOHW has attended meetings of the "Animal Epidemic Emergency Response Team" established by the Council of Agriculture

Figure 5-5 The Communicable Disease Control Medical Network

Region	Designated Hospital
North	Sinwu Branch, Taoyuan General Hospital, MOHW (34 isolation beds)

Region	Designated Hospital
Taipei	Heping Fuyou Branch, Taipei City Hospital (29 isolation beds)

Region	Designated Hospital
Central	Taichung Hospital, MOHW (20 isolation beds)

Region	Designated Hospital
East	Hualien Hospital, MOHW (7 isolation beds)

Region	Designated Hospital
South	Tainan Hospital, MOHW (22 isolation beds)

Region	Designated Hospital
Kaohsiung and Pingtung	PIngtung Hospital, MOHW (9 isolation beds)

Note: In 2015, the total number of isolation hospitals was 134. In each region, there is one Designated Hospital and one Supporting Hospital, with supporting manpower allocated accordingly.

(COA), Executive Yuan, helping it to stay up-to-date with the latest developments in animal infection incidents, and enabling it to adjust preventive measures accordingly.

(2) The MOHW monitors changes in avian influenza viruses and evaluates the potential risk of transmission to humans, so as to be able to implement necessary preventive measures and preparations in advance.

(3) The MOHW oversees the monitoring by county and city governments of the health status of poultry farm staff and of personnel involved in cleaning up poultry farm sites; in 2015, a total of 8,311 persons were monitored, with no instances of transmission of avian influenza to humans being found.

(4) The MOHW has overseen the transfer of protective clothing for preventive efforts, including arranging the transfer of over 420,000 N95 masks and surgical masks to the Ministry of National Defense and the Council of Agriculture to provide protection for personnel engaged in cleaning up poultry farms affected by avian influenza outbreaks.

5. On June 15, 2015, the Council of Agriculture announced the "Prohibition on the Display, Presentation and Sale of Live Chickens, Ducks, Geese, and Turkeys, etc. in Retail Markets." On the same day, the MOHW announced the termination of the restrictions imposed on May 2, 2014 on places and persons engaged in the display, presentation and sale of live poultry. Joint investigation operations will continue to be performed under the new Council of Agriculture regulations.

Section 2 Management of Disease Control Supplies

1. To be prepared for biological disasters, the MOHW has set up a three-tiered stockpile management system comprising the central government competent authority and medical care institutions. The national stockpile is monitored closely via a management information system. Taiwan's safe reserve level for disease control suppliers has been successfully maintained at 100% at all three levels of the three-tiered system.
2. The MOHW ensures that equipment is replaced on time, and has set up a joint procurement platform to ensure smooth inventory movement, ensuring that due attention is paid both to the replacement of old equipment during non-outbreak periods and to ensuring the maintenance of sufficient supplies during outbreaks.

On May 5, 2015 the "2015 Taiwan Hand Sanitizing Relay" activity was launched, with hospitals, long-term care institutions and medical student teams from all over Taiwan taking part.

Section 3 Nosocomial Infection Control and Laboratory Biosafety Management

Important achievements in 2015 included the following:

1. Revisions of Articles 32, 33, 67 and 69 of the Communicable Disease Control Act were promulgated, with the aim of strengthening infection control work in elderly centers, nursing homes, long-term care institutions, residential child care facilities, corrective facilities, etc.; in addition, the central competent authority was authorized to formulate infection control auditing regulations, and was authorized to impose suitable penalties in the event of violations of infection control requirements by medical institutions, long-term care institutions, etc.
2. The MOHW has continued to promote the Taiwan Nosocomial Infections Surveillance System (TNIS System) among hospitals, and periodically creates annual and quarterly reports on infection detection at hospitals and healthcare institutions, so that hospitals that participate in the reporting system can provide more accurate and comprehensive feedback. Additionally, planning has also been undertaken for the establishment of an antibiotics resistance management and monitoring mechanism, so as to be able to implement effective monitoring of antibiotics resistance in Taiwan, and promote appropriate antibiotics use and infection management.
3. The MOHW has also continued to implement on-site hospital infection control inspections, with inspections performed at 367 hospitals in 2015; 99.4% of these hospitals passed preliminary inspection. Inspections were also implemented at 340 nursing institutions, including 188 general nursing homes, 131 post-natal care homes, and 21 psychiatric nursing homes; the pass rates were 97.3%, 99.2%, and 100% respectively.
4. The MOHW has continued to implement the Antimicrobial Stewardship Program (National Action Plan), with 7 demonstration centers and 71 participating hospitals in the various regions. The Program emphasizes response strategies aimed at enhancing both the appropriate use of antibiotics and infection control. Hospitals undergo both internal and external inspections, with a mechanism in place for the provision of follow-up guidance, so as to optimize the appropriate use of antibiotics, thereby helping to protect patients' health and enhance the overall quality of medical care.
5. In 2015, the MOHW organized the "2015 Taiwan Hand Sanitizing Relay" activity, with a total of 98 hospitals, 80 long-term care institutions and 35 medical student teams participating. The aim of the activity was to promote proper hand sanitation, so as to reduce the incidence of nosocomial infection.
6. Biosafety management

(1) In 2015 biosafety inspections were carried out at 21 biosafety level 3 (BSL-3) laboratories,

one biosafety level 4 (BSL-4) laboratory, and 11 negative-pressure TB laboratories.

(2) A total of 8 biosafety training programs were held in 2015, with a combined total of 627 participants; three online courses were also implemented. In line with international best practice for laboratory risk management, guidance was provided to 11 high-protection laboratories regarding the adoption of new laboratory biohazard management systems, with the aim of strengthening laboratories' self-directed management capabilities.

(3) As of 2015, there were 517 units in Taiwan that stockpiled or used Level 2 or above infectious agents; data regarding submission of applications to the CDC by different categories of the unit to establish biosafety committees are shown in Table 5-2.

Section 4 Research and Laboratory Testing

1. In 2015, the total number of specimens sent to the Research and Diagnostic Center for testing was 137,354. Of these, 26,698 were found to contain a pathogen or tested positive for a related antibody, yielding a positive rate of 19%.
2. In 2015, the platforms used for monitoring emerging communicable diseases of the respiratory tract found 49 novel influenza A virus cases and 5 MERS-CoV cases. Enhanced proactive monitoring also led to the identification of 270 cases of pneumonia from unknown causes (where the test results ruled out novel influenza A virus or MERS-CoV).
3. The MOHW completed technology transfer with respect to Neisseria gonorrhea, and has been working to complete technology transfer with respect to the Dengue fever NS1 rapid antigen test method.
4. The MOHW has been implementing the second year of the "Plan to Consolidate and Improve the Surveillance Network for Food-borne Illnesses and Related Pathogens," with the establishment of a cross-institution collaboration model. In 2015, the effective integration of epidemic investigation and testing and research resources at the Centers for Disease Control (CDC), supported by collaboration with the Food and Drug Administration (FDA), revealed a significant increase in the number of cluster diarrhea outbreaks caused by new types of Norovirus. Follow-up of many of these cluster outbreaks made it possible to identify the source of infection and bring the outbreak under control promptly, with necessary preventive measures being taken.
5. The MOHW has continued to implement the accreditation system for institutions qualified to diagnose communicable diseases. In 2015, a total of 66 institutions were accredited for 162 items.
6. The MOHW has continued to collaborate with Japan's National Institute of Infectious Diseases and Research Institute of Tuberculosis, with the Centers for Disease Control and Prevention in the U.S., and with Taiwan's National Health Research Institutes (NHRI) and individual domestic hospitals designated for carrying out sentinel surveillance.

Table 5-2 Type and Number of Organizations in Taiwan with Biosafety Committees and Designated Biosafety Personnel

Type \ Category	Government Agencies	Medical Institutions	Academic Research Institutions	Other	Total
Biosafety Committee	16	150	53	172	391
Designated Biosafety Personnel	17	21	2	86	126

Chapter 4 Immunization

Section 1 Current Immunization Status and Trends

To ensure the sustainable implementation of the government's immunization policy, in 2010 an "Immunization Fund" was established in accordance with Article 27 of the Communicable Disease Control Act. The purpose of the Fund is to provide a stable funding source for immunization, and to facilitate the gradual implementation of new immunization policy recommendations. Starting from 2015, Pneumococcal Conjugate Vaccine (PCV) is being included in the list of routine vaccinations, thereby helping to strengthen the immunity and health of young children.

The government currently provides nine types of free routine vaccinations for infants and young children: BCG, DTaP-IPV-Hib 1 (5-in-1), PCV, Varicella, MMR, Japanese encephalitis (JE), Tdap-IPV, and Influenza. In all, these vaccinations protect against 14 different diseases. Children living in remote mountain districts and other high-risk areas also receive free vaccination against Hepatitis A. Children between the ages of 6 months and the final year of elementary school are also eligible for free influenza vaccination. The immunization schedule for the various vaccinations is shown in Table 5-3 below.

The Centers for Disease Control (CDC) have established a National Immunization Information System, which monitors and follows up on the immunization status of infants and young children in Taiwan. Following the introduction of the new System, immunization rates for the routine vaccinations for children have been raised to over 95%, a very high level. Immunization rates for the routine vaccinations are shown in Figure 5-6.

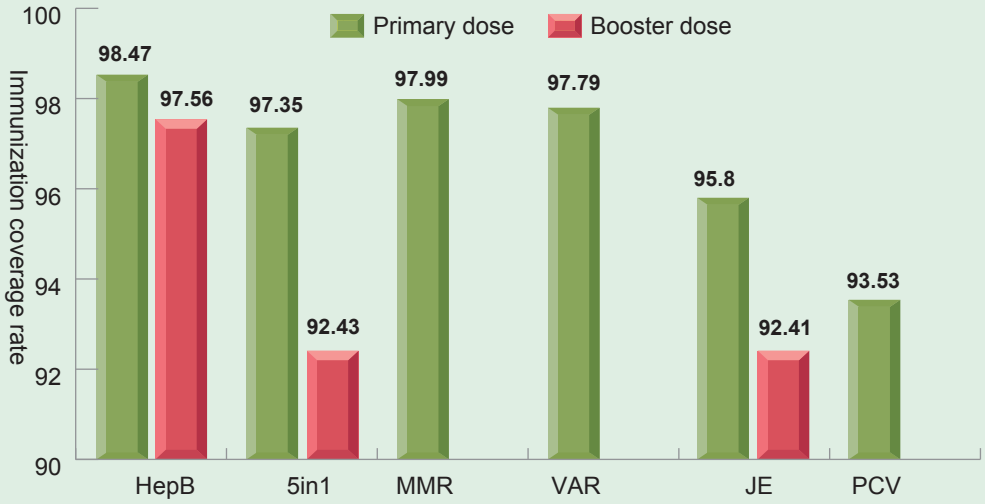
To help persons who have suffered harm as a result of immunizations, a mechanism established by the government ensure the persons in need making applications for emergency relief, and receive the assistance legally.

Table 5-3 Routine Vaccinations for Children, and Immunization Schedule

Age	Vaccine
Within 24 hours of birth	● HBIG 1[1]
	● HepB 1
1 month	● HepB 2
2 months	● DTaP-IPV-Hib 1 (5-in-1) ● PCV 1
4 months	● DTaP-IPV-Hib 2 (5-in-1) ● PCV 2
5 months	● BCG 1 (this vaccination should be given within 5 - 8 months of birth)
6 months	● HepB 3 ● DTaP-IPV-Hib 3 (5-in-1)
6 months to elementary school age	● Influenza
12 months	● MMR 1 ● Varicella 1
12 - 15 months	● PCV 3
1 year and 3 months	JE 1 and JE 2 (two-week gap)[2]
1 year and 6 months[3]	● DTaP-IPV-Hib 4 (5-in-1)
2 year and 3 months	● JE 3
Between 5 years and 1st grade in elementary school	● Tdap-IPV 1 ● MMR 2 ● JE 4

Notes:
1. If a mother is a hepatitis B carrier (HBeAg positive), then her baby should be given one dose of HBIG shortly after birth, and not later than 24 hours after birth.
2. The first dose of JE vaccine is given 15 months after birth, and the second dose is given two weeks later.
3. Faced with a worldwide shortage of DTaP-IPV-Hib vaccine, starting from January 2014 the age for the fourth dose of DTaP-IPV-Hib was temporarily changed to 27 months after birth.

Figure 5-6 Immunization Coverage Rates for Children, 2015



Source: National Immunization Information System, December 2015

Note: HepB: Hepatitis B vaccine; 5-in-1: Diptheria, tetanus, pertussis, haemophilus B, and polio vaccines (DTaP-IPV-Hib); MMR: Measles, mumps and rubella combined vaccine; VAR: Varicella vaccine; JE: Japanese encephalitis, PCV: Pneumococcal Conjugate Vaccine.

Section 2 Development and Manufacture of Serum Vaccines

1. Production of Biological Products

(1) In 2015, the MOHW produced 404.7 liters of horse-derived antivenin. The periodic supply of BCG vaccines, toxoids and antivenins totaled 661,483 doses.

(2) The National Horse Farm for Anti-Venom Production continues to operate smoothly. The number of horses raised has risen, and Good Manufacturing Practices (GMP) have been put in place with respect to the Farm's standard operating procedures, serum collection clean room operation and validation, and equipment operation. Anti-venom production operations have been successfully modeled.

(3) Production of some products that were formerly manufactured in-house by the MOHW, including BCG vaccine and snakebite anti-venom, is now being outsourced to the National Health Research Institutes (NHRI) bio-agents manufacturing facility. The facility has already obtained manufacturing permits for these two categories of product and is beginning to supply product. Over the course of 2015, the facility supplied a total of 10,739 vials of BCG vaccine.

2. Development of Biological Products

(1) A viral strain library has been established with 11 strains from three subtypes: B5, C2, and C5; C2-E98-07 was selected as a candidate strain. Through the research work carried out in 2014 and 2015, it has been determined that efforts to develop a vaccine for the new Enterovirus Type 71 will focus mainly on C2-subtype strains.

(2) Quality assurance methods and acceptable quality levels have been established for banded krait and cobra venom. The venom type is identified using a standard topology based on high-performance liquid chromatography, and the double immunodiffusion test is used to provide supporting evidence.

(3) The MOHW has been implementing the "Outsourced Poisonous Snake Raising and Snake Collecting and Supply Plan," collaborating with specialist organizations. This helps to overcome space constraints and spread risk. The MOHW has also been implementing the "Poisonous Snake Availability and Venom Collection Technical Service Plan," so as to reduce the risk of harm to personnel engaged in providing medical care to snakes and the snakes themselves.

6 Management of Food and Drugs

The primary purpose of the Taiwan Food and Drug Administration (TFDA)'s work is to protect the health of consumers. To achieve this goal, key working points in 2015 were: creating sound legal standards and review mechanisms; implementing the food source management; establishing detailed quality chain monitoring systems; pushing forward national laboratory responsibilities and capabilities; putting in place risk management systems, and proactively strengthening consumer protection and communication channels. The overall goal is to create an environment where consumers can eat at ease and be ensured of safe medicines.

Chapter 1 Management of Food

In order to guarantee the safety of Taiwan's food and beverages, the TFDA continues to add and amend food-related laws and regulations in accordance with international standards. Besides strengthening food industry self-management, the TFDA raises hygiene awareness among food service personnel and works together with business to build an environment where people feel safe when eating.

Section 1 Food Regulatory Standards and Product Review

1. In order to strengthen management of food safety, the TFDA amended the Act Governing Food Safety and Sanitation (below, AGFSS), as described in Table 6-1.
2. Amendments and additions in 2015 to food safety and sanitation management regulations and standards are shown in Table 6-2.
3. By the end of 2015, there were 16,696 permits issued for specified food products following inspection and registration.

Section 2 Management of Food Sources

1. Implementing a Food Safety Control System

   Required that high-risk food businesses use Hazard Analysis and Critical Control Points (HACCP) systems to prevent food hazards, and establish a food safety management task force with at least one professionally qualified member to ensure the safety of food manufacturing.

2. Border Inspection of Food

(1) Article 30 of the AGFSS states: "Application for inspection with the central competent authority and declaration of the relevant information of the product are required, and shall be in accordance with the customs commodity code and classification when importing food, genetically modified food raw materials, food additives, food utensils, food containers or packaging, and food cleansers designated by "the central competent authority in a public announcement". Until ending December 31, 2015, a total of 2,364 items DOI announcement column, enter the case of the use of food products shall be handled food import inspection.

(2) In 2015, inspection applications were completed for a total of 640,005 batches of food imports and related products, of which 50,149 were tested. Food that failed to meet regulations was either withdrawn or destroyed.

3. Management of Food Additives

(1) Border control: Announced the addition of 29 items that, if designated for use in food or food additives (including flavorings), shall be subject to inspection in accordance with the Regulations of Inspection of Imported Foods and Related Products.

(2) Full registration of manufacturing, import, and sales: Through December 31, 2015, 2,600 food

Table 6-1 Revisions to the AGFSS, 2015

Date	Objective of Revision
Feb.4	1. Announced that food businesses of certain categories and scales must, with regard to their health safety systems, undergo external auditing and monitoring that is certified by a third party (Article 8). 2. Added "other matters requiring labeling" to the restrictions on direct food and beverage vending locations and for bulk food products. Required that domestic certified agricultural products include a traceable source on the label (Article 25).
Dec.16	Authorized the central competent authority to restrict the methods or conditions of manufacture, processing and preparation, edible parts, usage quantity, product form, or other aspects of the raw materials provided for food use (Article 15-1).

Table 6-2 Amendments and Additions to Food Safety and Sanitation Management Regulations and Standards, 2015

Date	Name	Objective of Revision
Jun. 10	The food or food additive factories shall be established independently, and the production, processing and mixing of non-food commodities in the same factory space or building is prohibited.	The food or food additive factories that were not established independently before December 12th, 2014 shall complete the implementation before June 10th , 2016, and the production, processing and mixing of non-food commodities in the same factory space or building is prohibited.
Jun. 23	Regulations Governing the Registration of Food Businesses	Required manfacturers, processors and importers of food additives to complete registration of such additives and related matters.
Jul. 31	Mandatory Testing for Food Businesses, Minimum Testing Cycle, and Other Related Matters	Enhanced mandatory testing for eight new categories of staple food manufacturing and import businesses, and two categories of tea leaf businesses.
Jul. 31	Food Businesses Required to Establish Traceability Systems	Specified 19 categories of food businesses, including those using edible oils and fats, that shall establish traceability management systems in stages.
Oct. 15	Category and Scale of Food Businesses Required to Establish Laboratories	Specified 10 categories of businesses engaged in manufacturing, processing and preparation, and which have a registered factory and NTD100 million or more in capital, that shall establish laboratories to conduct internal testing.
Jan. - Dec.	Regulations on the Labeling of Food Nutrition Information, GMO Foods, and Product Name	Added or amended regulations on nutritional declarations for packaged food, packaged vitamin and mineral tablets and capsules, packaged infant formula, follow-up formula, and formulas for certain diseases.
		Added or amended regulations on labeling of GMOs in prepackaged food, food additives, unpackaged food, and food vending locations.
		Added or amended regulations for labeling of soup bases of hot pot at food vending locations, fungal foods, the domestic certified bulk agricultural products, on-site-produced drinks, and restructured meat products.
Jan. - Dec.	Standards for Pesticide Residue Limits in Food; Standards for Veterinary Drug Residue Limits in Food; Standards for Specification, Scope, Application, and Limitation of Food Additives; and Hygiene Standards for Food	Designated or added pesticide residue safety tolerances for 366 pesticides and 5,852 food items; safe veterinary drug limits for 137 veterinary drugs and 1,405 food items; scope of application, quantity limitations and specifications for 800 food additives; and sanitation standards for five food products.

additive businesses completed registration, and a total of 130,000 food additive products were registered.

(3) Harmonizing food additive classifications with international standards: By the end of 2015, 800 food additives had been approved for use, each with a designated scope of applications, quantity limitations and specifications to be complied with.

Section 3 Monitoring of the Food Safety Chain

1. Post-Market Monitoring

The TFDA conducts post-market monitoring of food in concert with local health bureaus to strengthen oversight of foods and ensure compliance with all health standards. Results from 2015 are shown in Table 6-3:

2. Sampling and Testing of Food

(1) Special inspections project: There were 47 special inspections, conducted via sampling and testing in cooperation with local health bureaus, with focus key policy, high risk, or items of public scrutiny.

(2) Joint inspections: Inspections are carried out at upstream suppliers and manufacturers of foods that are everyday needs and which have a major impact on health. In 2015, these inspections focused on 10 items, including edible salt, packaged tea beverages sold at market, bottled drinking water, water stations and their water sources, and pesticide residues in fruit.

Table 6-3 Outcomes of Post-Market Monitoring, 2015

Monitored item	Outcomes		
	Total sampled	Number meeting standards	Rate meeting standards (%)
Pesticide residues in market and packaged agricultural products	3,087	2,738	88.7
Veterinary drug residues in market food	1,745	1,714	98.2
Mycotoxin contamination in market food	574	545	94.9
Heavy metal contamination (lead, cadmium) in market fruits and vegetables	160	160	100.0
Heavy metal contamination (lead, cadmium, or mercury) in market food	601	595	99.0
Pesticide residues in market rice	200	200	100.0

Source: Food and Drug Administration, MOHW.

Section 4 Food Safety and Sanitation Management

1. Food and Beverage Hygiene Management

   Based on assessment results of food hygiene grading management system, caterings are awarded a rating of "excellent" or "good." From 2010 to 2015, more than 12,000 caterings received the certification.

2. Strengthening the Registration System for Food Businesses

   In 2015, the TFDA announced that it had newly added registration requirements for manufacturers, processors, and retailers of food containers, packaging, and cleansers, as well as food and beverage merchants and importers of products subject to inspection requirements of Article 30-1 of the AGFSS. By the end of 2015, more than 300,000 food businesses had completed registration.

3. Requirement that Food Businesses Implement Mandatory Testing

   In 2015 it was announced that mandatory testing would begin July 31, 2015, for the manufacture and import of staple foods, and for importers of tea products and manufacturers of tea beverages. Mandatory testing had already begun in 2014 for six types of food enterprises, including food manufacturers of seafood products, processed meat or dairy products; manufacturers and importers of food additives; dietary supplement businesses; and major edible oil and fat manufacturers. At present, 16 categories of food businesses are required to undergo testing.

4. Implementation of Food Traceability Management Systems

   In 2015, food traceability system requirements were expanded to 12 new categories, including seven types of food staples, two tea leaf products, soybean products, infant and follow-up formula, and packaged milk powder and modified milk powder. Seven categories had already been added in 2014: edible oils and fats, seafood products, meats, dairy products, lunchbox meals, food additives, and GMOs. By the end of 2015, 19 categories of food are required to have food traceability management.

Chapter 2 Management of Drugs

The main objective of drug management is to ensure public health. With this goal in mind, the TFDA reforms the drug policy to accelerate inspection, registration, and review, to manage drugs at the source, and to suppress illegal drugs. Creation of a sound management environment ensures the safe use of drugs and puts consumers' minds at ease.

Section 1 Drug Regulations & Standards and Product Approval

1. Improving Regulations & Standards

   After taking into account laws and regulations in more advanced nations, the TFDA continues to

make improvements to the drug management regulatory framework to ensure that it meets domestic needs and is in line with international standards. Related amendments and additions from 2015 are described in Table 6-4.

2. Managing Inspection and Registration of Drugs

(1) In 2015, there were 358 new domestic clinical trial applications and 2,603 applications for revisions. The total numbers represent a 5% increase over the previous year.

(2) In 2015, there were a record 170 new drug applications approved, an increase of 26% compared to the previous year. Two of the domestically produced drugs were the first of their kind to pass legal review in the world, a first for Taiwan.

Section 2 Drug Source Management

1. Promotion of PIC/S GMP Standards

In order to raise the quality of drug manufacturing and meet international standards, in 2007 Taiwan announced that it would adopt the Good Manufacturing Practice (GMP) standards of the Pharmaceutical Inspection Convention and Pharmaceutical Inspection Co-operation Scheme (PIC/S). All western medicine manufacturers in Taiwan had adopted PIC/S GMP by January 1, 2015. At the end of 2015, there were 120 qualified domestic manufacturers and 893 qualified overseas manufacturers.

2. Strengthening Management of Active Pharmaceutical Ingredients

(1) Management of manufacturing quality: To improve source management, manufacturers of all licensed active pharmaceutical ingredients were required to adhere to GMP standards starting from January 1, 2016. By the end of 2015, there were 233 items made by 21 qualified domestic manufacturers that adhered to GMP standards, and 1,313 GMP permits issued for imports.

(2) Management of imports: Between establishment of the Drug Master File (DMF) system in October 2009 and the end of 2015, there were 3,690 DMF applications, of which 2,323, or 63%, were approved.

Table 6-4 Amendments and Additions to Regulations Governing Drug Policy Management, 2015

Date	Name	Objective of revision
Jan.14	Revised Article 17 and Article 27-1 of the Rare Disease and Orphan Drugs Act	Explicitly stated that a pharmaceutical firm granted a permit to produce an orphan drug shall continue production for the duration of the license unless prevented by force majeure.
Jul.13	Announced the Minimum Requirements for the Inspection, Registration, and Review of Human Cell Therapy Products	Announced review standard items for products reviewing and registration of cell therapy products.
Aug.5	Promulgated the Regulations for Medicament Recall	Stipulation of these regulations strengthened the responsibility of pharmaceutical manufacturers and importers by advancing drug recall procedures.
Oct.5	Announced the Eligibility Determination Standards for Human Cell Therapy Donors	Explained conditions for deciding the suitability of donors to human cell products used in cellular or genetic therapy, in order to guarantee that such products carry no risk of communicable diseases.
Dec.2	Amended the Pharmaceutical Affairs Act	Established mechanisms for drug traceability, reporting supply shortages, information readability, and special approval in urgent situations. Sources of active pharmaceutical ingredients were also added to the standards for drug inspection, registration, and review.
Dec.4	Announced the Standards for the Inspection and Registration of Biosimilar Monoclonal Antibody Drugs	Announced current review principles and key areas of consideration for biosimilar monoclonal antibody drugs.

Section 3 Quality Chain Monitoring for Drugs

1. Management of Drug Distribution

In order to improve quality management of full drug supply chains, in 2011 implementation of a Good Distribution Practice (GDP) system for drugs began. In 2015, the government announced that the Part III of GMP for western medicine-distribution. By January 1, 2019, all licensed manufacturers and vendors of western medicine license holder will be expected to adhere to this standard.

2. Drug Quality Monitoring

(1) In 2015, there were ten joint inspections of drugs and cosmetics, with a total of 1,386 businesses inspected, and fines of NTD4.274 million issued. Results from 2015 are described in Table 6-5.

(2) In 2015, the TFDA completed release procedures for 457 batches of biological products. Two batches of approximately 228,520 doses were halted because of abnormal temperatures.

(3) To guarantee quality of commercially sold drugs, investigation and monitoring was carried out on nine types of western medicine in 2015. Of the 212 samples tested, 99.5% met standards, as illustrated in Table 6-6.

3. Suppressing Illegal Drugs, Food, and Cosmetics

On April 30, 2014, the TFDA established a joint task force dedicated to suppressing counterfeit drugs. Besides strengthening search & seizure of illegal drugs, the task force monitored for illegal food, drug, and cosmetic advertisements. Results from 2015 were as follows:

(1) Detected and seized 659 illegal drugs, and issued fines of NTD4.324 million. The seizure rate fell from 27.2% in 2010 to 2.3% in 2015 (Figure 6-1).

(2) Health agencies investigated and prosecuted 7,618 cases of illegal advertising for food, drugs, and cosmetics, and issued total fines of NTD221,138,000. The rate of illegal advertisements dropped from 13.9% in 2010 to 5.0% in 2015 (Figure 6-2).

Section 4 Management of Drug Safety

1. Strengthened Monitoring of Drug Safety Surveillance System

We have continued to implement several drug safety monitoring programs to strengthen drug safety surveillance system. In 2015, the Adverse Drug Reactions Reporting System received 12,815 cases and we also actively monitored 131 domestic and international drug safety warnings.

Table 6-5 Results of Joint Inspections of Illegal Drugs and Cosmetics, 2015

Inspection project	Results
Joint inspection of medical cosmetic shops	Inspected 370 medical-cosmetic shops and pharmacies, 11 of which were in violation of the Pharmaceutical Affairs Act and other regulations.
Inspection of unlicensed pharmacies	Inspected 382 betel nut stands, grocery stores, internet cafes, and sex toy shops, 39 of which had violations.
Sale of prescription drugs without a prescription	Inspected 207 pharmacies, 71 of which had violations.
Joint inspection of cosmetics	Inspected 48 hypermarkets, chain shops, beauty (hair) salons, hair and beauty supply shops, and medical-cosmetic shops. There were 25 cases of suspected labeling violations.
sleep of Controlled Drugs Inspection	Inspected 237 shops, 25 of which had violations.
Inspection of medical devices	Inspected 93 health institutions, pharmacies, medical-cosmetic shops, and medical device shops. There were four cases of the packaging label or package insert containing information that was inconsistent with that originally approved, and 11 cases of medical devices that were suspected of violating the Pharmaceutical Affairs Act.
Joint inspection of weight loss and beauty businesses	Inspected 49 weight loss and beauty businesses, out of which there were two cases of unlicensed medical devices.

Source: Food and Drug Administration, MOHW

2. Drug Risk Accessment and Management

The new signals of drug safety were detected from the drug safety information we monitored. In 2015, we completed drug safety reasscessment of 45 drugs and implemented risk management measures for 17 drugs, such as warnings, package insert revisions or usage restrictions.

3. Relief of Drug Injuries

When people are suffered from a proper usage of a legal drug, the reliefs are provided timely in accordance with the Drug Injury Relief Act. In 2015, there were 203 drug injury applications and relief was given in 129 cases, totaling NTD21,238,942.

Section 5 Management of Controlled Drugs

1. Management System for Controlled Drugs

The Controlled Drugs Act was used as the basis of a system to manage controlled drugs required for medical and scientific purposes. The system prevents abuse and illegal use.

Table 6-6 Results of Drug Quality Monitoring, 2015

Categories monitored	Completed items	Number meeting standards	Rate meeting standards (%)
Surveillance on the Quality of Uric Acid Synthesis Inhibitors, Corticosteroids, Antibiotics, Hypnotics and Antiepileptic Preparation	115	114	99.1
Sterility Survey of Steroid Eye Drops in Taiwan	57	57	100.0
Surveillance on the Quality of Gentamycin and Vancomycin injections	25	25	100.0
Sterility Survey of SVP in Taiwan	15	15	100.0
Total	212	211	99.5

Source: Food and Drug Administration, MOHW

Figure 6-1 Detection and Seizure Rate of Illegal Drugs, 2010 - 2015

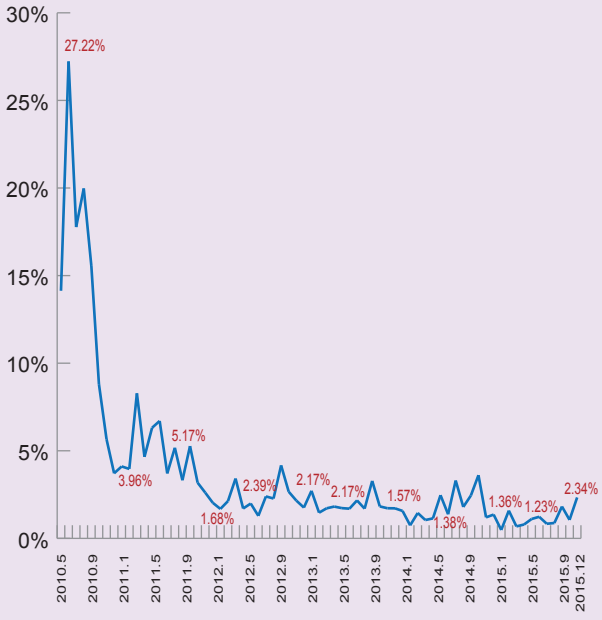


Figure 6-2 Illegal Advertisement Rate for Food and Drugs, 2010 - 2015

Source: Food and Drug Administration, MOHW

(1) Schedule management: Controlled drugs are classified into four schedules based on potential for habitual use, dependence, abuse, and danger to the society. Additions and amendments in 2015 are described in Table 6-7.

(2) License management: As of December 31, 2015, there were 15,148 institutions registered to handle controlled drugs and 51,111 people licensed to use controlled drugs.

(3) Distribution management: In 2015, on-site auditing of 17,454 institutions took place, of which 371, or 2.13%, were found to have committed a violation. Each was dealt with in an appropriate manner.

2. Controlled Drug Abuse Prevention Network

In 2015, hospitals and clinics reported 18,399 cases of drug abuse, an increase compared to 2014. Also, in order to strengthen the drug abuse prevention network, 319 people were trained to serve as drug abuse prevention instructors and eight anti-drug education resource centers were founded.

Section 6 Management of Chinese Medicine

1. The GMP system for Chinese medicine was founded in 2005. By the end of 2015, there were 97 manufacturers approved under the system. In 2015, 55 manufacturers were inspected in accordance with the Regulations of Medicament Manufacturer Inspection.
2. On May 5, 2015, in order to enhance border inspection of Chinese medicine materials by increasing to 16 items of Chinese medicine materials in the Regulations for Imported Traditional Chinese Medicine Materials Subject to Mandatory Inspection. Besides Jujube Fruit and nine other items that were previously subject to mandatory inspections, six new items were added: Bupleurum Root, Scutellaria Root, Pinellia Tuber, Cinnamom Bark, Twoteeth Achyranthes Root, and Rhubarb. In 2015, there were 3,164 cases that passed inspection, with a total weight of 12,846 tons. All item of imported goods have met the standards.
3. On August 1, 2015, revisions to the Disposal Directions for Chinese Medicine Materials Labelling and Packaging passed. Chinese medicine materials had to be labeled with product name, weight, manufacturer name , address, date of manufacture, expiry date, and production method (poisonous Chinese medicine materials needing to be labeled as such).
4. Inspection results for Chinese medicine advertisements and ingredients from 2015 are shown in Table 6-8.

Chapter 3 Management of Medical Devices and Cosmetics

With consumer protection at the core, a complete quality management policy was established from the international regulatory harmonization, production source control, pre-market gatekeeping, post-market monitoring and supply chain management, to effectively ensure the safety and quality of medical devices and cosmetics, as well as to guarantee the health and safety of public.

Table 6-7 Additions and Amendments to the Schedules of Controlled Drugs, 2015

Date	Schedule	Name of controlled drug(s)	Explanation
Dec. 7	II	[Lisdexamphetamine] Lisdexamphetamine	The US Food and Drug Administration permits this drug to treat attention deficit hyperactivity disorder and bulimia, but in Taiwan it is prohibited.
Mar.26	II	[Methoxymethcathinone] Pentylone; Methoxymethcathinone	They are central nervous system stimulants and psychedelics, but have no medical use.
Dec. 7	III	[AB-CHMINACA] AB-CHMINACA	A cannabinoid herb mixture that has no medical use.
Mar. 26	IV	Propofol	Commonly known as "milk of amnesia," its uses include the induction and maintenance of general anesthesia.

Table 6-8 Inspection Results for Chinese Medicine Advertisements and Ingredients, 2015

Item	Inspection Results
Investigation and prosecution of illegal Chinese medicine advertisements	Administrative penalties were issued in 327 cases, with fines totaling NTD16,826,000.
Inspection of package labeling for Chinese medicine materials	Inspected 2,417 cases, with nine violations detected.
Inspection of testing Chinese medicine materials for abnormal substances	Tested 367 cases, with two violations detected.

Source: Food and Drug Administration, MOHW

Section 1 Medical Device and Cosmetics Regulation Standards and Product Review

1. Regulatory Environment and International Regulatory Harmonization

   Regulations governing medical devices and cosmetics and related important announcements in 2015 are arranged in Table 6-9.

2. Review of Medical Devices, Cosmetics and Advertisements

(1) According to the different characteristics and level of risk, Taiwan classifies medical devices into 3 classes, 17 categories, and more than 1,700 items. By the end of 2015, 50 domestic preclinical testing guidance documents were developed, 918 medical device international standards and 90 medical device guidance documents were recognized to enhance review consistency and transparency.

Table 6-9 Relevant amendments and revisions to regulations governing medical devices and cosmetics in 2015.

Date	Name	Objective of revision
Apr. 13	Announced the Reference Guidance for Medical Software Categorization and Classification	These guidelines give businesses an initial reference for how to categorize and classify their products, and therefore serve as a basis to be followed in developing products and registration applications.
Jun. 18	Announced the Good Distribution Practice for Medical Devices	The purpose of this regulation is to ensure that when importers, distributors, or pharmacies engage in the distribution of medical devices, the product quality intended by the original manufacturer can be maintained and the product circulation can be controlled at the same time, in order to ensure the health and safety of the public.
Jul. 7	Announced an amendment to the Guidelines for Risk Assessment of Cosmetics Containing Nanomaterials	These guidelines clarify the physical and chemical characteristics and safety assessment considerations of cosmetics containing nanomaterials for businesses to reference in the development stage.
Oct. 15	Announced an amendment to the Annex of Paragraph 1 in the Classification and Registration Requirements of Mail Order Purchase for Medical Devices	After permitting the online sale of 726 items (including Class 1 and some Class 2 medical devices) by pharmaceutical firms starting in 2012, eight more items were added in 2015 to provide consumers more diverse ways for purchasing medical devices.
Oct.16	Announced the Good Clinical Practice for Trial Operations of Medical Devices	Strengthened the protection of rights, safety, and welfare of trial subjects, and provided as a reference for businesses and hospitals engaged in the clinical trials of medical devices.
Oct. 30	Announced the Regulation of Unique Device Identification (UDI) System for Medical Devices	Announced globally acceptable specifications for unique device identification coding and barcodes that facilitate establishment of the basis for automated distribution management.

(2) In 2015, a total of 123 cases of registration review for innovative medical devices with no similar products were completed, a 9% reduction from the duration incurred in 2014. These cases made innovative medical devices more accessible to consumers.

(3) The registration data from 2015 for medical devices and cosmetics are shown in detail in Table 6-10.

3. Comprehensive Regulatory Consultation Network for Medical Devices and Cosmetics

(1) A medical device legal consulting center was established. In 2015, it received 19,280 consultation calls, answering questions from every sector of society in a timely way. Also, a guidance mechanism for domestic manufacturers of innovative medical devices was implemented, and successfully assisted three high-end in vitro diagnostic reagents in gaining market approval, and one set of research development results in transferring its technology to the industrial sector.

(2) In 2015, a hotline offering legal consultations and assistance with a registration platform for cosmetics received more than 5,000 calls. The TFDA posted a FAQ section for the platform on its website.

Section 2 Medical Device and Cosmetics Source Control

1. Manufacturers of Medical Devices and Cosmetics that Comply with the Good Manufacturing Practice

All medical device manufacturers were brought under the regulation of medical device GMP. The voluntary cosmetic GMP was also promoted. (Table 6-11).

2. Promotion of the Cosmetic Product Notification Portal

The Cosmetic Product Notification Portal was established, for which there were three education and training sessions held in 2015. At the end of 2015, there were 1,694 registered items, an increase of 592 over 2014.

Section 3 Quality Chain Monitoring of Medical Devices and Cosmetics

1. Post-Market Quality Monitoring of Medical Devices and Cosmetics

Results of quality monitoring for medical devices and cosmetics for 2015 are shown in Table 6-12. Nonconforming products were officially reported to the local health bureaus

Table 6-10 Registration data for medical devices and cosmetics in 2015

Items	Medical devices		Cosmetics	
	Medical Device Registrations	Medical Device Advertisements	Medicated Cosmetic Registrations	Cosmetic Advertisements
Total Number of Applications	5,453	296	1,822	1,612
Total Number of Concluded Cases	5,321	299	1,878	1,618
Valid Licenses: 40,841 for medical devices (an increase of 3,043 compared to 2014), 14,906 for medicated cosmetics				

Source: Food and Drug Administration, MOHW

Table 6-11 Manufacturers of medical devices and cosmetics that comply with the GMP regulation in 2015

Item	Valid GMP compliance letters for domestically made medical devices	Valid quality system documentation compliance letters for imported medical devices	Valid voluntary cosmetic GMP
Items/ Manufacturers	685 items	3,640 items	44 manufacturers

Source: Food and Drug Administration, MOHW.

responsible for further administrative handling according to Pharmaceutical Affairs Act.

2. Joint Inspections of Medical Devices and Cosmetics

To enhance the monitoring of medical device and cosmetics package labeling, TFDA conducted the joint inspection with the local health bureaus. Results are shown in Table 6-13.

Section 4 Safety Management of Medical Devices and Cosmetics

1. Medical Device Safety Management

In 2015, submissions to the Taiwan National Adverse Drug Reactions Reporting System included 3,453 reports of defective medical devices and 375 reports of adverse reactions to medical devices (Figure 6-3). Total reports increased 2.4-fold over 2014. The TFDA, which actively monitors medical device safety vigilance information from Taiwan and overseas, translated and issued 128 alerts online for reference by all sectors of society.

2. Cosmetic Safety Management

In 2015, the reporting system for defective cosmetics was renamed the Food, Drug, and Cosmetic Post-Market Quality Management System. The same year, there were 28 reports of adverse events for cosmetics, 159 safety alerts monitored, and 177 consumer "red and green light alerts," which together served as references for all sectors of society.

Chapter 4 Management of National Laboratories and Risk

The TFDA continued improvements to national laboratories led to new testing techniques in line with international trends. A key task was strengthening the development of testing techniques and using testing technology to support administrative management. The TFDA also promoted risk and crisis management mechanisms. By building a comprehensive food and drug safety management system, it reduced risks and hazards while lowering the impact of incidents that did occur.

Table 6-12 Medical devices and cosmetics quality surveillance results in 2015

Name of Project	Total Cases	Inspection items			
		Quality		Package Labeling	
		Conforming no.	Rate of conforming (%)	Conforming no.	Rate of conforming (%)
Sterility Surveillance of Peritoneal Dialysis Catheters and Hemodialysis Catheters in Taiwan	28	28	100.0	19	67.8
Survey on the Quality of Non-Invasive Sphygmomanometers in Taiwan	18	18	100.0	18	100.0
Medical devices, total	46	46	100.0	37	80.4
Survey on Methanol, Benzene and Phthalate Esters in Marketed Nail Polishes in Taiwan	59	57	96.7	58	98.3
Survey on Hydroquinone, Mercury, Tretinoin and Steroids in Marketed cosmetics from hospitals in Taiwan	60	60	100.0	33	55.0
Survey on the contents of Methylisothiazolinone and Methylchloroisothiazolinone in Cosmetics Products Marketed in Taiwan	71	70	98.6	62	87.3
Survey on the Qualities of Commercial Hair Dyes in Taiwan	30	27	90.0	28	93.3
Survey on the Qualities of Commercial Sunscreens in Taiwan	31	30	96.8	31	100.0
Cosmetics, total	251	244	97.2	212	84.5

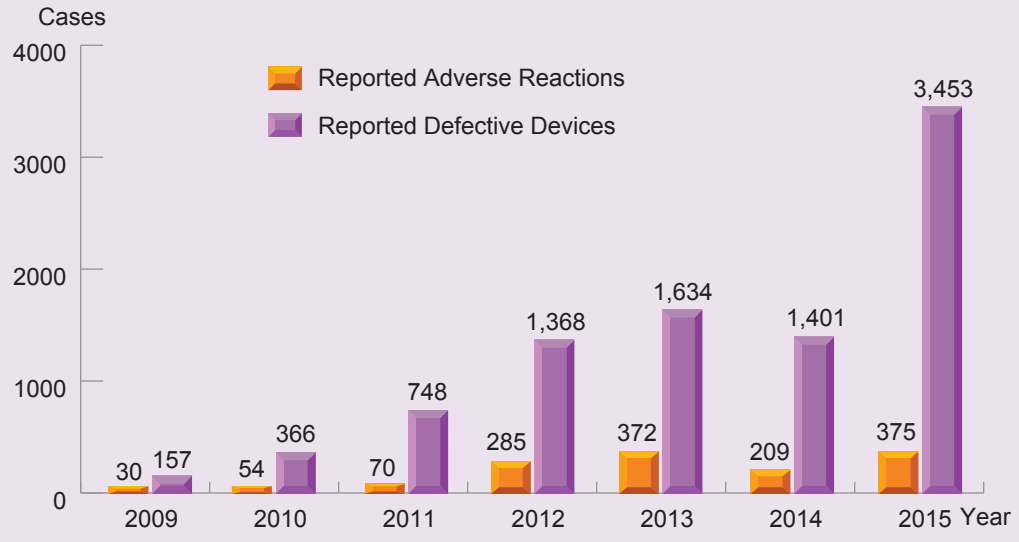
Source: Food and Drug Administration, MOHW

Table 6-13 Statistical Analysis for joint inspections on medical devices and cosmetics in 2015

Product categories	Counties & cities inspected	Businesses inspected	Labeling		
			items inspected	Conforming no.	Rate of conforming (%)
Platelet storage systems	9	73	16	11	68.8
Transcutaneous electrical nerve stimulators, facial transcutaneous electrical stimulators, ultrasound therapy devices	9		70	67	95.7
Powered heating pads	9		67	62	92.5
Blood pressure monitors	21	370	985	961	97.6
Blood glucose meters (including blood glucose test strips)	21		599	585	97.7
Medical devices, total	69	443	1,737	1,688	97.2
Cosmetics with hair dyeing properties	6	48	90	77	85.6
Cosmetics with sunscreen properties	6		113	103	91.2
Cosmetics with antiperspirant and deodorant properties	6		64	61	95.3
Cosmetics used as facial washes	22	370	1,039	1,017	97.9
Eye cosmetics	22		894	860	96.2
Cosmetics, total	22	418	2,200	2,118	96.3

Source: Food and Drug Administration, MOHW

Figure 6-3 Reported Defective Medical Devices and Adverse Reactions to Medical Devices, by Year



Source: Food and Drug Administration, MOHW

Section 1 Missions and Functions of National Laboratories

1. Testing and Examinations

Fast, accurate testing methods were developed for various products, so that the TFDA is ready to propose response strategies to emerging incidents. Press releases and news reports dispelled concerns among the general public.

In 2015, the TFDA conducted basic or cooperative testing in 8,597 cases and completed a total of 49,650 testing items for a wide range of specimens. Results were as follows:

(1) Basic testing: Inspected, registered, and tested medical devices, cosmetics, health food, dietary supplements, and food additives. Lot release for biological products, and border testing of condoms. Coordinated testing for sudden emerging incidents, such as the use of industrial-grade magnesium carbonate in food products, and suspected contamination of saline injections.

(2) Cooperative testing: Includes testing that local health bureaus are unable to perform themselves, and testing referred to us by local health bureaus following consumer appeals, as well as complicated food poisoning cases passed to the TFDA by local health bureaus, such as accidental consumption of poisonous plants or suspected cases of botulism.

2. Extending Testing Capacity and Methods

(1) Procured new equipment to expand testing capacity and held classes on identifying unknown items. After expanding laboratory testing capacity, the TFDA provided technical documents for public use.

(2) Held the APEC Conference on Management and Related Scientific Detection of Food Additives in Foods, the International Conference on Illegal Medicines and Adulterated Dietary Supplements, as well as more than 10 domestic seminars or experts' meetings. Participants shared technical knowledge and experiences.

(3) Published Minimum Requirements for Biological Products V and the 7th Chinese Pharmacopoeia Supplement. Adjustments were made to reconcile these publications with pharmacopeia from the United States, Europe, and Japan. A portion of the content, harmonized for the first time with international standards, was pioneering in Taiwan.

Section 2 Risk Management and Emergency Response Mechanisms

1. Promotion of an Organizational Risk Management Mechanism

(1) We established the Risk Management and Emergency Response Taskforce to employ management mechanisms to reduce risks and hazards while lowering the impact of incidents that did occur. We also incorporated risk and crisis management into everyday operations and decision making.

Press conference to kick off the 1919 National Food Safety Hotline (December 4, 2015)

(2) In 2015, classes were held to strengthen risk, and crisis management among various TFDA units included fundamental classes such as Basic Crisis Management Concepts, and Crisis Prevention Operations & Procedures, as well as practical classes such as Crisis Management & Recovery Strategies, and Crisis Prevention Tasks.

2. Strengthening Crisis Response

   We activated emergency response mechanisms in the following cases: illegal use of dimethyl yellow; control of Japanese food imports; incidents of pesticide residue in tea beverages; and the Formosa Fun Coast powder explosion. After each incident, we engaged in review and improvements that will serve as references for future crisis response.

Chapter 5 Consumer Protection and Communication

For better management of food, drugs, and cosmetics, channels used to communicate with consumers and the media were enhanced. We have provided professional, accurate information in order to strengthen public understanding, trust, and confidence.

Section 1 Providing Consumers with Immediate Information

1. We established the Food & Drug Rumor Dispelling Page, which gathers false rumors relating to food, drugs, medical devices, and cosmetics, then rebuts them with facts and provides correct information to the general public. The Page had issued 140 clarifications by the end of 2015.
2. In 2015, the TFDA issued 332 food warnings to keep consumers and businesses informed of international food safety warnings and information, the TFDA maintained the safety of the domestic food environment.
3. In the "Food Fans" Facebook group, posts detailing the latest useful food and drug news, the "TFDA Hito Radar Battle", and other games and activities provided consumers with valuable health information. Total fans exceeded 43,000.
4. Continued updates to the Food and Drug Consumer Knowledge website and the Interactive Digital Learning website for the Correct Use of Medicines provided more diverse, convenient information service platforms and correct information regarding the use of drugs.

Section 2 Consumer Communication and Campaigns

1. Food safety management was promoted using consumer communication and campaigns. This included a five-part series of reports called "The New Age of Food Safety," which detailed how the government's food safety protection network has ushered in a new era where people can eat safely.
2. The 1919 National Food Safety Hotline, the government's first dedicated cross-departmental hotline, opened on December 4, 2015. It provides a channel for consumers to report food safety incidents, file complaints, present evidence, and request consultation. Both consumers and businesses can use the hotline to quickly clear up food safety concerns quickly.
3. Across the country, more than 3,000 food sanitation volunteers were recruited to help local health bureaus get into local communities and raise understanding of food safety among the general public.
4. In order to create a supportive environment for proper use of drugs, 25 health education resource centers for safe medicine and 270 drug counseling stations in community-based pharmacies were established. The TFDA also cooperated with 104 correct drug use centers and seed schools to promote education on proper drug use.
5. The TFDA held an online quiz with prizes, the "Medical Devices Challenge," to spread knowledge regarding the purchase and use of medical devices through playing games. A total of 72,996 people participated in the activity, and 1,151,636 people visited the website.
6. Fun methods of promoting the public's understanding of safe cosmetics choices included the 1017 Safe Cosmetics Carnival and a theatrical script competition.

7 Social Insurance

In order to guarantee income security for individuals and families who face financial crises owing to birth and old age, sickness and death, injury and disability, and loss of daily functions and unemployment, the government has adopted social insurance to build a safety net based on the principles of self-sufficiency, mutual help, and risk sharing. This section describes key parts of that social safety net: National Health Insurance (NHI), National Pension (NP), and Long-term Care (LTC) insurance (in plan)

Chapter 1 National Health Insurance

Section 1 Status of National Health Insurance

In order to make NHI financially sustainable, in 2013 the government implemented the Second-generation NHI. Its vision is to raise quality, care for the disadvantaged, ensure sustainability, and serve as an international benchmark by providing comprehensive health care services and fair treatment. Measures of reform included establishing a linkage mechanism between financial revenues and expenditures, raising the financial contribution of the government, upgrading care for disadvantaged groups, expanding citizen participation, introducing diverse payment mechanisms, and revealing medical treatment quality information, bed volume data, and financial statements of medical institutions. Inmates at correctional facilities were also included in the NHI system to ensure their right to health care.

By the end of 2015, total enrollment in NHI was 23,747,000 persons and the enrollment rate exceeded 99.6%. Approximately 93% of the nation's medical care institutions have contracted with the National Health Insurance Administration (NHIA) under the NHI system, demonstrating the high accessibility of medical care.

The main sources of NHI's revenues are the premiums paid by the insured, their employers, and the government. A small portion of revenues comes from other sources, including Public Welfare Lottery Surplus and the Health and Welfare Surcharge on Tobacco Products. At the end of 2015, the cumulative surplus of NHI was NTD 228.9 billion, showing that financial status of NHI was in good shape.

Section 2 Access to Health Care Through Universal Coverage

In 2015, there were 355.50 million outpatient visits and 3.27 million hospital admissions. The average usage per person was 15.2 clinical visits (including Western and Chinese medicine clinics and dental clinics) and 0.14 hospital stays as well as an average length of hospitalization of 1.3 days.

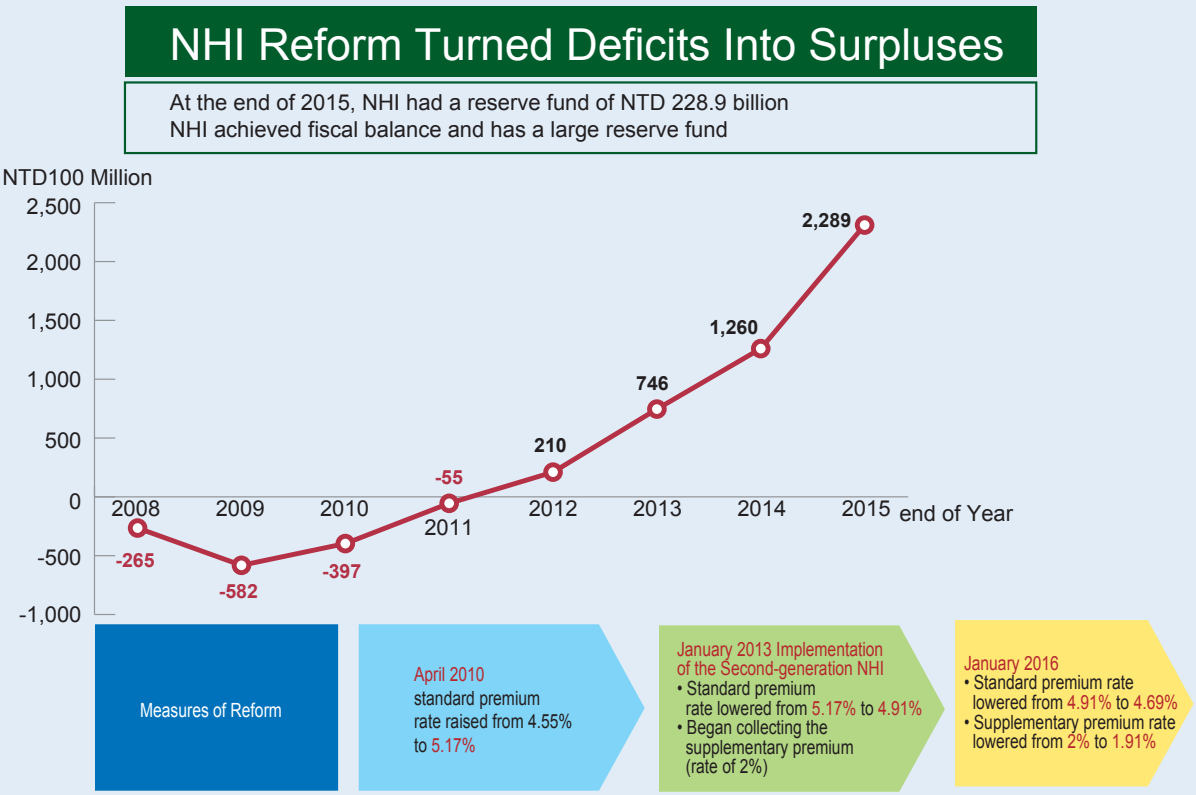
At the end of 2015, there were 27,683 NHI-contracted medical care institutions, including 20,736 contracted hospitals and clinics that accounted for 93.0% of the total health care providers. Insured persons can receive suitable care wherever they choose. Insured persons who suffer an unexpected illness or injury that requires immediate care while they are outside of Taiwan have six months from the day they receive clinical or emergency treatment or the day they check out of hospital to claim for reimbursement of their health care expenses. Reimbursements are subjected to the NHI payment scheme and are capped at the average fee charged by NHI-contracted medical centers.

Section 3 Improving Finances by Establishing a Linkage Mechanism between Revenues and Expenditures

Since the Second-generation NHI has expanded the premium base that includes supplementary premiums on other forms of income and higher contribution ratio of payments by the government, the system achieved fiscal balance (Figure 7-1). Led to the premium rate on salaries was lowered from 5.17% to 4.91%. By reducing the burden on large families and people who mostly rely on their salary, the new system became fairer and did a better job of charging people based on their ability to pay.

Reforms implemented under the Second-generation NHI ushered in a new age of fiscal balance. When the National Health Insurance Committee reviewed the 2016 NHI standard premium rate, it sought to establish a formula-based rate adjustment mechanism that is not subject to external interference and that focuses on sustainability of the system and a long-term balanced budget. In the spirit of the Second-generation NHI commitment to balance

Figure 7-1 Reserve Fund, Before and After Implementation of the Second-generation NHI



Source: National Health Insurance Administration, MOHW

expenditures and revenues, and in accordance with Article 78 of the National Health Insurance Act, which states: "In principle, 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," the committee set up new mechanisms to sustain fiscal balance. It also recommended that the standard premium rate be lowered from 4.91% to 4.69% and the supplementary premium rate be lowered from 2% to 1.91%. After the MOHW passed these recommendations to the Executive Yuan, they were approved and went into effect on January 1, 2016.

Section 4 Promotion of Diverse Payment Systems

The NHI payment system is primarily based on fee-for-service model. Problems with this model include proliferation of unnecessary examinations, tests, medications, and surgeries, which not only cause excessive growth of health care expenditure but also impact the quality of care.

Since July 2002, the NHIA has introduced different payment systems based on the principle of global budget, such as case payments and pay-for-performance, in order to change diagnosis and treatment behaviors and improve health care quality. Also, to achieve more efficient use of medical care resources and increase the comparability of treatment quality among different hospitals, the Taiwan Diagnosis Related Groups (Tw-DRGs) system came into effect on January 1, 2010. This was followed by the second stage of the Tw-DRGs system, which began on July 1, 2014.

A pilot program was launched in 2014 to build post-acute care models. It started with establishing customized therapy plans for stroke patients during

the golden rehabilitation period. The goal was to minimize loss of function, so patients could return to their former way of life. In 2015, a total of 39 medical teams from 157 contracted hospitals and 23 upstream hospitals participated. Among the 3,302 accepted patients, 87.4% showed functional progress (their activities of daily living scale performance progressed from severe dependence to functional independence), 85.4% returned home, and there was a satisfaction rate of 86.9%. Also, on September 9, 2015, announcement of the NHI Post-Acute Care Plan for Burns expanded community care and rehabilitation services to all burn victims.

Section 5 Disclosure of Information to Raise Quality

In order to improve medical care quality, the NHIA releases medical treatment information of hospitals on its website. Users have access to data on performance of contracted health institutions, payment ranges, and more. Implementation of the Second-generation NHI led to the release of even more valuable treatment data that could help patients make informed medical choices. The public release of major infractions encouraged medical institutions that operate under the NHI system to further improve quality.

Patients benefit from transparent information on the cost of self-paid medical devices. In 2014, the NHIA established a price comparison site that allows patients to check self-payment variations among different institutions for medical devices (such as drug-eluting stents, manmade crystals with purported special functions, and ceramic joints), allowing them to protect their rights as a consumer.

Section 6 Care for the Disadvantaged in Remote Regions

1. Subsidies for the Economically Disadvantaged

(1) Besides NHI premium subsidies, the right to treatment of economically disadvantaged patients is guaranteed through relief fund loans, payment by installments, and charity donation referrals. Assistance offered in 2015 is described in Table 7-1.

(2) Health Care Assistance: Following implementation of the Second-generation NHI in January 2013, in accordance with the spirit of Article 37 of the National Health Insurance Act, benefits could be temporarily suspended (via NHI card locking) for those applicants that had the ability to pay premiums but declined to do so. People in this situation were encouraged to quickly pay arrears. Those unable to pay or facing economic difficulty qualified to have their NHI card unlocked. At the end of 2015, there were 827,000 people in arrears on their premium payments, including more than 785,000 of them qualified for continuation of benefits.

(3) Use of feedback from Public Welfare Lottery to Reduce the Financial Burden of Health Care and Eliminate Barriers to Treatment for the Disadvantaged: Assistance provided in 2015 included payment of NHI premium arrears and fees associated with treatment. Assistance was provided 62,800 cases of people, with approximately NTD285 million in total.

Table 7-1 NHI Premium Payment Assistance Measures, 2015

Item	Beneficiaries	Total Assisted	Total Contribution
Premium Subsidies	Low-income households, lower-middle-income households, unemployed veterans, unemployed laborers and their families, disabled persons, unemployed indigenous peoples under the age of 20 or 55 above	3.246 million persons	NTD26.36 billion
Relief Fund Loans	People who qualify as facing "economic difficulties"	2,525 cases	NTD177 million
Payment by Installments	People unable to pay their premium arrears at one time	112, 246 cases	NTD3.21 billion
Charity Donation Referrals	People unable to pay their premiums	9,201 cases	NTD21.6 million

Source: National Health Insurance Administration, MOHW

"The value-added and upgraded version of NHI My Health Bank Mobile App" awards ceremony

2. Care for People in Remote Regions and Areas with Insufficient Medical Resources

(1) Plan for Improving Health Care in Remote Regions via Integrated Delivery Systems: In November 1999, the NHIA launched a plan to solve problems associated with insufficient medical care resources in mountainous regions and on outlying islands. By 2015, there were 26 contracted clinics and hospitals participating in a total of 50 regions. They served more than 450,000 people and achieved average overall satisfaction rate of 95%.

(2) Plan for Improving Health Care Treatment in Areas with Insufficient Resources: Implementation of this plan began in 2012 through the provision of a special budget and value guarantees. Regional hospitals located in or near areas with insufficient resources were encouraged to provide 24-hour emergency treatment, internal medicine, surgery, OB/GYN, pediatrics, and hospitalization. At the end of 2015, there were 72 hospitals participating.

3. Care for Patients with Major Illness and Injury or Rare Diseases

(1) Beneficiaries who hold a Major Illness/Injury Certificate are exempt from co-payments of expenses when receiving treatment for issues related to the illness or injury. At the end of December 2015, there were more than 960,000 certificates granted (covering more than 900,000 people, or about 3.8% of NHI insured). Related treatment fees exceeded NTD171.9 billion in 2015 (accounting for 27.3% of total medical expenditures).

(2) Once announced as 'rare diseases' by the MOHW, rare diseases are treated like major illnesses or injuries. Patients are eligible for a Major Illness/Injury Certificate, which exempts them from co-payments, and drugs designated by the MOHW as necessary for the treatment of rare diseases are fully covered by NHI. At the end of December 2015, there were 10,151 certified rare disease patients.

Section 7 Using Technology to Raise Efficiency

Advances in cloud and virtual technology led the NHIA to begin moving its public and internal information platforms from self-maintained servers to virtual hosts, with approximately 300 platforms moved by the end of 2015. Advantages include fast access to a host when service is expanded. Virtual hosts reduce the high electricity, maintenance, and manpower costs associated with running servers. Also, whenever a public platform suddenly faces high-volume connection or service needs, flexibility offered by virtual hosts disperses or reduces traffic to lower waiting times.

NHI cards store extensive information. Besides records of major illness and injury, they indicate drug allergies and medical history (including prescriptions, testing, and examinations). Doctors use this information to ensure patient safety. Cardholders can indicate their willingness to donate organs and register for hospice and palliative care along with do-not-resuscitate orders. This will give family members and physicians a clear understand of how cardholders who have lost consciousness feel about end-of-life issues.

In order to implement e-government policy and diversify services, in January 2006 the MOHW updated its network OS by building "multiple authentication internet platform". By the end of December 2015, more than 147,000 insurance registration organizations had used the system. Each month there were approximately 1.35 million online applications made to update information, accounting for more than 71% of such information update.

Following the launch of the Second-generation NHI in 2013, in order to simplify declaration procedures for the supplementary premium, the NHIA began to provide free downloads of the standalone "Supplementary Insurance Premium E-Reporting System." The system facilitates digital recordkeeping and retrieval by those required to withhold supplementary premiums. To reduce errors caused by the time gap between declaration and payment, in February 2015 an additional online system to request and print supplementary premium payment information was launched, further simplifying the withholding process. Through February 2016, the online system was used nearly 28.4 million times to apply for withholding information from 2015, accounting for 90 percent of all such records.

In 2013, the NHIA established the NHI PharmaCloud system, which physicians and pharmacists can use to check patient medication records. This prevents duplicate prescription and misuse of drugs and minimizes the risk of unfavorable drug interactions. By the end of December 2014, there were already 18,690 hospitals and medical care providers that were using the system and a total of 165,620,000 inquiries were made on 18,010,000 patients (Table 7-2). Closer analysis of prescriptions entered into the PharmaCloud system shows a decrease from 2014 to 2015 in the number of drugs, the average drug fees per person, usage of six major drug types (high blood pressure, high blood lipids, diabetes, schizophrenia, depression, and sedatives), and overlap of similar drugs prescribed by different medical institutions. These results show that PharmaCloud effectively reduced duplicate prescriptions and lowered drug risks.

Table 7-2 NHI PharmaCloud System Usage in 2015

	Hospitals and Clinics Using the System	Health Workers Using the System	Patients Checked Using the System	Total Inquiries
Medical Centers	26	11,064	3,771,298	27,663,634
Regional Hospitals	84	13,110	5,241,700	36,617,583
District Hospitals	385	8,937	3,363,396	17,400,565
Western Medicine Clinics	8,817	14,319	13,201,633	65,352,915
Chinese Medicine Clinics	693	1,054	280,750	809,782
Dental Clinics	3,942	4,804	2,085,926	4,217,759
Contracted Pharmacies	4,728	5,719	4,455,243	13,562,001
Residential Care	15	28	111	160
Total	18,690	51,440	18,012,709	165,624,399

Notes:
1. Source: Report on inquiries made using the NHI PharmaCloud System; totals consist of records from all regions
2. Survey Period: January 1 - December 31, 2015

In order to improve the general public's control over personal health and health care, My Health Bank was completed on September 25, 2014. The system takes into account protection of personal information, convenience, and treatment transparency. People with a registered NHI card or Citizen Digital Certificate only need to pass authentication to check and download data on outpatient and inpatient visits, Chinese medicine and dental health records, allergies, test and examination results, medical discharge summaries, organ donor and hospice/palliative care intentions, adult preventive health, and immunizations. My Health Bank can also be used to see NHI card status and records as well as insurance fee and premium records. By the end of 2015, there were 332,517 inquiries made to the system and personal health information was downloaded 294,589 times.

Chapter 2 National Pension (NP)

NP was established as a new form of social insurance on October 1, 2008. Citizens aged between 25 and 65 years old who do not participate in related social insurances for military personnel, civil servants and teachers, laborers, and farmers will be covered by the NP. By providing basic economic security for beneficiaries and their families when insured persons become old or face maternity, disability, or death, the NP system has played a role as an indispensable part of the nation's social safety net and a key milestone to comprehensive social security. Establishment of NP marked the start of a new era for Taiwan, in which all citizens were covered by social insurances and the elderly could be assured of basic economic security.

Section 1 Status of NP

1. There were 3,509,970 insured persons in the NP in December 2015. Data on the different categories of insured persons are shown in Table 7-3.
2. Insurance Premium Rate: 8% (the premium is calculated based on the monthly insurance amount and insurance Premium rate)
3. Insurance Premium Subsidies: In principle, the government will subsidy 40% (NTD585 monthly) of NP insurance premiums. For middle-low income and mild or medium disabled insured persons, the government will subsidy 55% (NTD805) or 70% (NTD1,024) of the premiums. For low-income households and the extremely severe or severe disabled insured persons, the government will subsidy 100% (NTD1,463) of the premiums.
4. Monthly Insurance Amount: According to the National Pension Act, the monthly insurance amount shall be adjusted according to the accumulated growth rate of the consumer price index (CPI) when accumulated growth rate reaches 5%. Since accumulated growth rate of October 2008 and September 2014

Table 7-3 Insured Persons and Ratios of NP, December 2015

Classification	Insured Persons	Ratio (%)
General Insured Persons	3,024,520	86.2
Low-Income Households	75,620	2.1
Persons with Severe or Extremely Severe Disability	97,409	2.8
Persons with Medium Disability	77,447	2.2
Persons with Mild Disability	65,558	1.9
Middle-low income persons (income less than 1.5-fold minimum cost of living)	121,514	3.5
Middle-low income persons (income less than 2-fold minimum cost of living)	47,902	1.3
Total	3,509,970	100.0

reached 5.8%, on January 1, 2015, the monthly insurance amount was raised from NTD17,280 to NTD18,282.

5. Premium Payment Rate of the Insured: From the establishment of NP insurance in October 2008 to December 2015, premiums receivable of insured persons were more than NTD224.6 billion and premiums paid were more than NTD125.9 billion. The payment rate of the insured was 56.1% (62.7% for females and 49.2% for males).

6. Benefit Payments

(1) Insurance Payments: Include old age pension payments, maternity payments, mental/physical disability pension payments, funeral payments, and surviving family pension payments.

(2) Other Payments: Include old age basic guaranteed pension payments, mental/physical disability basic guaranteed pension payments, and aboriginal pension payments.

(3) NP Benefit payments are described in Table 7-4.

7. Financial Status of the National Pension Insurance Fund: At the end of December 2015, the accumulated value of the fund was NTD217,075,040,299.

Section 2 NP System Reform

1. Some Legal Revisions were made to the *National Pension Act* in 2015 in order to make NP fairer and more rational. Highlights are described in Table 7-5:

2. For the topic of national pension that has attracted much attention, implementation of various measures will be continued.

(1) The MOHW continues to gather a wide range of recommendations and opinions on NP and has rolling reviews and researchs into NP qualifications and payments. The objective is to make NP fairer and more rational and to implement the legislative purpose to ensure the basic economic security of the disadvantaged.

(2) The MOHW continues to oversee the Bureau of Labor Insurance (BLI) to carry out the

Table 7-4 NP Benefit Recipients and Payments, 2015

Payment Type		Recipients (People)	2015 Payment Amounts (NTD1,000s)
Insurance Payments	Old Age Pension Payments	675,649	27,342,429
	Maternity Payments	17,194	316,191
	Mental/Physical Disability Pension Payments	5,908	257,439
	Funeral Payments	17,372	1,574,954
	Surviving Family Pension Payments	64,848	2,776,202
	Subtotal	780,971	32,267,215
Other Payments	Old Age Basic Guaranteed Pension Payments	692,129	29,791,022
	Mental/Physical Disability Basic Guaranteed Pension Payments	21,421	1,219,428
	Aboriginal Pension Payments	36,852	1,522,492
	Subtotal	750,402	32,532,942
Total		1,531,373	64,800,157

Note: Recipients of lump sum payments are accumulated of the persons per month over the course of the year. Recipients of pension payments are the recipients at the end of the year.

Table 7-5 Major Revisions to the National Pension Act in 2015

Date	Amended Articles	Objective of Revisions
Dec. 16	Article 32-1	Maternity payment amounts were increased from one month of the monthly insurance amount to two months. If the insured person is entitled to maternity payments and applies to pay the premium in installments or postponement of the payments, the amount of the premium and interest paid should not be less than half of the total amount of maternity payments.
Dec. 30	Article 18-1	From March 1, 2016 onwards, when the death contingency happens, and the beneficiary of surviving family pension don't submit application on the month they qualify for the benefits, the insurer should compensate the benefits retroactively to those who are entitled to trace back five years starting from the date that they submitted the application.

actuarial assessments every two years, in order to review whether NP insurance rate shall be adjusted. In January 2015, insurance premium rate was increased from 7.5% to 8% to ensure the long-term fiscal stability of the National Pension Insurance Fund.

(3) To strengthen investments of the National Pension Insurance Fund, the MOHW continues to oversee the Bureau of Labor Funds (BLF) to arrange the investment policies. These policies are used to make yearly utilization plans and encourage diverse investment portfolios in order to improve investment performance.

(4) To raise the NP premium payment rate and ensures the rights of benefits , the MOHW continues to oversee the BLI to undertake systematic collection of payments from citizens in arrears (including from new applicants and those who already withdrew) using a combination of overdue bills and informational pamphlets. In 2015, there was NTD22,517,500,776 in arrears and NTD1,182,860,646 collected, for a collection rate of 5.3%.

(5) To reduce incidents of benefit over-payments and make the administration of NP benifit payments more accurate, the MOHW has urged the BLI to improve databases and auditing mechanism, and to improve audits and oversights of electronic media information. At the end of December 2015, 96.1% of over-payments has been reclaimed.

(6) In order to increase people's willingness to contribute the NP premium, the MOHW has collected strategies and issued a plan for increasing the payment rate among the insured. To implement this plan, the MOHW has cooperated with the Council of Indigenous Peoples, the BLI, and local governments. In 2015, there were 257,235 people visited by the local government servants. There were 37,601 promotional events with total attendance of 2,619,856 people and 11,037 local "seed" instructors were trained.

(7) In order to create a more sound pension system in the country, the Office of the President has set up the National Pension Reform Committee in 2016. The MOHW will continue to operate in accordance with the National Pension Reform Committee's overall consensus to amend the National Pension Act.

Chapter 3 Planning Long-Term Care Insurance

As Taiwan's population aging rapidly, for long-term care (LTC) demand is rising. At the same time, the capacity of households to care for older family members is declining, putting greater pressure on those in need of care and their caretakers while raising social and economic difficulties. In response, planning of LTC insurance is underway. Originally, Taiwan was going to fund insurance system for LTC service, though a change in policy has led to plans to fund the system through tax increases. The following provides a summary of progress.

Section 1 Planning Evolution and important Points

Evolution of LTC insurance planning is described in Table 7-6.

Section 2 Planning Mechanisms and Content

1. Planning objectives and principles are described in Table 7-7
2. Planning Content

(1) Planning LTC Insurance Financial Mechanisms

Most LTC systems around the world are funded through taxation or insurance premiums. In Taiwan, where total tax revenues as a percentage of GDP are only about 12%, far below the 40% or more in many European welfare states. Therefore, plans were made to fund LTC using social insurance paid for by the government, employers, and the insured. By providing the opportunity for people to care for themselves and others by spreading risk, the new system will ease the burden of care on LTC users and their families.

(2) Conducting The National Long-Term Care Need Survey

a. The National Long-Term Care Need Survey is used to determine future care needs in order to aid development of service systems and databases for assessing LTC insurance scope and premium rates. Insight gained into functional disability rates at the national and

Table 7-6 Evolution of LTC Insurance Planning

Timeframe	Event
2008	During his presidential election campaign, Ma Ying-jeou proposed starting LTC insurance.
May. 2008	The premier's Administrative Report issued by then-Premier Liu Chao-shiuan announced: "Due to rapid growth in LTC needs that will arise in the future, the government will promote legislation of an LTC insurance system that can reduce the public's burden and foster a healthy, happy environment for the aged." Officials from the Council for Economic Planning and Development then met with representatives of the Ministry of the Interior and the Department of Health (DOH) to conduct preliminary planning
Jul. 2009	Acting in accordance with an Executive Yuan request, the DOH established the Long-Term Care Insurance Preparatory Task Force. The task force formally accepted responsibility for follow-up planning and preparations.
2011	The second vision of Taiwan's "Golden Decade – National Vision" plan called for building a just society. Part of this vision was caring for the young and old, and one of its administrative objectives was to promote LTC insurance.
Jul. 23 2013	Upon formal establishment of the MOHW, planning of LTC insurance was assigned to the Department of Social Insurance. The department continued LTC planning and legislation.
Sep. 30 2014	The MOHW sent a draft version of the Long-Term Care Insurance Act to the Executive Yuan for review.
Jun. 4 2015	After being passed by the Executive Yuan, the draft version of the Long-Term Care Insurance Act was sent to the Legislative Yuan for review.
Jun. 12 2015	The Long-Term Care Insurance Act was passed in the 16th meeting of the seventh session of the Eighth Legislative Yuan. It was sent to the Social Welfare and Environmental Hygiene Committee for review.
Jan. 7 2016	Since the Eighth Legislative Yuan closed without completing review of the draft Long-Term Care Insurance Act, the MOHW resubmitted the draft to the Executive Yuan.

Table 7-7 LTC Insurance Planning Objectives and Principles

Planning Objectives	1. Build a sound LTC system fit for an aging society. 2. Rely on self-care and joint care to spread LTC financial risks. 3. Advance LTC resource development while expanding accessibility. 4. Maintain and advance independent, autonomous lifestyles for people with functional disabilities.
Planning Principles	1. System: Adopt a universal social insurance system. For administrative resources to achieve the greatest economic benefits, the NHIA will be responsible for LTC insurance. 2. Underwriting and Finance: Base insured person categories, insurance amount, and insurance fee burden on the *National Health Insurance Act*, apart from a three-year waiting period to qualify for LTC insurance. 3. Create independent financial mechanisms that link revenues and expenditures. 4. Develop a Multi-dimensional assessment instrument (MDAI) that can be used to determine payments. 5. Plan reasonable insurance benefits and focus on provision of services. 6. Following evaluation, basic benefits are offered based on approved LTC need levels and care plans. Surplus amounts are self-pay. 7. The insurer shall select insurance service institutions and implement service quality control mechanisms.

city/county level is used to provide in-depth analysis of the need for LTC, the resources required by caregivers, and the challenges encountered during care.

b. After The National Long-Term Care Need Survey in 2010 to 2011, to continue to grasp disability status needs and change trends, another survey was conducted in 2014 and 2015, and will be completed in first half of 2016.

(3) Development of a Multi-dimensional Assessment Instrument (MDAI)

a. Assessment tools for the provision of LTC insurance are used to determine payment levels and standards. They cover six main areas: (a) Activities of daily living and instrumental activities of daily living; (b) Communication skills; (c) Special and comprehensive care needs; (d) Cognition capabilities, mood, and behavioral patterns; (e) Home environment, household support, and social support; and (f) The burden of main caregivers.

b. Testing and modification of LTC insurance evaluation forms and control handbooks ensured suitability for different LTC users. In 2012 and 2013, the focus was on mental disorders, intellectual disabilities, dementia, and long-term rehabilitation training. In 2014, the focus was on children. Standardized instructional and study handbooks for LTC assessment personnel were completed in 2015.

(4) Planning LTC Insurance Benefits and Payment Systems

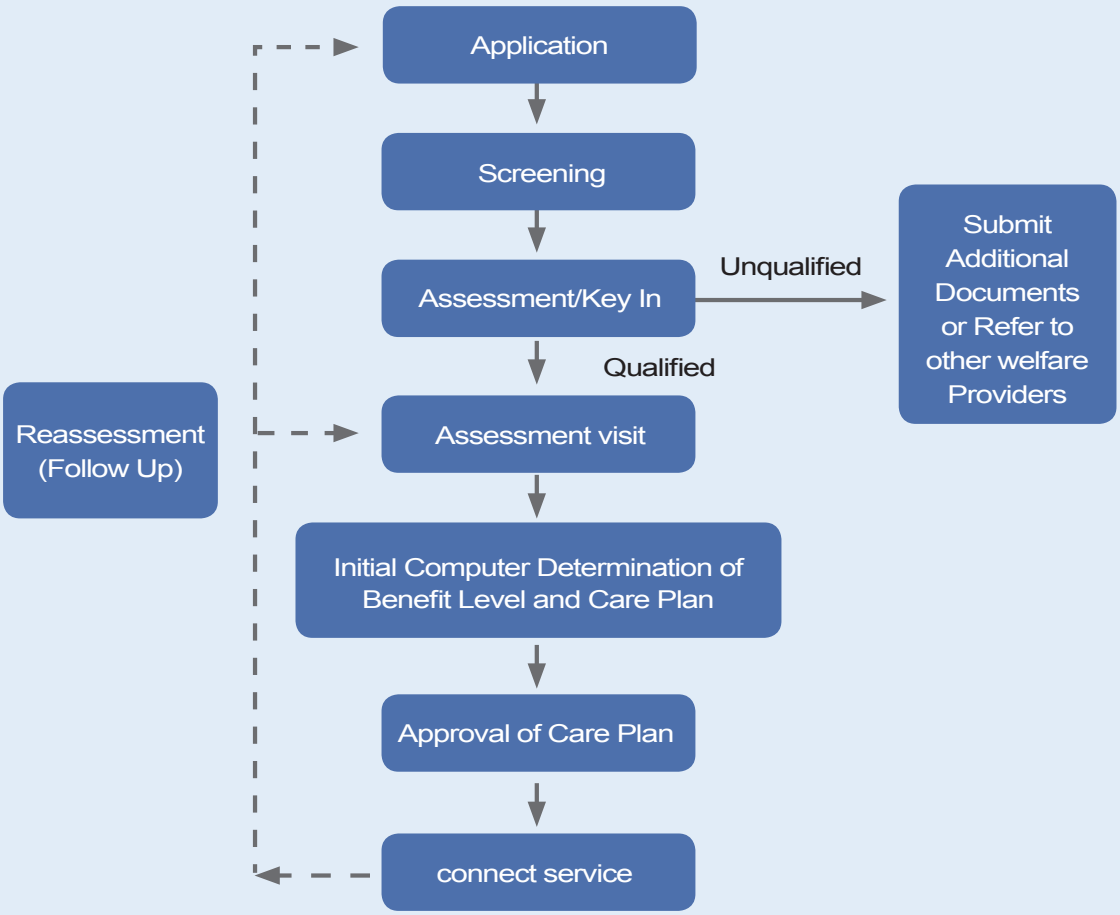
a. Benefits System: At the end of 2013, the MOHW completed the first draft version of the Long-Term Care Case-Mix System (abbreviation as LTC-CMS), which will serve as a foundation of future LTC insurance benefit standards. In 2015, Ten–year LTC Plan empirical data were gathered and feedback from LTC workers and expert meetings was used to regulate the LTC case's classification system.

b. Payments System: According to the benefit item and benefit group, payment standards are designed for home, community, and institutional LTC services. Payment units are assessed on a case-by-case basis. Other payment items are designed based on the special requirements of each service item. For example, payments to rent assisted devices are assessed by the day (month). Point values used to pay for service are based on cost data, budget neutrality, and improving care quality.

(5) Planning an LTC Insurance Care Management System

Key tasks for LTC Insurance care Management include assessment visits, drafting care plans, approving care plans, connect service, regular follow-ups and re-assessment, and assisting insured persons in applying for re-approval. The insurer (originally designated as the NHIA) must establish service center across the country. See Figure 7-2 .

Figure 7-2 LTCI service Delivery Process



8 Social Welfare Services

Since July 23, 2013, the Social and Family Affairs Administration (SFAA), MOHW, has planned and integrated welfare policies for women, children and youth, the elderly, and the disabled. By combining family and community resources, it advances the rights, well-being, and benefits of all people while providing suitable care for disadvantaged groups. Its visions are guaranteed rights, supportive families, a friendly society, and progress for all.

Chapter 1 Children and Youth Welfare

At the end of 2015, Taiwan had 4,043,357 children and youth, accounting for just 17.2% of the total population. In order to ease the low birth rate, the SFAA worked with related agencies to promote friendly, supportive measures for children and youth, in accordance with the *Population Policy White Paper* (approved by the Executive Yuan in 2013, figure 8-1). At the same time, inspired by the Convention on the Rights of the Child, as well as social, population, and family environment changes, The Protection of Children and Youths Welfare and Rights Act was amended on November 30, 2011, and the Implementation Act of the Convention on the Rights of the Child was announced on June 4, 2014. These provided a legal framework in Taiwan to be assured of rights for children in line with international standards.

Section 1 Welfare Subsidies for Children and Youth

1. Allowances for Unemployed Parents with Children Under 2 Years Old

   Monthly allowances of NTD2,500 - 5,000 are available for families with a consolidated tax rate under 20% over the most recent year and with at least one parent who did not work due to childrearing responsibility. In 2015, there were 255,722 children, consisting of 132,621 boys (51.8%) and 123,101 girls (48.1%) who benefitted from their families receiving more than NTD5,045,090,000.

Figure 8-1 Friendly, Supportive Measures for Children and Youth

<table>
<tr><th>Item \ Age</th><th>0</th><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th></tr>
<tr><td rowspan="5">Economic Support Measures</td><td colspan="3">Child-care subsidy for employed parents with qualified childcare providers</td><td colspan="4"></td></tr>
<tr><td colspan="3">Allowances for Unemployed Parents with children under 2 years old</td><td colspan="4"></td></tr>
<tr><td colspan="5">Special for preschool children Deductions</td><td colspan="2"></td></tr>
<tr><td colspan="4"></td><td colspan="2">Preschool Subsidies</td><td>Free Tuition for 5 Year Olds</td></tr>
<tr><td colspan="7">Assistance for Families in Hardship (Living / nursery allowances for children)</td></tr>
<tr><td></td><td colspan="6">Living Subsidies for Children of Low Income and Disadvantaged households</td></tr>
<tr><td rowspan="3">Low-Cost High-Quality Child Care Measures</td><td colspan="3">Public-privatel collaborative infant centers</td><td colspan="4">Non-Profit Preschools</td></tr>
<tr><td colspan="4">Public-private collaborative Resource centers for childcare</td><td colspan="3"></td></tr>
<tr><td colspan="7">The Centers of Family Childcare Service</td></tr>
<tr><td rowspan="2">Friendly Workplace Measures</td><td colspan="4">Allowances for Unpaid Parental Leave</td><td colspan="3"></td></tr>
<tr><td colspan="7">Family Care Leaves</td></tr>
<tr><td rowspan="4">Preventive Healthcare Measures</td><td colspan="4">Medical Care Subsidies for Children Under 3</td><td colspan="3"></td></tr>
<tr><td colspan="7">Intervention and Transportation Subsidies for Children with Developmental Delays</td></tr>
<tr><td colspan="7">NHI Subsidies for Children and Youth of Middle-to-Low-Income Households</td></tr>
<tr><td colspan="7">Children's Preventive Health care Services</td></tr>
<tr><td>Personal Safety Protection Measures</td><td colspan="7">Three-Level Preventive Measures</td></tr>
</table>

Source: Social and Family Affairs Administration, MOHW

2. Emergency Living Assistance for Children and Youth from Disadvantaged Families

   Families with children and facing hardship, high risk, or economic difficulties will be qualified for monthly emergency living assistance payments of NTD3,000 per person. In 2015, 6,010 families 7,777 children and youth were assisted and total payment was NTD140,740,000.

3. NHI Subsidies for Children and Youth of Middle-to-Low-Income Families

   In 2015, there were 1,556,698 payments totaling more than NTD951,470,000.

4. Medical Care Subsidies for Children Under 3 Years Old

   In 2015, these subsidies provided free treatment 15,453,602 times and reduced the financial burden on families by more than NTD1,856,860,000.

5. Medical Care Subsidies for Disadvantaged Children and Youth

   In order to provide children from disadvantaged families with suitable health care, payment assistance was offered for NHI arrears; intervention, training, and evaluation fees for children with developmental delays; nursing fees during hospital stays; and copayments. In 2015, there were 2,183 recipients of subsidies totaling more than NTD87,540,000.

Section 2 Protecting the Interests and Rights of Children and Youth

1. Building Communication Platforms Dedicated to the Welfare and Rights of Children and Youth

   Both the Executive Yuan and the MOHW established task force committees to promote the welfare and rights of children and youth. The committees conducted negotiations, research, reviews, and consultations for children and youth welfare policies and implemented the Convention on the Rights of the Child.

2. A Safety Plan to Prevent Accidents and Injuries Among Children and Youth

   The Children and Youth Safety Implementation Plan was formulated to promote personal, home, traffic, school, play, water, and occupational safety for children and youth. Also, the Promotional Team for Children and Youth Accidental Injury Prevention meets regularly to discuss performance and evaluation of various agencies in implementing eight major objectives for children and youth safety. Its purpose is to provide safe, worry-free environments for children and youth to grow.

3. Protecting the Rights of Children and Youth Without Household Registration (Stateless)

   The MOHW regularly follows up on children and youth without household registration or who are stateless and guarantees their schooling, home care, and health care rights. At the end of 2015 there were 70 registered cases, 20 of which were closed and 50 which were still in progress.

4. Promoting the Rights, Development, and Social Participation of Children and Youth

(1) Events advocating the rights of children and youth are carried out in cooperation with local governments and NGOs. In 2015, 64 organizations held 316 subsidized events, with total attendance of 96,742.

(2) On October 11, for Taiwan Girl's Day everyone is encouraged to work together toward building environments conducive to growth and diverse development of girls. In 2015, the day's theme was "Girls, Lean In." Celebrities like news anchor Jennifer Shen contributed promotional videos and 15 school lectures and news conferences brought even greater exposure to the day's events.

News conference for 2015 Taiwan Girl's Day

(3) Assistance was offered to local governments and NGOs to cultivate children and youth representatives who could foster greater social participation and free expression among their peers. In 2015, Tainan and seven other cities and counties held 112 subsidized children and youth empowerment activities with total attendance of 20,256.

Section 3 Placement Services

1. Better Promotion of Institutional Placement service

(1) The MOHW encouraged and commissioned NGOs to participate in placement to aid children and youth in need of assistance. At the end of 2015, there were 122 placement institutions (Table 8-1).

(2) In 2015, subsidies for institutional professional fees, facilities and equipment, schoolwork guidance, welfare activities, and research and training totaled NTD80,249,748.

2. Joint Accreditation of Institutions Specializing in Placement and Education of Children and Youth

Based on paragraph 2, Article 84 of "The Protection of Children and Youths Welfare and Rights Act," placement institutions shall be regularly accredited. In the most recent accreditation, there were 117 institutions evaluated, with those institutions that rated fair or poor designated for re-evaluation in 2017 (Table 8-2).

3. Promoting Foster Care

Guidline is developed and provided to local governments and NGOs which are commissioned to provide foster care. In December 2015, there were 1,326 households registered to serve as foster care homes, 307 reserve foster care homes, and 1,662 children and youth receiving foster care (Table 8-3).

Table 8-1 Institutions Specializing in the Placement and Education of Children and Youth, 2011-2015

Year		2011	2012	2013	2014	2015
Number of Institutions		120	123	126	124	122
Approved Number of Beds		4,577	4,816	4,985	4,991	5,004
Children	Boys	1,837	1,858	1,842	1,818	1,771
	Girls	1,772	1,691	1,700	1,683	1,704

Source: Social and Family Affairs Administration, MOHW

Table 8-2 Accreditation Results for Institutions Specializing in Placement and Education of Children and Youth, 2014 and 2015

Rating	Taipei Evaluations (2014)	Joint Central Government Evaluations (2015)	Subtotal (Institutions)	Ratio (%)
Outstanding	8	27	35	29.9
Excellent	6	49	55	47.1
Good	2	17	19	16.2
Fair	0	6	6	5.1
Poor	0	2	2	1.7
Subtotal	16	101	117	100.0

Source: SFAA, Department of Social Welfare (Taipei City Government)

Table 8-3 Children in Foster Care, 2011-2015

Year		2011	2012	2013	2014	2015
Foster Family Homes		1,243	1,248	1,275	1,289	1,326
Children	Boys	927	927	899	847	804
	Girls	908	908	905	896	858

Source: SFAA

4. Building a National Case Management System for Placement of Children

   The MOHW developed a national case management system for placement and follow-up of children and youth placed in foster care and institutional placement. The system, which includes utilization procedures and regulations, helps local agencies and national placement organizations understand the cases they oversee. Besides system maintenance, advances in 2015 included numeric field corrections and expansion of 12 system functions to be more user-friendly.

Chapter 2 Welfare for Women and Family Support

Social and economic changes over the past decade led the Social Welfare Promotion Committee of the Executive Yuan to issue the following objective proposals Taiwan's national family policies at its 23rd meeting on May 26, 2015: (1) develop holistic care and support systems for families, (2) advance economic security and caregiver-friendly workplaces to promote family-work balance, (3) use domestic violence prevention and residential justice to promote harmonious families, (4) strengthen family education and gender equality to promote better domestic relationships, and (5) advocate family values and tolerance for diversity to bring families together. Included as part of these objectives were 33 policies and 98 action measures to be implemented starting in 2016.

Section 1 Women's Welfare

Diverse welfare options to empower women are available. Key achievements follow:

1. In collaboration with NGOs, the government promoted support services to boost women's welfare and empowerment, to increase women's capabilities, and to create opportunities for development. In 2015, these services were offered 7,080 times.
2. By strengthening capacity of 20 women's welfare centers, the MOHW linked government and private resources to improve welfare, rights, legal, and learning services for women. In 2015, the centers provided services 421,202 times.
3. By operating the Taiwan Women's Center, which serves as a platform for popularizing women's welfare, women's rights, and gender mainstreaming, and promoting interaction between domestic and international women's organizations and between public and private agencies. In 2015, there were 11,803 visits made to the center and 71 domestic organizations used its facilities. The center also welcomed 74 domestic organizations and foreign guests.
4. In 2015, the New Taipei and Pingtung governments operated Women's Dream Pavilions for empowering women's groups and cultivating inter-group exchanges. The pavilions encourage women to participate in social and public affairs while developing empowerment mechanisms and operation models.
5. Local governments are empowered to promote welfare plans for women. In 2015, the MOHW assisted Tainan, Taoyuan, Keelung, Yunlin, Chiayi County, and Hualien in forming expert oversight teams to help with operational difficulties and to customize women's services to fit local characteristics.

Section 2 Services for Disadvantaged Families

1. Welfare for Single-Parent Families

(1) In 2015, 16 single-parent family service centers consolidated local welfare resources and NGOs held 56 subsidized support groups and welfare promotion activities for single parents.

(2) Single parents are encouraged to advance their education as part of an empowerment plan. In 2015, 304 single parents (male-to-female ratio of 1:19.3) received subsidized tuition, miscellaneous school fees, course credit fees, and child care fees so they could attend college or university, high school or vocational school.

(3) In 2015, there were 105 family (social) welfare service centers that provided integrated and preventive services.

2. Welfare for Families with Foreign Spouses

In 2015, 35 service centers for families with foreign spouses managed 15,853 cases ,87 community service centers for foreign spouses, and 100 special plans.

3. Community Care for Children and Youth from Disadvantaged Families

NGOs conduct subsidized family visits, after-school child care, and parental education for disadvantaged families with children or youth.

A family welfare service center held a friendly family competition

In 2015, 58 related plans benefitted 740,515 people.

4. Intervention for Children and Youth from High-Risk Families

In 2015, 85 NGOs employed 232 social workers responsible for visiting families (an increase of 8 social workers compared to 2014). Visits to 36,751 households resulted in opening 22,050 cases that assisted 32,193 children and youths.

Section 3 Childcare and Early Intervention Services

1. Services for Families with Childcare Needs

(1) Childcare subsidies for employed parents with qualified child-care providers:For both parents (or guardians) or single parents, who could not care for the young children (aged between 0-2) due to employment, could apply the subsidies between NT2, 000 and NT5, 000 to alleviate their burdens of raising children. In 2015, there were 77,721 children who benefited from a total of NTD1,440,218,325 in subsidies.

(2) Childcare Services

a. Family Childcare Service: In 2015, nationwide 72 centers of family childcare service managed 48,681 childcare providers (Including family/stepfamily relationship) who cared for 41,983 children (Figure 8-2).

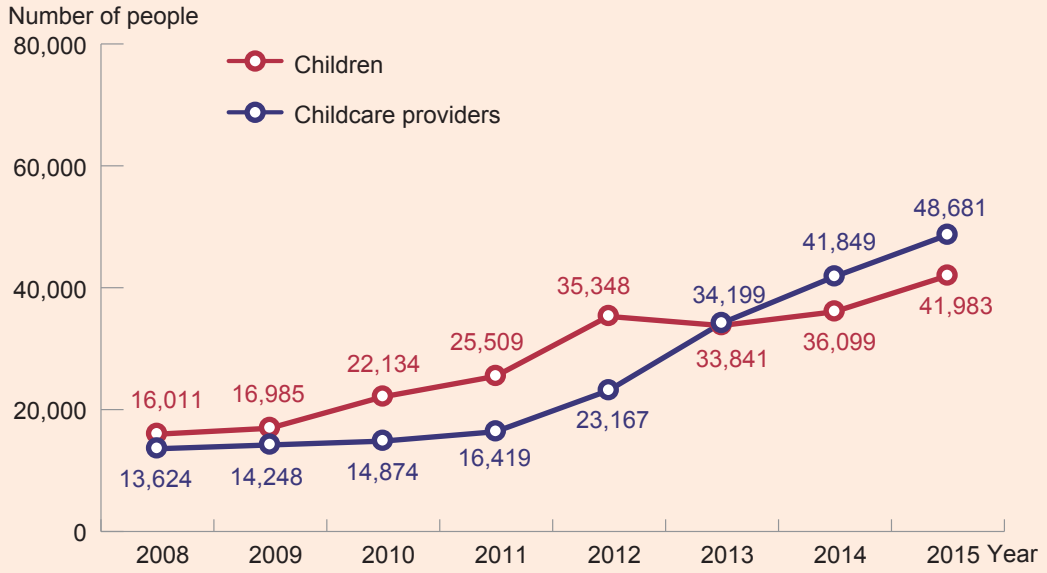
b. Infant Centers Services: At the end of 2015, 735 private infant centers cared for 17,246 children (Figure 8-3).

c. Community-Based Family Support Services: Local governments are supervised to set public-privately collaborative infant centers. At the end of 2015, 92 public-privately collaborative infant centers opened and cared for 4,258 children. Furthermore, local governments also institute resource centers for childcare to provide childcare consultations, parental education and other related services. At the end of 2015, 100 resource centers for childcare opened and provided services approximately 1.44 million times.

2. Early Intervention for Children with Developmental Delays

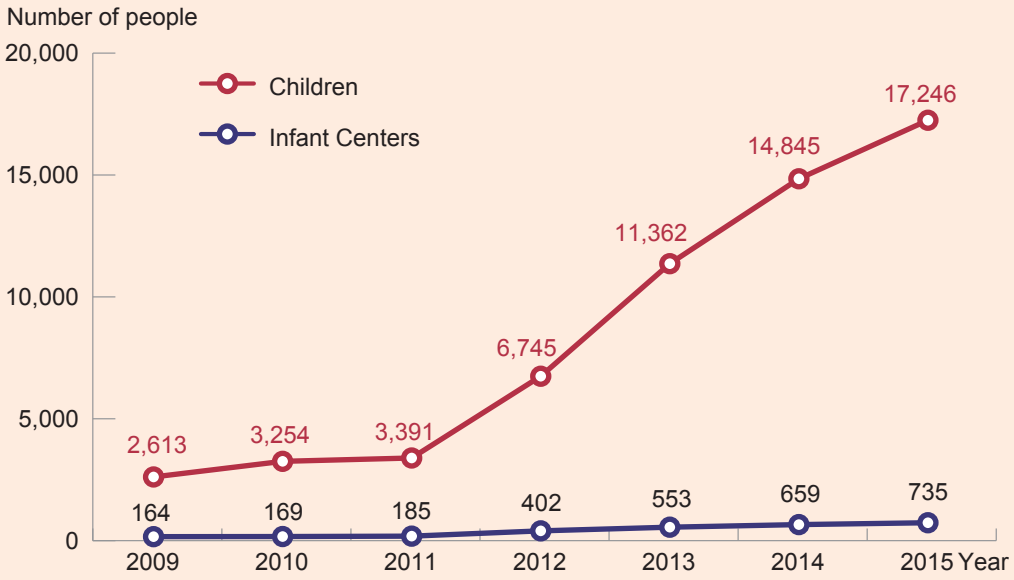
(1) Reporting Services: Local governments are supervised to set 28 reporting and referral centers. In 2015, 20,658 children with

Figure 8-2 Family childcare provider and Children under 2 years



Source: SFAA

Figure 8-3 Volume of Infant Center and Children



Source: SFAA

developmental delay are reported, and the nationwide reporting rate was 10.25%.

(2) Case Management and Subsidies for Intervention Fees: Local governments are supervised to set 55 case management centers. In 2015, there were 44,765 developmentally delayed children who received subsidies for intervention fees and were benefited from total subsidies of NTD355,869,294 (Figure 8-4)

(3) Home-based and Community-based Intervention Services: In 2015, local governments were guided in offering home-based services to 1,500 children. Furthermore, combine with 8 local governments promoted community-based intervention services in 40 townships and villages with insufficient early intervention resources.

Section 4 Services for Families with Special Needs

1. Children and Youth Adoption Service Providers

Starting from May 30, 2012, unless there is a direct family or stepfamily relationship, all adoptions must be screened and evaluated by approved children and youth adoption providers or companies and preference must be given to domestic adoptive parents. At the end of 2015, there were nine approved institutions (with 13 service points). These institutions matched 301 children with adoptive parents in 2015 (143 adopted domestically and 158 adopted overseas).

2. Assistance for Families in Hardship

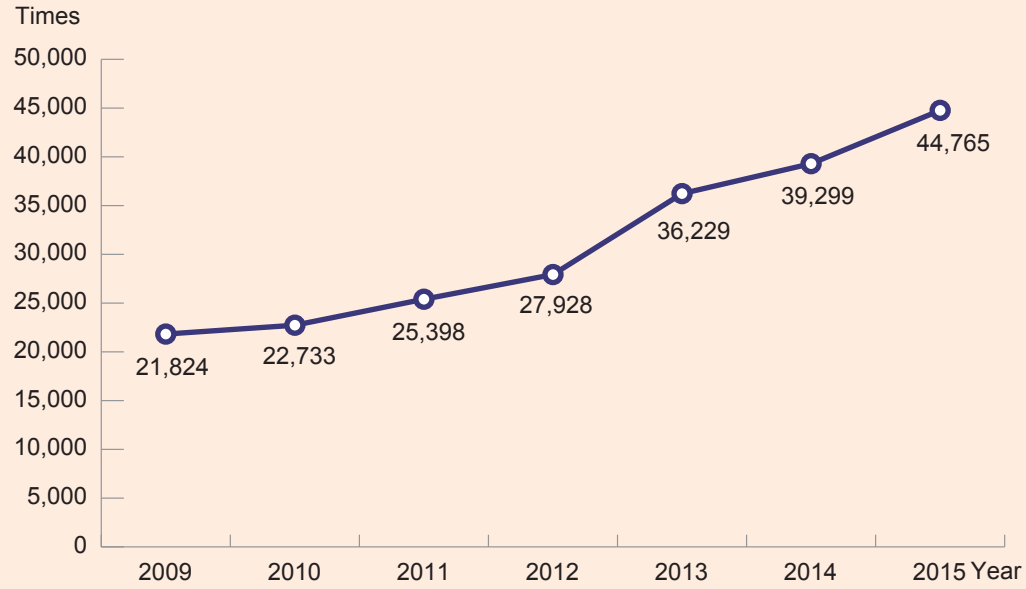
Emergency living assistance, living allowances for children, nursery allowances, health care subsidies for injury or illness, litigation subsidies, education subsidies for children, and career development loans are available for families in hardship. In 2015, 19,297 families used these benefits a total of 133,370 times, with total subsidies exceeding NTD420,120,000.

3. Support for Pregnant Teens

(1) A teen pregnancy hotline (0800-25-7085) and website (http//www.257085.org.tw) provide assistance and consultation to minors who became pregnant. In 2015, there were 823 calls to the hotline, 54,717 visits to the website, and 403 consultation letters and online inquiries received.

(2) Each city and county provides case management and assists with financial subsidies, health care, child care, and referrals for foster care and adoptions. In 2015, these services were used 1,280 times.

Figure 8-4 Subsidies for intervention fees, by Year



Source: Social and Family Affairs Administration, MOHW

Chapter 3 Welfare for Elderly people

At the end of 2015, there were 2,938,579 elderly people in Taiwan, accounting for 12.51% of the population. Becoming an aging society in 1993, the MOHW adopted a three-pronged policy approach focused on economic security, health maintenance, and daily care. Measures that meet the psychological, social, educational, and leisure needs of elderly people contribute to friendly environments conducive to health, safety, and lifelong learning and sustain the vitality, dignity, and autonomy of elderly people.

Section 1 Income Security for Elderly people

1. Monthly living allowances of NTD3,600 - 7,200 are offered to guarantee the economic security and basic living standard of middle-to-low-income elderly people. In 2015, 124,490 elderly people received more than NTD9,630,800,000 in subsidies.
2. Monthly special care allowances worth NTD5,000 were offered to middle-to-low-income caregivers who sacrificed employment to care for an elderly family member. In 2015, there were 9,407 such allowances worth a total of NTD47,530,000.
3. In order to help elderly people enjoy greater economic security by turning their property into monthly income, a pilot reverse mortgage mechanism was launched on March 1, 2013. After recognizing that similar schemes abroad rely heavily on financial products, an amendment to the Senior Citizens Welfare Act was made on December 9, 2015 to encourage financial regulators to urge banking institutions to offer commercial reverse mortgage loans.

Section 2 Health Care for Elderly people

1. In order to reduce the economic barrier to health care due to NHI premiums and co-payments for elderly people with economic problems, premiums are fully subsidized for middle-to-low-income elderly people aged 70 and above. In 2015, these subsidies were provided to 79,048 people.
2. Daily subsidies of NTD1,800, with an annual limit of NTD216,000, are offered to pay the attendant care during hospitalization for lower-middle-income elderly people who are in the care of MOHW-commissioned institutional care facilities. In 2015, four institutions received these subsidies to care for a total of 135 people.

Section 3 Lifestyle Care for Elderly people

1. In recognition of the contributions Dr. George Mackay made to the poor in Taiwan, starting from June 1, 2011, Mackay Project was launched for foreigners living in Taiwan. Discounted public transit was available to foreigners who met the following qualifications: had lived in Taiwan at least 20 years, were physically located in Taiwan for at least 183 days each of those years, had received an Alien Permanent Resident Certificate from the National Immigration Agency, MOI, were at least 65 years old, and were formally recognized for long-term dedication or special contributions to Taiwan. They will enjoy the discounts just like all Taiwanese elderly citizens. At the end of 2015, a total of 239 foreigners were qualified.
2. Ongoing efforts to improve care for elderly people living alone included operation of a 24-hour emergency assistance network. A center for tracking missing elderly people had reunited 1,266 out of 2,157 reported missing people between its founding and the end of 2015.
3. A subsidized, private elderly consultation center operates a specialized hotline that answers a variety of questions for elderly people (0800-228585). The hotline handled close to 1,000 calls per month on average.
4. Measures to protect the physical and mental health of disabled elderly people include care at home and day care centers. Since 2008, the government has also subsidized equipment, staff, and operating costs that provide home bathing services. At the end of 2015, there were 24 bathing vehicles operating in 18 cities and counties. They had provided more than 14,000 baths.

5. A combination of inter-departmental resources and cooperation between local governments, experts, and NGOs led to drafting and implementation of the second phase of a plan for friendly care services for elderly people. The second phase introduced 84 action measures to achieve healthy aging, aging in place, smart aging, vigorous aging, and continuing education. To meet the needs of an "aged" society, the Executive Yuan approved a special white paper on October 13, 2015. It named increasing the number of healthy years and decreasing the number of people with disabilities as policy goals for building an aged society that is healthy, happy, active, and friendly.
6. Local governments cooperated with village offices and community organizations to establish 2,476 community care points (Figure 8-5). Volunteer staff contributed through home visits, phone calls, referrals, food services, and health promotion activities to assist more than 210,000 people.

Section 4 Social Participation by Elderly people

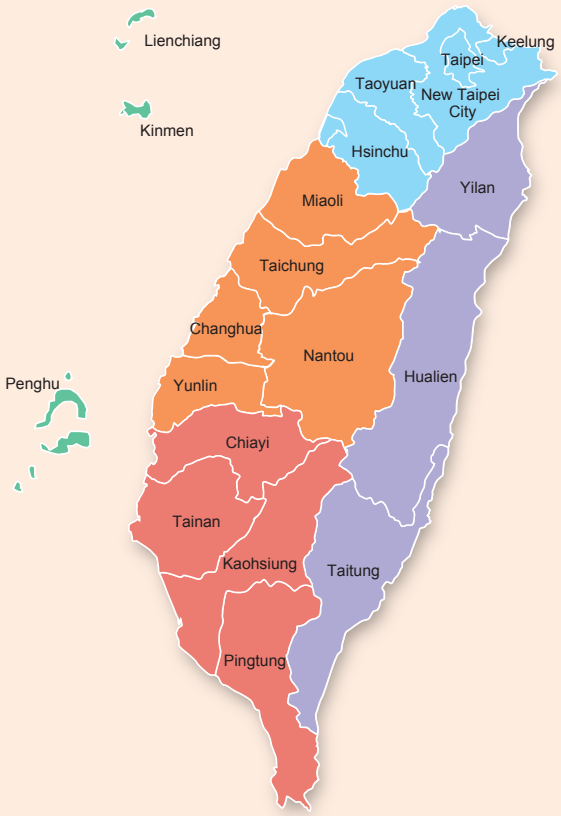
1. Variety of services and activities are available for seniors. Besides curriculum specialized for elderly, retirement preparation workshop, seminars, health lectures, sporting events, croquet competitions, and singing contests, elderly people benefitted from discounts of up to half off on public transit and entry into health and leisure centers and cultural and educational facilities. These subsidized activities and financial incentives encourage people to leave home and be more active. In 2015, there were 405,522 elderly people who benefitted.

Figure 8-5 Distribution of Nationwide Community Care Points

Central Region	
Miaoli	85
Taichung	278
Nantou	93
Changhua	146
Yunlin	74

Outlying Islands	
Kinmen	11
Lienchiang	7
Penghu	25

Southern Region	
Chiayi County	85
Chiayi City	25
Tainan	339
Kaohsiung	252
Pingtung	192



Northern Region	
Keelung	68
Taipe	85
New Taipei	240
Taoyuan	182
Hsinchu County	50
Hsinchu City	36

Eastern Region	
Yilan	71
Hualien	70
Taitung	62

Source: Social and Family Affairs Administration, MOHW

A national croquet competition for seniors

The inaugural Golden Community Care Stations Awards were held

A picnic and walking event were held for Senior Citizens' Day 2015

2. Mobile culture, health, and leisure tours for elderly people were made possible by the subsidized purchase of 18 multi-functional buses by 16 cities and counties. Services included welfare and health consultations as well as leisure, culture, and entertainment activities. Participating cities and counties hosted an average of 35 or 36 tours with a total attendance of 1,100 - 1,200 elderly people each month.
3. Close to 700 families and more than 3,300 people joined a special picnic and walking activity for the Senior Citizens' Day 2015. The spirit behind the event was for everyone to respect elderly people and care for elderly family members Besides calling on younger generations to join the celebration, families were urged to spend more time with elderly family members outside the home to increase social participation among elderly people and achieve greater family harmony. The event fulfilled the Senior Citizens' Day objectives of caring for, respecting, and honoring elderly people.

Chapter 4 Welfare for the Disabled

At the end of December 2015, there were 1,155,650 disabled persons in Taiwan, accounting for 4.9% of the population. Taiwan's welfare policy for the disabled is based on actual needs as well as the People with Disabilities Rights Protection Act and a white paper on protecting the rights of people with disabilities. Besides new mechanisms to identify disabled persons and evaluate their needs, the disabled receive guarantees of economic security, multiple continuous services, friendly living environments, and opportunities for social participation.

Section 1 Guaranteeing the Rights of the Disabled

1. A major milestone for the disabled was reached in 2006 when the United Nations passed the Convention on the Rights of Persons with Disabilities (CRPD). A legal basis for the CRPD was established in Taiwan when the Act to Implement the Convention on the Rights of Persons with Disabilities was announced by Presidential Order on August 20, 2014, and enacted on the International Day of Persons with Disabilities later that year on December 3. The MOHW has already planned related measures to implement regulations contained in the convention.
2. A new system for identifying people with disabilities and analyzing their needs was formally enacted on July 11, 2012. It adopted the WHO's International Classification of Functioning, Disability, and Health (ICF), in particular its use of body structures and functions, activities and participation, as well as its reliance on professional assessment teams. A single channel was also created for people to receive a range of personalized welfare services. In 2015, there were 299,325 people who applied for disability identification, with 202,279 people qualified and 272,590 who underwent needs assessment.

Section 2 Income Security for the Disabled

1. For greater income security, disabled persons with qualifying household income and assets receive monthly living subsidies of NTD3,500, NTD4,700, or NTD8,200. In 2015, more than NTD20,562,150,000 was spent to benefit an average of 350,813 recipients each month.
2. Daycare and residential care subsidies for disabled persons exceeded NTD7,646,630,000 in 2015 and benefitted an average of 38,354 recipients each month.

Section 3 Daily Care for the Disabled

1. Personalized Care for the Disabled (Home and Community Care)

   Services to advance life quality and social participation among the disabled include home care, independent living support, life reconstruction, day care, family foster care, and community housing. More than NTD1,609,540,000 was spent to benefit people 5,468,566 times.
2. Home Support for the Disabled

   Emergency and short-term care, training and education for caregivers, and home visits provide diverse care channels for households with a disabled person and reduce the burden on caregivers. More than NTD660,890,000 was spent to benefit people 2,993,539 times.
3. Localizing and Downsizing of Care Institutions

   At the end of 2015, there were 271 welfare institutions for the disabled that had a total of 23,326 beds and 18,744 patients. Primary services included day care, art education, work activities, and inpatient care. The MOHW also helped the institutions to downsize and integrate with the community to raise accessibility.

Section 4 Assistive Devices for the Disabled

1. A nationwide joint meeting on assistive device resources and integrated services took place and a web portal was established to consolidate information.
2. Assistive Device Services at the Local and Central Levels

(1) A centralized assistive device resources center commissioned consolidation and promotion centers for multifunctional assistive devices, orthotics/prosthetics & mobility assistive devices, and communication & information assistive devices. The centers provided consultations, education and training, website maintenance, exhibitions, and promotional activities.

(2) Subsidies and guidance are offered for local governments to establish assistive device centers that provide accessible evaluations, consultations, publicity, and maintenance. In 2015, there were 26 such centers across Taiwan.

Assistive device centers let visitors try out a variety of devices (pictured is a patient lift)

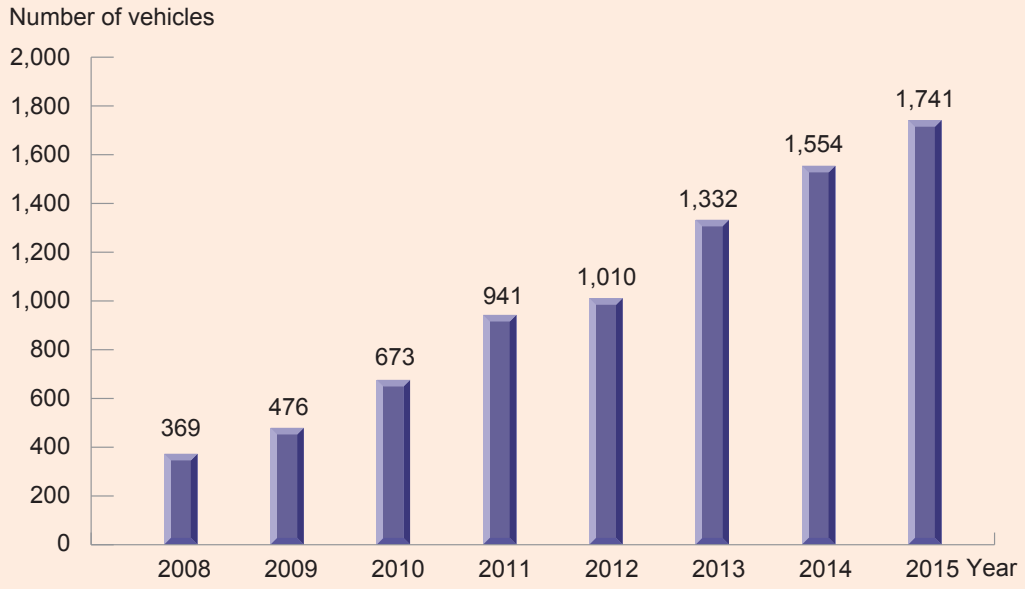
3. The disabled continued to receive subsidies to cover assistive device fees. In 2015, more than NTD766,160,600 was spent on 80,148 subsidies.
4. In order to help the disabled, the elderly, and others with mobility issues caused by stairs, assistance is provided to local governments that install stair climbers for the disabled. Also, with support from the public welfare lottery, New Taipei city government had a pilot project to provide stair climbers to residents in need of assistance.
5. An annual budget of NTD6 million subsidizes health, rehabilitation, and assistive device center plans for at least 10 hospitals across Taiwan. It provides assistive device consultations, analysis, and customized design, so the disabled can live independent and autonomous lives.
6. A comprehensive plan for subsidizing medical assistive devices for the disabled was implemented on July 11, 2012. By the end of 2015, there were 29,077 payments (72% of males, 28% of females) totaling NTD195,875,140.

Section 5 Social Participation for the Disabled

1. Subsidies for NOGs that hold leisure, entertainment, training, and other activities for the disabled are used to add or enhance web pages, facilities, and equipment used by the disabled. In 2015, 595 subsidies benefitted more than 50,000 users.
2. Besides holding activities to commemorate International Day of Persons with Disabilities, a special ceremony to present Golden Eagle Awards to outstanding disabled persons were held on November 28, 2015.
3. Subsidized guide dog training and advocacy programs helped support 38 in-service guide dogs and 140 younger dogs in training.

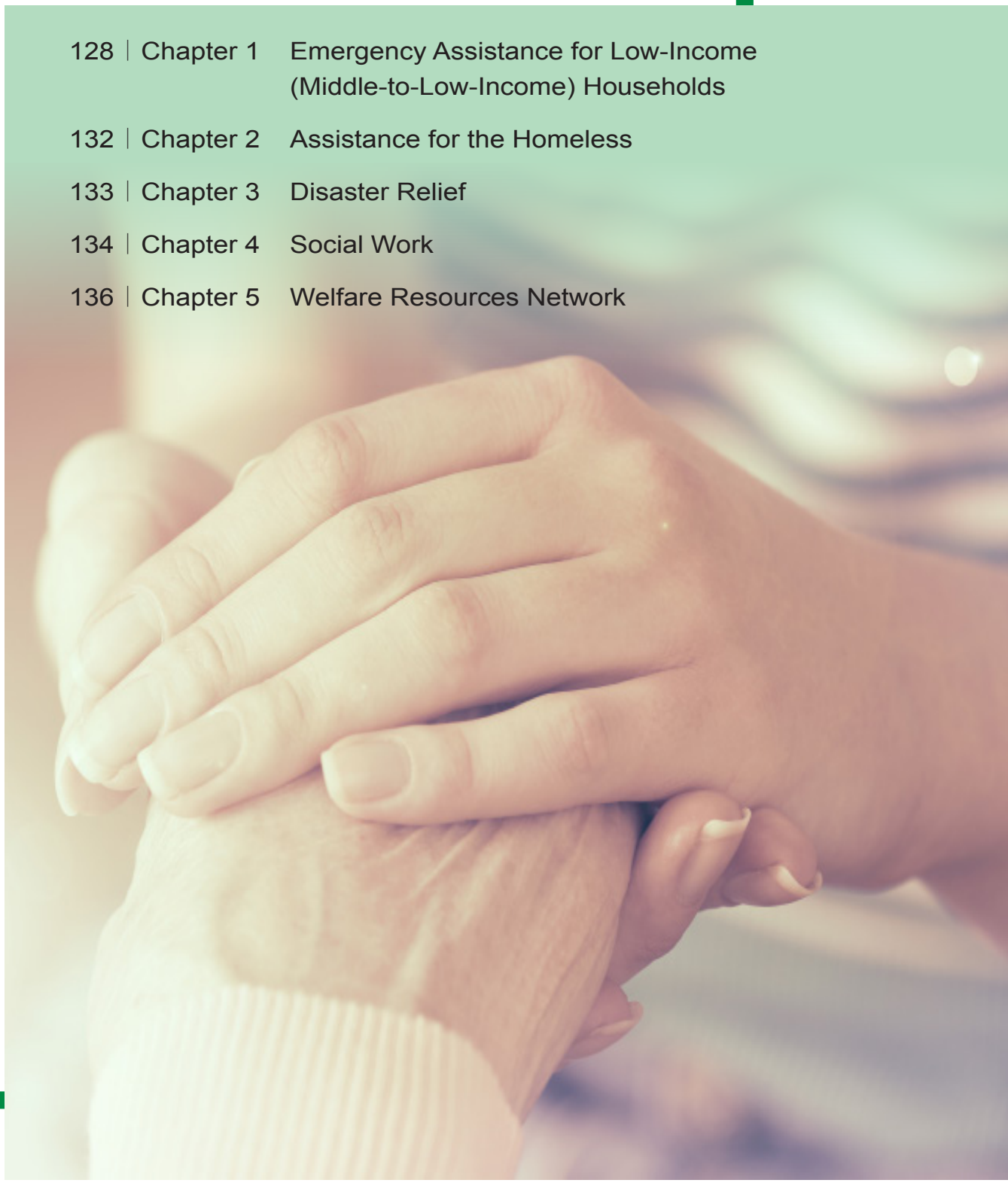
4. Measures to provide parking for the disabled and identify qualified users included establishment of 18,283 designated parking spaces and distribution of special license plates and more than 310,000 disabled parking permits.
5. In order to promote barrier-free spaces that can increase social participation for the disabled, the MOHW uses revenues from the public welfare lottery and private contributions to subsidize the purchase of special "Rehabus" vehicles by local governments. In 2015, there were 1,741 of these buses in Taiwan (Figure 8-6) and total ridership of 3,548,628.
6. Local governments were guided on establish channels for sign language interpretation and setting standards for service scope and procedures, with the goal of increasing social participation among the hearing impaired. In 2015, there were 227 certified sign language interpreters.

Figure 8-6 Number of "Rehabus" Vehicles, 2008 - 2015



Source: Social and Family Affairs Administration, MOHW

9 Social Assistance and Social Work



Taiwan's social assistance operates under the principles of "active care, needs-centered, and self-sufficiency." The government conducted regular review and revision of social assistance regulation, along with unemployment benefits and the welfare system, to ensure that people receive the help they need.

In respect of establishing professional social work system, the MOHW has enhanced social work professionalism by ensuring the rights of clients, and expanding job opportunities and job security of social workers by local governments. In terms of community development, community awareness was raised in the tasks of social welfare, health promotion, and cultural inheritance. By encouraging volunteerism, the spirit of compassion has flourished. Consolidation of human resources has encouraged people to participate in public affairs, which has improved social welfare and quality of life.

Chapter 1 Emergency Assistance for Low-Income (Middle-to-Low-Income) Households

Section 1 Current Status of Assistance

The purpose of social assistance is to care for low-income and middle-to-low-income households and to provide emergency assistance to those facing critical or disaster situations. Its aim is to make recipients self-sufficient, to guarantee a basic living standard for the disadvantaged, and to help people overcome difficulties. According to Articles 4 and 4-1 of the Public Assistance Act, low-income households are those approved by their local municipality or county (city) competent authority, with an average monthly income per person within the household that falls below the poverty line, and with total household assets not exceeding the amount announced by the central and local competent authorities in the year of application. middle-to-low-income households are those approved by the municipality or county (city) competent authority in which the applicant is registered and household is located, their average monthly income among each person in the household falls below the amount 1.5 times of the poverty line and does not exceed the national median rate of the expenditure per person announced by the central government, and their total household assets shall not exceed the specific amount announced by the central and local competent authorities in the current year.

Before December 29, 2010, amendment to the Public Assistance Act, a majority of the assistance the government gave to the destitute went to people with the lowest incomes. Less help was given to the low-income population that did not qualify for social assistance due to work ability, family assets, or assistance from family members. In order to reduce the occurrence of the working poor and to further self-sufficiency among beneficiaries, the poverty line was lifted to extend coverage to middle-to-low-income households. Adjustments made to the poverty line calculation methods were based on the disposable income ratio method, in line with current practices in most European Union and OECD nations. By synchronizing the poverty line with international standards, the program now fulfill its intention to guarantee the lowest living standard for the poor.

Based on the revised calculation methods, the poverty line for low-income households in Taiwan rose from NTD9,829 to NTD10,244. The poverty line for the past five years is shown in Table 9-1. At the end of 2015, cities and counties had evaluated and approved public assistance for 146,379 low-income households (with 342,490 people) and 117,686 middle-to-low-income households (356,185 people). A total of 698,675 disadvantaged people were included, with an increase of 149,628 households, or 153% (422,547 people), compared to those before June 2011 (Figure 9-1).

According to the Report on the Low-Income and Middle-to-low-Income Family Living Condition Survey, 2013, the five main reasons for poverty among low-income and middle-to-low-income households were: low income, unstable income, lack of working ability among household members, a high dependency ratio among household members, and prolonged illness among primary breadwinners (Figure 9-2).

Section 2 Living Support

Living support for low-income households is an important part of social assistance and a

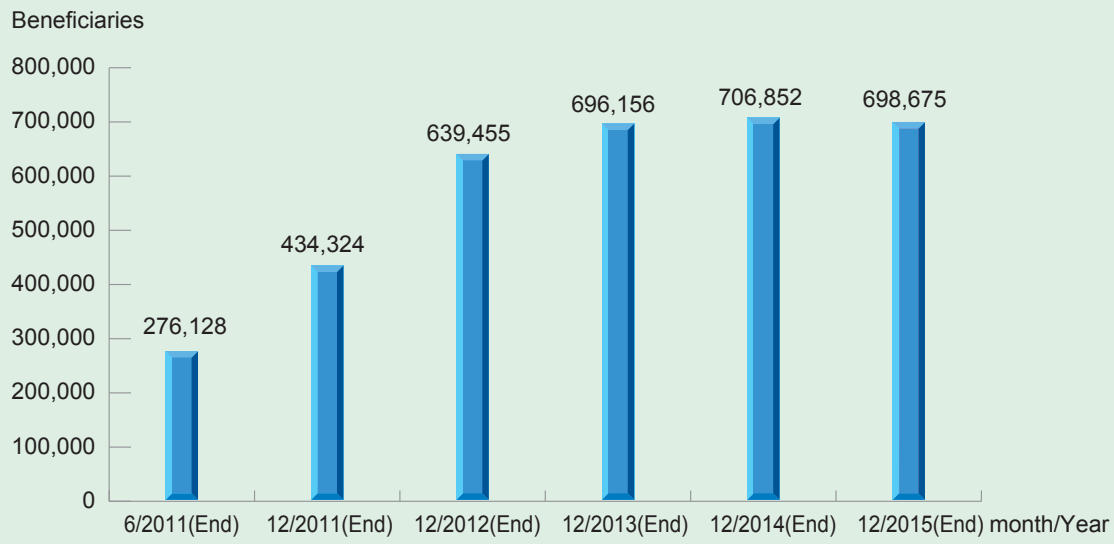
Table 9-1 The Lowest Living Index Over the Past 5 Years

(NTD)

Region / Year	Taiwan Province	Taipei	Kaohsiung	New Taipei	Taichung	Tainan	Taoyuan	Fujian Province	
								Kinmen	Lienchiang
2011 (Jan.-Jun.)	9,829	14,794	10,033	10,792	9,945	9,829	-	7,920	
2011 (Jul.-Dec.)	10,244	14,794	11,146	11,832	10,303	10,244	-	8,798	
2012	10,244	14,794	11,890	11,832	10,303	10,244	-	8,798	
2013	10,244	14,794	11,890	11,832	11,066	10,244	-	8,798	
2014	10,869	14,794	11,890	12,439	11,860	10,869	-	9,769	
2015	10,869	14,794	12,485	12,840	11,860	10,869	12,821	9,769	

Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

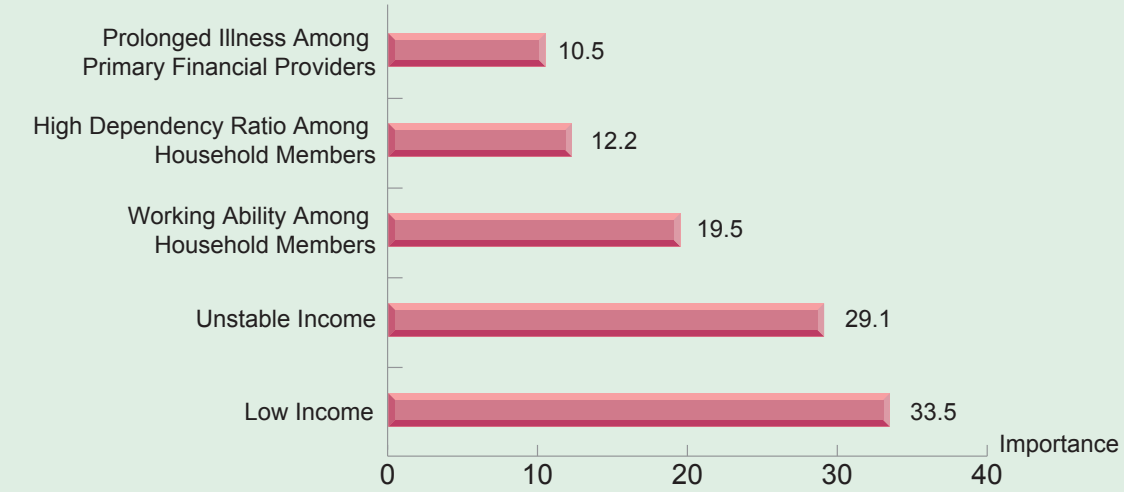
Figure 9-1 Beneficiaries after Revised Social Assistance Regulations



Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

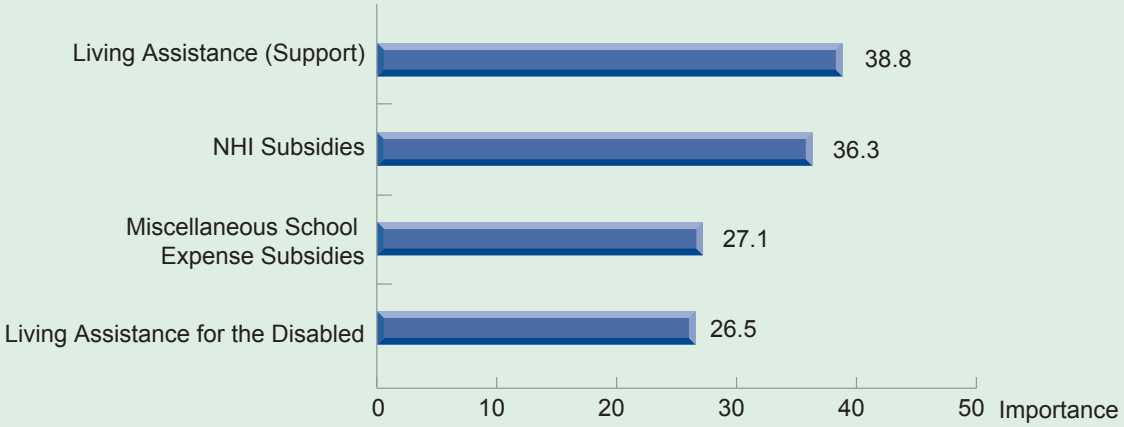
continuous source of economic support for those in need. To guarantee the rights and benefits of the disadvantaged, an amendment in 2015 to the Public Assistance Act stipulated that living support shall be adjusted once every four years based on the growth rate of the consumer price index. According to the 2013 Report on the Low-Income and Middle-to-Low-Income Family Living Condition Survey, the leading social assistance measures in order of importance to low-income and middle-to-low-income households were: family living assistance, NHI subsidies, miscellaneous school expense subsidies, and living assistance for the disabled (Figure 9-3), which means important measures in public social assistance for low-income households were mostly long-term in nature.

Figure 9-2 Five Leading Causes of Poverty among Low-Income and Middle-to-Low-Income Households



Source: Ministry of Health and Welfare, R.O.C. (Taiwan)
Note: Importance = leading cause x 1 + 2nd leading cause x 2/3 + 3rd leading cause x 1/3

Figure 9-3 Importance of Social Assistance Measures Provided to Low-Income and Middle-to-Low-Income Households



Source: Ministry of Health and Welfare, R.O.C. (Taiwan)
Note: Importance = most important x 1 + 2nd most important x 2/3 + 3rd most important x 1/3

Local governments offer family living support, student and child living assistance, and related relief measures to low-income households. According to Article 12 of the Public Assistance Act, members of low-income households who are elderly, have been pregnant for three months or longer, or are disabled can qualify for an additional public subsidy that is no more than 40% of the original amount of cash. To prevent welfare payments from affecting a recipient's willingness to work, Article 8 of the Act states that the amount of assistance granted by the government under this act or other acts shall not exceed the current year's basic wage. Highlights of key living support measures provided to low-income households in 2015 are illustrated in Table 9-2.

Table 9-2 Key Living Support Measures Provided to Low-Income Households, 2015

Subsidy Item	No. of Subsidies	Total Subsidy Amount (NTD)
Family Living Support	1,201,568	6,052,526,735
Student Living Support	646,749	3,808,654,610
Workfare Programs (Including middle-to-low-income Households)	23,685	371,588,177
Holiday Bonus	583,622	543,430,146

Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

Besides cash payments, based on needs local governments must provide nutritional supplements for pregnant women and infants (including nutritional subsidies for newborns of single mothers), birth subsidies, prioritized placement in social housing, rent subsidies, subsidies for basic repairs of a residence, loan interest subsidies for the purchase or building of a residence, student meal subsidies, and subsidies for hospitalization of the injured or sick. These measures guarantee that the basic needs of low-income and middle-to-low-income households are met.

Section 3 Medical Subsidies

By Articles 18 and 19 of the Public Assistance Act, medical subsidies offered to low-income and middle-to-low-income households include the following:

1. NHI Subsidies: Article 19 of the Public Assistance Act states that "the insurance premium for low-income households to cover NHI shall be paid from the budget of the central competent authority. As for the insurance premium for middle-to-low-income households to cover NHI, 50% of it shall be paid by the central competent authority. Those who meet the subsidies conditions in other acts that have common provisions as this act shall not receive subsidies from both legal provisions." In 2015, NHI premium subsidies totaled NTD6,875,320,000.
2. Co-payment Fee Subsidies: In order to reduce the health care burden faced by low-income households, Article 49 of the National Health Insurance Act states that "when low-income households receive medical care, the care expenses shall be paid out of the budget of the central competent authority in charge of social affairs." In 2015, subsidies for these expenses (including clinical and hospitalization fees) totaled NTD1,655,160,000.
3. Subsidies for Medical Care Not Covered by NHI: In order to satisfy health care needs of low-income and middle-to-low-income households, local governments established laws and regulations governing subsidy standards for medical care fees. In 2015, there were 4,499 subsidies totaling NTD102,559,166.

Section 4 Workfare and Poverty Reduction

In order to promote self-sufficiency among low-income and middle-to-low-income households, Article 15 of the Public Assistance Act states: "For persons in low-income and middle-to-low-income households who are able to work, municipality and county (city) competent authorities shall, according to needs, provide or make referrals to employment services, vocational training, or workfare programs to help them to be self-sufficient." Government agencies at each level provide employment services in accordance with this regulation. Based on need, they also provide career counseling, loan interest support for establishing careers, subsidies for transportation when the job was seeking, temporary childcare or allowances for daycare during the job seeking or vocational training period, and other employment services and subsidies. Participants in vocational training programs can apply for special living allowances to help pay for family expenses during their schooling period.

To help low-income households out of poverty, each local government uses social resources to develop suitable self-sufficiency education, employment investment, and asset accumulation models based on the needs of low-income households. The MOHW encourages local governments to initiate pilot projects aimed at fostering greater self-sufficiency among the poor. In 2015, there were 27 subsidized projects by local governments and NGOs to help people become self-sufficient and out of poverty. Another NTD13,433,700 in subsidies for 52 local government service projects provided benefits to 30,715 people.

Section 5 Emergency Relief

1. The Public Assistance Act provides timely assistance to people who are impoverished due to misfortune or other emergency situations. After municipal or county (city) competent authorities approve and grant assistance, if the beneficiary is still impoverished, the MOHW can approve and grant assistance in accordance with its own regulations governing the application, review, approval, and distribution of emergency relief.
2. The "immediate care" plan delivering emergency relief was initiated. Under the Immediate Plan, when impoverishment results from an accident befalling a family's primary financial provider, assistance is granted following visits and confirmation by the local neighborhood office, private charitable organizations, and the local township (village/city/district) office.
3. Related achievements in 2015 are described in Table 9-3.

Chapter 2 Assistance for the Homeless

Rather than relying on earlier ways of expulsion and suppression to manage the homeless, the government now offers a helping hand. Sheltering and support is managed over a three-staged model of emergency, transition, and stabilization. Basic human rights and regional differences are taken into account to help the homeless start over a new life.

Section 1 Analysis of the Homeless Issue

According to local government data, there were 2,770 homeless persons registered for assistance at the end of 2015, more than 70% of whom stayed in Taipei, New Taipei, Taichung, Tainan, Kaohsiung, or Taoyuan. There were no registered homeless persons in islands such as Kinmen, Lienchiang, or Penghu. The data shows a significant gap between different localities, with most homeless people concentrated in the highly urbanized six special municipalities.

According to a 2013 MOHW survey on the living conditions of homeless persons, 92.1% of the homeless were male. Most were between 45 and 65 years of age and the average age of homeless persons in non-urban areas tended to be higher than those in urban areas. As for education, 72.1% had gone no further than junior high school. Most were single, with 47.4% never married and 46.9% divorced, separated, or widowed. There were many reasons why the homeless ended up on the streets. By the accounts of homeless people who were interviewed, the main reasons were loss of employment, insufficient money to pay rent, living alone with nobody to depend on, and poor family relations.

Table 9-3 Emergency Relief Achievements, 2015

Type	Beneficiaries (People)	Relief Payment Amount (NTD)
Emergency Relief from Municipal and County (City) Authorities	37,794	232,077,000
Emergency Relief from the MOHW	1,003	16,385,000
"Immediate Care" Emergency Relief	14,197	200,031,695

Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

Section 2 Homeless Assistance Measures

Measures to guarantee the rights of the homeless are as follows:

1. Living Maintenance: In order to ensure a basic living standard for the homeless, the government and related institutions conduct outreach with NGOs. Measures fulfill basic living maintenance, such as hot meals, showers, warmth, barber services, clean clothes, sleeping bags, and health care.
2. Multiple Forms of Shelter: Municipal and county (city) governments are taking additional steps to offer professional shelter assistance. Besides helping the homeless to reconnect with their family and friends, for those with no home to return to, roaming the streets, or unwilling to accept institutional placement, flexibility is provided in offering temporary placement, such as homeless shelters (there were 10 public homeless shelters, including seven that were privately operated). The MOHW also subsidizes the development of short-term accommodation facilities by NGOs to further expand the range of shelter options.
3. Living Rehabilitation: In cooperation with the competent authority of labor affairs, vocational training is provided to homeless persons with the ability and motive to work. Each homeless person's unique traits are considered when referred to relevant units to seek job opportunities. Workfare programs and other innovative measures make the homeless more accustomed to work. Community rental housing assistance raises self-sufficiency and encourages the homeless to return to their families.
4. Care in the Cold: On November 10, 2014, the MOHW issued a plan to improve care for the vulnerable when the weather is cold and during the Lunar New Year holiday period. Whenever the Central Weather Bureau issues a cold weather warning for temperatures below 10° C, local governments and NGOs jointly offer cold weather care to ensure the homeless access to hot meals and clothes as well as information on temporary shelters.
5. Integrated Services: By integration of different systems, transfer services are provided to ex-inmate support programs, medical care, and psychiatric service, with a focus on groups at high risk of becoming homeless, to connect with services and resources such as employment services and social assistance. For example, released inmates receive employment guidance and assistance with social welfare applications to facilitate a seamless return to the community that prevents them from ending up on the streets.
6. Achievements: In 2015, local governments assisted homeless persons 289,008 times by offering care services (259,570 times), assistance returning to family (241 times), Lunar New Year holiday assistance (11,354 times), referral to welfare services (3,924 times), referral to employment services (3,504 times), housing rental (366 times), placement (3,029 times), and other services (6,901 times).

Chapter 3 Disaster Relief

An increase in extreme weather events in recent years has led to higher frequency of disasters and therefore a greater focus on disaster relief. Efforts are constantly made in preventing and preparing for disasters as well as response and restoration after disasters hit. Reviews and improvements are made by the social administration. For disaster relief, the primary duties of the MOHW's Department of Social Assistance and Social Work are to provide shelter and placement for victims, to prepare necessary living supplies, and to reassure and care for victims. Preparation is the focus before disasters strike and effective responses are needed when disasters are underway.

Section 1 Sheltering of Disaster Victims and Supply Preparations

1. With the arrival of flooding and typhoon season, local governments must be ready to respond by providing temporary accommodation, social assistance, and special protection measures for disadvantaged groups, in accordance with the "Disaster Prevention and Protection Act."

In 2015, there were 5,793 shelters for disaster victims nationwide that had a total capacity to serve 1,971,168 people.

2. In response to challenges posed by climate change, the MOHW strengthened disaster preparation and response among social administration departments. In 2015, it used surplus from the social welfare lottery to subsidize the Kaohsiung Social Affairs Bureau, Fu Jen Catholic University, and World Vision in holding disaster relief forums, seminars, and three professional research and training events attended by 598 people.
3. The MOHW established "regional alliance, timely assistance" and "one person, one case," models for social administration workers. Local governments are separated into five geographic areas: northern, central, southern, eastern, and outlying islands. Cities and counties in each area assist with each other when disasters occur. Depending on the type of disaster, special social work models are developed. For example, following the Formosa Fun Coast powder explosions the "one person, one case" model was used to assign social work responsibility. Together, these measures include on-time relief and assistance, trauma recovery, psychological support, and needs surveys.

Section 2 Disaster Relief Payments

1. When major natural disasters occur, following instruction from the Executive Yuan or the Central Emergency Operation Center (if convened), the MOHW contacts local governments to confirm the numbers of deaths, missing people, and major injuries. It then instructs senior officials to begin issuing condolence payments.
2. After checking related documentation, municipality or county (city) governments distribute disaster relief payments to qualified people. Families of the dead or missing receive NTD200,000 and those who were severely injured receive NTD100,000. The MOHW also provides consolation payments and the Relieve Disaster Foundation uses private donations to increase payment amounts. Standards used by the MOHW and the foundation to give consolation payments to the dead, missing, and severely injured include the following:

(1) Consolation Payments for Deaths: NTD600,000 (MOHW NTD200,000, foundation NTD400,000)

(2) Consolation Payments for the Missing: NTD600,000 (MOHW NTD200,000, foundation NTD400,000)

(3) Consolation Payments for Major Injuries: NTD150,000 (MOHW NTD50,000, foundation NTD100,000)

3. Consolation Payments in 2015: After Typhoon Soudelor struck in August 2015, the MOHW issued a total of NTD2.15 million in consolation payments to the families of 10 dead and missing victims and three victims with major injuries. Another NTD600,000 in total was provided to the families of three people killed during Typhoon Dujuan.

Chapter 4 Social Work

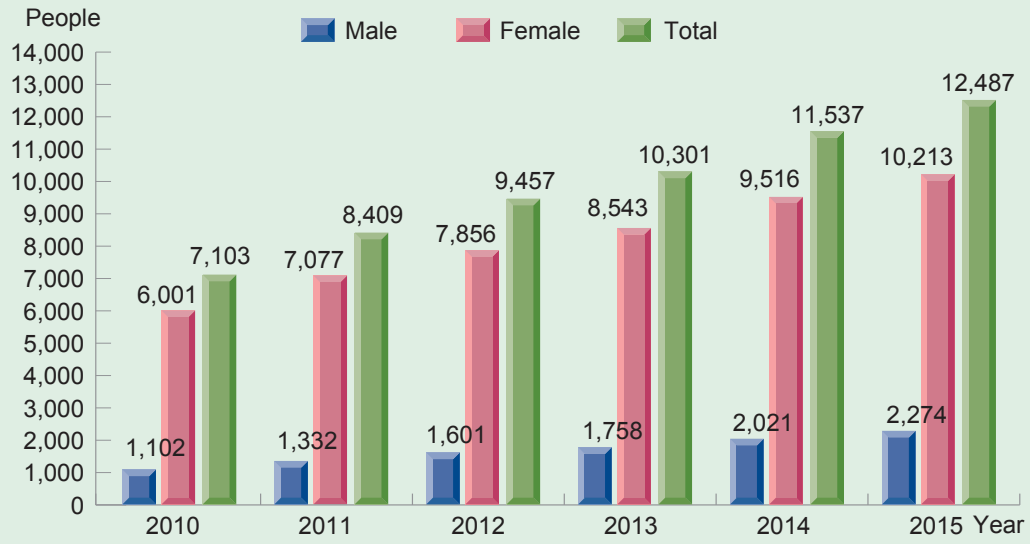
Section 1 Social Work System

Countries around the world are implementing professional social work systems. By the end of December 2015, there were 9,074 people in Taiwan with social work license, 5,107 professional social workers and 12,487 social workers assigned to social welfare tasks in public and private agencies (for the number of social workers from 2010 to 2015 see Figure 9-4). On average, there was one social worker for every 1,842 people.

The following measures have been conducted to enhance a professional social work system:

1. Since years of practices can waive certain subjects from the social work examination by the Ministry of Examination, the MOHW held 65 committee meetings had conducted secondary reviews of 10,016 social work applications by December 2015.

Figure 9-4 Social Workers Assigned to Social Welfare Tasks in Public and Private Agencies, 2010-2015



Source: Number of Professional Social Workers, Department of Statistics, MOHW Form 9-3

2. The first national examination for specialist social workers were completed in March 2014. A total of 217 social workers passed (with passing rate of 81.3%), 78 specialized in medical care; 66 in mental health; 50 in children, youth, women, and family; 12 in aging ; and 11 in disability.
3. The MOHW and NGOs select outstanding social workers based on recommendations from public and private agencies. On April 2, 2015, 128 social workers were honored on Social Worker's Day.
4. In accordance with updated regulations governing continuing education and professional licensing of social workers, review and certification of 2,224 continuing education cases took place in 2015.
5. In 2014, a national social worker database was completed to improve management of social worker resources. In 2015, the social worker resource management system was updated and features were adjusted in accordance with revisions to new regulations for continuing education and professional licensing of social workers as well as regulations for the distribution, selection, review, and continuing education of specialist social workers.

Section 2 Augmenting the Social Work Workforce

Throughout Taiwan, local governments face social worker shortages. On September 14, 2010, the Executive Yuan therefore approved a plan for local governments to increase deployment of social workers. The plan was estimated to add 1,462 social workers between 2011 and 2016 and another 394 formal social workers between 2017 and 2025 (Table 9-4). Between 2010 and the end of 2016, the total number of social workers in public agencies were forecast to increase from 1,590 to 3,052. Starting in 2011, the central government also provided a 40% subsidy to add 366 contracted social workers who primarily provide direct services

Table 9-4 2010 Plan for Local Governments to Increase Deployment and Use of Social Workers

Period	People	Notes
2011 - 2016	1,462	1. Added 366 contracted social workers in 2011 2. Added 1,096 formal social workers between 2012 and 2016
2017 - 2025	394	Formal workers added to vacant positions

Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

related to child protection, prevention of domestic violence and sexual assault, and social assistance for the disabled, older people, and women.

After implementation, the population per public social worker fell from 14,549 to 7,580. The lower case burdens that followed allow front-line social workers to provide better quality of investigations and support for clients of child protection, domestic violence, sexual assault, and disadvantaged families. More than 60% of social workers were formally incorporated, ensuring proper use, promotion, and reasonable salary. By creating a system that encourages long-term experience in specialized areas, social workers have been able to raise their professional capacity.

Section 3 Safety of Social Workers

Protection of social workers falls under the scope of the "Social Worker Act," the "Protection of Children and Youths Welfare and Rights Act," the "Domestic Violence Protection Act," and other related laws and regulations. To strengthen occupational safety of social workers, on April 1, 2015, the Executive Yuan approved a social worker professional safety program that seeks to create friendly work environments through safe employment, secure services, and stable management. Measures include the following:

1. A table detailing high-risk and general risk work carried out by social workers was completed and additional allowances were offered based on risk.
2. The MOHW sought funding from 2015 public welfare lottery to provide NTD10 million in subsidies toward a plan for guaranteeing the personal safety of social workers and improving their professional capacity. Local governments and NGOs use the funding continuously to strengthen pre-employment and on-the-job safety training to enhance risk awareness and capabilities. Social workers also receive better protective facilities and equipment. By the end of December 2015, NTD5,106,000 in subsides were provided.
3. The MOHW compiled a social worker safety handbook that has become a mandatory part of training for frontline social workers.

Chapter 5 Welfare Resources Network

Section 1 Community Development

1. Community development in Taiwan is based on a civil association model in accordance with the "Guidelines for Community Development." Construction and social welfare are community based and focus on three major areas: public facilities, welfare production, and moral ethics. The goal is to improve community welfare.
2. An important part of community development involves using social forces to promote community welfare. Subsidies are offered for communities to issue publications and hold activities that consolidate community awareness. Bringing people together promotes interaction within communities and improves quality of life. Achievements include the following:

(1) Establishment of Community Activity Centers: At the end of 2015, Taiwan was home to 3,770 community activity centers that provide space for community development associations to hold meetings; for local children, women, and

older people to engage in activities; and for residents to gather for recreation purpose.

(2) Building Community-Based Welfare: The MOHW conducts flagship plans, community manpower cultivation, disaster prevention and preparation advocacy, and community empowerment. In 2015, subsidies provided in 18 cases totaled NTD8,658,000.

(3) National Demonstration Activities: There were two national demonstration activities in 2015 based on the themes of community customs & entertainment (attendance of 2,910) and community-based social welfare (attendance of 1,068).

(4) Conducting Community Development Accreditation: In 2015, community development accreditation was carried out in nine city and county governments in southern Taiwan and community development associations within their jurisdictions. Tainan, Kaohsiung, Changhua, Chiayi County, and Pingtung earned outstanding marks; Taitung, Penghu, and Chiayi City earned excellent marks. Dagang Community, in Tainan's North District, and 30 other community development associations earned super, outstanding, or excellent marks or individual category honors. Events held to honor these communities were attended by 534 people.

Section 2 Public Fundraising Management

In order to manage charitable fundraising and to ensure proper use of donations, on May 17, 2006, the government announced the "Charity Donations Destined for Social Welfare Funds Implementation Regulations." The regulations cover social welfare activities, educational and cultural affairs, social charity, international humanity rescue, and other programs recognized by the central government agencies. In 2015, there were 373 permits issued to 442 groups, with total funds collected surpassing NTD2,156,360,000.

Each year an accounting agency audits MOHW-approved charity fundraising cases in order to improve financial accountability and effectiveness of public donations. In 2015, there were 149 audits, comprising 46 cases from 2013 and 2014, 78 cases from 2013 and 2014 that were reported delay to the MOHW, 22 ongoing cases for major international and domestic disasters, and three cases of special concern to related competent authorities.

Special seminars were held to increase professional knowledge of those who carry out charitable fundraising initiatives, to improve capabilities of charitable organizations, and to familiarize organizations with related laws and regulations. In 2015, there were two such seminars with total attendance of 184 people.

Section 3 Promoting Volunteerism

In order to integrate with NOGs' capacity, encourage people to help one another, and fully develop volunteerism, the Volunteer Service Act was enacted on January 20, 2001. The act designates the definition and scope of volunteerism, responsibilities of competent authorities and related units, rights and obligations of volunteers, and measures to promote volunteering. Better integration of social resources facilitates deployment of volunteers.

Incentives to boost volunteerism include awarding gold, silver, and bronze medals for outstanding volunteer in health and welfare services and for nationwide volunteer achievements. Volunteer seminars, training, and other related activities by NGOs are subsidized in accordance with guidelines governing social welfare subsidies in order to promote greater participation. A national volunteer information platform and management systems for disaster material resources and an online volunteer network platform helps local governments in disaster suffering areas announce updated information and assist with matching disaster assistance to areas in need. In 2015 national volunteering competition, six cities and counties were awarded for outstanding service and 11 for excellent service.

Total volunteers nationwide increased from 898,765 in 2012 to 944,038 in 2015 (Figure 9-5).

There were 309,539 male volunteers (33%) and 634,499 female volunteers (67%) in 2015, for a male-to-female ratio of approximately 3:7.

Regarding service fields, education had the highest number of volunteers at 388,843, followed by health and welfare with 297,021 volunteers, environmental protection with 159,466 volunteers, and culture with 24,884 volunteers. An additional 73,824 volunteers were involved in legal affairs, transportation, internal affairs, and other fields.

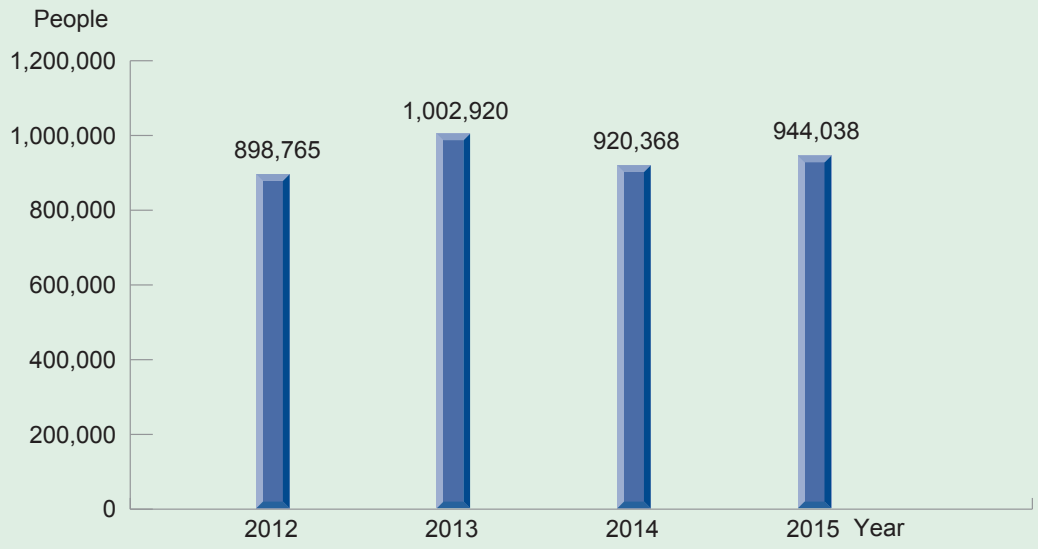
In terms of age, young adults led the way with 238,458 volunteers (25%) between 18 and 29. There were 165,263 elderly volunteers (18%) who were 65 or above. Volunteers assisted people 446,434,327 times in 2015 and worked 74,932,277 hours, equivalent to the working hours of 36,025 full-time workers.

Section 4 Welfare Information Hotline

In order to assist families and individuals facing hardships, the MOHW used public and private resources to launch a toll-free welfare information hotline. Dialing 1957 on a mobile phone or landline provides access to a single entry for welfare consultations, reporting, and referrals.

1. Operation of the welfare consultation hotline was commissioned by the Taiwan Fund for Children and Families(CCF) on September 1, 2010. CCF employs 35 professional social workers (including one administrator) who, from the hours of 8 am to 10 pm, offer daily consultations and assistance to people facing hardships or in need of welfare.
2. In 2011, a reporting system that integrated the welfare information hotlines with municipality and county (city) government channels was developed. When responders receive a call that requires reporting or referral, they use the system to notify local social welfare departments. After accepting the case, the departments dispatch social workers for visits or related services. A hotline knowledge bank was also created that consolidates welfare and safety network resources and links to related occupational safety, suicide prevention, school safety, and public security networks. By consolidating resources, central and local governments have built strong social safety nets with multiple levels of protection.
3. From 2010 to the end of December 2015, there were 335,242 calls to the welfare information hotline. Reports issued to municipal or county (city) governments in 2,238 cases (in 2015, there were 64,203 calls, with 477 cases reported to municipal or county [city] governments).

Figure 9-5 Number of Volunteers, 2012 - 2015



Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

10 Protective Services and Prevention of Gender Violence

Central Value of the Department of Protective Services, MOHW is to protect safety of women and the vulnerable. Major duties under the central value include prevention of domestic violence, sexual assault, and sexual harassment; protection of the elderly, the disabled, children and youth; and prevent children and youth from sexual transactions. Treatment Service of offenders is assigned to the Department of Mental and Oral Health. By working together, these two agencies consolidate social welfare and health professionals into an integrated model.

Chapter 1 Prevention of Sexual Harassment and Gender Violence

Section 1 Sexual Harassment Issues Analysis

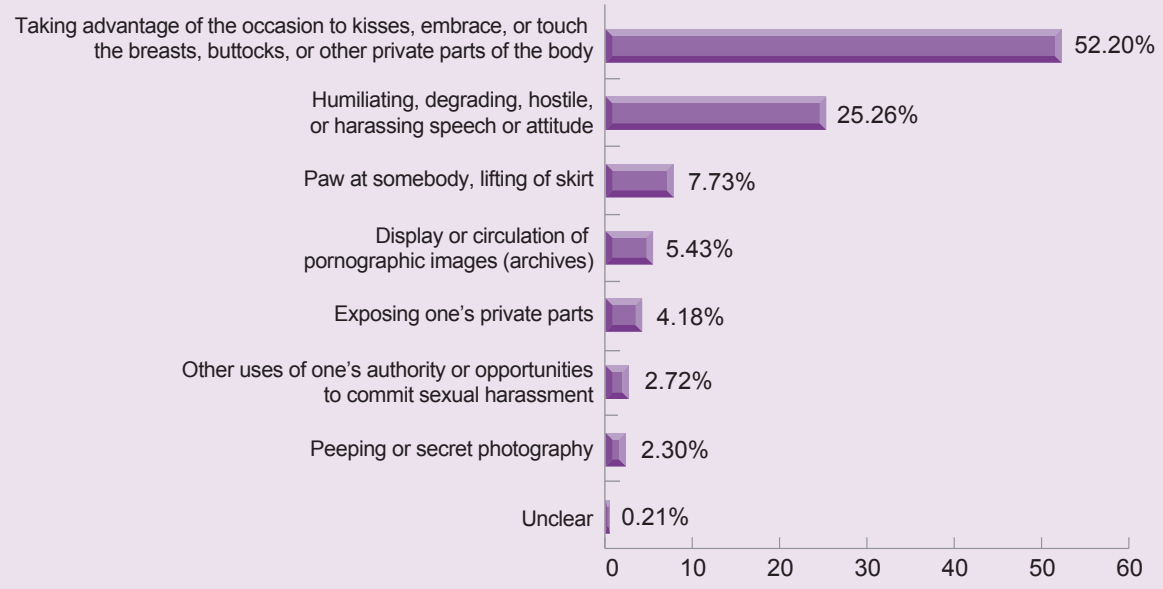
The Sexual Harassment Prevention Act was promulgated on February 5, 2006. In 2015, a total of 651 sexual harassment complaints was investigated (430 established, 95 unestablished, and 126 others). Most of the cases were investigated by police departments(81.7%), followed by the agency or organization which the offender affiliated with (16.9%). The total number of cases increased by 18.4% compared to the 550 cases investigated in 2014 (383 established, 72 unestablished, and 95 others).

Around 98.7% of the victims were women and 93.8% of the offenders were men. The two major types of relationships were "strangers" accounting for 71.63% followed by "friends" accounting for 7.2%. The most common place of infraction was "public areas," accounting for 50.7%, followed by "through technological equipment (such as the internet, cell phone text messages, etc.)" accounting for 16.7%. The main behavioral patterns, accounting for 52.2% were "taking advantage of the occasion to kisses, embrace, or touch the breasts, buttocks, or other private parts of the body." This was followed by "humiliating, degrading, hostile, or harassing speech or attitudes "accounting for 25.26% (Figure 10-1).

Section 2 Quality of Sexual Harassment Prevention and Education

1. "Sexual Harassment Prevention Digital Learning Material– Solving Sexual Harassment Myth": In 2015, the MOHW posted the completed "Solving Sexual Harassment Myth" digital learning material on the Taiwan eLearning Center website. The material explains sexual harassment prevention

Figure 10-1 Types of Sexual Harassment Appeal Cases, 2015



Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

concepts, the responsibility of venue proprietors, and procedures for handling complaints and investigations.

2. Improving Quality of Sexual Harassment Investigations and Mediation: The plan completed sexual harassment investigation training standards, recordkeeping standard forms and a practical operations manual for investigations and mediation. These contributed to establish a training and human resources data bank for sexual harassment investigators.
3. Subsidizing 11 local governments to conducted "the competitive plan of constructing sexual harassment prevention service system." The plan provided 720 legal and psychological consultations; 64 professional training sessions; 1,048 mass media reports; 489 community promotion activities; and 1,502 on-site reviews. In order to further discussion of the systems, the MOHW held a demonstration and invited the Keelung, Changhua, Hsinchu, Chiayi County, and Kaohsiung governments to share experiences. There were 110 persons from National Police Agency, NGOs, local governments to participate the demonstration.

Section 3 Prevention of Gender Violence

1. Taiwan Against Gender-Based Violence (TAGV) Website and TAGV Newsletter: By 2015, the TAGV website contained 17,029 volumes of data and had exceeded 2.34 million hits and nine issues of the TAGV newsletter had been published. Website users can browse the multimedia section to search for videos on topics such as prevention of domestic violence, sexual assault, and sexual harassment as well as protection of children and youths. The videos can be uploaded onto social media sites to further promote the prevention of violence.
2. The Second Annual Purple Ribbon Awards: On November 20, 2015, the second annual Purple Ribbon Awards were held to honor workers who made outstanding contributions in protecting against gender violence. There were 17 winners in categories such as social administration, police administration, health, education, the justice system, the internet, creative organizations, and special contributions.

Section 4 Inter-Departmental Network Integration

1. Constructing the Inter-departmental Communication Platform: In 2015, 8 group meetings and preliminary meetings that aimed to prevent domestic violence and sexual assault prevention Initiative Committee was convened. Attendees reviewed the current state of gender violence prevention and protection networks and suggested ways to improve multi-disciplinary network coordination and intervention strategies.
2. Gender Violence Prevention and Protection Consensus Camp: The April 2015 camp was joined by workers involved in the prevention of domestic violence, sexual assault, and sexual harassment; people who assist with the disabled, protection of children and youth, and the ending of sexual exploitation against children and youth; local and central protection network staff responsible for offender intervention; and NGOs. A total of 260 participants participated in the discussion of key topics and the future direction of protective services.

Chapter 2 Prevention of Domestic Violence

Section 1 Status of Domestic Violence Services

The Domestic Violence Prevention Act promulgated on June 24, 1998. There are approximately 100,000 domestic violence cases reported with an average yearly increase of about 10%. In 2015, there were 95,818 reported domestic violence victims, 6.6% of whom were suspected of or confirmed as handicapped. A majority of cases involved violence between intimate partners, with 49,709 reported victims (86% were female), and was followed by harm toward children and adolescents with 17,386 victims (53.2% male), violence between other family members with 17,216 victims (58% female), and elderly abuse, including children by blood who abused parents over or under 65 years of age, with 11,057 victims (60.5% female) (Figure 10-2). Municipality and county (city) governments provided protection more than 1.41 million times and paid more than NTD690,040,000 to defray costs associated with

emergency shelter, emergency living assistance, psychological rehabilitation, health care, legal fees, and other services.

The amendment of the Domestic Violence Prevention Act that was announced on February 4, 2015. A total of 33 articles were amended (including revisions to 25 articles and the addition of eight new articles). Major changes were as follows:

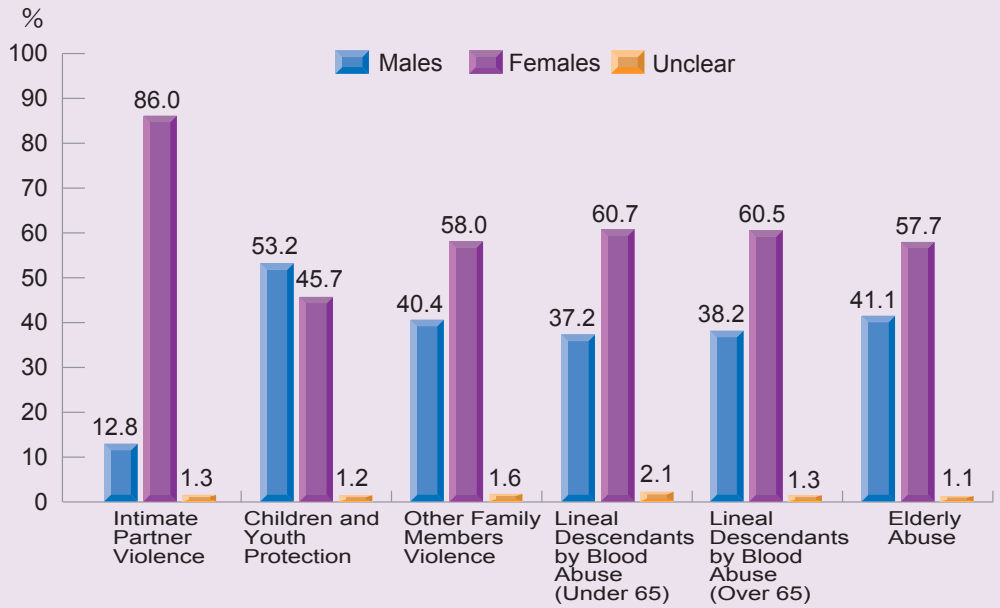
1. Children, adolescents, who were witnesses to domestic violence and intimate partners who does not live with were included within the scope of persons under protective orders.
2. The period of validity was extended for general protective orders and limits on the number of extensions were abolished.
3. Stipulated that the central competent authority "established," funding to strengthen the prevention of domestic violence and sexual assault.
4. The media was restricted from reporting or documenting identity information of victims or their underage children in order to protect the victims' right to privacy.

When a respondent is no longer bound by judicial authorities, the judiciary must immediately notify county or city police administrations and the Center for Prevention of Domestic Violence and Sexual Assault so the victim can be notified.

Section 2 Diverse Intervention for Victims of Domestic Violence

1. Funding for Plans in collaboration with NGOs by Local Governments: Social welfare subsidies from the public welfare lottery are used to help local governments join NGOs in carrying out domestic violence prevention programs. Assistance granted in 2015 included 328 cases of mid- or long-term shelter, with 601 beds provided. Legal or welfare consultations and court escorts were provided 122,790 times by 19 domestic violence centers affiliated with district courts. Subsidies of more than NTD56.46 million for another 89 plans supported direct services to victims, domestic violence prevention in indigenous villages and communities, employment assistance, and guidance for children and youth who witnessed domestic violence. The MOHW helped local governments apply to use the Foreign Spouse Care and Guidance Fund to carry out plans for protecting new immigrants, including

Figure 10-2 Reported Victims of Domestic Violence by Gender, 2015



Victim's Gender = Number of victims of a particular gender/total victims * 100%
Example: Violence between intimate partners, ratio of female victims = 42,725/49,709 * 100% = 86%

Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

applying to use NTD4.54 million to pay for legal proceedings, emergency living fees, and rent subsidies.

2. Promoting the "Safety and Protection Network against Domestic Violence":

(1) Convened regular review meetings to survey the state of each municipality and county (city) government's implementation of the Domestic Violence Safety and Protection Network Plan and investigate common or systematic problems that each of the central administrations face.

(2) A multi-faceted evaluation index was developed for removal of high-risk cases from the Domestic Violence Safety and Protection Network. Network members use the index to objectively evaluate risk factors of high-risk cases then determine whether removal is appropriate. New Taipei, Taichung, Yunlin, Kaohsiung, Pingtung, and Hualien were selected as the sites of a trial plan that was carried out from November 2015 to April 2016.

(3) By December 2015, the Taiwan Intimate Partner Violence Danger Assessment (TIPVDA) was being applied to 94% of reported domestic violence cases.

Section 3 Intervention for Domestic Violence Offenders

1. Advocating Civil Protection Orders in Offender Intervention Plans and Advising Local Governments on Plan Implementation: In 2015, intervention was provided to 4,138 people, 1,488 of whom already completed the program. The intervention rate was 100% when excluding offenders who died, were incarcerated, or had protection orders cancelled.

2. Preventive Services for Domestic Violence Offenders

(1) The 0800-013-999 male hotline was established in 2004 to consult men in domestic conflicts and reduce the risk of violence. In 2015, the hotline received 19,399 calls and provided services on 17,253 calls, including 8,309 in-depth discussions and 8,936 general consultations.

(2) Surplus from the public welfare lottery subsidize domestic violence offender prevention plans, which are co-handled by local governments and NGOs and include direct guidance for offenders, case management, follow-up, and professional training. In 2015, there were 26 plans subsidized, with total subsidies of NTD26.8 million and services provided 23,259 times.

Section 4 Quality of Domestic Violence Prevention and Education

1. Strengthening Cooperation Mechanisms for the Domestic Violence Prevention Network: In 2015, three meetings were convened to discuss 18 serious domestic violence cases. In each case, violence had resulted in serious injury or death. Discussion centered on the state of operations of the domestic violence prevention network and recommendations to improve inter-professional coordination and intervention strategies.

2. Development of Victim Assessment Guidelines: In order to improve the professionalism and knowledge of social workers who handle domestic violence cases, in 2015 the MOHW developed new assessment and intervention guidelines for victims of intimate partner violence and new assessment and guidelines for children and youth who witnessed domestic violence.

3. Improving the Quality of Local Domestic Violence Safety Protection Network Plans: Two implementation and review meetings were held to gain a better understanding of the state of domestic violence protection network plans underway in 2015 in each city and county. For shared problems, participants cooperated on devising strategic solutions. The MOHW also held one administrative lecture attended by 200 protection network members, including police officers, social and health agency workers, educators, prosecutors, and legal officials. Each initiative improved professional capacity of network members.

4. Strengthening the Professional Knowledge of Domestic Violence Prevention Workers: In 2015, to further advance domestic violence prevention, the MOHW conducted preliminary training of social workers and held administrative seminars. Total attendance by senior social workers and directors from local governments and NGOs were 280.

5. Improving Professional Capacity of Elderly Protection Workers: The MOHW and professional organizations joined to hold preliminary and advanced training and case seminars on topics related to protection of the elderly. Total attendance at the training sessions was 219.
6. Raising Community Prevention Awareness: In order to promote awareness of zero tolerance for violence and to cultivate early anti-domestic violence concepts among men, young adults, and youth, the MOHW called for creative anti-violence submissions in 2015. Events encouraged people to contribute based on the themes of "neighborhood action – stopping domestic violence in the community" and "digital creativity – preventing intimate violence." At a ceremony on November 28, 11 award-winning submissions for the first theme and 10 nominees for the second theme were honored.

Chapter 3 Prevention of Sexual Assault

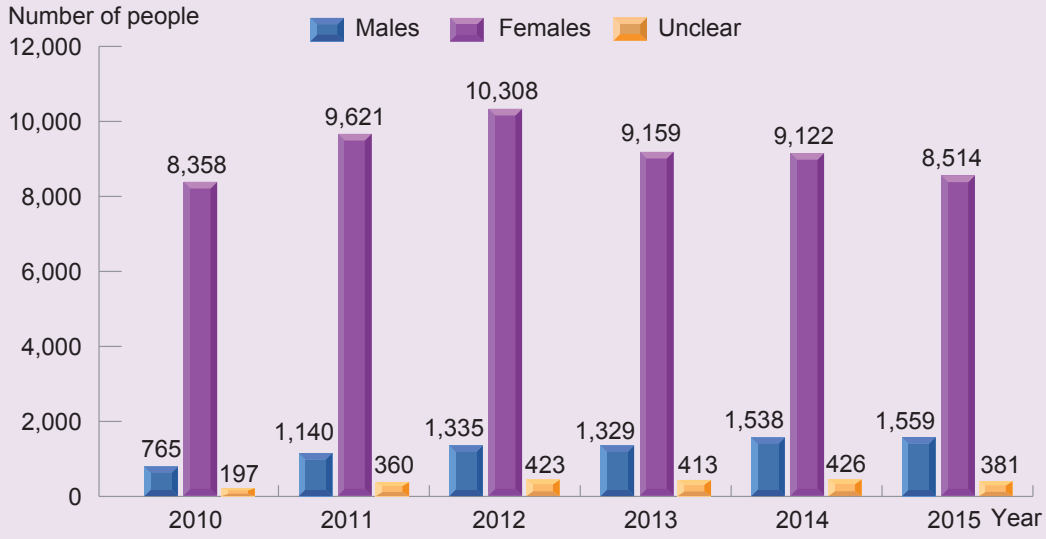
Section 1 Status of Sexual Assault Services

Following enactment of the Sexual Assault Crime Prevention Act on January 22, 1997, there have been approximately 13,000 cases of suspected sexual assault reported each year. In 2015, there were 10,454 reported victims of sexual assault. Details of the victims and alleged perpetrators of these acts follow:

1. In 81% of the reported sexual assaults, the victim knew the perpetrator and 57% of cases occurred in private locations.
2. About 81% of the victims were women (Figure 10-3) and 54% were between the ages of 12 and 18. About 85% of the suspects were male and 36% were between the ages of 12 and 24.
3. There were 1,116 victims, or approximately 10% of the total, who were either confirmed or suspected of being disabled.
4. The most common relationships were (ex) boyfriends and girlfriends and direct or collateral blood relatives, comprising 37% of total cases. The second most common relationships were classmates (10%), general friends (8.7%) and online friends (6%).

   In 2015, domestic violence and sexual assault prevention centers operated by municipal and county (city) governments provided protection and support services to sexual assault victims, including shelters, reporting and investigation accompaniment, economic support, injury diagnosis and treatment, legal support, psychological counseling, and school transfers and enrollment. The centers assisted

Figure 10-3 Sexual Assault Cases Over the Past Five Years, by Gender



Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

people 121,587 times and spent more than NTD113,530,000 to support victims.

Section 2 Reporting System and Information Platform

1. Mandatory Reporting and Systems for National Protection Information and Case Management Procedures: In addition to an "e-Care" program and a system to follow up sexual assault cases, prevention network workers have access to an information-sharing platform.
2. 113 Protection Hotline: In 2015, there were 147,105 valid calls received, including 9,534 calls to report violence between married, divorced, or cohabited couples; 9,812 calls to report abuse of children or youth; and 747 calls to report sexual assault.
3. Diverse Reporting Channels: In 2015, there were 138,962 cases of domestic violence, sexual assault and child abuse reported online and 1,207 online consultation cases. Text messaging was added to the 113 protection hotline to enable the hearing and speech impaired to request help. The messages are answered by professional hotline workers to confirm the safety of the sender.

Section 3 Diverse Intervention for Victims of Sexual Assault

1. Protection and Assistance for Victims of Sexual Assault: The MOHW has established standards for services and subsidies in sexual assault cases. In accordance with regulations, it guides protection centers in providing emergency assistance, health diagnoses and treatment, examinations and evidence gathering, emergency placement, psychological therapy, and legal consultations. In 2015, domestic violence and sexual assault prevention centers operated by municipal and county (city) governments assisted people more than 120,000 times and spent more than NTD100 million to support victims.
2. strengthening Sexual Assault Prevention Among Men and People with Learning Disabilities: By fostering inter-disciplinary communication and effective training, a sexual assault case management resource center program enabled use of professional resources to improve interventions for men and people with learning disabilities who were victims of sexual assault. The program also advanced prevention policies and planning. In 2015, it provided service to people 924 times.
3. Review Meetings for Major Sexual Assault Cases: In 2015, there were three meetings convened to discuss 10 cases. Participants reached resolutions on guidelines for administering HIV prevention drugs to victims of sexual assault as well as designated hospitals and treatment channels; adding fugitives suspected of sexual assault to wanted lists; procedures for municipal and county (city) governments to handle notices issued by district prosecutors of sexual assault offenders leaving designated areas or persons; and improving sex education among people with learning disabilities. Members of the protection network were asked to strengthen handling of cases.
4. Improving Evidence Collection and Testing Quality in Cases of Sexual Assault: In 2015, samples were collected and tested from 3,514 victims of sexual assault. In 1,736 cases, the samples were sent to the Criminal Investigation Bureau for further testing and collection of evidence.
5. Promoting the Relieving Victims of Sexual Assault from Repeated Statements Program: In 2015, measures were taken to relieve 1,617 sexual assault victims from making repeated statements. Coordination of police, public prosecutors, social workers, and medical care teams improved the quality of questioning and prevented victims from the repetitive statement of their painful experiences. District prosecutors investigated 4,677 cases of sexual assault in 2015 and issued indictments in 2,066 cases, for an indictment rate of 44.2%. In 1,779 of the cases, the court found the defendant guilty, for a conviction rate of 86.6%.

Section 4 Intervention for Sexual Assault Offenders

1. The MOHW oversaw compulsory therapy for sexual assault offenders who had completed criminal prison sentences. At the end of December 2015, there were six medical institutions designated to handle compulsory therapy (Tsaotun Psychiatric Center [MOHW], Tsaotun's Dadu Villa [MOHW], Jianan Psychiatric Center [MOHW], Kai-Syuan

Psychiatric Hospital, Taipei Veterans General Hospital Yuli Branch, and Taichung Prison's Pei Teh Hospital).

2. Community intervention provided for sexual assault offenders. In 2015, a total of 6,559 offenders underwent therapy and counseling, including 1,594 offenders who completed the intervention and 4,050 who were still undergoing intervention. There were eight offenders referred for compulsory therapy, 551 who did not complete therapy due to explained excuses, and 356 punished for failure to show.

Section 5 Quality of Sexual Assault Prevention and Education

1. Training of Sexual Assault Prevention Social Workers: In 2015, nine training sessions benefited a total of 520 social workers. The training was stratified into basic, advanced, and supervisory levels and focused on issues related to child sexual assault victims, especially counseling skills for children's physical and mental development.
2. Scheduling Control for Child Sexual Assault Cases: Using the National Domestic Violence, Sexual Assault, and Children-Juvenile Protection Information System, social workers received regular reminders of the legal processing period for child protection cases they oversaw.
3. Professional Intervention Training: In 2015, the education and training of social workers who provide professional intervention for sexual assault offenders were listed as the core task for the teaching hospitals in the Psychiatry and Medicine Network Regional Plan. One foundational and nine advanced classes were held with the total attendance of 407 people.
4. Promoting Community and Campus Prevention Education: The MOHW holds competitions and calls for submissions to promote sexual assault prevention. Participants propose ideas for preventing sexual assault for special groups, such as children and adolescents, indigenous people, and the disabled, or work with NGOs to promote the community-based sexual assault prevention activities. In 2015, there were 13 subsidized projects that reached people 1,226,488 times, including males 612,601 times and females 613,887 times.

Chapter 4 Children and Youth Protection and Sexual Exploitation Prevention

Section 1 Protection of Children and Youth

1. Mandatory Reporting System: In 2015, municipal and county (city) governments assisted 9,604 abused children and youths, including 4,649 males (48%) and 4,955 females (52%). There was a 17% reduction compared to 2014, when there were 11,589 abused children and youth (5,304 males and 6,285 females).
2. In accordance with an amendment to The Protection of Children and Youth Welfare and Rights Act announced on February 4, 2015, and an amendment to the "Regulations for Reporting, Differential Processing and Investigating Cases of Children and Youth Protection" announced on August 5 of the same year, municipal and county (city) governments are instructed to rank children and youth protection cases based on urgency and category. By determining which cases require urgent intervention and facilitating individualized service, the rankings raise the professionalism of workers in children and youth protection.
3. Supervising Children and Youth Protection by Municipal and County (City) Governments: In 2014, three group meetings were convened for major children and youth abuse prevention incidences to review a total of 27 cases. Resolutions included implementation of active care mechanisms for disadvantaged children under the age of 6 and early detection of children in need of assistance and protection. Local governments were urged to continue to strengthen cooperation between health and medical care, legal, police, and education agencies, in order to provide a better safety net.
4. Improving Professional Training and Practical Seminars for Social Workers Specializing in Children and Youth Protection: In February 2015, two beginner training seminars were held and attended by 106 people. Another 167 social workers and supervisors attended 12 meetings on policy-making models and outside supervision of children and youth protection safety evaluations. In December 2015, 230

people attended a practical seminar on inter-disciplinary integration of children and youth protection services.

Section 2 Health Care for Children and Youth

1. Children and Youth Protection Health Care Demonstration Centers: In 2015, health care services, post-discharge follow-up consultations, and social welfare assistance were provided on a case-by-case basis by integrating inter disciplinary teams within hospitals and various agencies and organizations outside of hospitals. As of the end of December 2015, these services were provided 990 times.
2. Strengthening Services for the Offenders in Children and Youth Protection Cases: The MOHW's "Management Information System of Psychiatric Care," "Suicide Prevention Notification System," and "Protection Information System" were linked to efficiently access case information and related offender's information in order to accurately assess risk of child abuse.

Section 3 Children and Youth Sexual Exploitation Prevention

1. Amending the Child and Youth Sexual Transaction Prevention Act: An amendment announced by presidential order on February 4, 2015, changed the name of the act to the Child and Youth Sexual Exploitation Prevention Act. Other major revisions were as follows:

(1) Expanding Scope of Protection: In addition to the scope of the original definition of sexual exploitation, which was "causing a child or youth to engage in sexual intercourse or obscene acts in exchange for monetary or other considerations," the term was expanded to include "causing children or youth to engage in sexual transactions or obscene behavior for others to watch," meaning using children for sexual performances to be viewed by others. The scope of sexual exploitation also includes filming or producing any other materials involving child or youth in sexual acts. The original specifications for the enforcement of regulations regarding using children or youths for sexual service jobs such as hosts/hostesses or for services, tour escorts and singing or dancing companions, that involve sexual activities were also added to the scope of protection in the Act.

(2) Evaluation of Placement Needs for Victims: In contrast to current practices that are based on the possibility of re-engaging in a sexual exploitation, the needs for placement will depend on the evaluation of professional social worker.

(3) Authorizing the Government to Supervise Parental Duty on Children or Youth: After a child or youth victim returns home, competent authorities are required to follow up for at least one year or until the victim reaches the age of 20. If necessary, the parent or guardian of the child can be required to take eight to 50 hours of compulsory parental education.

(4) Increasing the Scope and Severity of Criminal Responsibility for Illegal Behavior: Penalties and fines were increased for paying to watch children or youth engaging in sexual intercourse or obscene acts or using children or youth for sexual service jobs such as host/hostess or sexual escort, singer, or dancer. When an offender is imprisoned, the competent authority is required to provide rehabilitation.

2. Implementation Results:

(1) Aid to Victims from Judicial Officials and Police: In 2015, emergency shelter was offered to 308 people, including placement of 279 people in short-term shelters.

(2) Victims Placed in Transitional Schools (Total of Five Schools) on Second Ruling by the Court: In 2015, 355 students were placed in transitional schools.

(3) Victims Placed in Welfare Institutions on Second Ruling by the Court: In 2015, 35 institutions provided placement services 103 times.

(4) Follow-Up and Assistance for Victims: In 2015, services were provided to 366 victims. Counseling was provided to 440 offenders.

3. Children and Youth Sexual Exploitation Prevention Oversight Committee: Two oversight committee meetings were held in January and August 2015 in order to review performance by related agencies and discuss improvement strategies.

4. Children and Youth Sexual Transaction Prevention Activities: In 2015, the MOHW

cooperated with NGOs to conduct prevention advocacy and training. It also held explanatory meetings following passage of the Child and Youth Sexual Exploitation Prevention Act and revised related workbooks. Total subsidies were NTD7.5 million.

5. Production of Educational Materials and Multi-media Promotion: Using the three themes of "putting an end to juvenile pornography and prevention of sexual exploitation of children," "alcohol, tobacco, betel nut, and other harmful substances shall not be provided to children and youth," and "the promotion of internet safety for children and youth," 30-second short promotional films and broadcast tapes were made in order to prevent children and youth from being exposed to sexual violence and undesirable substances.

Section 4 Internet Safety Mechanisms for Children and Youth

1. Procedures and Principles for Handling Online Content Violations Relating to Children and Youth: In August 2015, revisions were completed to the procedures and principles which social administration authorities use to handle online content violations relating to children and youth. These are used by the Institute of Watch Internet Network (iWIN) during case assignment and by municipal and county (city) governments when intaking, handling, and closing cases.
2. Guiding Municipal and County (City) Governments on Using iWIN for Case Assignment: In 2015, two meetings were convened to discuss iWIN's assignment of cases relating to children and youth violations. Resolutions required iWIN to build a database for domestic false domain registrations, to define what it means to harm the physical or mental health of children and Youth, to set standards for evaluation order of iWIN case assignment, and procedures and principles for police to report transfers to social administration officials for those suspected of violating Articles 29 and 33 of the prevention act. Of the 6,785 complaints filed, 92.9% involved pornography or obscenity, including 4,142 which had foreign IP addresses and 1,433 which had domestic IP addresses. Social administration agencies were assigned to 985 cases.
3. Preventing Children and Youth from Accessing Harmful Internet Content: In order to protect children and Youths' rights in the digital world, the MOHW conducts advocacy events and seminars, produces instructional materials and promotional videos, and establishes safety websites. A total of 3,156,000 in subsidies has been provided to seven NGOs.
4. Children and Youth Internet Safety Project Development Plan: In order to have a basis for future policy planning and legal amendments, the MOHW gathers information from Taiwan and abroad on internet content, rules governing internet institutions, and online app rating management.

Section 5 Long-Term Employment for Social Workers Specializing in Protective Services

1. Program to Boost Deployment and Staffing of Social Workers by Local Governments: Subsidies continued for local governments to staff social workers who specialize in children and youth protective services. In 2015, subsidies totaling NTD146 million supported 508 social workers.
2. Staff Planning Reviews for Social Workers Specializing in Protective Services: Since 2014, annual staff planning reviews and reports for social workers specializing in protective services have been required. Using the "Quality Assessment and Improvement Plan for Social Workers Specializing in Protective Services," the MOHW oversees efforts by municipal and county (city) governments to improve quality assessments of social workers in their jurisdictions.
3. Ending Shortages of Social Workers Engaged in Protective Services: According to municipal and county (city) government statistics on social workers engaged in Children and Youth protection and the prevention of domestic violence and sexual assault, public agencies employed the equivalent of 966 such social workers in 2015 and commissioned NGOs to employ another 590. There was a total of 1,556 social workers engaged in protective services, which reached the MOHW's desired threshold and showed that improvements had been made for social worker shortages.

11 Research, Development, and International Cooperation

Chapter 1 Science and Technology Research in Health and Welfare

In 2015, the MOHW's budget for technological development was NTD4,193,176,000 (Figure 11-1), an amount that accounted for approximately 3.07% of the total budget. Funding was primarily invested in policy-based empirical research in the areas of food and drug management, communicable disease monitoring, and disease control; building an environment advantageous to development of the drug and health industries; and biomedical technology. There was a total of 817 projects or grants for research programs.

Section 1 Mission-Oriented Research

1. Communicable Disease Preparedness

(1) A Fast Screening Reagent for Dengue Fever: A fast point-of-care reagent was developed that combined dengue fever antibodies and antigens. It is convenient to use and more sensitive than commercial brands. In the future, this reagent could become available to more front-line disease control workers through a technology transfer.

(2) Monitoring and Investigation of Foodborne Diseases: Work focused on the four main causes of foodborne diseases in Taiwan: norovirus, rotavirus, salmonella, and campylobacter. Cross-departmental cooperative mechanisms, spatial and temporal pathogenic monitoring and warning systems, cross-departmental information sharing platforms, and automatic reporting systems for laboratories automatic reporting systems(LARS) were built to speed up responses.

2. Public Health Promotion

(1) Healthy Birth and Growth: Intervention Program for Vision Care in Lower Grade School children shows that outdoor activities reduces the incidence of myopia and slows the progression of myopia among those already affected. Spending at least 200 minutes a week for sunlight exposed and at least 11 hours of outdoor activities a week was shown to reduce the incidence rate of new cases of myopia in students by 49% and 55%, respectively; while for those already affected, it was seen that over the course of one year, it could reduce the progression of myopia by 0.12 dioptre

Figure 11-1 Yearly Technological Research Budgetary Trends and Variations

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

and reduce the axial length elongation by 0.04mm. The results of this study were similar to an international study which showed those outdoor activities for 10 – 14 hours a week can prevent myopia among children.

(2) Healthy Ageing: An instrument to assess health literacy among diabetes patients in Taiwan and a health literacy screening tool for cancer patients were developed. Using social platform to enhance elderly obtain relevant resources and services.

(3) Building Healthy Lifestyles and Environments: "Models for promoting physical activity in the workplace" were developed. The intervention programs were conducted according to the recommendation of WHO Healthy Workplace Model report, and workers are advised to overcome their lack of physical activity. Healthy workplace certifications are included as part of a comprehensive workplace health promotion strategies.

3. Food and Drug Administration

(1) Development of Food Testing Techniques

a. There were 37 new food testing techniques announced to the public. Also, there were 15 rapid testing methods and 25 commercial testing kits that were validated.

b. Pioneering new methods for identifying fish types in fish floss were used to determine label accuracy and lower incidence of adulteration and fraud.

c. New techniques were developed for assessing whether food contains illegal additives, such as the determination of illegal dyes in dried bean curd and the determination of unknown chemicals in durian imported from Thailand.

d. New methods to test for the phytosterols and 3-monochloro-1, 2-propanediol in edible oil were developed in order to determine the recycled oil (gutter oil) and eliminate illegal oil products.

(2) Development of Drug Technology Research

a. In order to promote the quality of vaccines in Taiwan, the potency evaluation platform of EV71 subtype C4 for EV71 vaccines and potency assay for rabies vaccines for human use were developed to ensure the safety and effectiveness of vaccination.

b. In response to a rise in drug abuse, a quantitative analysis method used for 35 synthetic cathinones and 3 PCP analogues in urine samples was developed, as an important basis for drug prevention and strategy.

(3) Better Research, Development, and Promotion of Chinese Medicine and Pharmacy

a. In order to promote standardization of Chinese medicine terminology and improve diagnostic accuracy, terms used to describe 60 symptoms and diagnoses of 60 diseases were compiled into a handbook.

b. An editorial committee established to publish the supplement edition of Taiwan Herbal

Pharmacopeia. In 2015, the research achievements were 20 kinds of Chinese medicine materials standard ingredients including aloe and 58 kinds of Chinese medicine as well as testing method confirmation, development, and alternative research.

4. Health Care System Advances

(1) In 2015, in response to emergency health care needs, the MOHW revised Taiwan's five-level triage and acuity scale and then issued a new review mechanism, checklist, and standalone computer version. It produced a 30-second promotional video to familiarize the general public with triage procedures and provided additional training to emergency health workers in order to improve both triage and health care quality.

(2) Digital IC Technology: At the end of 2015, 55 health centers and 140 health rooms in aboriginal villages and on outlying islands had broadband speeds of at least 12M.

(3) Disaster prevention and response methods at general nursing homes were improved by completing comprehensive disaster risk analysis, custom guidance and improvement plans, and a draft version of response guidelines.

5. Optimization of National Health Insurance system

(1) Smart Environments and Administrative Effectiveness: Besides using "NHI PharmaCloud" system to improve prescription safety, the MOHW popularized a digital payment and collection mechanism for NHI premium and expanded service platforms and digital convergence to raise service quality. Other advances included modules to monitor supplementary premium, review procedures for electronic health records, and platforms for inter-departmental sharing of NHI data. Procedures were simplified and administrative efficiency was improved.

(2) Integrated Plans to Raise Medical Care Service Quality: Analyzed and researched NHI payment standards and items, including the adoption of new medical techniques and treatment items, the effectiveness of drugs and medical devices already covered under NHI, and the impact of the International Classification of Diseases (ICD-10-CM/PCS). Evaluate results of the post-acute care pilot program and built a pay-for-performance mechanism for cancer treatment.

6. Better Mental and Oral Health Monitoring

(1) National Mental Health Investigation Plan (2015 - 2018): Preliminary research shows that when compared to the general adult population, the elderly are happier and have more positive emotions, a greater sense of self-actualization, a better understanding of their environment, and fewer lifestyle goals. A survey design was already completed for adolescents, adults, and the elderly and recommendations have been made for a formal investigation.

(2) Oral Health Survey for Adults and the Elderly (2015 - 2016): First-year results showed that the prevalence of tooth decay among adults and the elderly was 99.1%. Of those with tooth decay, 43.5% had not sought treatment, 85.6% were missing teeth, and 0.8% had no teeth. The periodontitis rate was 80.48%.

(3) Commissioned Research on the Post-Community Intervention Recidivism Rate of Different Types of Sexual Assault Offenders and the Effectiveness of Intervention (2015 - 2016): Completed a study on domestic community intervention status (including the protection information system database, statutory meetings, utilization of community intervention and analysis tools, and recidivism risk factors). Findings were used to analyze the five-year recidivism rate of different types of sexual assault offenders.

(4) Establishment of the Taiwan Mental Health Information Service and Multi-Faceted Study Platform (2015 - 2017): Completed website environment infrastructure, a national mental health service resource map, and 50 mental health articles.

7. Gender Violence Prevention and Protection Services

(1) Research on Establishing Gender-Based Violence Prevention Indicators: In 2015, the network indicators including social, healthy, policing, justice and educational areas has been established. Moreover, has accomplished the

questionnaire design of public beliefs towards gender-based violence, and announced the research results in November.

(2) Structured Decision-Making Model for Child and Youth Protection: Besides developing a long-term treatment model that focuses on the family utility and function, in 2015 the MOHW cooperated with a US child research center to develop a structured decision-making model suited to Taiwan. Included is a suite of assessment instruments that can determine the risk of children being subjected to repeated abuse and neglect. Social workers also have access to a management information system to evaluate family function and build an integrated treatment plan based on the strength and need of the family.

8. Improvements to Emergency Relief Systems

In 2015, development of an integrated system for emergency relief information was completed. The system, which combines central and local emergency relief data and vertically and horizontally links township/county (city) hall and MOHW emergency relief data, expedites data retrieval procedures while improving relief efficiency.

9. Improvements to Welfare Services for the Elderly

(1) Advances to community care points included the completion of resource inventory, service capacity estimates, and resource integration service models as well as the proposal of diverse innovative service items and operation models.

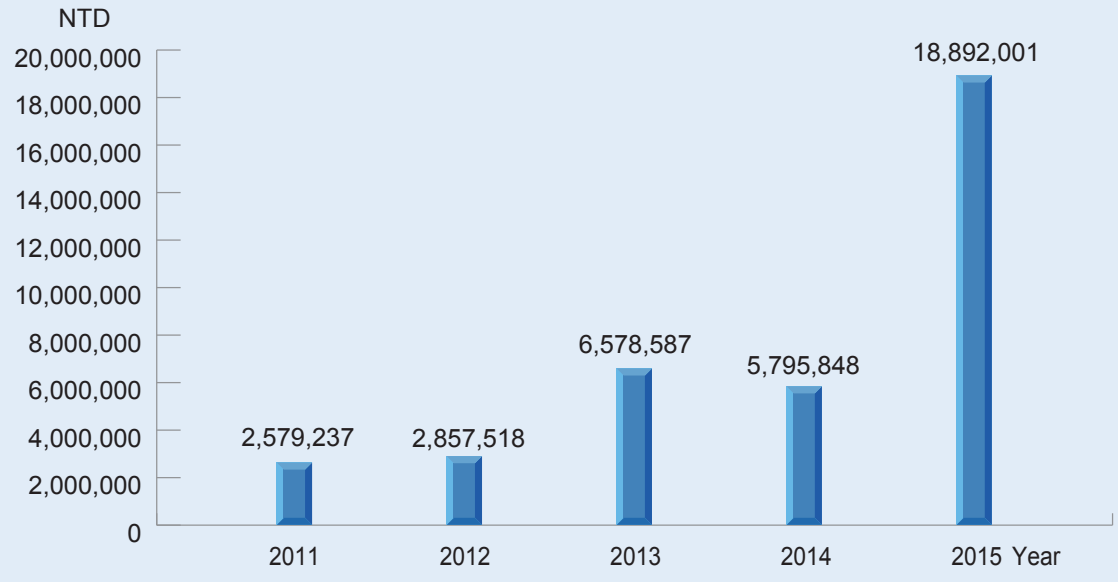
(2) A Long term care application information network provides fast and convenient service channels to the general public. A cross-system integrated interface and service orientation framework simplifies service procedures and raises information competence to improve overall platform effectiveness.

Section 2 Translational Medicine and Industrial Research and Development

1. Technology Transfer and Licensing

In 2015, there were seven cases of technology transfers granted for R&D results in basic and applied biomedical research, earning a total revenues of NTD18,892,001 (Figure 11-2).

Figure 11-2 Annual Trends of R&D Income



Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

2. To Promote Innovation and Competitiveness of Clinical Trials Project

(1) To Promote IRB Review Efficiency for Multicenter Clinical Trials: the c-IRB review mechanism was established for clinical trials of drugs. There were 160 cases completed with an average review period of 10 days.

(2) MOHW grants six clinical trial centers. The results are as follows. National Taiwan University Hospital (NTUH) cooperates with international pharmaceuticals in research and development of new drugs and vaccines in clinical trials. National Cheng Kung University Hospital cooperated with Taiwan Liposome Company to conduct phase II clinical trials to estimate whether TLC388 is an effective and safe second-line therapy for advanced hepatocellular carcinoma. Taipei Veterans General Hospital published Taiwan's first consensus on thrombosis therapy. Taipei Medical University cooperates with Formosa Pharmaceuticals in MPT0E028 small molecule anti-cancer new drug, which has passed IND in Taiwan. Taipei Medical University Hospital and NTUH are planning to work on First in Human clinical trials. China Medical University Hospital leads multicenter clinical trial of cilostazol of Otsuka Pharmaceutical. The result showed the inhibition of arteriosclerosis. Chang Gung Memorial Hospital established imaging center for early diagnosis of Alzheimer's disease.

3. Promoting the Second Phase (2014 - 2017) of the Cancer Research Project (Figure 11-3)

(1) Cancer Therapy and Prognosis

a. Acute Myeloid Leukemia Research: On July 2, 2015, the Hematology Society of Taiwan announced a national consensus on therapy standards for acute myeloid leukemia. Domestic research on leukemia gained global recognition when Taiwan was invited to join a WHO clinical advisory committee on bone marrow diseases that was launched in 2016.

b. Liver Cancer Research: By treating liver tumor with a new transarterial chemoembolization (TACE with DC-Beads loaded with doxorubicin) before liver transplantation, there is a 73% success rate.

(2) Early Detection and Diagnosis

Lung Cancer Screening Study: In this study, low-dose computed tomography was administered to 4,498 non-smokers with lung cancer risks, which resulted in 56 patients who were tested positive for lung cancer and had tumors excised. The cancer detection rate was 12.7/1,000 participants, and 96% of them were stage I lung adenocarcinoma. Our preliminary results were comparable to the US National Lung Screening Trial, which had a detection rate of 5.2/1,000 smoking participants. The efficacy was more effective than standard chest X-ray.

(3) Epidemiology and Prevention

Gastric Cancer: Preliminary results show that the eradication of Helicobacter pylori infection has the potential to decrease the risk of chronic gastritis, peptic ulcers, and the future risk of gastric cancer. The long term benefit can be expected through the screen-and-treat for H. pylori infection that can interrupt the natural progression of gastric cancer carcinogenesis.

4. Biomedical Technology and R&D

(1) Anti-ENO1 antibody has been shown to inhibit tumor growth and can be used in the treatment of multiple sclerosis, rheumatoid arthritis, and sepsis. The MOHW has applied for several patents and technology transferred to a domestic biotech firm in September 2015 for commercial development.

(2) The MOHW has demonstrated that caged Pt nanocluster (NHRI-CPN) exert tumor-inside activation for anticancer chemotherapeutic with minimal systemic toxicity, which minimizes potential side-effects and reduces the burdens on patients. A transfer of related technology transfer is in progress (Figure 11-4).

(3) A pre-clinical study of an H7N9 flu vaccine has been completed, with approval for phase I and II clinical trials granted in February 2015. The following month PIC/S GMP certification was obtained. In April of the same year, the technology was transferred to a domestic manufacture, which has commenced phase I and II clinical trials.

Figure 11-3 Clinical Trial Centers and Cancer Centers

Cancer Research Centers

Koo Foundation Sun Yat-Sen Cancer Center
Tri-Service General Hospital
Chung Shan Medical University Hospital
Taichung Veterans General Hospital
Kaohsiung Medical University Hospital
Kaohsiung Chang Gung Memorial Hospital

Integrated Cancer Research Centers

National Health Research Institutes

Cancer Research Centers and Clinical Trial Centers

National Taiwan University Hospital
Taipei Medical University
Taipei Veterans General Hospital
Linkou Chang Gung Memorial Hospital
China Medical University Hospital
National Cheng Kung University Hospital

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

(4) A phase I clinical trial demonstrated that the anti-diabetic drug candidate DBPR108 is highly active and safe. It has received mainland China's approval for a clinical trial in March 2015, which can accelerate subsequent multi-national, multi-center clinical trials. The MOHW will continue to assist in DBPR108's phase I and II clinical trials to help achieve the ministry's goals of supporting domestic biotechnology industry and expanding the nation's presence in the global pharmaceutical market.

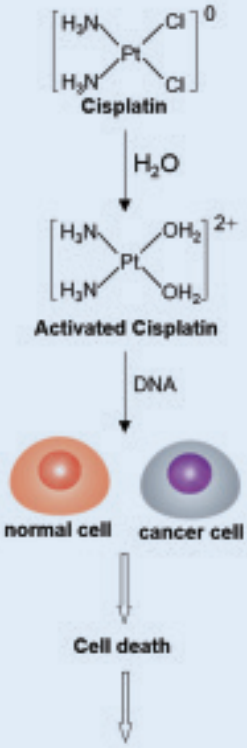
Section 3 Promoting Health and Welfare Data Statistical Applications

1. Management of the Service Platform of Health and Welfare Data Statistical Applications

The Health and Welfare Data Science Center which is a service platform provided through government planning and management began to provide external services in February 2011. The center aims to enhance the quality of public health decision-making, expand academic

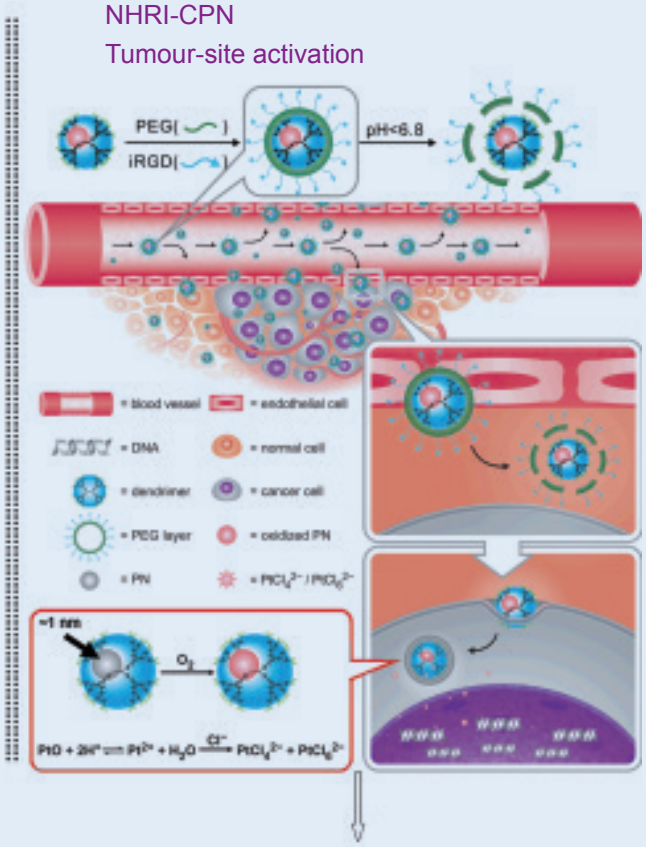
Figure 11-4 Theory and Advantages of CPN Treatment

Cisplatin
(Hydrolysis-dependent activation)



Standard cancer drugs attack both cancer cells and healthy cells, causing significant harm to the patient

NHRI-CPN
Tumour-site activation



CPN treatment only targets tumor cells. Since it bypasses healthy cells, the side effects are milder. The technique has great potential for use on drug-resistant cancer cells

Source: National Health Research Institutes

research, promote the quality of medical care services, and further promote general welfare of well-being. With the support of the Executive Yuan from 2012 – 2015, the goal of the cloud service is planning and expanding health and welfare related databases and actively developing databases for all types of topics. In addition to continuing to strengthen information security management operations in 2015, the center promoted big data applications and establish management review mechanisms.

The center's service system is compliant with all relevant regulations. Applicants can only work in isolated independent areas under limited time, limited place, and limited field area to carry out successive statistical analyses of health data using de-identified and fuzzy methodology. In addition, they can only take out statistical results which have undergone a critical review.

2. Service Content and Volume of the Health and Welfare Data Science Center

(1) In December 2015, 61 databases were open for application. The reference manual for each database was produced.

(2) In order to balance regional academic and research needs, there are six research sub-centers located at Taipei Medical University, National Taiwan University, Kaohsiung Medical University, Chang Gung University, National Yang Ming University, and Tzu Chi University.

(3) The number of ongoing cases gradually roses from 58 in 2011 to 326 in 2015, with an average annual growth rate of 54%. The number of service man-days roses from 676 in 2011 to 5,955 in 2015, with an average annual growth rate of 72%.

Chapter 2 International Cooperation

In response to globalization, Taiwan has been actively participating in international health cooperation and emergency humanitarian assistance. Currently, it has been invited to participate in the World Health Assembly(WHA) as an observer in order to share health experiences and promote public health.

Section 1 Participation in International Organizations

1. World Health Organization

The MOHW was invited to attend the 68th WHA as an observer from May 18 – 26, 2015 in Geneva, Switzerland. Former Health Minister Chiang Been-Huang spoke on the assembly theme, "Building resilient health systems," as well as Taiwan's shared efforts to combat the Ebola virus and the achievements and vision of NHI. Our delegation also attended technical meetings during the assembly and spoke on a record 28 technical topics in five major categories. Taiwan also engaged in bilateral talks with 54 nations and international organizations, including the United States, the European Union, and Japan, in order to promote mutual and multilateral health cooperation.

Former Health and Welfare Minister Chiang Been-Huang spoke at the plenary meeting of the 68th WHA

2. Asia-Pacific Economic Cooperation (APEC)

Former Health Minister Chiang Been-Huang led a delegation to the Fifth APEC High-Level Meeting on Health and the Economy, which took place on August 30, 2015, in Cebu, Philippines. Minister Chiang delivered a keynote speech at the meeting and shared Taiwan's efforts to implement the "health in all policy" concept into communicable disease prevention, emergency disaster response, and chronic disease care. He urged cross-departmental and cross-field cooperation and coordination to respond to future challenges related to health and economic aspects.

The Fifth APEC High-Level Meeting on Health and the Economy.

Section 2 International Exchanges and Assistance

1. International Cooperation and Exchanges

(1) The state of international operations is shown in Table 11-1.

a. Participation in International Conferences

a) In June 2015, Thailand Ministry of Public Health held the 14th Annual International Mental Health Conference, which emphasized on the theme "Public Mental Health for Human Dignity." Taiwan's MOHW attended and shared international mental health information.

b) In October 2015, the MOHW attended the 6th Credentialing and Regulators Forum in Dubai, hosted by the International Council of Nurses and the Emirates Nursing Association. In attendance were 62 nursing regulators from 24 countries and representatives from the National Nursing Associations (NNA). Topics included advancing practice nursing, envisioning the future of nursing, regulation of internationally educated nurses, and global strategy on human resources for health.

b. Hosting International Meetings

a) Taiwan's NHI 20th Anniversary Symposium and Round Table: The symposium was held in Taipei on March 16 and 17, 2015, with the theme "the achievements, challenges, and reforms of health systems among major advanced nations". More than 100 foreign guests from 23 countries participated and approximately 900 domestic health officials, health workers, and members of related industries joined.

b) The 2015 Taiwan-U.S. Health and Welfare Policy Symposium: The symposium, held on May 12 and 13 in Taipei, was based on the theme "Transforming Health, Sustaining

Table 11-1 The State of International Health and Welfare Operations, 2015

International Operations Conducted by the MOHW	2015
Participation in international conferences and research	68 events
Hosting of international conferences	50 events
Foreign visitors	1,051 visitors from 78 countries

Taiwan's NHI 20th Anniversary Symposium and Round Table.

The 2015 Taiwan-U.S. Health and Welfare Policy Symposium.

Well-being." In attendance were seven US health and welfare officials and experts together with close to 300 local health officials and workers. Major topics included future development challenges and bilateral health policy achievements.

c) 2015 Aging Innovation Week – International Forum and Workshop: On October 23, 2015, experts from the Netherlands, the United Kingdom, Japan, and the United States gathered in Taipei to present elderly care models based on use of innovative home and community technological applications. Lectures and demonstrations from international experts facilitated cross-field integration and development of high-quality elderly services in Taiwan.

d) The 2015 Global Health Forum in Taiwan: The forum was held in Taipei on November 1 and 2, 2015, with the theme of "Public Health Governance." A total of 66 foreign guests from 32 countries participated, including nine health ministers and high level officials as well as renowned experts and scholars. Total participation in the two-day forum was 1,122, the most ever since the first forum in 2005.

e) The International Conference on Dengue Prevention and Control: The conference and joint experts meeting was held on December 7 and 8, 2015. A total of 190 people attended, including environmental and health officials from 10 Asia-Pacific and Southeast Asia countries.

The 2015 Aging Innovation Week – International Forum and Workshop.

The International Conference on Dengue Prevention and Control.

The 2015 Global Health Forum in Taiwan.

c. Visits by Foreign Guests: A total of 1,051 foreign guests from 78 countries visited in 2015. They shared information related to health and welfare policy, drugs, food, health care, technology, and bilateral cooperation (Figure 11-5).

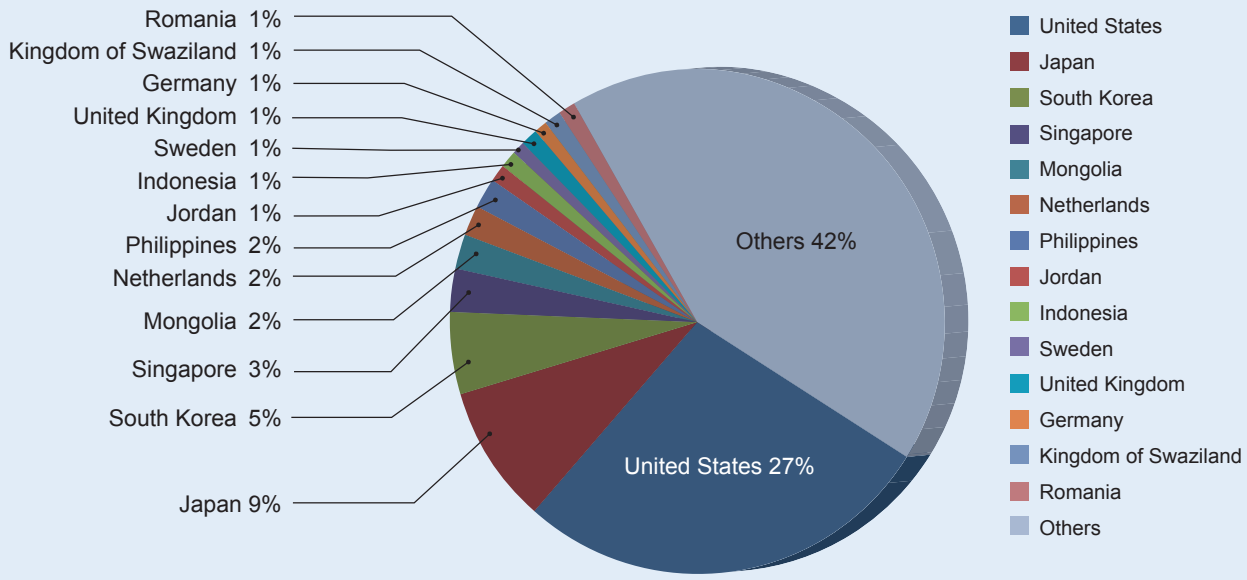
(2) International Cooperation

a. Taiwan International Health Action (TaiwanIHA), an emergency medical aid platform jointly established by the MOHW and the Ministry of Foreign Affairs (MOFA), signed a Memorandum of Understanding with Thailand's National Institute for Emergency Medicine, under the Ministry of Public Health, on February 10, 2015. In the future, the two sides will build a cooperation network through staff cultivation, academic activities, joint research, and inspection visits. They will jointly attend activities held by international organizations to facilitate provision of international humanitarian aid.

b. On April 13, 2015, TaiwanIHA held a meeting on international disaster assistance. Among the speakers was René Van Slate, a senior humanitarian advisor from the USAID Office of Foreign Disaster Assistance, who discussed medical aid coordination between the government and NGOs in times of disaster. More than 85 people attended, including representatives from the Taiwan Red Cross, Taiwan Root, Tzu Chi Foundation, and World Vision.

c. Memorandum of Understanding on Cooperation Concerning Pharmaceutical Products and Medical Devices between Warsaw Trade Office in Taipei and The Taipei Economic and Cultural Office in Warsaw: According to MoU, Food and Drug Administration of the Ministry of Health and Welfare in Taiwan and the Office for Registration of Medicinal Products, Medical Devices and Biocidal Products in Poland will exchange information over marketing, authorization, surveillance of safety use and efficacy of pharmaceutical products and clinical trials, which is believed to be helpful in further strengthening medical industries co-operation between Taiwan and Poland and ensuring the supply of safe and quality medical products.

Figure 11-5 Nationalities of Foreign Guests, 2015



Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

d. Health Inequalities in Taiwan Cooperative Project: After signing a cooperation agreement in 2014, the MOHW and the Institute of Health Equity, University College of London released a draft of the Health Inequalities in Taiwan report and preliminary analysis results in October 2015. The institute head, Michael Marmot, a former chair of the WHO's Commission on Social Determinants of Health, was in Taiwan for the release.

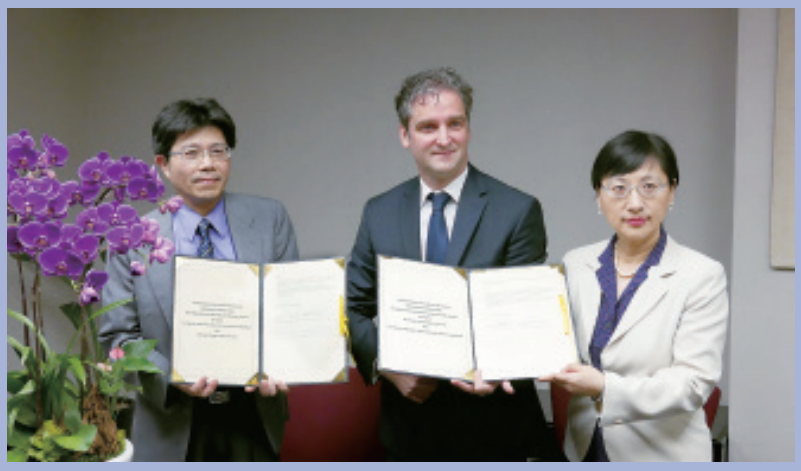
2. International Medical Aid

With the world beset by global climatic anomalies and frequent disasters, Taiwan is fully devoted to providing international health assistance. The compassion that it brings has shown the international community that Taiwan can play an important role in humanitarian efforts.

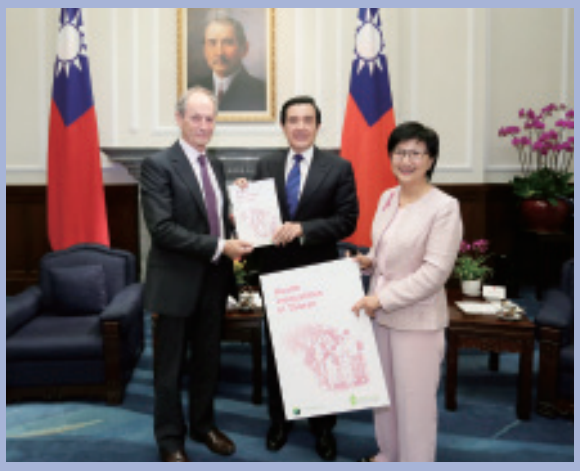
(1) Humanitarian Assistance

a. Taiwan's Contributions to the Haiti Earthquake Rebuilding Plan: The MOHW carried out three public health subprojects planned by the MOFA: the Taiwan Health Promotion Center Project, the Medical Equipment Donation Project, and the Epidemic Prevention Project.

b. TaiwanIHA: Since its founding in 2006, TaiwanIHA has already carried out 24 humanitarian medical aid missions. In 2009, it signed a Memorandum of Understanding on cooperation with the Association of Medical Doctors of Asia (AMDA), an international NGO founded in Japan that is dedicated to international humanitarian aid missions. Since 2011, TaiwanIHA and the AMDA have jointly offered volunteer cataract and dental care clinics.



Source: Warsaw Trade Office in Taipei
Taiwan and Poland signed the Memorandum of Understanding on Cooperation Concerning Pharmaceutical Products and Medical Devices



Former President Ma Ying-Jeou and Sir Michael Marmot signed a poster board showing the cover of the Health Inequalities in Taiwan report

a) TaiwanIHA, AMDA, the Noordhoff Craniofacial Foundation, and Chang Gung Medical Foundation joined to carry out 29 cleft lip and palate surgeries in Parepare, Indonesia from May 27 - 31, 2015. During the medical mission, the Taiwanese team shared surgical techniques with local doctors.

b) TaiwanIHA, AMDA, the Taiwan Dental Association, and Shuang Ho Hospital held dental clinics in Bodhgaya, India from October 1 - 7, 2015. Also, in cooperation with the local Rotary Club, Rotaract Club, and the chairperson of the Lions Club, the medical mission team offered oral cavity health examinations to 150 patients in schools and orphanages in Mastipur village.

3. Nepal Disaster Medical Aid Assessment and Material Donation: In April 2015, a magnitude 7.8 earthquake struck Nepal. At the request of the MOFA, TaiwanIHA sent a team to conduct a post-disaster medical aid assessment. The team donated five containers of Taiwan-made drugs and other materials and supplies.

4. Helping Indonesia Cope with Haze: Each year, during the dry season from June to October, Indonesia is blanketed in a thick haze. Since July 2015, the problem has grown more severe. With the pollution spreading to the capital of Jakarta, more than 500,000 people have suffered from acute respiratory syndrome. At the request of the MOFA, the MOHW's Taipei Hospital donated 6,000 N95 masks to help Indonesians cope with the poor air quality.

(2) Medical Assistance

a. Global Medical Instruments Support & Service Program (GMISS): The MOHW gathers old medical instruments from hospitals throughout Taiwan and donates them to ally countries in accordance with foreign policy. In 2015, there were four donation cases with a total of 580 pieces of medical equipment delivered to Haiti, Paraguay, Belize, and Papua New Guinea.

b. The Taiwan International Healthcare Training Center (TIHTC) promotes diplomatic relations by training health care workers in overseas regions which lack medical resources. In 2015, training was provided to 133 foreign health care personnel from 18 countries.

c. The 2015 National Health Cooperation Program in Africa: Assistance with the advancement of public health in Africa cover national health insurance, AIDS prevention, e-Health, staff training and other public health issues.

A TaiwanIHA team carried out cleft lip and palate surgeries in Indonesia

The TaiwanIHA team cleaned and polished teeth and provided dental fillings to children in India

d. In 2015, the MOHW continued a cooperative effort with the MOFA by commissioning eight hospitals to implement the Medical Cooperation Program in Pacific Allied and Friendly Countries. The Taiwan Medical Program and Mobile Medical Mission took place in Palau, Kiribati, Nauru, and Tuvalu. The Taiwan Health Center Plan took place in the Marshall Islands and Solomon Islands. The Mobile Medical Mission Plan took place in the Republic of Fiji and Papua New Guinea. All programs were fully funded by the MOFA.

Section 3 Internationalization of Health Care

1. Development and Background of Health Care Industry

As population aging and technological development continue to grow, the domains within the health care market are expanding. A trend in the health care industry, which formerly concentrated on the simple treatment of diseases, is to become more service oriented. Through the internationalized advancement of health care, the advantages of Taiwan's health care technology and quality will emerge. Accompanying development will raise international competitiveness.

2. Development Goals of Health Care Internationalization

(1) The MOHW guided hospitals on developing distinct strengths and features to build their own health care brand and provide diverse health care services. By cooperating with businesses inside and outside the industry, new innovative business strategies were developed that sparked further development in health care.

(2) Development of the international health care industry has driven development of the biomedical, pharmaceutical, medical device, information, and health maintenance industries.

3. Internationalization of Medical Services

(1) The Taiwan Task Force for Medical Travel, which was established to provide a platform for information exchange and dissemination, continued to advise 63 hospitals on building internationally competitive environments. The task force reviewed foreign language switchboards and websites and conducted on-site guidance.

(2) Health institutions were encouraged to bolster their medical brand. To strengthen Taiwan's branding as a medical tourism destination, in June 2014 the MOHW hosted the Asia regional meeting and the cooperative meeting of the World Medical Tourism and Global Health Care Congress.

(3) Deregulation and accommodations to entry regulations made it easier for mainland Chinese citizens to enter Taiwan. There were 55 hospitals that could apply to carry out health examinations and cosmetic medical care for mainland Chinese citizens.

(4) A pilot program eased restrictions on overseas Chinese from designated Southeast Asian nations (Myanmar, Laos, and Cambodia) to apply to visit Taiwan for health examinations, cosmetic medical services, and disease treatment. By December 2015, a total of 300 groups with 4,851 people had applied to enter the program.

(5) Annual international medicine promotion results are shown in Table 11-2.

(6) On December 28, 2013, international health liaison centers were launched at four airports: Taipei Songshan, Taoyuan, Taichung Cingcyuangang, and Kaohsiung Siaogang. The centers provide foreign tourists with medical service information and appointment assistance.

Table 11-2 International Medicine Promotion Results, by Year

Type \ Year	2008	2009	2010	2011	2012	2013	2014	2015
Outpatient	63,388	78,553	96,850	92,931	115,569	123,107	174,342	208,198
Inpatient	1,102	1,818	2,157	3,105	3,845	4,293	6,078	6,970
Medical Cosmetics	1,072	3,902	3,125	3,254	5,822	10,627	4,308	4,874
Heath Examinations	2,983	5,234	8,532	9,843	48,075	93,137	74,946	85,003
Total	68,545	89,507	110,664	109,133	173,311	231,164	259,674	305,045
Output Value (NTD100 Million)	20.29	34.33	41.49	54.14	96.23	136.48	141.35	158.96

Source: Ministry of Health and Welfare, R.O.C. (Taiwan)

Appendices

Appendix 1 Health and Welfare Indicators

Table 1 Population

Year	Total Population	Population Structure			Crude Birth Rate	Crude Death Rate	Natural Increase Rate	Total Fertility Rate		Population Density
		0-14 years	15-64 years	65 years & Over					Adolescent Pregnancy	
	1,000s	%	%	%	‰	‰	‰	Per Woman	‰	People/Km^2
2002	22,521	20.4	70.6	9.0	11.0	5.7	5.3	1.3	13	622
2003	22,605	19.8	70.9	9.2	10.1	5.8	4.3	1.2	11	625
2004	22,689	19.3	71.2	9.5	9.6	6.0	3.6	1.2	10	627
2005	22,770	18.7	71.6	9.7	9.1	6.1	2.9	1.1	8	629
2006	22,877	18.1	71.9	10.0	9.0	6.0	3.0	1.1	7	632
2007	22,958	17.6	72.2	10.2	8.9	6.2	2.8	1.1	6	634
2008	23,037	17.0	72.6	10.4	8.6	6.3	2.4	1.1	5	637
2009	23,120	16.3	73.0	10.6	8.3	6.2	2.1	1.0	4	639
2010	23,162	15.6	73.6	10.7	7.2	6.3	0.9	0.9	4	640
2011	23,225	15.1	74.0	10.9	8.5	6.6	1.9	1.1	4	642
2012	23,316	14.6	74.2	11.2	9.9	6.6	3.2	1.3	4	644
2013	23,374	14.3	74.2	11.5	8.5	6.7	1.9	1.1	4	646
2014	23,434	14.0	74.0	12.0	9.0	7.0	2.0	1.2	4	647
2015	23,492	13.6	73.9	12.5	9.1	7.0	2.1	1.2	4	649

Source: Ministry of the Interior, R.O.C.(Taiwan)

Table 2 Life Expectancy and Mortality Rate

Year	Life Expectancy at Birth			Under-Five Mortality Rate	Adult Mortality Rate (Ages 15-60 Years)
	Both Sexes	Male	Female		
	Years	Years	Years	Per 1,000 Live Births	Per 1,000 Population
2002	77.2	74.6	80.2	7.6	111.8
2003	77.3	74.8	80.3	6.9	110.7
2004	77.5	74.7	80.8	7.3	110.9
2005	77.4	74.5	80.8	6.9	112.8
2006	77.9	74.9	81.4	6.6	112.8
2007	78.4	75.5	81.7	6.4	105.6
2008	78.6	75.6	81.9	6.3	103.3
2009	79.0	76.0	82.3	5.6	101.0
2010	79.2	76.1	82.5	5.5	99.2
2011	79.1	76.0	82.6	5.7	99.0
2012	79.5	76.4	82.8	5.1	96.3
2013	80.0	76.9	83.4	4.7	93.6
2014	79.8	76.7	83.2	4.6	94.5
2015	80.2	77.0	83.6	5.0	93.6

Source: Ministry of the Interior, R.O.C.(Taiwan). Ministry of Health and Welfare, R.O.C.(Taiwan).

Table 3 National Health Expenditure

Year	GDP Per Capita		National Health Expenditure (NHE)		Public Sector Ratio	NHE as a share of GDP	NHE Per Capita	
	NTD	USD	NTD Millions	USD	%	%	NTD	USD
2002	475,484	13,750	617,279	17,851	61.0	5.8	27,480	795
2003	486,018	14,120	655,326	19,039	60.8	6.0	29,045	844
2004	514,405	15,388	710,870	21,264	59.0	6.1	31,389	939
2005	532,001	16,532	747,305	23,223	57.3	6.2	32,878	1,022
2006	553,851	17,026	782,443	24,053	56.7	6.2	34,282	1,054
2007	585,016	17,814	814,591	24,805	57.2	6.1	35,545	1,082
2008	571,838	18,131	834,686	26,464	56.9	6.3	36,294	1,151
2009	561,636	16,988	873,223	26,413	57.4	6.7	37,837	1,145
2010	610,140	19,278	889,351	28,100	57.8	6.3	38,432	1,214
2011	617,078	20,939	914,665	31,037	57.5	6.4	39,436	1,338
2012	631,142	21,308	925,591	31,249	59.2	6.3	39,776	1,343
2013	652,429	21,916	965,271	32,424	59.3	6.3	41,349	1,389
2014	687,816	22,648	995,544	32,781	59.4	6.2	42,538	1,401

Source: Directorate-General of Budget, Accounting and Statistics, R.O.C.(Taiwan). Ministry of Health and Welfare, R.O.C.(Taiwan).

Table 4-1 Institutions of Health Facilities

Year	Medical Care Institutions											
		Hospitals							Clinics			
			Western Medicine			Chinese Medicine				Western Medicine	Chinese Medicine	Dentistry
				Public	Private		Public	Private				
	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units
2002	18,228	610	574	91	483	36	2	34	17,618	9,287	2,601	5,730
2003	18,777	594	558	91	467	36	2	34	18,183	9,565	2,729	5,889
2004	19,240	590	556	88	468	34	2	32	18,650	9,819	2,852	5,979
2005	19,433	556	531	79	452	25	1	24	18,877	9,948	2,900	6,029
2006	19,682	547	523	79	444	24	1	23	19,135	10,064	3,006	6,065
2007	19,900	530	507	79	428	23	1	22	19,370	10,197	3,069	6,104
2008	20,174	515	493	79	414	22	1	21	19,659	10,326	3,160	6,173
2009	20,306	514	496	79	417	18	1	17	19,792	10,361	3,217	6,214
2010	20,691	508	492	81	411	16	1	15	20,183	10,599	3,289	6,295
2011	21,135	507	491	81	410	16	1	15	20,628	10,815	3,411	6,402
2012	21,437	502	488	81	407	14	1	13	20,935	10,997	3,462	6,476
2013	21,713	495	482	80	402	13	1	12	21,218	11,105	3,548	6,565
2014	22,041	497	486	80	406	11	1	10	21,544	11,277	3,637	6,630
2015	22,177	494	486	80	406	8	1	7	21,683	11,313	3,705	6,665

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 4-2 Beds of Health Facilities

Year	Beds							Beds Per 10,000 Population				
		Hospitals					Clinics		Hospitals			Clinics
			Public	Private	Acute Care Beds					Acute Care Beds		
						Acute General Beds					Acute General Beds	
	Beds	Beds	Beds	Beds	Beds	Beds	Beds	Beds	Beds	Beds	Beds	Beds
2002	133,398	119,847	41,904	77,943	74,902	69,572	13,551	59.2	53.2	33.3	30.9	6.0
2003	136,331	121,698	42,777	78,921	75,097	69,545	14,633	60.3	53.8	33.2	30.8	6.5
2004	143,343	127,667	43,865	83,802	78,168	72,300	15,676	63.2	56.3	34.5	31.9	6.9
2005	146,382	129,548	44,273	85,275	78,423	72,411	16,834	64.3	56.9	34.4	31.8	7.4
2006	148,962	131,152	44,076	87,076	79,005	72,932	17,810	65.1	57.3	34.5	31.9	7.8
2007	150,628	131,776	44,873	86,903	79,695	73,337	18,852	65.6	57.4	34.7	31.9	8.2
2008	152,901	133,020	45,450	87,570	80,021	73,426	19,881	66.4	57.7	34.7	31.9	8.6
2009	156,740	134,716	45,913	88,803	80,884	74,132	22,024	67.8	58.3	35.0	32.1	9.5
2010	158,922	135,401	45,981	89,420	81,072	74,140	23,521	68.6	58.5	35.0	32.0	10.2
2011	160,472	135,431	45,603	89,828	81,173	74,082	25,041	69.1	58.3	35.0	31.9	10.8
2012	160,900	135,002	45,549	89,453	81,064	73,876	25,898	69.0	57.9	34.8	31.7	11.1
2013	159,422	134,197	45,134	89,063	80,096	72,692	25,225	68.2	57.4	34.3	31.1	10.8
2014	161,491	133,518	44,524	88,994	79,745	72,303	27,973	68.9	57.0	34.0	30.9	11.9
2015	162,163	133,335	43,881	89,454	79,663	72,255	28,828	69.0	56.8	33.9	30.8	12.3

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 4-3 Health Workforce

Year	Health Workforce									
		Physicians	Chinese Medicine Doctors	Dentists	Pharmacists (Assistants)	Medical Technologists (Assistants)	Medical Radiation Technologists (Assistants)	Nurses (Assistants)	Midwives (Assistants)	Dieticians
	People	People	People	People	People	People	People	People	People	People
2002	175,444	31,532	4,101	9,206	25,355	6,725	3,410	89,568	490	845
2003	183,103	32,390	4,266	9,551	25,033	7,055	3,557	95,271	476	895
2004	192,611	33,360	4,588	9,868	26,079	7,122	3,704	101,465	459	978
2005	199,734	34,093	4,610	10,141	26,750	7,323	3,880	104,786	397	1,056
2006	206,959	34,899	4,743	10,412	27,412	7,457	4,052	109,153	368	1,137
2007	214,748	35,849	4,862	10,740	28,040	7,642	4,211	113,832	347	1,239
2008	223,623	37,142	5,112	11,093	28,741	7,896	4,443	118,785	308	1,379
2009	233,553	37,880	5,290	11,351	29,587	8,203	4,651	125,081	258	1,563
2010	241,156	38,887	5,354	11,656	30,001	8,377	4,913	128,955	208	1,687
2011	250,258	40,002	5,570	11,992	31,300	8,579	5,133	133,336	134	1,824
2012	258,283	40,938	5,740	12,391	32,015	8,751	5,341	137,641	120	2,050
2013	265,759	41,965	5,977	12,794	32,668	9,006	5,507	140,915	132	2,234
2014	271,555	42,961	6,156	13,178	33,162	9,132	5,774	142,708	149	2,304
2015	280,508	44,006	6,298	13,502	33,516	9,261	5,952	148,223	150	2,392

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 4-4 Density of Health workforce (Per 10,000 Population)

Year	Density of Health workforce (Per 10,000 Population)									
		Physicians	Chinese Medicine Doctors	Dentists	Pharmacists (Assistants)	Medical Technologists (Assistants)	Medical Radiation Technologists (Assistants)	Nurses (Assistants)	Midwives (Assistants)	Dieticians
	People	People	People	People	People	People	People	People	People	People
2002	77.9	14.0	1.8	4.1	11.3	3.0	1.5	39.8	0.2	0.4
2003	81.0	14.3	1.9	4.2	11.1	3.1	1.6	42.1	0.2	0.4
2004	84.9	14.7	2.0	4.3	11.5	3.1	1.6	44.7	0.2	0.4
2005	87.7	15.0	2.0	4.5	11.7	3.2	1.7	46.0	0.2	0.5
2006	90.5	15.3	2.1	4.6	12.0	3.3	1.8	47.7	0.2	0.5
2007	93.5	15.6	2.1	4.7	12.2	3.3	1.8	49.6	0.2	0.5
2008	97.1	16.1	2.2	4.8	12.5	3.4	1.9	51.6	0.1	0.6
2009	101.0	16.4	2.3	4.9	12.8	3.5	2.0	54.1	0.1	0.7
2010	104.1	16.8	2.3	5.0	13.0	3.6	2.1	55.7	0.1	0.7
2011	107.8	17.2	2.4	5.2	13.5	3.7	2.2	57.4	0.1	0.8
2012	110.8	17.6	2.5	5.3	13.7	3.8	2.3	59.0	0.1	0.9
2013	113.7	18.0	2.6	5.5	14.0	3.9	2.4	60.3	0.1	1.0
2014	115.9	18.3	2.6	5.6	14.2	3.9	2.5	60.9	0.1	1.0
2015	119.4	18.7	2.7	5.7	14.3	3.9	2.5	63.1	0.1	1.0

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 5 Infectious Diseases

Year	Number of Confirmed Cases							
	Cholera	Diphtheria	Japanese Encephalitis	Hansen's Disease (Leprosy)	Malaria	Measles	Meningococcal Meningitis	Mumps
2002	2	…	19	8	28	24	46	665
2003	1	…	25	9	34	6	26	676
2004	1	…	32	9	18	-	24	1,081
2005	2	-	35	9	26	7	20	1,158
2006	1	-	29	11	26	4	13	971
2007	-	-	37	12	13	10	20	1,208
2008	1	-	17	8	18	16	19	1,145
2009	3	-	18	7	11	48	2	1,068
2010	5	-	33	5	21	12	7	1,125
2011	3	-	22	5	17	33	5	1,171
2012	5	-	32	13	12	9	6	1,061
2013	7	-	16	7	13	8	6	1,170
2014	4	-	18	9	19	26	3	880
2015	10	-	30	16	8	29	3	773

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Notes: 1. Mumps and tetanus were reported cases.

2. All cases of malaria were imported.

3. Since 2008, leprosy has been referred to as Hansen's disease.

Table 5 Infectious Diseases (Cont.)

Year	Number of Confirmed Cases							
	Pertussis	Poliomyelitis	Congenital Rubella Syndrome	Rubella	Neonatal Tetanus	Total Tetanus	Tuberculosis	Yellow Fever
2002	18	-	-	4	…	15	16,758	-
2003	26	-	-	2	…	13	15,042	-
2004	21	-	-	4	…	16	16,784	-
2005	38	-	-	7	…	16	16,472	-
2006	14	-	-	6	…	14	15,378	-
2007	41	-	1	54	-	10	14,480	-
2008	41	-	1	33	-	18	14,265	-
2009	90	-	-	23	-	12	13,336	-
2010	61	-	-	21	-	12	13,237	-
2011	77	-	-	60	-	10	12,634	-
2012	54	-	-	12	-	17	12,338	-
2013	51	-	-	7	-	24	11,528	-
2014	78	-	-	7	-	9	11,326	-
2015	70	-	-	7	-	12	10,711	-

Source : Ministry of Health and Welfare, R.O.C.(Taiwan)

Notes: 1. Mumps and tetanus were reported cases.

2. All cases of malaria were imported.

3. Since 2008, leprosy has been referred to as Hansen's disease.

Table 6 Food and Pharmaceutical Affairs

Year	Incidents of Food Poisoning			Number of Pharmaceutical Firms			
		Number of Cases	Number of Deaths		Pharmacies	Dealers of Drugs or Medical Devices	Manufacturers of Drugs or Medical Devices
	Number of Outbreaks	People	People	Units	Units	Units	Units
2002	262	5,566	1	49,752	6,990	41,996	766
2003	251	5,283	2	51,447	7,155	43,500	792
2004	274	3,992	2	52,685	7,435	44,395	855
2005	247	3,530	1	55,802	7,673	47,198	931
2006	265	4,401	-	57,976	7,397	49,580	999
2007	248	3,231	-	59,061	7,381	50,633	1,047
2008	272	2,924	-	58,834	7,215	50,514	1,105
2009	351	4,642	-	58,524	7,450	49,814	1,260
2010	503	6,880	1	60,222	7,558	51,289	1,375
2011	426	5,819	1	63,274	7,699	54,090	1,485
2012	527	5,701	-	64,024	7,620	54,843	1,561
2013	409	3,890	-	65,280	7,701	55,926	1,653
2014	480	4,504	-	66,678	7,866	57,125	1,687
2015	632	6,235	-	67,597	7,922	57,945	1,730

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 7-1 Major Causes of Death

Year	Infant Mortality Rate	All Causes of Death		Major Causes of Death									
				Malignant Neoplasms		Heart Diseases		Cerebrovascular Diseases		Pneumonia		Diabetes Mellitus	
	Per 1,000 Live Births	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate
		People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Population
2002	5.4	126,936	539.8	34,342	144.2	11,441	48.5	12,009	50.5	4,530	19.4	8,818	37.1
2003	4.9	129,878	532.3	35,201	143.1	11,785	47.9	12,404	49.9	5,099	20.8	10,013	40.5
2004	5.3	133,680	528.7	36,357	142.8	12,861	50.1	12,339	47.8	5,536	21.5	9,191	35.8
2005	5.0	138,957	530.0	37,222	141.2	12,970	48.3	13,139	48.9	5,687	21.0	10,501	39.4
2006	4.6	135,071	495.4	37,998	139.3	12,283	43.8	12,596	44.7	5,396	18.9	9,690	34.9
2007	4.7	139,376	491.6	40,306	142.6	13,003	44.4	12,875	43.8	5,895	19.6	10,231	35.5
2008	4.6	142,283	484.3	38,913	133.7	15,726	51.7	10,663	35.0	8,661	27.5	8,036	26.9
2009	4.0	142,240	466.7	39,918	132.5	15,094	47.7	10,383	32.8	8,358	25.3	8,230	26.6
2010	4.2	144,709	455.6	41,046	131.6	15,675	47.4	10,134	30.6	8,909	25.6	8,211	25.3
2011	4.2	152,030	462.4	42,559	132.2	16,513	47.9	10,823	31.3	9,047	24.8	9,081	26.9
2012	3.7	153,823	450.6	43,665	131.3	17,121	47.9	11,061	30.8	9,314	24.4	9,281	26.5
2013	3.9	154,374	435.3	44,791	130.4	17,694	47.7	11,313	30.3	9,042	22.5	9,438	25.8
2014	3.6	162,886	443.5	46,093	130.2	19,399	50.2	11,733	30.4	10,353	24.7	9,846	26.0
2015	4.1	163,574	431.5	46,829	128.0	19,202	48.1	11,169	27.9	10,761	24.6	9,530	24.3

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Notes: 1. The standardized mortality rate is based on the WHO standard world population age structure for 2000.
2. Began using the International Classification of Diseases (ICD-10) as a standard diagnostic tool in 2008.

Table 7-1 Major Causes of Death (Cont.)

Year	Major Causes of Death											
	Accidents and Adverse Effects		Chronic Lower Respiratory Diseases		Chronic Liver Disease and Cirrhosis		Hypertensive Diseases		Nephritis, Nephrotic Syndrome, and Nephrosis		Intentional Self-Harm (Suicide)	
	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate
	People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Population
2002	8,489	36.3	5,226	22.0	4,795	19.9	1,947	8.2	4,168	17.7	3,053	12.5
2003	8,191	34.5	5,192	20.9	5,185	20.9	1,844	7.4	4,306	17.5	3,195	12.8
2004	8,453	35.0	5,292	20.3	5,351	20.8	1,806	7.0	4,680	18.2	3,468	13.6
2005	8,365	34.0	5,484	20.0	5,621	21.3	1,891	7.0	4,822	17.9	4,282	16.6
2006	8,011	31.9	4,969	17.2	5,049	18.6	1,816	6.4	4,712	16.8	4,406	16.8
2007	7,130	27.9	4,914	16.2	5,160	18.4	1,977	6.6	5,099	17.3	3,933	14.7
2008	7,077	27.0	5,374	16.9	4,917	17.1	3,507	11.2	4,012	13.2	4,128	15.2
2009	7,358	27.7	4,955	14.9	4,918	16.6	3,721	11.5	3,999	12.5	4,063	14.7
2010	6,669	24.4	5,197	14.8	4,912	16.1	4,174	12.2	4,105	12.4	3,889	13.8
2011	6,726	24.1	5,984	16.2	5,153	16.5	4,631	12.9	4,368	12.6	3,507	12.3
2012	6,873	23.8	6,326	16.4	4,975	15.6	4,986	13.3	4,327	12.1	3,766	13.1
2013	6,619	22.4	5,959	14.9	4,843	14.8	5,033	12.9	4,489	11.9	3,565	12.0
2014	7,118	23.7	6,428	15.3	4,962	14.8	5,459	13.5	4,868	12.5	3,542	11.8
2015	7,033	22.8	6,383	14.6	4,688	13.6	5,536	13.2	4,762	11.8	3,675	12.1

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Notes: 1. The standardized mortality rate is based on the WHO standard world population age structure for 2000.
2. Began using the International Classification of Diseases (ICD-10) as a standard diagnostic tool in 2008.

Table 7-2 Major Causes of Cancer Death

Year	Major Causes of Cancer Death									
	Cancers of Liver and Intrahepatic Bile Ducts		Cancers of Trachea, Bronchus, and Lungs		Cancers of Colon, Rectum, and Anus		Cancers of Breast		Cancers of Prostate	
	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate	Number of Deaths	Standardized Mortality Rate
	People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Population	People	Per 100,000 Female Population	People	Per 100,000 Male Population
2002	6,943	29.4	6,846	28.5	3,649	15.3	1,203	10.2	750	6.2
2003	7,010	28.8	6,911	27.9	3,711	15.0	1,381	11.3	742	5.9
2004	7,059	28.1	7,153	27.8	3,898	15.2	1,339	10.5	821	6.2
2005	7,108	27.3	7,302	27.4	4,111	15.5	1,439	11.0	909	6.6
2006	7,415	27.6	7,479	27.0	4,284	15.5	1,439	10.6	957	6.6
2007	7,809	28.1	7,993	27.9	4,470	15.6	1,552	11.1	1,003	6.7
2008	7,651	26.8	7,777	26.3	4,266	14.4	1,541	10.7	892	5.7
2009	7,759	26.2	7,951	25.9	4,531	14.8	1,589	10.6	936	5.9
2010	7,744	25.2	8,194	25.8	4,676	14.6	1,706	11.0	1,021	6.1
2011	8,022	25.3	8,541	26.0	4,921	15.0	1,852	11.6	1,096	6.4
2012	8,116	24.7	8,587	25.4	5,131	14.9	1,912	11.6	1,187	6.7
2013	8,217	24.2	8,854	25.3	5,265	14.9	1,962	11.6	1,207	6.6
2014	8,178	23.3	9,167	25.3	5,603	15.3	2,071	11.9	1,218	6.5
2015	8,258	22.8	9,232	24.7	5,687	14.9	2,141	12.0	1,231	6.4

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Notes: 1. The standardized mortality rate is based on the WHO standard world population age structure for 2000.
2. Began using the International Classification of Diseases (ICD-10) as a standard diagnostic tool in 2008.

Table 8 Social Insurance

Year	National Health Insurance						
	Beneficiaries	Coverage	Health Care Utilzation				
			Outpatient Visits per Beneficiary	Inpatient Visits per 100 Beneficiaries	Average Costs per Outpatient Case	Average Costs per Inpatient Case	Average Length of Stay
	1,000 Persons	%	No.	No.	Points	Points	Days
2002	21,869	…	13.6	13.0	806	41,046	9.1
2003	21,984	…	13.4	12.0	849	45,265	9.6
2004	22,134	…	14.6	13.2	874	49,048	9.7
2005	22,315	…	14.7	13.2	897	51,406	9.9
2006	22,484	…	14.0	13.0	959	52,417	9.9
2007	22,803	…	14.0	13.1	985	53,027	10.0
2008	22,918	…	14.0	13.1	1,032	54,534	10.0
2009	23,026	99.3	14.4	13.4	1,052	54,774	9.9
2010	23,074	99.4	14.6	13.6	1,067	54,693	10.0
2011	23,199	99.5	15.1	13.8	1,086	55,253	9.9
2012	23,281	99.5	15.1	13.8	1,113	55,569	9.9
2013	23,463	99.6	15.1	13.5	1,168	57,168	9.9
2014	23,622	99.6	15.2	13.7	1,197	58,573	9.8
2015	23,737	99.7	15.1	14.0	1,229	58,989	9.6

Source: National Health Insurance Administration, Ministry of Health and Welfare, R.O.C.(Taiwan).

Notes: 1. Date comes from 2nd-generation storage system of NHIA(Updated on May 5, 2016)
2. Commission cases excluded.
3. When calculating visits per beneficiary/100 beneficiaries, the average number of NHI beneficiaries in February, May, August and November is used the number of the beneficiaries of the current year.
4. Outpatient visits exclude cases to home nursing care and community psychiatric rehabilitation, medical examination referrals commissioned by medical institutions, refillable prescriptions for patients with chronic illnesses, pathology centers, delivery institutions and supplementary claims. Other cases seeking medical attention in which the case report was split in accordance with the regulations are also excluded.
5. Outpatient cases exclude cases to medical examination referrals commissioned by other medical institutions, refillable prescriptions for patients chronic illnesses, pathology centers, delivery institutions and supplementary claims. Other cases seeking medical attention in which the case report split in accordance with the regulations are also excluded.
6. Inpatient cases exclude cases to supplementary claims. Other cases seeking medical attention in which the case report was split in accordance with regulations are also excluded.
7. The length of hospitalized stay is equivalent to the sum of acute and chronic bed days.

Table 8 Social Insurance (Cont'd)

Year	National Pension								
	Insured	As a Share of Aged 25-64 years	General Insured Person	Low-Income Households	Income Below Designated Threshold		Disabled Persons		
					Item 1	Item 2	Severe Or extremely	Moderate	Mild
	1,000s Persons	%	1,000s Persons	1,000s Persons	1,000s Persons	1,000s Persons	1,000s Persons	1,000s Persons	1,000s Persons
2002	-	-	-	-	-	-	-	-	-
2003	-	-	-	-	-	-	-	-	-
2004	-	-	-	-	-	-	-	-	-
2005	-	-	-	-	-	-	-	-	-
2006	-	-	-	-	-	-	-	-	-
2007	-	-	-	-	-	-	-	-	-
2008	4,221	31.3	3,931	39	6	3	88	81	72
2009	4,015	29.4	3,563	50	100	51	95	84	72
2010	3,872	27.9	3,390	51	120	62	96	83	70
2011	3,784	27.1	3,296	62	120	55	98	83	70
2012	3,726	26.5	3,221	73	127	57	99	81	69
2013	3,678	25.9	3,180	76	123	52	100	79	67
2014	3,584	25.2	3,086	77	126	52	98	78	66
2015	3,510	24.6	3,025	76	122	48	97	77	66

Source: National Health Insurance Administration, R.O.C.(Taiwan)

Note: Item 1 refers to Article 12 of the National Pension Act, for when the amount of total family income divided by the number of insured family members fails to reach 1.5 times of the lowest living expense of that specific year and does not exceed 1 time of the average monthly consumption per person in the Taiwan area; item 2 is for when the amount of total family income divided by the number of insured family members does not reach 2 times of the lowest living expense of that specific year and does not exceed 1.5 times of the average monthly consumption per person in the Taiwan area.

Table 9 Social Assistance

Year	Low-Income Households				Middle-to-Low-Income Households			
	Number of Households	As a Share of Total Households	People	As a Share of Total People	Number of Households	As a Share of Total Households	People	As a Share of Total People
	Households	%	People	%	Households	%	People	%
2002	70,417	1.0	171,200	0.8	-	-	-	-
2003	76,406	1.1	187,875	0.8	-	-	-	-
2004	82,783	1.2	204,216	0.9	-	-	-	-
2005	84,823	1.2	211,292	0.9	-	-	-	-
2006	89,900	1.2	218,166	1.0	-	-	-	-
2007	90,682	1.2	220,990	1.0	-	-	-	-
2008	93,032	1.2	223,697	1.0	-	-	-	-
2009	105,265	1.3	256,342	1.1	-	-	-	-
2010	112,200	1.4	273,361	1.2	-	-	-	-
2011	128,237	1.6	314,282	1.4	35,420	0.4	120,042	0.5
2012	145,613	1.8	357,446	1.5	88,988	1.1	282,019	1.2
2013	148,590	1.8	361,765	1.5	108,589	1.3	334,391	1.4
2014	149,958	1.8	357,722	1.5	114,522	1.4	349,130	1.5
2015	146,379	1.7	342,490	1.5	117,686	1.4	356,185	1.5

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Note: Implementation of the new Public Assistance Act on July 1, 2011, eased standards for inclusion and added middle-to-low-income households."

Table 9 Social Assistance (Cont'd)

Year	Medical Subsidies		Nursing Care Assistance for Low-Middle Income Households		Disaster Aid	Emergency Aid	
	Person-Times	NTD10,000s	Person-Times	NTD10,000s	NTD10,000s	Person-Times	NTD10,000s
2002	10,049	10,485	4,678	9,191	17,900	39,335	20,536
2003	11,242	8,963	4,683	9,523	8,129	35,257	19,914
2004	12,146	10,522	4,880	9,246	66,271	36,134	24,592
2005	10,756	9,376	5,145	10,429	54,774	33,960	21,794
2006	5,326	5,681	5,148	10,200	8,422	37,094	21,596
2007	5,734	6,154	5,854	10,965	13,255	46,666	26,845
2008	5,295	5,627	6,501	11,411	18,870	48,074	27,366
2009	5,486	6,639	7,033	12,167	82,180	44,129	24,576
2010	5,773	6,403	8,066	12,871	79,226	47,863	28,373
2011	5,383	7,092	9,761	16,269	4,672	45,418	27,423
2012	5,013	7,176	9,667	16,283	17,363	46,978	26,910
2013	4,322	8,041	10,258	16,936	8,853	40,961	24,669
2014	4,260	8,987	10,767	18,050	4,816	42,232	25,349
2015	4,499	10,256	10,923	17,837	7,337	37,897	23,261

Source: Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 10 Social Welfare

Year	Children and Youth Welfare (0-17 Years)						Elderly Welfare (65 Years & Over)					
	Number of People	As a Share of Total Population	Children Foster Care		Living Support for Disadvantaged Children and Youths		Number of People	As a Share of Total Population	Living Allowance Subsidies for Middle-to-Low-Income Elderly People		Special Care Allowances for Middle-to-Low-Income Elderly People	
			Placed in Care	Amounts	Person-Times	Amounts			Approved, as of End of Year	Amounts	Person-Times	Amounts
	People	%	People	NTD10,000s	Person-Times	NTD10,000s	People	%	People	NTD10,000s	Person-Times	NTD10,000s
2002	5,544,533	24.6	…	…	…	…	2,031,300	9.0	182,392	999,266	-	-
2003	5,429,950	24.0	…	…	…	…	2,087,734	9.2	173,951	987,948	7,634	3,554
2004	5,345,047	23.6	1,960	37,220	597,918	108,056	2,150,475	9.5	156,446	926,000	8,517	3,971
2005	5,242,928	23.0	2,052	39,579	824,842	171,496	2,216,804	9.7	148,118	892,951	7,847	3,646
2006	5,107,181	22.3	2,031	43,861	906,194	172,393	2,287,029	10.0	140,544	867,302	7,123	3,287
2007	5,002,123	21.8	1,941	44,529	820,487	126,308	2,343,092	10.2	134,644	846,696	6,429	3,032
2008	4,868,304	21.1	1,849	48,253	1,039,134	158,318	2,402,220	10.4	125,951	785,875	6,519	3,177
2009	4,745,159	20.5	1,761	48,160	1,222,200	195,916	2,457,648	10.6	122,523	768,898	7,263	3,535
2010	4,595,767	19.8	1,905	43,785	1,355,253	205,352	2,487,893	10.7	119,861	760,908	7,862	3,814
2011	4,469,350	19.2	1,802	43,366	1,348,606	199,776	2,528,249	10.9	120,266	761,814	8,116	4,062
2012	4,380,203	18.8	1,835	46,625	1,466,688	288,034	2,600,152	11.2	120,968	923,968	9,042	4,529
2013	4,258,385	18.2	1,804	45,030	1,406,040	278,058	2,694,406	11.5	120,869	924,823	9,152	4,587
2014	4,149,792	17.7	1,743	43,185	1,406,033	281,434	2,808,690	12.0	122,423	938,459	9,077	4,555
2015	4,043,357	17.2	1,662	42,342	1,390,203	278,290	2,938,579	12.5	124,490	963,091	9,470	4,753

Source: Social and Family Affairs Administration, Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 10 Social Welfare (Cont.)

Year	Family Support			Welfare for Women			
	Single-Parent Cases Accepted by Halfway Homes	Assistance for Families in Hardship		Women's Welfare Service Centers	Halfway Homes and Protective Centers for Women		
					Institutions	People Accepted	Cases Accepted
	Person-Times	Person-Times	NTD10,000s	Number	Number	People	Person-Times
2002	…	109,598	27,035	39	27	305	853
2003	…	169,999	33,806	41	37	280	1,129
2004	…	172,683	34,172	55	42	370	1,371
2005	…	188,293	36,244	60	49	408	1,753
2006	…	98,858	24,220	63	40	385	1,924
2007	1,444	103,612	28,547	75	37	330	1,902
2008	2,661	107,149	30,625	58	37	331	2,987
2009	2,150	153,175	40,913	61	38	345	3,340
2010	2,055	188,433	47,861	63	41	412	3,292
2011	539	188,987	48,159	52	37	460	2,917
2012	548	156,784	44,840	51	40	449	2,927
2013	581	137,464	40,303	56	41	440	2,982
2014	678	139,513	42,978	72	58	464	3,178
2015	662	133,370	42,012	74	60	496	3,206

Source: Social and Family Affairs Administration, Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 10 Social Welfare (Cont'd)

Year	People with Disabilities										
	Number of People	Ratios of Persons with Disabilities			As a Share of Total Population	Living Assistance		Subsidies for Day Care and Residential Care		Auxiliary Appliances Assistance	
		0-17 Years	18-64 Years	65 Years & Over							
	People	%	%	%	%	Person-Times	NTD10,000s	People, as of End of year	NTD10,000s	Person-Times	NTD10,000s
2002	831,266	6.6	57.9	35.5	3.7	2,370,720	753,556	13,709	226,751	58,169	64,061
2003	861,030	6.6	58.6	34.8	3.8	2,654,420	824,960	16,429	265,940	61,223	70,846
2004	908,719	6.6	58.7	34.7	4.0	2,975,141	1,217,452	20,162	292,195	54,843	58,832
2005	937,944	6.5	58.5	34.9	4.1	3,273,538	1,333,763	21,658	323,290	45,162	47,753
2006	981,015	6.4	57.9	35.7	4.3	3,474,205	1,412,015	23,771	353,576	50,817	52,470
2007	1,020,760	6.2	57.4	36.4	4.4	3,635,680	1,472,416	25,529	396,277	53,243	53,931
2008	1,040,585	6.1	57.4	36.5	4.5	3,712,397	1,498,714	26,823	431,025	55,425	53,900
2009	1,071,073	5.9	57.1	37.0	4.6	3,862,823	1,565,270	29,860	475,602	64,138	60,975
2010	1,076,293	5.8	57.6	36.6	4.6	3,998,947	1,621,943	30,449	517,837	70,873	66,296
2011	1,100,436	5.6	57.4	37.0	4.7	4,132,534	1,680,850	32,592	565,535	76,289	72,187
2012	1,117,518	5.6	57.6	36.8	4.8	4,176,404	2,016,490	33,779	613,446	77,422	72,882
2013	1,125,113	5.3	57.2	37.5	4.8	4,179,802	2,042,821	37,298	648,569	70,564	67,823
2014	1,141,677	5.1	56.7	38.2	4.9	4,206,306	2,052,774	39,199	706,541	75,057	72,924
2015	1,155,650	4.9	56.1	39.0	4.9	4,209,760	2,056,215	41,225	764,264	80,148	76,617

Source: Social and Family Affairs Administration, Ministry of Health and Welfare, R.O.C.(Taiwan)

Table 11 Protective Services

Year	Domestic Violence Incidents			Sexual Assault Incidents			Children and Youth Protective Services
	Reported Victims	Protection Assistance for Victims		Reported Victims	Protection Assistance for Victims		Children and Youths Subjected to Abuse
	People	Person-Times	NTD10,000s	People	Person-Times	NTD10,000s	People
2002	…	…	…	…	…	…	…
2003	…	…	…	…	…	…	…
2004	…	…	…	…	…	…	7,837
2005	58,614	…	…	4,900	…	…	9,897
2006	63,274	285,171	13,825	5,638	48,462	4,925	10,093
2007	68,421	330,606	19,886	6,530	72,090	5,319	13,566
2008	75,438	416,844	25,456	7,285	95,247	5,878	13,703
2009	83,728	478,769	32,684	8,008	101,482	6,491	13,400
2010	98,720	601,567	34,427	9,320	100,942	6,027	18,331
2011	94,150	871,146	40,561	11,121	140,326	7,360	17,667
2012	98,399	915,859	39,116	12,066	158,258	7,077	19,174
2013	110,103	988,586	46,854	10,901	177,258	7,753	16,322
2014	95,663	1,127,819	53,360	11,096	199,846	10,947	11,589
2015	95,818	1,191,465	57,650	10,454	221,587	11,354	9,604

Source: Ministry of Health and Welfare and Municipal, County (City) Governments.

Table 12 International Comparisons

Country	Population					Life Expectancy and Mortality Rate						
	Median Age	Crude Birth Rate	Crude Death Rate	Total Fertility Rate	Adolescent Birth Rate	Life Expectancy at Birth			Infant Mortality Rate	Under-Five Mortality Rate	Adult Mortality Rate (Aged 15-60 Years)	
						Both Sexes	Male	Female			Male	Female
	2013	2013	2013	2013	2007-2012	2013	2013	2013	2013	2013	2013	2013
	Years	‰	‰	Per Woman	‰	Years	Years	Years	Per 1,000 Live Births	Per 1,000 Live Births	Per 1,000 Population	
R.O.C. (Taiwan)	39	9	7	1.1	4	80	77	83	4	5	132	54
Japan	46	8	10	1.4	5	84	80	87	2	3	81	42
Republic of Korea	39	10	6	1.3	2	82	78	85	3	4	93	38
United States	37	13	8	2.0	34	79	76	81	6	7	128	76
Canada	40	11	7	1.7	14	82	80	84	5	5	81	52
United Kingdom	40	12	9	1.9	22	81	79	83	4	5	88	55
Germany	46	9	11	1.4	8	81	79	83	3	4	92	50
France	41	12	9	2.0	9	82	79	85	4	4	109	52
Australia	37	13	6	1.9	15	83	80	85	3	4	78	45
New Zealand	37	14	6	2.1	25	82	80	84	5	6	80	52

Source: 2015 WHO Statistical Information System. World Bank. Ministry of the Interior, R.O.C.(Taiwan). Ministry of Health and Welfare, R.O.C.(Taiwan).

Table 12 International Comparisons (Cont'd)

Country	Health Expenditure			
	Health Expenditure Ratios		Health Expenditure per Capita	
	Health Expenditure as a share of GDP	Public Health Expenditure as a share of Health Expenditure	Health Expenditure per Capita	Public Health Expenditure per Capita
	2013	2013	2013	2013
	%	%	USD PPPs	USD PPPs
R.O.C. (Taiwan)	6.0	62.4	2,621	1,635
Japan	10.2	83.2	3,713	3,090
Republic of Korea	6.9	55.9	2,275	1,272
United States	16.4	48.2	8,713	4,198
Canada	10.2	70.6	4,351	3,074
United Kingdom	8.5	86.6	3,235	2,802
Germany	11.0	76.3	4,819	3,677
France	10.9	78.7	4,124	3,247
Australia[a]	8.8	67.6	3,866	2,614
New Zealand	9.5	79.8	3,328	2,656

Sources: 2014 OECD Health Data, Ministry of Health and Welfare, R.O.C.(Taiwan)

Note: 1. "a" means that data were from 2012.

2. A System of Health Accounts released by OECD recently, health expenditure and financing are based on current expenditure on health care to compile health care indicators.

Appendix 2 Notifiable Diseases Statistics

Table 1 Number of Confirmed Cases of Acute Notifiable Disease, 2015

Category	Disease	Total	Indigenous Case	Imported Case
I	Smallpox	0	0	0
	Plague	0	0	0
	Severe Acute Respiratory Syndrome (SARS)	0	0	0
	Rabies	0	0	0
II	Diphtheria	0	0	0
	Typhoid Fever	29	15	14
	Dengue Fever	43,784	43,419	365
	Meningococcal Meningitis	3	3	0
	Paratyphoid Fever	3	2	1
	Poliomyelitis	0	0	0
	Acute Flaccid Paralysis (Note 3)	19	19	0
	Shigellosis	186	81	105
	Amoebiasis	350	154	196
	Malaria	8	0	8
	Measles	29	23	6
	Acute Hepatitis A	171	126	45
	Enterohaemorrhagic Escherichia coli Infection	0	0	0
	Hantavirus Hemorrhagic Fever with Renal Syndrome	2	2	0
	Hantavirus Pulmonary Syndrome (HPS)	0	0	0
	Cholera	10	9	1
	Rubella	7	3	4
	Chikungunya Fever	4	0	4
	West Nile Fever	0	0	0
	Epidemic Typhus Fever	0	0	0
	Anthrax	0	0	0

Table 1 Number of Confirmed Cases of Acute Notifiable Disease, 2015 (Continued)

Category	Disease	Total	Indigenous Case	Imported Case
III	Pertussis	70	70	0
	Tetanus (Note 4)	12	-	-
	Japanese Encephalitis	30	30	0
	Congenital Rubella Syndrome	0	0	0
	Acute Hepatitis B	125	119	6
	Acute Hepatitis C	217	215	2
	Acute Hepatitis D	2	2	0
	Acute Hepatitis E	8	5	3
	Acute Hepatitis Unspecified	2	2	0
	Mumps (Note 4)	773	-	-
	Legionnaires' Disease	153	148	5
	Invasive Haemophilus Influenzae Type b (Hib) Infection	3	3	0
	Neonatal Tetanus	0	0	0
	Enteroviruses Infection with Severe Complications	6	6	0
IV	Herpesvirus B Infection	0	0	0
	Leptospirosis	81	79	2
	Melioidosis	32	30	2
	Botulism	2	2	0
	Invasive Pneumococcal Disease	524	522	2
	Q Fever	43	41	2
	Endemic Typhus	35	34	1
	Lyme Disease	2	0	2
	Tularemia	0	0	0
	Scrub Typhus	494	491	3
	Complicated Varicella	54	53	1
	Toxoplasmosis	13	12	1
	Complicated Influenza	857	853	4
	Brucellosis	1	0	1

Table 1 Number of Confirmed Cases of Acute Notifiable Disease, 2015 (Continued)

Category	Disease	Total	Indigenous Case	Imported Case
V	Rift Valley Fever	0	0	0
	Marburg Haemorrhagic Fever	0	0	0
	Yellow Fever	0	0	0
	Ebola Virus Disease	0	0	0
	Lassa Fever	0	0	0
	Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infections	0	0	0
	Novel Influenza A	0	0	0

Notes:

1. Date of Download: Data were downloaded on May 1, 2016.
2. Day of disease onset is used as the basis of analysis for all acute notifiable diseases.
3. No wild poliovirus has been detected in Taiwan since 1984. Nationwide surveillance of acute flaccid paralysis has been used for detecting cases of poliomyelitis since implementation of the Eradication Program for Measles, Congenital Rubella Syndrome, Poliomyelitis, and Neonatal Tetanus in 1992.
4. Tetanus and mumpsare cases reported by the physician without laboratory testing of specimens.

Table 2 Number of Confirmed Cases of Chronic Notifiable Disease, 2015

Categories	Diseases	Number of Confirmed Cases
II	Multidrug-Resistant Tuberculosis (MDR-TB)	117
III	Tuberculosis	10,711
	Syphilis	7,471
	Gonorrhea	3,587
	Human Immunodeficiency Virus Infection (HIV Infection)	2,327
	Acquired Immunodeficiency Syndrome (AIDS)	1,440
	Hansen's Disease	16
IV	Creutzfeldt-Jakob Disease	0

Notes:

1. Date of Download: Data were downloaded on May 1, 2016.
2. Caseloads of MDR-TB were calculated based on the registration date by the Taiwan CDC. Tuberculosis caseloads were based on the notification date. Other chronic notifiable diseases were analyzed based on the diagnosis date.

Taiwan Health and Welfare Report 2016

Published by the Ministry of Health and Welfare, R.O.C. (Taiwan)
Address: No.488, Sec. 6, Zhongxiao E. Rd.,Nangang Dist., Taipei City 115
Tel: +886-2-8590-6666
Fax: + 886-2-8590-7092
Design by Arteck Design & Consulting
First edition: November 2014

Available on the MOHW website (www.mohw.gov.tw), also available at the following bookstores:
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ISSN: 2409-2630
GPN: 2010302163

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GPN : 2010302163
Price：NT$300