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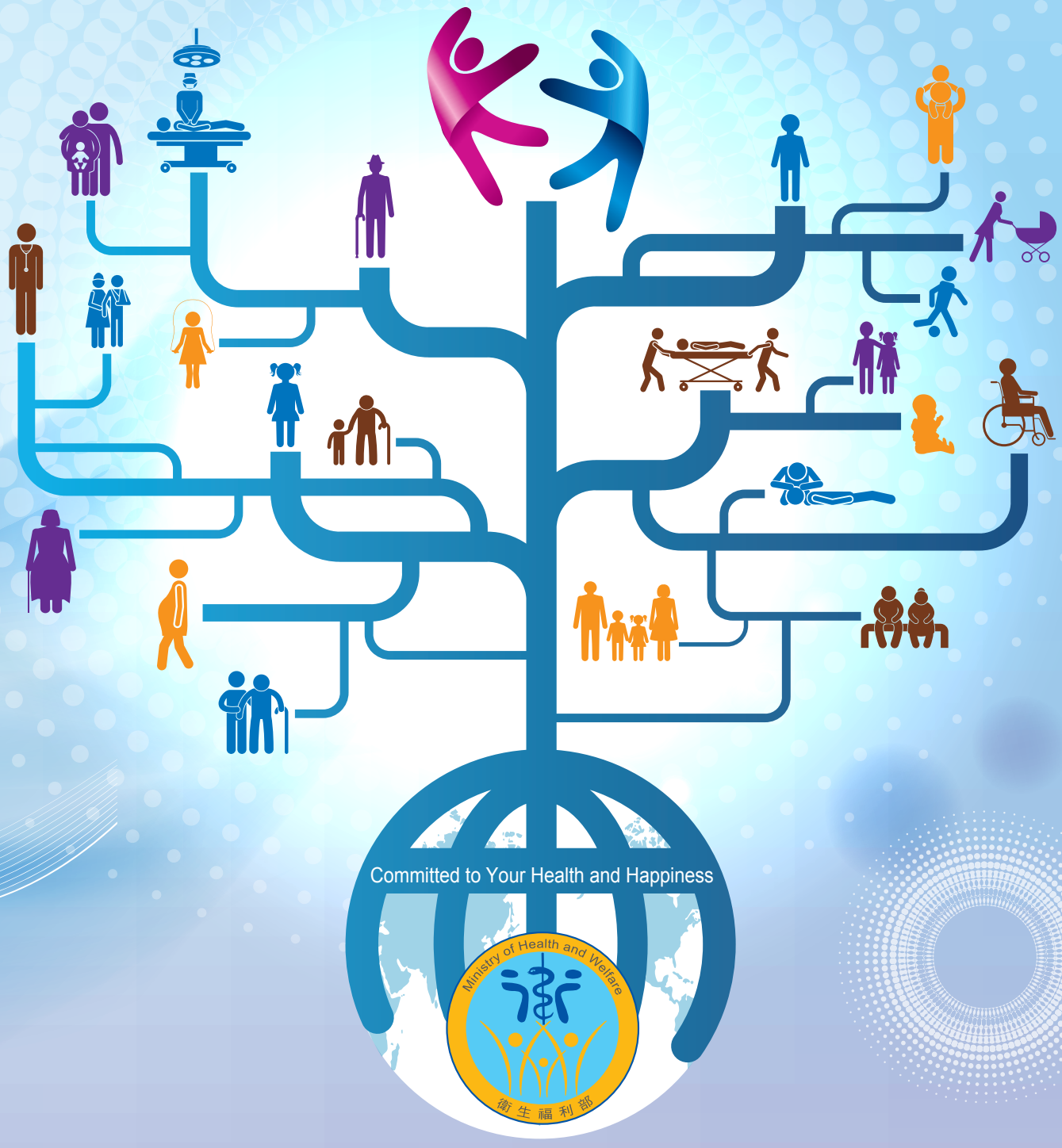
2015 Taiwan Health and Welfare Report

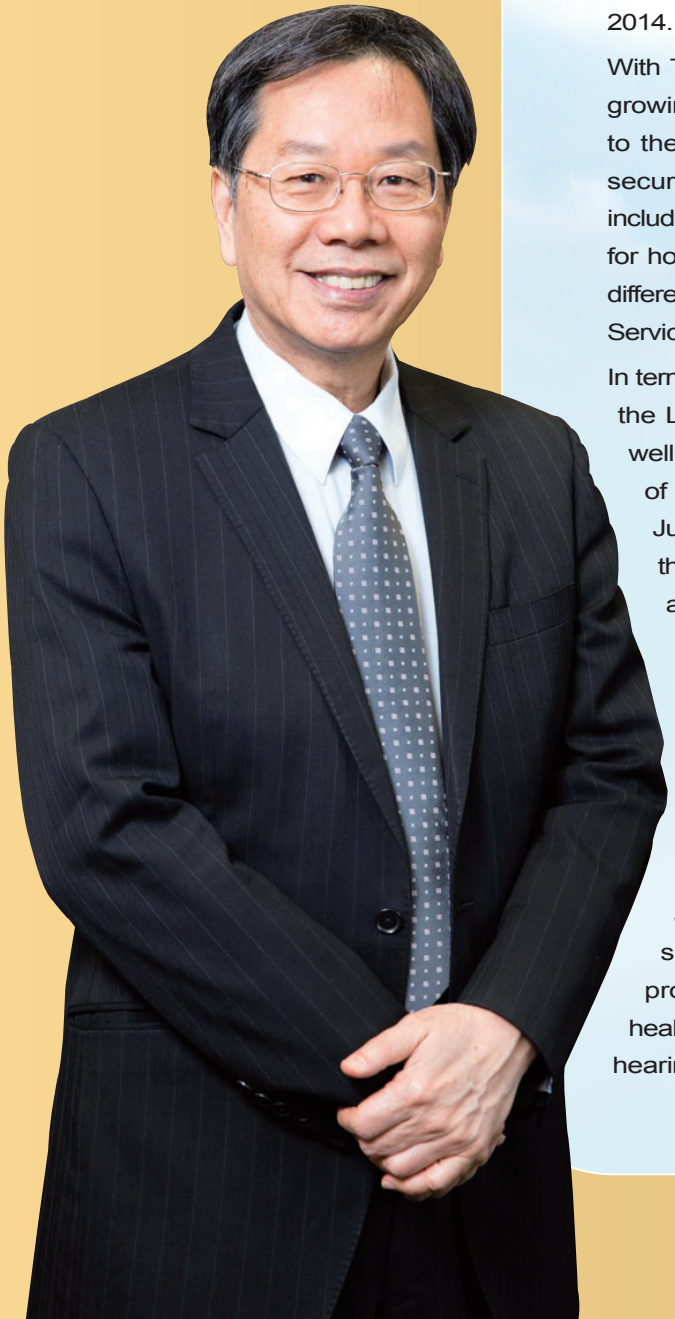


Ministry of Health and Welfare, R.O.C.(Taiwan)

Taiwan Health and Welfare Report 2015

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

Foreword



Taiwan's Ministry of Health and Welfare (MOHW) is responsible for overseeing the nation's health care and social welfare. Its duties include health care policies, health promotion, disease prevention and control, food safety, drug management, social insurance, welfare services, social relief, protective services, biotechnology R&D, international health cooperation and other areas affecting public health and well-being. To meet citizens' expectations, the MOHW maintains a global perspective that uses international strategies and localized approaches to implement policies and plan for the future.

To help the public understand health and social administration policies, each year the MOHW publishes a *Taiwan Health and Social Welfare Report*. This latest report details our ministry's achievements in responding to health and social welfare issues in 2014.

With Taiwan now considered an aging society, we must meet a growing demand for geriatric care. Comprehensive assistance to the elderly is based on three main policy areas: economic security, health maintenance and life care. Specifically, these include subsidized living allowances for the elderly and allowances for household caregivers. By integrating inter-agency resources, different departments are implementing a plan called Friendly Care Services for the Senior Phase II.

In terms of long-term care (LTC), we have continued implementing the LTC 10-Year Plan and the LTC Service Network Plan, as well as drafting laws governing LTC services. Following years of effort, a Long-Term Care Services Act was announced in June 2015, with implementation scheduled for 2017. Through these initiatives, Taiwan is building an LTC service system. To address financial risks faced by the disabled and to reduce the care burden on their families, the MOHW drafted a Long-Term Care Insurance Act that has been sent to the Legislative Yuan for review. By creating a better LTC system, Taiwan will build a more comprehensive social safety net.

To achieve the World Health Organization's goal of health for all, the MOHW plans health promotion policies that address all life stages. These include prenatal checkups, subsidies for genetic testing of high-risk pregnant women, promotion of breastfeeding, immunizations and preventive health services, dental fluoride treatments, vision screenings and hearing exams. Screenings also have been expanded for four

major types of cancer. Taiwan supports health-supportive environments and has promoted Healthy City certification and other programs to implement holistic health approaches.

To improve the quality of health services and build a patient-oriented medical care environment, our ministry has set annual goals to improve health care quality and patient safety, as well as a patient safety incident reporting system. Accreditation of hospitals and teaching hospitals were amended to emphasize safety and patient-centered care, two of our core values. By integrating hospital accreditation with medical and health service inspections and certification of medical schools, we helped health care organizations to run more smoothly.

To improve health workers' employment conditions, since 2012 the MOHW has implemented a pilot program for birth accident relief. In October 2014 the plan was expanded to include surgical and anesthesia incidents to reduce malpractice claims. Reform plans also include increasing nursing salaries and benefits, improving nurse/patient ratios and including these ratios in hospital accreditations, as well as more closely monitoring hospitals' adherence to labor regulations.

When an Ebola outbreak emerged in 2014, the MOHW monitored the international situation, warned the public and doctors to raise alert levels, and established an Ebola Emergency Response Task Force. In 2014, two disease control doctors were dispatched to Nigeria, where they assisted Taiwanese businesspeople and compatriots with epidemic prevention strategies.

Higher temperatures and rainfall have increased threats from dengue fever, with confirmed indigenous cases rising to a record of 15,492 in 2014. In terms of disease prevention strategies, the MOHW continued to both expand and revise guidelines. Diverse publicity channels encouraged communities to clear vector breeding sites and form preventive teams to supervise local disease control efforts.

To protect young people, the MOHW revised laws and regulations and expanded specific policies. In June 2014, we issued the Implementation Act of the Convention on the Rights of the Child to bring legal protections in line with international standards. And in February 2015, the Child and Youth Sexual Prevention Act was amended as the Child and Youth Sexual Exploitation Prevention Act.

The MOHW established standards for reporting and resolving domestic violence cases as part of a comprehensive safety network. On January 23, 2015, the Domestic Violence Prevention Act was amended to further protect children and youths who witness domestic violence, as well as partners who live separately.

Inferior cooking oil incidents in 2014 damaged public confidence in food safety. To better protect consumers, the Executive Yuan established an office that focuses on eight major measures to improve food safety. The MOHW continues to expand and amend food regulations to strengthen safety management at the source and instill confidence, as well as restore order to the market.

Looking back on 2014, our ministry was able to respond to and resolve many difficulties and challenges promptly through coordination and cooperation. I hope this annual report effectively describes our work and achievements. I look forward to any comments and criticism it provokes that will help us better meet people's health and welfare needs.

Minister of Health and Welfare

Contents

1 Health and Welfare Policies

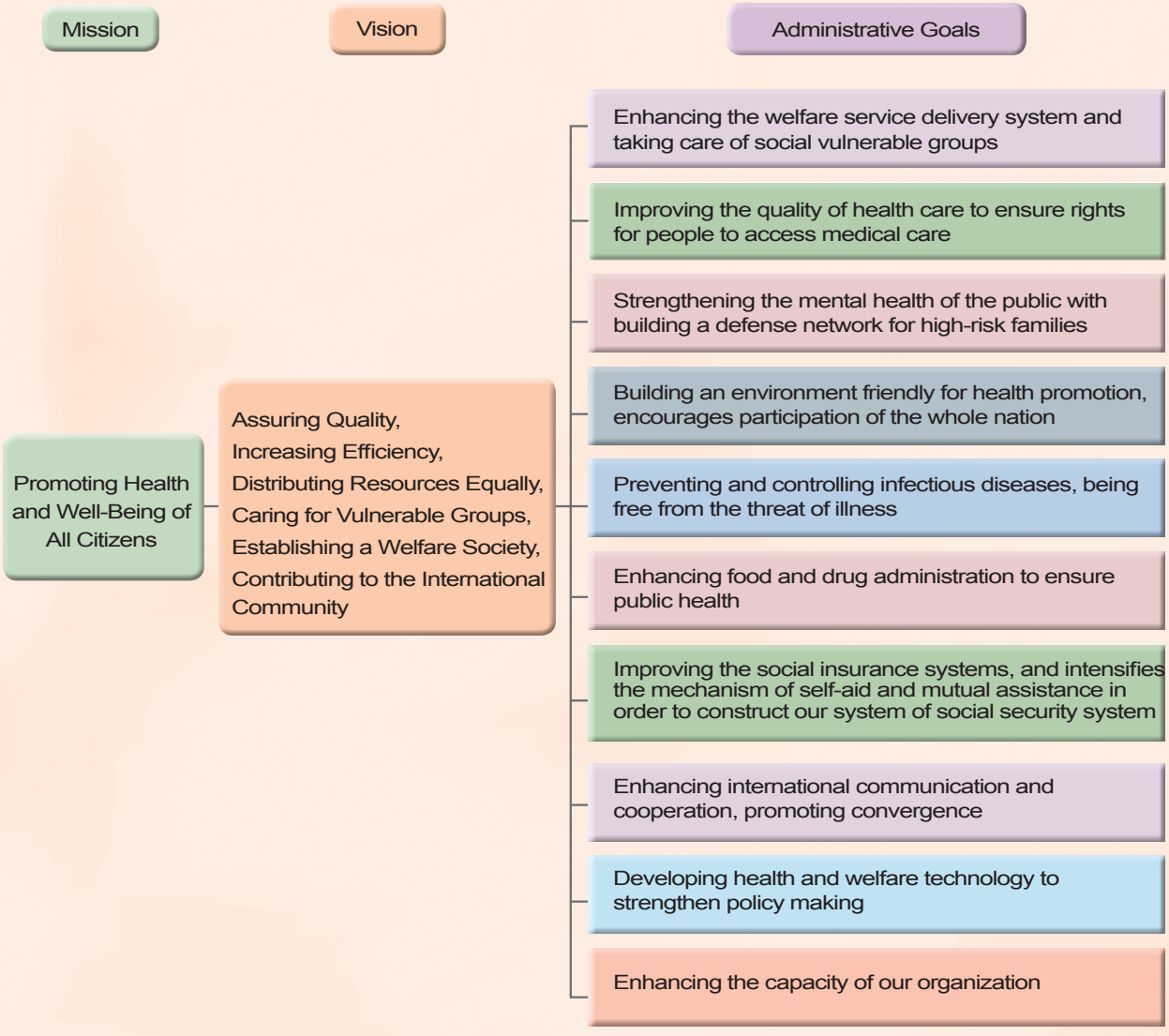
The mission of the MOHW is promoting health and welfare for our people, and the visions are carrying out the best qualities, improving efficiency of our services, equally distributing the resources, caring for the vulnerable groups, guarding social welfare and marking international contributions. Therefore, the ministry builds an environment friendly for health promotion, encourages participation of the whole nation and makes efforts to construct a comprehensive health and social welfare system in order to provide a holistic care oriented service of health and welfare.

Chapter 1 Administrative Goals

Section 1 Administrative Goals, 2014

In accordance with the administrative policy guidelinesof the Executive Yuan, 2014, the MOHW took our current social situation and the need of national development into consideration, and established 10 major administrative goals for 2014 to fulfill the mission of promoting public health and well-being (Figure 1-1).

Figure 1-1 Administrative Goals of the MOHW, 2014



A ceremony to mark the completion of the MOHW building

Section 2 Gender Mainstreaming Plan, 2014

In response to the gender mainstreaming strategy of the United Nations, the MOHW formed a program to put gender mainstreaming into practice in 2014, which was aimed to integrate gender perspective with missions and implementing the "Convention on the Elimination of All Forms of Discrimination against Women, CEDAW." The key elements of our gender mainstreaming related missions include:

1. Identifying high-risk cases of intimate partner violence at early stage with interventions through the risk assessment mechanism in order to prevent the victims from being involved in violence again.
2. Implementing the seamless supervision of the released sex offenders with a strengthened the community control network to reduce the recidivism rate.
3. Constructing a disseminated long-term care service network and enhancing the skills of long-term care workforce in order to improve overall service capacity and provide the disabled and their family caregiver with an accommodating care service.
4. Cooperating with the local governments and NGOs in carrying out parent education including gender equality and gender violence prevention.
5. Constructing a friendly childcare with the Program of Management and Subsidy for Childminder Services and providing subsidies of nursery expenses to lessen the financial burden in accordance with the program. Besides, the local governments are encouraged to complete the childcare system in ways of public-private partnership to offer a high-quality, multifunctional and nonprofit nursery service.
6. Integrating the resources of the local government and NGOs to promote community care services for the children and juvenile from disadvantaged families and to strengthen the care of grandparenting and single-parent families.
7. To increase the manpower of Ob/Gyn specialists, a subsidy program for resident doctors of appointed specialties is carried out to promote the enrolment rate of Ob/Gyn specialists.
8. Improving the nursing practice environment and enriching nursing manpower:

   In the hope of retaining the nurses in the post and enhancing reflux of nursing workforce, we promote a short- and mid-term program of reforming nursing workforce with 6 primary objectives and 10 major strategies to reduce nursing workload, raising the pay and benefits of nurses and improving the nursing practice environment. Besides, the ministry cooperates with nursing associations to promote professional nursing images and continue employment matchmaking in order to draw male workers to nursing profession.

The MOHW was honored by the Executive Yuan at its 13th awards ceremony for the promotion of gender mainstreaming

Section 3 Smart Health Policies

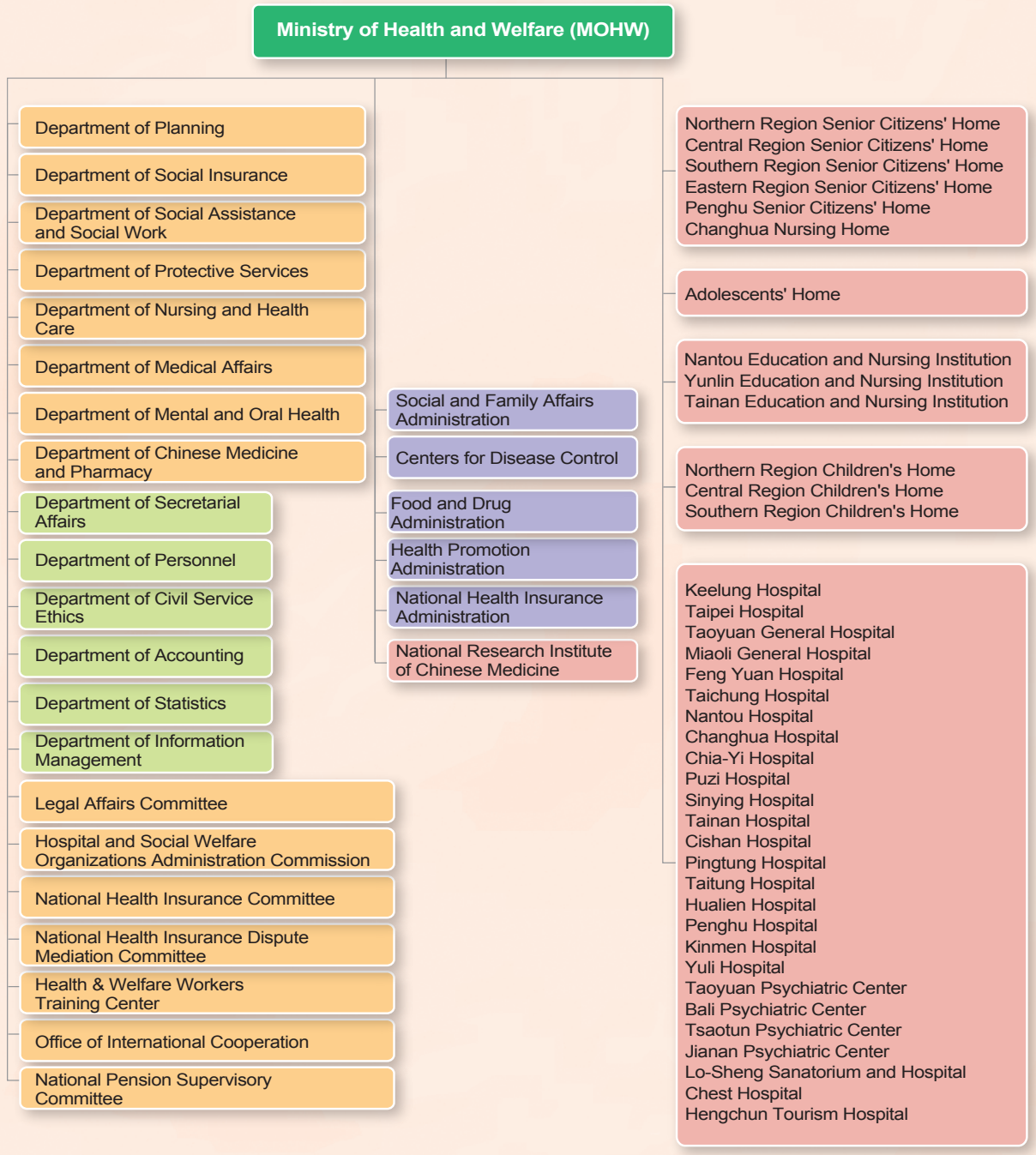
In accordance with the Executive Yuan's "Cloud Computing Applications and Industry Development Program", the MOHW launched "Taiwan Health Cloud, which will be completed between 2014 and 2016 and consists of four sub-programs: a health promotion cloud, a medical care cloud, a health care cloud, and a communicable disease control cloud. In addition, based on electronic medical records, the MOHW has promoted inter-operability of the information systems between various medical care institutions, with shared information including prevention, medical care, extended care, and communicable disease control. To be specific, the health promotion cloud improves transmission of personalized preventive health information to those most in need. The medical care cloud takes advantage of electronic medical records transmission to promote interconnected diagnostic and treatment services between different medical care institutions. The health care cloud builds joint IT platforms of care for institutions at different levels. The communicable disease control cloud enables medical care institutions reporting communicable disease cases to the Taiwan Centers for Disease Control of the MOHW through the communicable disease reporting modules in the electronic medical records system, therefore the transmission of disease is under control. It is expected to benefit from the cloud and promote public health.

In terms of cloud information services, to improve the safety of medicine use and avoid duplicate prescription and administration of medications, the MOHW established the NHI Pharma Cloud system that physicians and pharmacists can use to check patients' medication records. In order to promote self-management, the MOHW established "My Health Bank", for people to check their medical record sanytime and anywhere. Also, to make it easier for people to search for accurate health and social administrative information immediately and precisely, the MOHW set up the "health and welfare e-treasure chest" on the official site. For novice parents,the MOHW established the "stork information service website," which provides information and services of marriage, pregnancy, and rearing of preschool children.

Chapter 2 Health and Welfare Organization

Formally established on July 23, 2013, the MOHW consists of eight departments (Department of Planning, Department of Social Insurance, Department of Social Assistance and Social Work, Department of Nursing and Health Care, Department of Protective Services, Department of Medical Affairs, Department of Mental and Oral Health, and Department of Chinese Medicine and Pharmacy), six administrative departments (Department of Secretarial Affairs, Department of Personnel, Department of Civil Service Ethics, Department of Accounting, Department of Statistics, Department of Information Management), seven mission-oriented units (Legal Affairs Committee, Hospital and Social Welfare Organizations Administration Commission, Health and Welfare Workers Training Center, National Pension Supervisory Committee, National Health Insurance Committee, National Health Insurance Dispute

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



Mediation Committee, Office of International Cooperation), and six affiliated third level agencies (institutes) (Centers for Disease Control, Food and Drug Administration, National Health Insurance Administration, Health Promotion Administration, Social and Family Affairs Administration, National Research Institute of Chinese Medicine). It oversees 26 hospitals and 13 social welfare institutions (Figure 1-2). The ministry is responsible for health promotion, medical care services, disease control, food and drug management, social insurance, welfare service, social assistance, and protective services.

Chapter 3 Health and Welfare Budget

Final accounts from 2014 showed health and welfare expenditures of NTD137,214,091,000, comprising NTD93,663,667,000 for social insurance (68.26%), NTD18,998,036,000 for medical and health care (13.85%), NTD19,082,149,000 for welfare services (13.91%), NTD3,889,834,000 for science (2.83%), NTD1,518,782,000 for social assistance (1.11%), and NTD61,623,000 for education (0.04%), as illustrated in Figure 1-3.

The total budget for 2015 was NTD 175,393,100,000 comprising NTD133,199,554,000 for social insurance (75.94%), NTD18,348,718,000 for medical and health care (10.46%), NTD17,965,949,000 for welfare services (10.24%), NTD4,193,176,000 for science (2.39%), NTD1,607,937,000 for social assistance (0.92%), and NTD77,766,000 for education (0.05%), as illustrated in Figure 1-4.

Figure 1-3 Central Government Health and Welfare Expenditures, 2014 Final Accounts

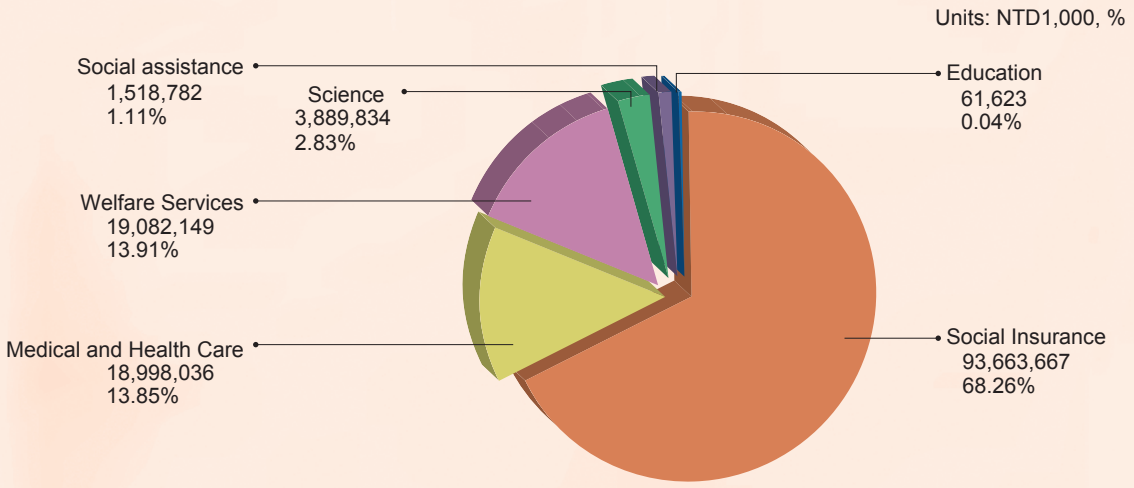
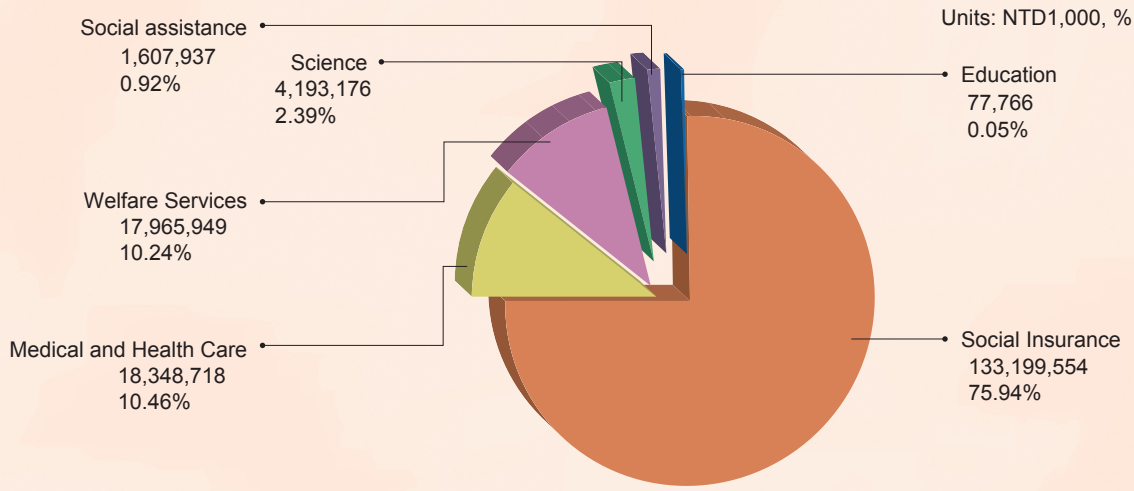


Figure 1-4 Central Government Health and Welfare Budget, 2015



2 Health and Welfare Indicators

Taiwan's annual growth in life expectancy over the past half century can be attributed to many factors, including rising incomes, an improved living environment and nutrition, and advances in medicine and health care. These positive changes havebeen accompanied by new challenges. As baby boomers grow old, greater attention must be paid to health and disease problems among the elderly. Population aging, intensified by the low birth rate, is impacting the rate of economic growth and national health expenditure (NHE). In this part, these topics will be examined by looking at important health and welfare indicators, including population indicators, vital indicators, NHE, and international comparisons.

Chapter 1 Population Indicators

At the end of 2014, Taiwan had a registered population of 23 million, consisting of 12million males and 12 million females. The sex ratio (ratio of males to females normalized to 100) was 99.7, and annual population growth was 2.6‰.

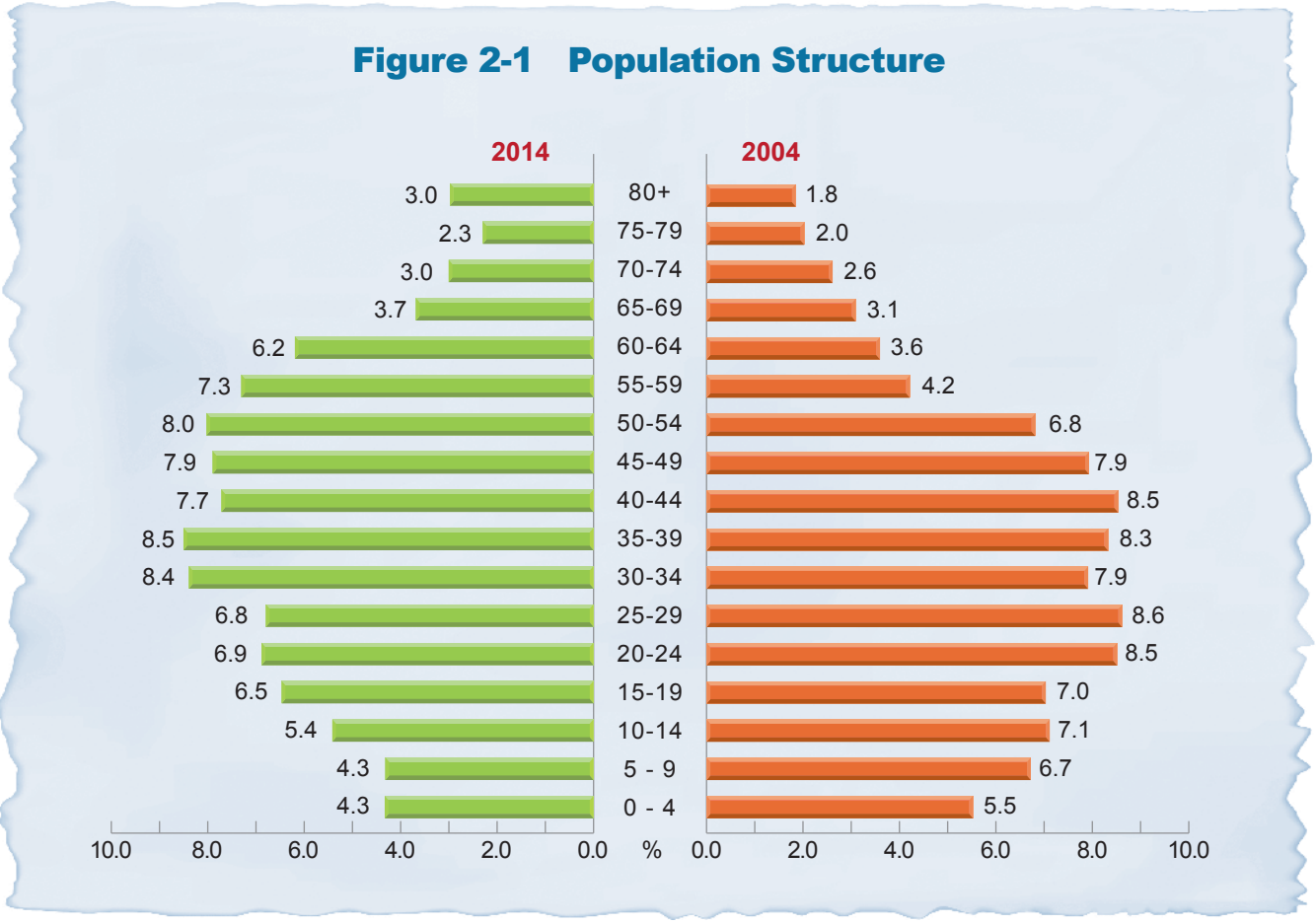
The population density at the end of 2014 was 647 people per km^2. The densest city was Taipei, at 9,942 people per km^2, followed by Chiayi City, at 4,513 people per km^2. The least dense jurisdictions were on the east coast: Hualien and Taitung counties, at 72 people per km^2 and 64 people per km^2, respectively.

Section 1 Population Structure

Between 2004 and 2014, the gradually declining birth rate caused the proportion of the population aged 14 and younger to drop and the proportion of the population aged 65 and older to increase during the same period (Figure 2-1).

Historic age structure data show that the percentage of the population aged 65 and older reached 7% in 1993, making Taiwan an aged society. The percentage of the population aged 14 and younger dropped from 20.8% in 2001 to 14.0% in 2014. During the same period, the proportion of the population aged 65 and older increased from 8.8% to 12.0%. Aging of the population was becoming increasingly evident (Figure 2-2 and Table 2-1).

Figure 2-1 Population Structure



The dependency ratio, (people aged 14 and younger and 65 and older) to the working-age population (those aged 15-64), fell from 42.1% in 2001 to 35.1% in 2014. The decline can be attributed to the rapid decrease in the young age dependency ratio (the ratio of dependents aged 14 and younger to the population aged 15-64) and the steady increase in the old age dependency ratio (ratio of population aged 65 and older to the population aged 15-64).

Section 2 Birth and Death

Changes in social values led to annual decreases in the fertility rate, with the crude birth rate (live births per 1,000 population) falling from 11.7‰ in 2001 to 9.0‰ in 2014. The crude death rate (total number of deaths per 1,000 population) rose from 5.7‰ in 2001 to 7.0‰ in 2014. The rate of natural increase (crude birth rate minus crude death rate) fell to a record low of 0.9‰ in 2010 before rising to 2.0‰ in 2014 (Figure 2-3).

Figure 2-2 Age Structure and Dependency Ratio, 1981-2014

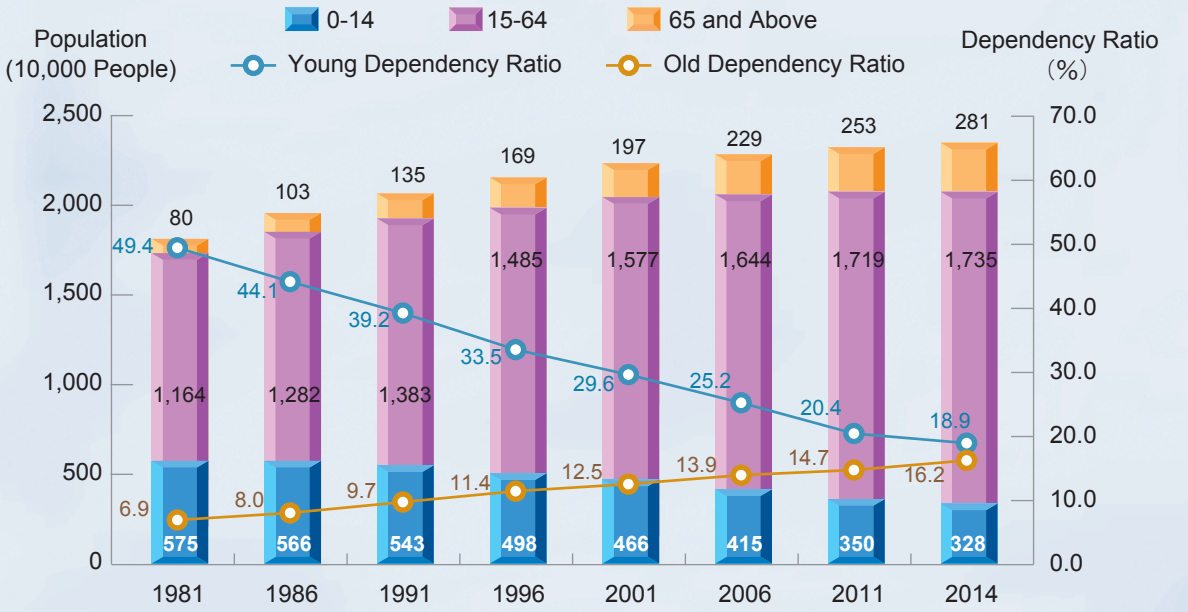
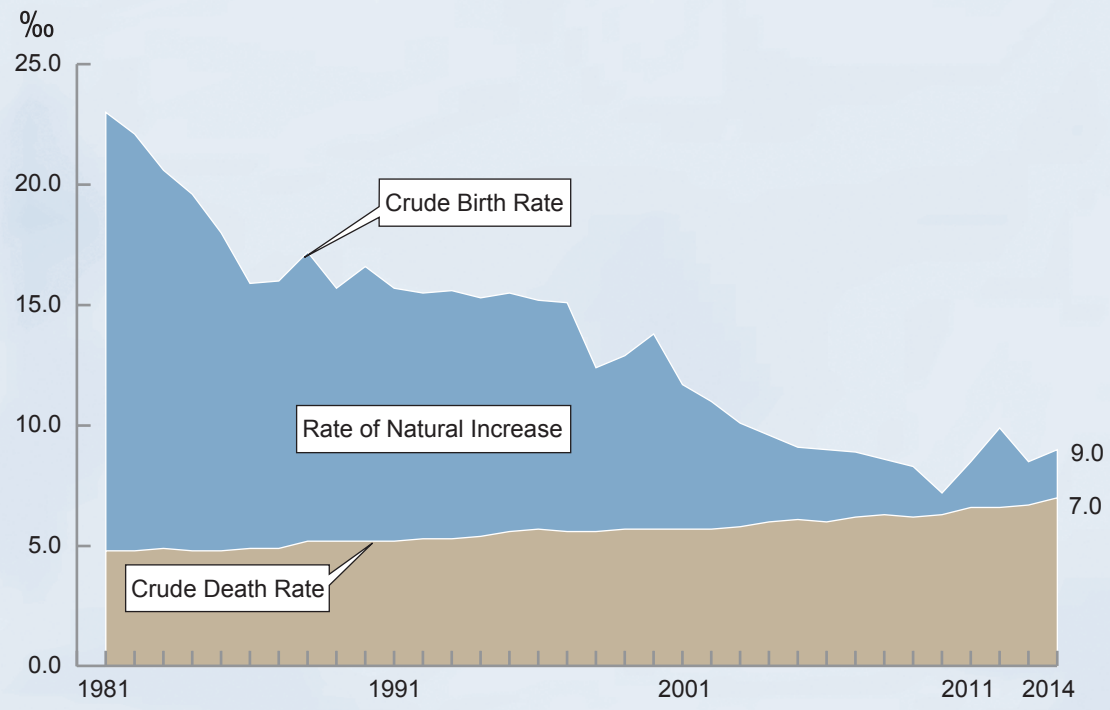


Table 2-1 Age Structure and Dependency Ratio, 1981-2014

End-year	Total Population (1,000s)	Population Structure (%)			Dependency Ratio (%)	
		0-14	15-64	65 and Above	Young Dependency Ratio	Old Dependency Ratio
1981	18,194	31.6	64.0	4.4	49.4	6.9
1991	20,606	26.3	67.1	6.5	39.2	9.7
2001	22,406	20.8	70.4	8.8	29.6	12.5
2011	23,225	15.1	74.0	10.9	20.4	14.7
2014	23,434	14.0	74.0	12.0	18.9	16.2

Source: Department of Household Registration Affairs, Ministry of the Interior

Figure 2-3 Crude Birth Rate, Crude Death Rate, and Rate of Natural Increase, 1981-2014



Section 3 Life Expectancy

According to estimates from the Ministry of the Interior, the life expectancy at birth for both sexes was 79.8 in 2014, an increase of 2.3 years compared to 10 years earlier. For males in the same period, life expectancy at birth increased by 2.0 years to 76.7, and for females it increased by 2.4 years to 83.2. The higher increase for females caused the life expectancy gap between the sexes to widen (Figure 2-4 and Table 2, Appendix 1).

Chapter 2 Vital Indicators

Section 1 10 Leading Causes of Death

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

In 2014, there were 162,911 deaths, and the crude mortality rate was 696.1 per 100,000 population, an increase of 5.3% compared to 2013, and an increase of 17.9% compared to 2004. The standardized mortality rate (based on the WHO standard world population age structure for 2000) was 443.6 people per 100,000 population, an increase of 1.9% compared to 2013, and a decrease of 16.1% compared to 2004.

In 2014, the 10 leading causes of death accounted for 77.5% of all deaths and were primarily chronic diseases. In order they were: 1.Malignant neoplasms, 2.Diseases of the heart (except hypertensive diseases), 3.Cerebrovascular diseases, 4.Pneumonia, 5.Diabetes mellitus, 6.Accidents and adverse effects, 7.Chronic lower respiratory diseases, 8.Hypertensive diseases, 9.Chronic liver disease and cirrhosis, and 10.Nephritis, nephrotic syndrome, and nephrosis. When compared to 2004, pneumonia and hypertensive diseases rose in the rankings; diabetes mellitus, accidents and adverse effects, chronic liver disease and cirrhosis, and nephritis, nephrotic syndrome and nephrosis fell (Figure 2-5).

Figure 2-4 Life Expectancy at Birth

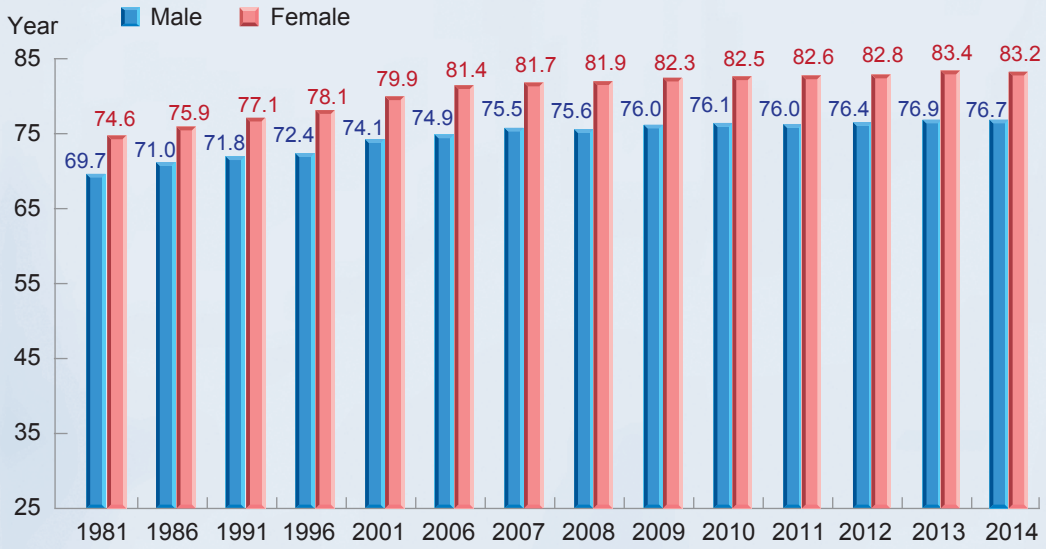
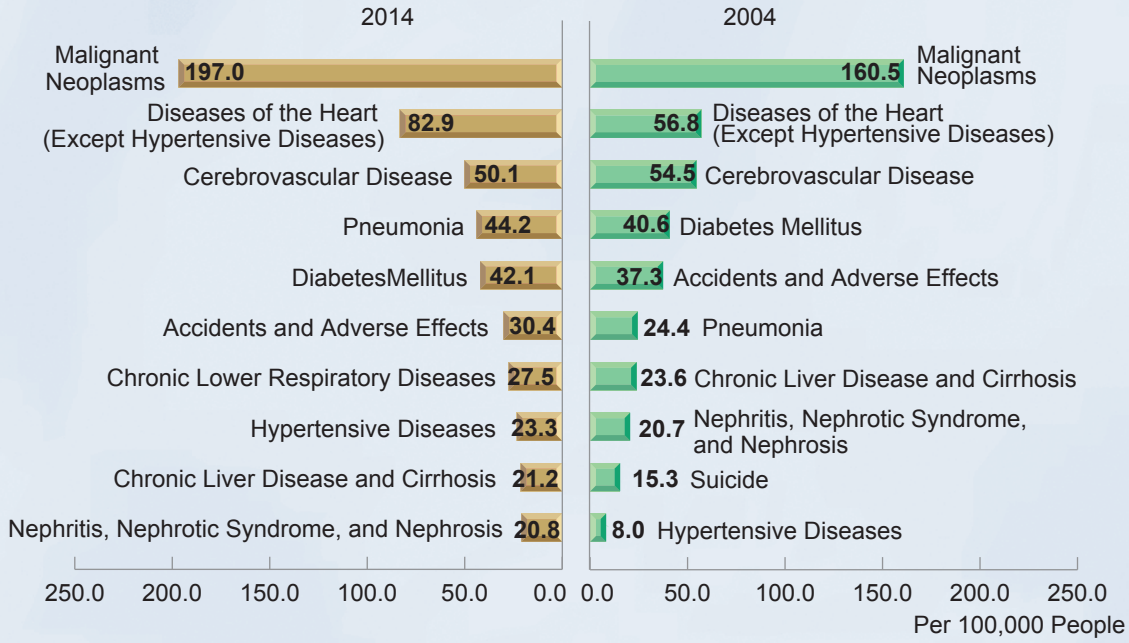


Figure 2-5 Changes in the 10 Leading Causes of Death



Section 2 Cancer Incidence and Causes of Cancer Death

1. Cancer Incidence

According to 2012 cancer registry data, the crude incidence rates of cancer for males and females were 458.8 and 370.6 people per 100,000 population, respectively. If adjustments are made based on the WHO-constructed standard world population age structure from 2000, the age-standardized incidence rates for males and females were to 341.4 and 263.3 people per 100,000 population, respectively (Table 2-2).

2. Causes of Cancer Death

In 2014, there were 46,095 cancer deaths. This accounted for 28.3% of total deaths and a crude mortality rate of 197.0 per 100,000 population, an increase of 2.6% compared to 2013, and an increase of 22.7% compared to 2004. The standardized cancer mortality rate in 2014 was 130.2 per 100,000 population, a decrease of 0.2% compared to 2013, and a drop of 8.8% compared to 2004.

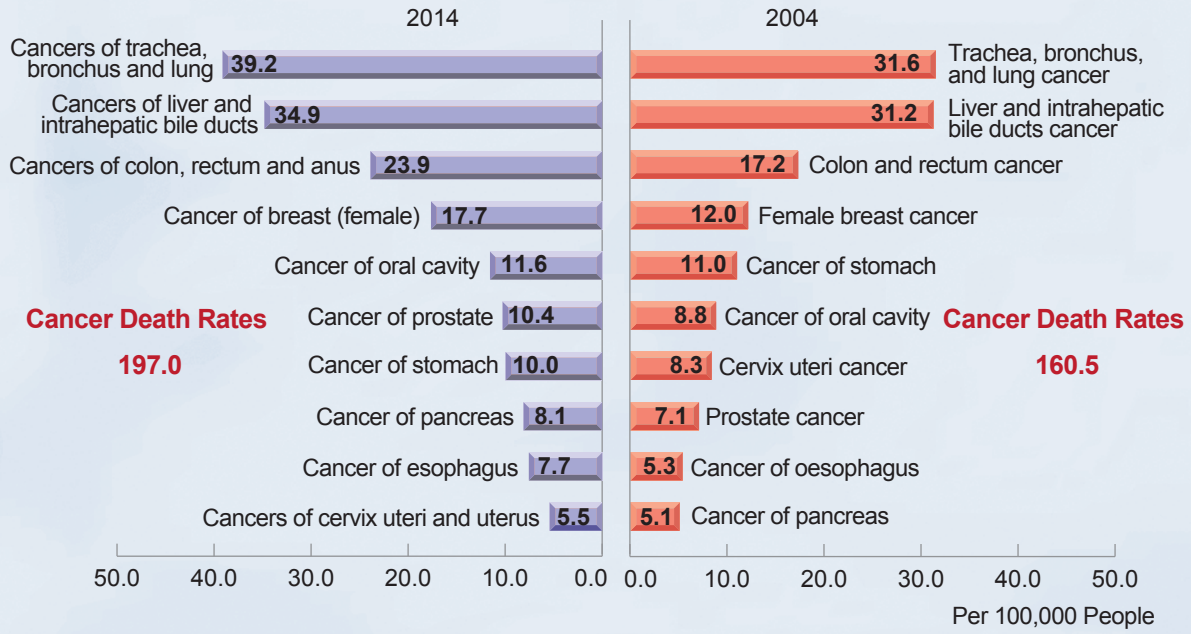
The 10 leading causes of cancer death in 2014 were: 1. Cancers of the trachea, bronchus, and lung, 2.Cancers of the liver and intrahepatic bile ducts, 3.Cancers of the colon, rectum, and anus, 4.Cancers of the breast (female), 5.Cancer of the oral cavity, 6.Cancer of the prostate, 7.Cancer of the stomach, 8.Cancer of the pancreas, 9.Cancer of the esophagus, and 10. Cancers of the cervix uteri and uterus, part unspecified. When compared to 2004, Cancer of oral cavity, Cancer of prostate, and Cancer of pancreas rose in the rankings; Cancer of stomach and Cancers of cervix uteri and uterus fell (Figure 2-6).

Table 2-2 Incidence of 10 Leading Cancers, 2012

Male				Female			
Rank	Site	No. of Cases	Age-Standardized Incidence Rate (per 100,000 People)	Rank	Site	No. of Cases	Age-Standardized Incidence Rate (per 100,000 People)
1	Colorectal	8,558	53.7	1	Female Breast	10,525	65.9
2	Liver and Intrahepatic Bile Ducts	7,924	50.6	2	Colorectal	6,407	37.3
3	Lungs, Bronchus, and Trachea	7,072	44.0	3	Lungs, Bronchus, and Trachea	4,620	26.8
4	Oral Cavity, Oropharynx, and Hypopharynx	6,462	41.7	4	Liver and Intrahepatic Bile Ducts	3,498	20.3
5	Prostate	4,735	29.7	5	Thyroid	2,236	15.3
6	Stomach	2,387	14.5	6	Corpus Uteri	1,936	12.0
7	Esophagus	2,194	13.8	7	Cervix	1,567	9.6
8	Skin	1,820	11.3	8	Skin	1,454	8.2
9	Bladder	1,416	8.7	9	Ovary, Fallopian Tube, and Broad Ligament	1,236	8.0
10	Non-Hodgkin's Lymphoma	1,269	8.3	10	Stomach	1,409	8.0
	Total	53,553	341.4		Total	43,141	263.3

Notes: 1. Ranked from highest to lowest by age-standardized incidence rate.
2. The age-standardized incidence rate is based on the standard world population age structure in 2000.
3. Source: Cancer registry data (excluding carcinoma in situ)

Figure 2-6 Changes in the 10 Leading Causes of Cancer Death



Section 3 Infant and Neonatal Mortality Rates

Advances in public health led to general declines in both the infant mortality rate (deaths before completing the first year of age 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 2014, the infant mortality rate had declined to 3.6 per 1,000 live births, compared to 8.9 deaths per 1,000 live births in 1981. Over the same period, the neonatal mortality rate dropped from 3.1‰ to 2.2‰ (Figure 2-7).

Chapter 3 National Health Expenditure

Good health care, a basic need in modern society and a measure of a country's advancement, comes at a cost. National health expenditure in Taiwan rose by 17.3% in 1995 after it implemented NHI in March of that year, exceeding growth in national income over the same period and contributing to sustained subsequent increases in health expenditure as a share of (Gross Domestic Product) GDP.

NHE per capita has steadily risen since 1991, with NHE reaching NT$963 billion in 2013. Increases in recent years can be attributed to several factors, such as the expansion of international medicine, development of biomedicine and technology, and rapid population aging. In the future, increases to NHE are expected to continue.

After the NHI was implemented in 1995, NHE as a share of GDP rose to 5.3%, compared to 4.9% in 1994, and by 2013 it had reached 6.6%. NHE per capita rose from NTD10,765 in 1991 to NTD41,242 in 2013, equivalent to an annual average growth rate of 6.3% (Figure 2-8).

Figure 2-7 Infant and Neonatal Mortality Rates

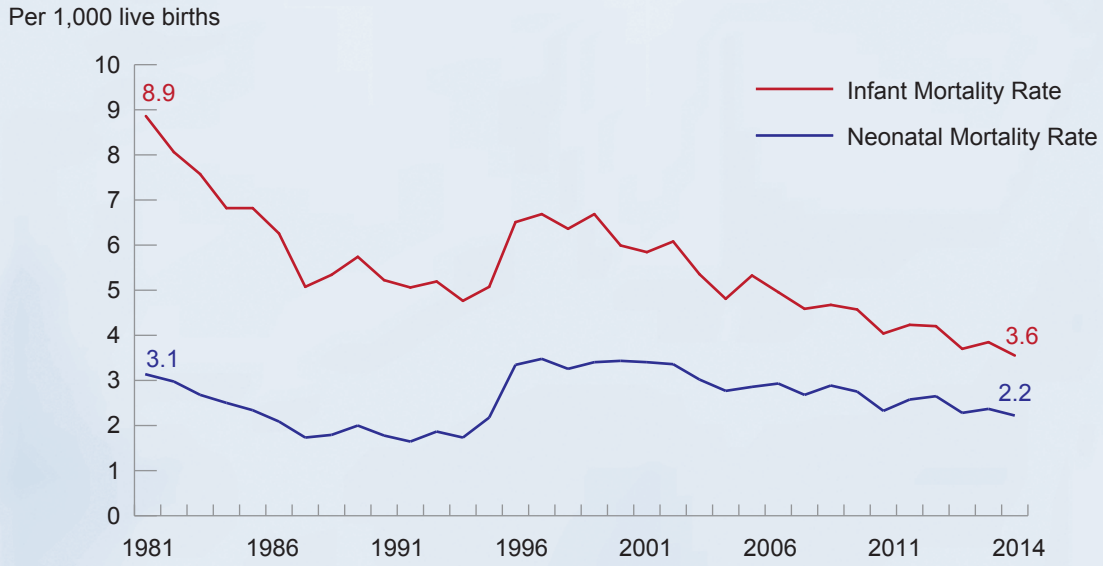
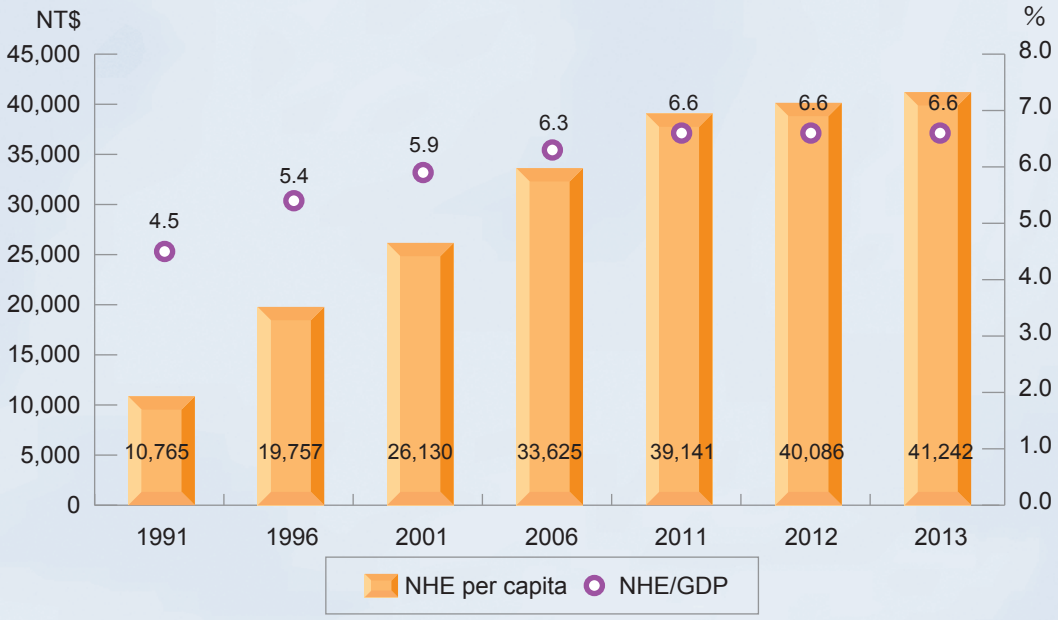


Figure 2-8 NHE/GDP Ratios and NHE per capita, 1991-2013



Chapter 4 International Comparisons

Section 1 Life Expectancy

According to the 2015 WHO Statistical Information System, among major developed countries in 2013, life expectancy for males at birth was greatest in Japan, Canada, Australia, and New Zealand, at 80 years. In Taiwan, it was 77 years, an increase of 6 years over the past two decades.

For females in major developed countries in 2013, life expectancy at birth was greatest in Japan, at 87 years. In Taiwan, it was 83 years, an increase of 6 years over the past two decades (Table 2-3).

Section 2 Rate of Natural Increase

According to the 2015 WHO Statistical Information System, the global total fertility rate in 2013 (the average number of live births for a woman over her lifetime) was 3.0. Fertility rates in the Asian countries listed were below average, indicating that Asia has become a low fertility rate region, particularly in Taiwan, which had a rate of just 1.1. The worldwide birth rate stood at 23 per 1,000 population and the death rate at 8 per 1,000 population. Japan and Germany were noted for having birth rates lower than their death rates. In general, demographic structures in developed countries were trending toward lower birth rates and lower death rates (Table 2-4).

Section 3 Dependency Ratio

According to the latest World Bank data, among major nations in 2013, Japan had the highest dependency ratio, at 61.6%, followed by France at 56.5%, and the United Kingdom at 54.0%. Taiwan's ratio of 34.9% was relatively low. Historic population data show that the dependency ratio in Taiwan fell by 57.1 percentage points over the past five decades, a change primarily attributed to a significant decrease in the young age dependency ratio (Table 2-5).

Section 4 Health Expenditure

Taiwan's NHE per capita at purchasing power parity (PPP) was US$2,668 in 2012-lower than the Organization for Economic Co-operation and Development (OECD) median of US$3,413. If ranked among OECD member states, Taiwan would have been 22nd. GDP per capita in Taiwan was US$40,270 (PPP) -higher than the OECD median of US$35,484 and ranked 14th when compared to OECD member states. Generally, higher GDP per capita is accompanied by higher NHE per capita. In 2012, NHE accounted for a 6.6% share of Taiwan's GDP, a relatively low amount that was 2.7 percentage points below the OECD median and which would have placed Taiwan 32nd among OECD member states (Table 2-6).

Table 2-3 Life Expectancy at Birth in Major Developed Countries

Unit: Years

	Both Sexes		Male		Female	
	1990	2013	1990	2013	1990	2013
Taiwan	74	80	71	77	77	83
Japan	79	84	76	80	82	87
Republic of 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

Sources: 2015 WHO Statistical Information System

Table 2-4 Population Status of Major Countries

	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	3.0	23	8	1.5
Taiwan	23.4	1.1	9	7	0.2
Japan	127.1	1.4	8	10	-0.2
Republic of 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:1. Department of Statistics, Ministry of the Interior
2. 2015 WHO Statistical Information System

Table 2-5 Dependency Ratios of Major Countries

Unit: %

	1960	1970	1980	1990	2000	2005	2010	2013
Taiwan	92.0	74.2	57.3	49.9	42.3	39.7	35.8	34.9
Japan	56.0	45.3	48.4	43.4	46.6	50.7	56.9	61.6
Republic of Korea	80.7	83.3	60.7	44.1	39.5	39.6	37.6	37.1
United States	66.5	61.4	51.3	51.9	50.9	48.9	49.0	50.4
Canada	70.7	61.6	47.4	46.9	46.5	44.5	44.1	46.3
United Kingdom	54.0	59.0	56.1	53.2	53.4	51.3	51.9	54.0
Germany	48.3	58.4	51.8	45.1	46.9	49.9	52.0	52.0
France	61.1	60.4	57.1	51.5	53.7	53.7	54.2	56.5
Australia	63.4	59.4	53.6	49.5	49.6	48.6	47.9	50.2
New Zealand	71.0	67.3	58.6	52.3	52.7	50.5	50.4	51.9

Source: The World Bank
Note: Dependency ratio = People aged 14 and younger + People aged 65 and older/People aged 15-64

Table 2-6 Comparisons of NHE per Capita and GDP per Capita Between Taiwan and OECD Member States, 2012

Ranking	Country - Ranked by NHE per Capita	NHE per Capita (USD PPPs)	GDP per Capita (USD PPPs)	NHE/GDP (%)
Median		3,413	35,484	9.3
1	United States	8,745	51,749	16.9
2	Norway	6,140	66,141	9.3
3	Switzerland	6,080	53,191	11.4
4	Netherlands[2011]	5,219	43,148	12.1
5	Austria	4,896	44,122	11.1
6	Germany	4,811	42,700	11.3
7	Denmark	4,698	42,775	11.0
8	Canada	4,602	42,115	10.9
9	Luxembourg	4,578	89,510	7.1
10	Belgium	4,419	40,563	10.9
11	France	4,288	36,933	11.6
12	Sweden	4,106	42,866	9.6
13	Australia[2011]	3,997	44,023	9.1
14	Ireland	3,890	43,834	8.9
15	Japan	3,649	35,492	10.3
16	Finland	3,559	39,160	9.1
17	Iceland	3,536	39,118	9.0
18	United Kingdom	3,289	35,477	9.3
19	Italy	3,209	34,924	9.2
20	New Zealand[2011]	3,172	31,720	10.0
21	Spain	2,987	32,135	9.3
22	Taiwan	2,668	40,270	6.6
23	Slovenia	2,667	28,476	9.4
24	Portugal[2011]	2,642	25,828	10.2
25	Greece	2,409	25,987	9.3
26	Israel	2,304	31,345	7.3
27	Republic of Korea	2,291	30,011	7.6
28	Slovak Republic	2,105	25,842	8.1
29	Czech Republic	2,077	27,523	7.5
30	Hungary	1,803	22,635	8.0
31	Chile	1,577	21,545	7.3
32	Poland	1,540	22,782	6.8
33	Estonia	1,447	24,572	5.9
34	Mexico	1,048	17,019	6.2
35	Turkey	984	18,260	5.4

Source: 2014 OECD Health Data

3 Friendly Environments Supportive to Health

In order to achieve the "Health for All" policy goal advocated by the World Health Organization (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). When confronting the challenges posed by unhealthy lifestyles, the MOHW not only uses empirical data gathered from health surveillance and research as a basis for action but also human rights, gender, and health equality perspectives, as outlined in the UN "Health in All Policies" initiative, which seeks to take into account the health implications of all decisions. Also, in accordance with the 2012 World Health Assembly "25 by 25" objective (to reduce preventable deaths due to non-communicable diseases by 25% by 2025), the MOHW has incorporated the nine global targets and 25 indicators contained in the objective into its polices. The overall goal is to improve health at the individual, community, national, and global levels.

Chapter 1 Healthy Childbirth and Growth

Achieving healthy growth in children includes detecting and correcting abnormalities at an early stage of development. The MOHW therefore promotes health among pregnant women, infants, toddlers, and adolescents.

Section 1 Maternal Health

1. Prenatal Care

(1) Expectant mothers are offered 10 prenatal checkups during the course of their pregnancy, a benefit that was used 1.949 million person-times and achieved an average usage rate of 94.3% in 2014. Since November 1, 2014, the MOHW has offered two prenatal health education assessment and guidance meetings during the first and third trimester of pregnancy. Through the end of December 2014, there were already 1,196 doctors participating in the program and 66.8% of pregnant women had joined, and these support services were offered 52,126 person-times.

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

Raise health knowledge and capacity to achieve healthy lifestyles
Generalize preventive healthcare services to promote effective prevention and screening
Raise health care quality to improve chronic disease control and prognosis
Build a friendly support environment with more health choices and equality

Womb

◆ Sex education	◆ Birth control guidance
◆ Prenatal care	◆ Group B streptococcus screening
◆ Breastfeeding	◆ Newborn screening
◆ Newborn hearing screening	◆ Children' s preventive health care
◆ Children' s fluoride gel applications	◆ Preschool visual tests
◆ Visual defect screenings	◆ Dental sealant treatment on permanent molars
◆ Fluoride mouth rinse	◆ Adolescent friendly health clinics
◆ Student health examinations	◆ Adult preventive health care
◆ Cancer screenings	◆ Smoking cessation services
◆ Diabetes management	◆ Kidney disease management
◆ Cancer diagnosis and treatment quality certification	◆ Cancer patient services
◆ Hospice and palliative care	

Tomb

A comprehensive international foundation, with a strong legal basis, monitoring and research, education and training, and domestic cooperation

(2) Since April 15, 2012, a NTD500 subsidy toward group B streptococcus screening has been available for all pregnant women. In 2014, there were 182,605 such screening, for a coverage rate of 85.3%, and 21.1% of those screened testing positive.

(3) Subsidies covering prenatal karyotype tests and genetic tests for mothers at high risk of having a child with a genetic disease were raised from NTD2,000 to NTD5,000 in 2014. Another sample collection subsidy of NTD3,500 offered to disadvantaged households in 56 areas lacking in medical resources was expanded to an additional 24 areas. Among the 51,422 people who received these subsidies in 2014, follow-up consultations were provided in all 1,565 cases with abnormalities.

2. Sex Ratio at Birth

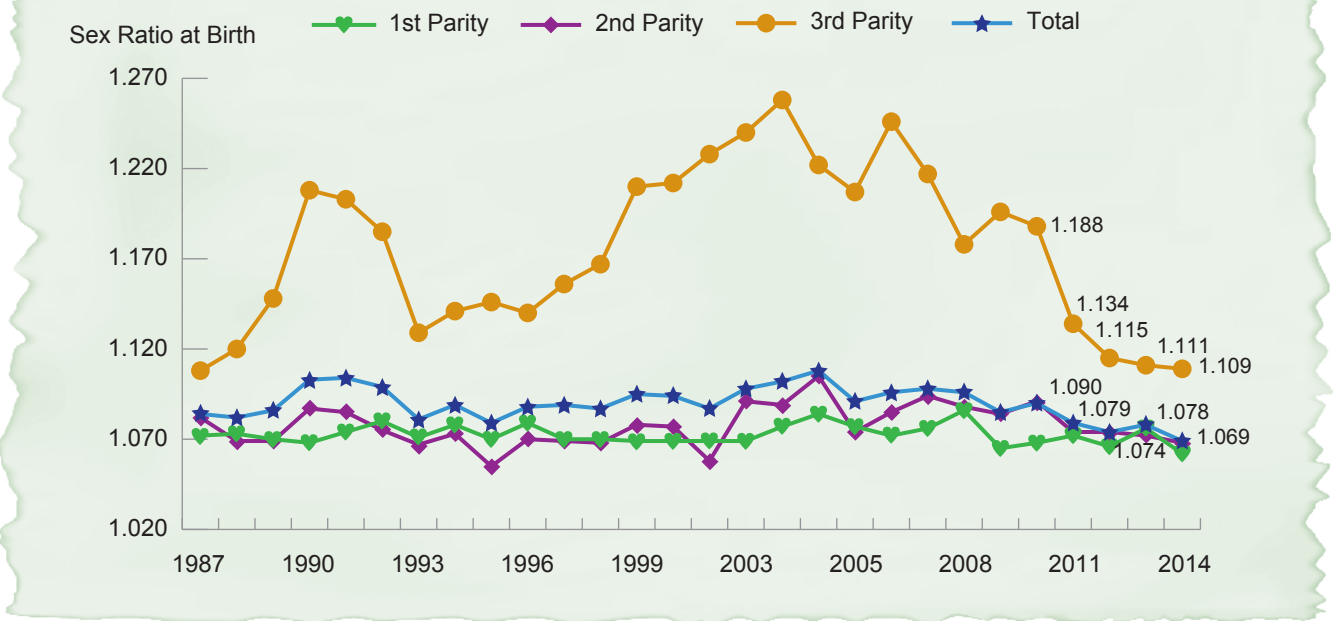
In 2010, the Health Promotion Administration, the Department of Medical Affairs, and the Food and Drug Administration established a ministry task force charged with monitoring the sex ratio at birth. It has used monitoring mechanisms, the legal framework, and monitoring of reagent sources and tests while working in conjunction with local health departments. It has checked local censuses and provided guidance to institutions offering birth and prenatal checkup services. Also, it has strengthened gender equality education and medical ethics training among health workers as well as publicity among the general public, all to ensure the right to birth of female babies and a normalization of Taiwan's sex ratio at birth within five to 10 years. The results have been positive: Taiwan's sex ratio at birth dropped from 1.090 in 2010 to 1.069 in 2014, a 28-year low (since 1986). Gradually, the sex ratio at birth is approaching the natural ratio of 1.06 (Figure 3-2).

3. The Pregnant Women Care Centers offer preconception, prenatal, and postnatal health information on nursing and other issues via a free hotline, an app, and a website (http://mammy.hpa.gov.tw).

4. Between promulgation of the Public Breastfeeding Act on November 24, 2010, and the end of 2014, a total of 2,061 public locations and another 599 venues had established breastfeeding rooms.

5. In line with the WHO policy on breastfeeding, since 2001 the MOHW has offered Baby-Friendly hospital accreditation. Besides promoting 10 steps that lead to successful breastfeeding, it has improved the professional training of medical workers, health education for pregnant women, and the policy and

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



environment of hospitals. In 2014, 177 hospitals were accredited as Baby-Friendly hospital, with total coverage reaching 76.6% of all births. The exclusive breastfeeding rate under 6 months of age rose to 45.8%, beating the world average of 38% and bringing Taiwan closer to the WHO target of 50% by 2025.

Section 2 Health for Infants, Children, and Adolescents

Besides providing screenings for the newborns, the Centers for Assessing Child Development was established to provide timely assessment and intervention to children suspected of developmental delays. Other measures include seven times of children's preventive healthcare and health education; oral, visual and hearings health exams for children; and a program to promote sexual health among adolescents (Figure 3-3). Achievements are described as follows:

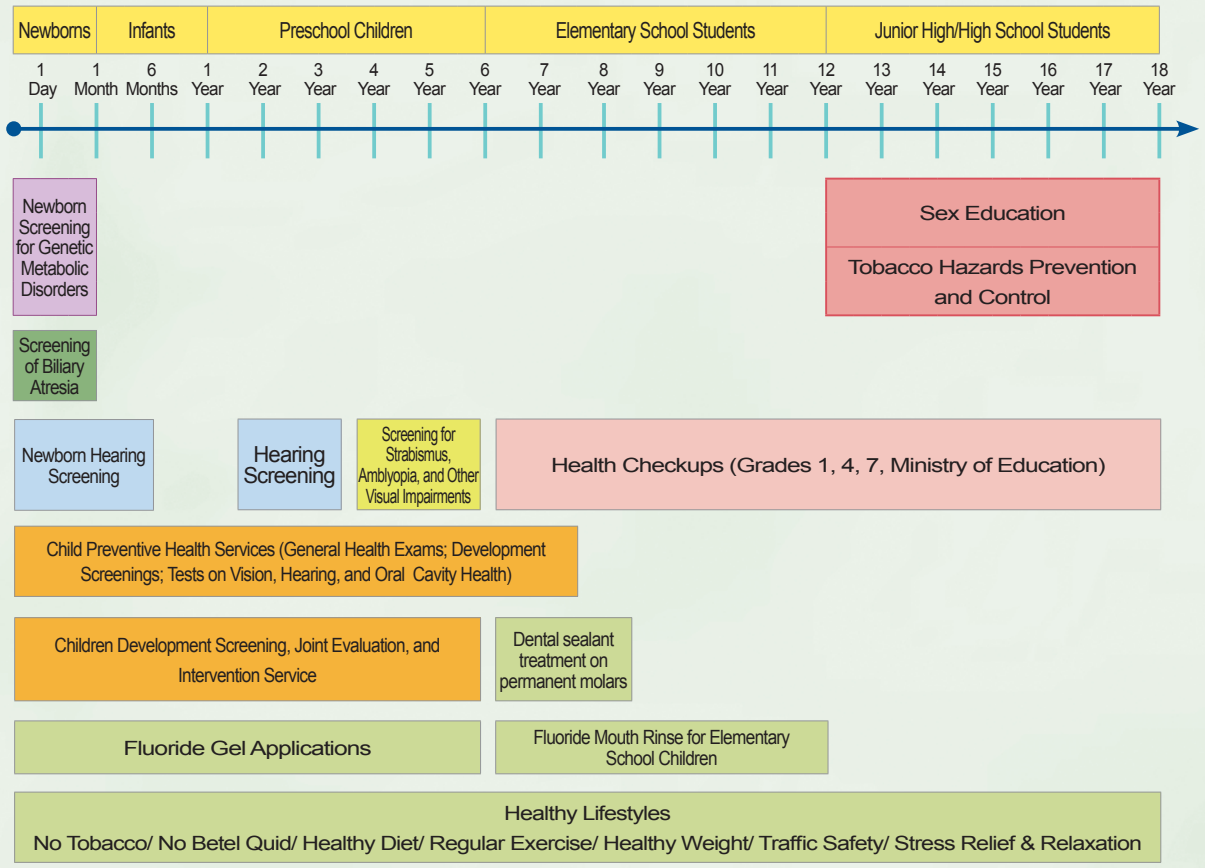
1. Screening of the Newborns for Genetic Metabolic Disorders

   Within 48 hours of birth, the newborns in Taiwan are screened for 11 genetic metabolic disorders, with follow-up referrals, diagnosis, and treatment provided in all atypical cases. In 2014, there were 211,272 newborns screened, for a coverage rate of over 99%.

2. Preventive health services for children under 7 years old were used 1,104,160 person-times in 2014, with 77.7% of children taking advantage of all seven rounds offered and 97.2% of children one year old and below receiving at least one round of service.

3. In order to further raise safety and health among children, on July 1, 2013, the MOHW implemented a subsidy plan for children's health education guidance services. From November 1, 2014, the plan was expanded to cover seven rounds of visits by children 7 years old and

Figure 3-3 Infants and children, adolescent health policy



below. By the end of December 2014, 1,932 doctors had qualified to administer the program and 78.1% of children had participated (based on children's preventive health service volume in 2013). The service was offered 327,579 person-times in 2014.

4. By 2014, there were 45 Centers for Assessing Child Development in Taiwan, with between one and four center(s) located in each of the nation's 22 cities and counties. These centers diagnosed 16,231 developmental delayed children in 2014. In order to raise the quality of the centers, the MOHW completed formulation of the indicators for assessment, and completed on-site consultations and visits.
5. Inter-ministerial units continued to encourage strabismus, amblyopia, and visual defect screenings for preschool children 4 and 5 years of age. In 2014, the screening rate was 95.4%, with 99.3% of suspected abnormalities referred for treatment.
6. Since 2012, hearing screening have been offered to all newborns under 3 months old. In 2014, a total of 204,641 babies underwent screening, the screening rate was 97.2%, with referrals and follow-up intervention provided to each of the 777 babies were diagnosed with hearing impairment.
7. In June 2013, the MOHW expanded subsidized fluoride gel applications to twice annually for children under 6 years old and four times annually for disabled children and children under 12 years old from disadvantaged families, aboriginal regions, or remote/offshore island areas. In 2014, this benefit was used 1,001,512 person-times, with 88.3% of children 3 to 5 years old receiving at least one application.
8. In September 2014, a program for offering dental sealant treatment on permanent molars was expanded to all first graders as well as second graders who were disabled, from mountainous indigenous areas or offshore islands, or from low or mid-to-low income households. A total of 140,809 people benefited in 2014.
9. A program to promote use of fluoride mouth rinse among elementary school children continued, with 1.2 million children, or 90% of the qualifying population, covered in 2014. Empirical research was behind the promotion of an oral health campaign that stressed two dos and two don'ts for better teeth.
10. 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 special clinics, with website traffic reaching 125,025 hits in 2014 and video consultations offered 2,105 times. Total attendance at 110 sexual health school lectures and parental education lectures was 26,429 person-times. There were also 65 adolescent friendly health clinics, with coverage extending to each of the nation's cities and counties and visits totaling 7,445 person-times.

Chapter 2 Healthy Living

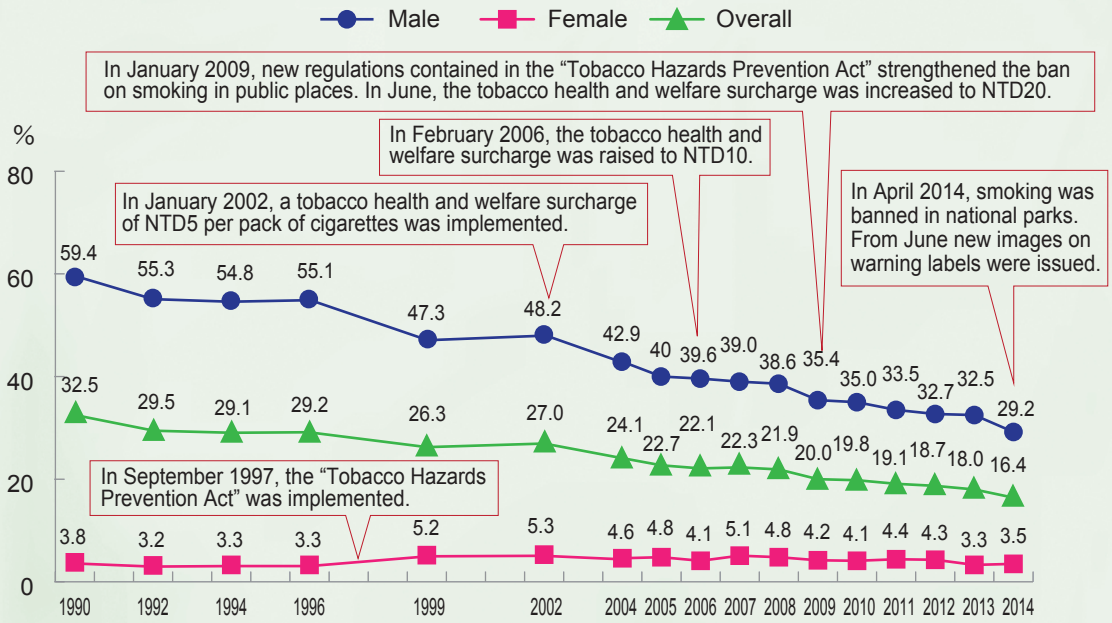
Major everyday hazards include personal unhealthy behaviors, such as smoking, chewing betel quid, poor diet, and lack of exercise, as well as environmental factors, such as accidents. Among these, smoking and betel quid are both group 1 carcinogens and accidents are among the 10 leading causes of death, underscoring how rejecting tobacco and betel quid while building a safe environment is critical to creating 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 16.4% in 2014, a decline of over a quarter, equal to about 890,000 smokers (Figure 3-4). The rate among adolescents fell to a 10-year low, with the rate among junior high school students falling from 7.8% in 2008 to 5.0% in 2014 and the rate among high school and vocational school students falling from 14.8% in 2009 to 11.5% in 2014 (Figure 3-5). The secondhand smoking exposure rate in public places fell from 23.7% in 2008 to 7.5% in 2014. In accordance

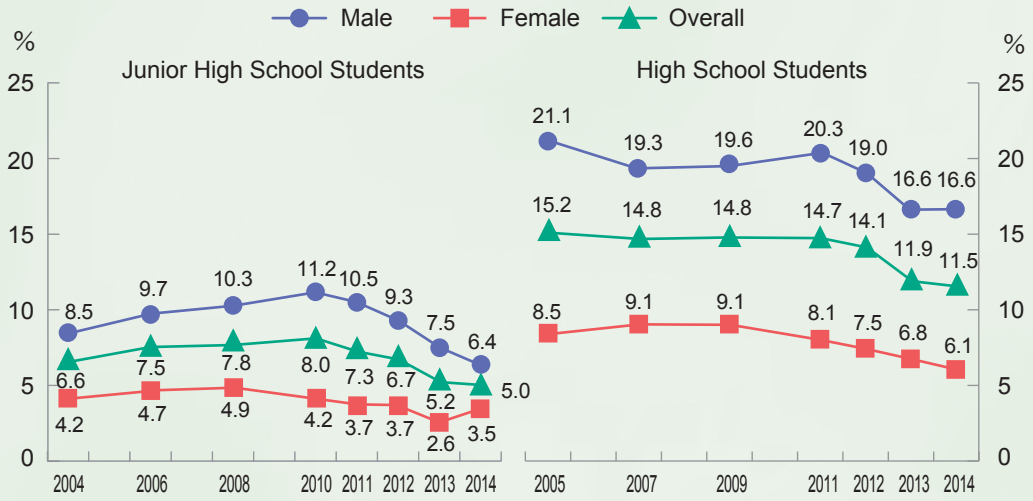
Figure 3-4 Smoking Rates of Adults over 18 Years Old in Taiwan by Year



Sources:

1. 1971-1996 survey data from the Taiwan Tobacco and Wine Monopoly Bureau.
2. 1999 survey data provided by Professor Lee Lan.
3. 2002 data obtained from the Health Promotion Administration's Survey on Citizen's Knowledge, Attitude, and Behavior Regarding Health Promotion.
4. 2004-2013 data obtained from the Health Promotion Administration's Adult Smoking Behavior Survey.
5. From 1999 to 2013, a smoker was defined as someone who had previously smoked 100 cigarettes (five packs) and who had used a tobacco product within the past 30 days.
6. Data from 2004 to 2013 were weighted and standardized by gender, age, education, and area of residence from 2000 collected by the Directorate-General of Budget, Accounting and Statistics.

Figure 3-5 Taiwan Adolescent Smoking Rates, by Year



Notes:

1. Data obtained from the Health Promotion Administration's Global Youth Tobacco Survey.
2. A smoker was defined as someone who had tried smoking within the past 30 days, even if he or she only had one or two puffs.

with international advances, Taiwan also has implemented the Framework Convention on Tobacco Control and the MPOWER measures. Major projects and achievements are as follows:

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

a. On April 1, 2014, Taiwan became the second nation in the world to ban smoking in national parks, national nature parks, designated zones in scenic areas and forest recreation areas, and park green areas, apart from specially marked smoking zones. One month after implementation, a poll suggested that 96% of people supported the measure.

b. Taiwan is already home to 179 hospitals that have been internationally certified as smoke free. In 2014, of 27 hospitals worldwide that were admitted into the prestigious Gold Forum global platform, 11 were from Taiwan, again giving Taiwan the most affiliates of any country in the world.

c. The MOHW continues to implement smoke-free school, workplace, military, and community plans. It also published a children's book called "Smoke-Free Home- A 3D Play Book"" that was distributed to 7,082 public and private preschools.

d. Local health departments carry out inspections and provide guidance. In 2014, more than 710,000 businesses were inspected a total of 4.91 millions times, with violations recorded in 8,764 cases and total fines of NTD53.86 million.

(2) Providing Diverse Smoking Cessation Services

a. Following implementation of the second-generation cessation payment program in March 2012, cessation drugs were treated like other drugs covered under the NHI, with the copayment of each course not to exceed NTD200. Funding for the program was drawn from the tobacco health and welfare surcharge. In 2014, a total of 125,504 smokers received cessation services, an increase of 29.5% compared to 2013. More than 35,000 of these people successfully quit smoking, as shown by the tobacco abstinence rate of 28.1% at six months.

b. The 2014 Quit & Win competition attracted 27,427 smokers and was estimated to help 17,800 households avoid the hazards of secondhand smoking.

c. The free smoking cessation hotline provided assistance on 104,436 calls.

d. Total attendance at 474 smoking cessation classes was 6,027.

(3) Ban on Tobacco Advertisements, Promotions, and Sponsorship: Violations in 13 cases in 2014 led to fines of more than NTD36 million.

(4) Increasing 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.

(5) Adolescent Smoking Hazard Prevention Achievements

a. The MOHW cooperates with local health departments to carry out inspections of tobacco vendors. In 2014, more than 400,000 such inspections uncovered 331 cases of tobacco being sold to minors, leading to total fines of over NTD2.98 million. Another 430,000 investigations uncovered 3,071 cases of minors smoking, with smoking cessation classes completed in 2,851 of these cases.

b. In accordance with a Ministry of Education initiative to eliminate smoking on 100 college and university campuses, the MOHW offered guidance to 27 colleges and universities and facilitated cooperation by 51 NGOs and 55 local health departments. It also held three smoking hazards prevention camps that were joined by 376 person-times and 74 schools. Another seven classes to train seed instructors who encourage adolescents to quit smoking produced 338 qualified instructors.

c. In order to create a smoke-free culture and environment, cases involving the sale of tobacco products to children under 18 years old (in violation of the "Tobacco Hazards Prevention Act") have been included as part of evaluations of local health departments and youth project effectiveness assessment since 2014.

2. Betel Quid Hazards Prevention

(1) Besides using media channels to spread the betel quid hazards prevention message, the MOHW worked with the Ministry of Education,

the Ministry of the Interior, 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 2014, these cessation services were provided to 15,000 people, helping approximately 7,500 of them quit, for a success rate of 49.4%.

(2) Oral cancer screening has been offered for betel quid chewers and smokers aged 30 and older as well as indigenous people aged 18 and older who chewed betel quid. The recognition rate of betel quid's carcinogenic effects had risen from 39.9% in 2007 to 50.6% in 2014, as whereas the betel quid chewing rate among men aged 18 and older had dropped from 17.2% in 2007 to 9.7% in 2014, a reduction of 44%.

(3) In order to reinforce source control, monitor the transforming abandoned betel quid farm into other crops and betel quid re-growth areas, and analyze whether the total area used for growing betel has continued to decline, the Health Promotion Administration (HPA) has subsidized the Council of Agriculture on the transformation of abandoned betel quid farm into other crops from 2014 to 2017.

Section 2 Promotion of Physical Activity

1. Since 2002, the MOHW has promoted the health benefits of walking. In cooperation with government agencies, NGOs, and private enterprises, the MOHW promoted "10,000 Steps Everyday, Your Health is Guaranteed" and encouraged walking 10,000 steps every day to ensure better health. Since 2006, November 11th has been designated as the "National Walking Day". In 2014, the MOHW organized 4 walking events with more than 10,000 people participated in Taipei City, Taichung City, Kaohsiung City, and Yilan Country. The MOHW also held a contest to solicit walking slogans that could encourage people to incoporate walking at anytime and anyplace during their everyday life.
2. Remade and promoted a video "15-minute Health Exercise for office workers". Issued handbooks, broadcasts, and press releases that provided information related to healthy eating, exercise, and weight management.
3. The MOHW encouraged institutions to schedule time for physical activity and create exercise supporting environments, creating health promoting schools, workplaces, and hospitals.

Section 3 Nutrition and Obesity Control

In order to advocate an active lifestyle, increase the citizen's knowledge towards calories and nutrition, enhance mental, physical, and social health, and prevent chronic diseases, the key strategies and achievements in 2014 were as follows:

1. Monitoring of national weight, iodine intake, and nutrition status. Formulation of a project for providing guidance on healthy foods in areas surrounding school campuses.
2. Development of Personal Skills: Revised and released the Move Toward a Healthy Life handbook. Disseminated signs and published a book related to achieving a healthy weight. The HPA presented press release and held press conference at key moments and on special holidays press releases, press conferences, and other forms of as well as planned publicities, to spread the important issue of healthy eating.
3. Launching the Healthy Weight Management Campaign: At the end of In 2014, a total of 1.14 million kgs were lost, and participant lost an average of 1.6 kgs per person. Among these participants, the rate of overweight and obesity fell from 61.3% to 53.8%.
4. According to the Nutrition and Health Survey in Taiwan, the prevalence of overweight and obesity among adults increased from 33.2% between 1993 and 1996 to 43.5% between 2005 and 2008. Preliminary results from 2013 and 2014 suggested a rate of 43%. Among youths, the prevalence of overweight and obesity in elementary school students fell from 28.2% in 2012 to 26.3% in 2013 and 2014, for junior high school students, the rate rose from 27.1% in 2010 to 28.5% in 2013 and 2014, for senior high school students, the rate fell from 31.1% in 2011 to 20.8% in 2013 and 2014. These results showed that weight problems among adults, elementary school students, and high school students had eased.

Section 4 Prevention of Accidents and Injuries

1. In order to build safe household environments for young children, local health bureaus (centers) conducted home safety inspections and improvements. In 2014, there were 21,499 homes inspected.
2. In order to enhance the knowledge of parents and caregivers accident prevention, a table for assessing children's accidents and injuries and information on basic steps for preventing such problems from occurring were included in The Child Health Handbook.
3. By promoting special exercises and issuing a pamphlet, the MOHW sought to prevent senior citizens from falling. It also conducted safety inspections of homes where seniors live, with improvements made to 2,191, or 49.4%, of the 4,436 homes inspected in 2013.
4. As part of a safe community plan, safety promotion assistance was offered to 15 community organizations in 2014. There were also 19 organizations in Taiwan that received international safe community certification from the WHO Collaborating Center on Community Safety Promotion.

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. By building friendly support environments, it creates conditions conducive to physical, mental, and social health.

Section 1 Healthy Cities, Communities, Schools, and Workplaces

1. Healthy Cities

(1) Since 2003, the MOHW has supported a health promoting city plan for Tainan. By 2014, there were 21 cities and counties in Taiwan that had launched healthy city plans, as well as 12 cities and counties and 11 regions became an associate members of Alliance for Health City (AFHC).

(2) In 2014, the MOHW cooperated with the Alliance for Healthy Cities, Taiwan in hosting the 6th Annual Taiwan Healthy Cities and Friendly Cities Awards Nomination Ceremony. A total of 65 awards in categories ranging from excellence and innovation to outstanding contributions in the area of healthy cities were presented. In the same year, Taiwan cities and counties attended the 6th Annual Alliance for Healthy Cities International Seminar in Hong Kong. Among the 77 accepted submissions, 7 had been awarded with development awards.

2. Healthy Communities

Since 2009, the MOHW launched community health building program. In 2014, 19 local health departments were subsidized to work with 151 communityi units. Achievements included recruiting 4,716 volunteers with volunteer manuals and participated in community health building; 82,272 people who received oral examination service; 4,739 people who participated in the betel nut cessation services; and 141,144 senior citizens who joined senior health promotion activities. The MOHW also assisted 1,569 restaurants in providing low-salt meals; a total of healthy weightloss of 205,692 kgs, and held 592 health purchase advocacy events. There were 999 walking teams established and 184 healthy walking trails with calories labeling.

3. Health Promoting Schools

(1) Since 2002, the MOHW and Ministry of Education have committed cross-departmental resources toward implementation of health promoting school plans, including the 2008 establishment of the Health Promoting School Promotion Center. which publicizes oral health, vision care, healthy BMI, and tobacco hazards prevention. By 2014, 3,905 health promoting schools at the high school/vocational school level or lower and 142 health promoting universities and colleges have participated in the program.

(2) The MOHW conducted 2nd health promoting school international accreditation in 2014 and selected to 5 schools with gold awards, 20 schools with silver awards, and 31 schools with bronze awards.

(3) In cooperation with the US Association for Supervision and Curriculum Development, the Canadian International School Health Network, the Schools for Health in Europe network, and the Asia Cross-Sector Network/Exchange on School Health & Development, the MOHW held the International Conference on Health Promoting School on November 14 and 15, 2014. A dozen experts from the United States, Canada, France, Germany, the Netherlands, Belgium, Japan, and Hong Kong were invited to share experiences related to the promotion of health promoting schools.

4. Health Promoting Workplaces

Between 2007 and 2014, the MOHW had passed healthy workplace certification 12,439 times. In 2014, there were 30 workplaces awarded for excellence in health promotion, one "10 year excellent achievement awards", and five "excellent promotion staff awards. "

In order to promote exercise in the workplace, the MOHW held a "SHOW Health at Workplace Together" national workplace exercise competition. Attended by 40 workplace teams, there were gold, silver, and bronze medals awarded along with seven special category awards.

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 April 2014, the 22nd International HPH Conference took place in Barcelona, Spain. As President of the International HPH Network, Dr. Shu-Ti Chiou, Director-General of Taiwan's Health Promotion Administration, chaired the General Assembly of the International HPH Network. The Jianan Psychiatric Center, MOHW, became the third straight Taiwan hospital to win the Outstanding Fulfillment of WHO HPH Standards Award since the award's founding three years earlier.

(2) By the end of 2014, Taiwan had 151 institutions (137 hospitals, one long-term care institution, and 13 health centers) that were certified by the WHO International Network of Health Promoting Hospitals & Health Services. This makes the Taiwan Network the largest within the entire international network.

(3) Subsidies were provided to 21 local health departments and 130 health care institutions to encourage participation in health promoting working plans by health care institutions At another 2014 competition to recognize improvements to quality of care by health care institutions, there were 15 institutions that received the awards.

(4) At the 2014 Health Promoting Hospital Conference in December, the MOHW awarded six hospitals for outstanding fulfillment of health promoting hospital standards and recognized 52 innovative plans.

2. Promotion of Low Carbon Hospitals

(1) In 2014, the MOHW held two workshops on environmental friendliness, in which it assisted hospitals in implementing measures to save energy and reduce carbon emissions.

(2) Teams of experts allocated to specific regions conducted onsite visits of 29 hospitals and provided professional guidance on saving

The national workplace exercise competition

The Jianan Psychiatric Center, MOHW won the 3rd Outstanding Fulfillment of WHO HPH Standards Award

energy and reducing carbon emissions. A 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 self-assessment forms on environmentally friendly actions. The MOHW also issued a publication on how hospitals in Taiwan are at the forefront of carbon emissions reduction as well as the Health Promotion and Environment-Friendly Hospital Manual.

(4) Ten domestic health care institutions attended the 2014 International Environment-Friendly Hospital Team Work Best Practice Awards, hosted by the HPA.

(5) By the end of 2014, there were 169 hospitals in Taiwan that had undertaken energy saving and carbon reduction actions.

Chapter 4 Healthy Ageing

By 2018, Taiwan is expected to meet the standards for an aged society. People have also adopted a more sedentary lifestyle and western eating habits, factors that together are causing the population afflicted by chronic diseases to increase. In order to raise the quality of life of older people and reduce the threat posed by chronic diseases, Taiwan promotes age-friendly cities, age-friendly health care, health promotion among elderly persons, prevention of major chronic diseases, and prevention of cancer.

Section 1 Health Promotion for Middle-Aged and Older People

1. A free preventive health examination is provided every three years for people aged 40 to 64 and annually for people aged 65 and older. In 2014, 1.85 million people used these services (including more than 900,000 people aged 65 and older), for a usage rate of 32.5%.
2. Eight factors were selected to use as a basis for ensuring health among the elderly and preventing functional decline. Also, local health departments (centers) and medical care institutions cooperated with community care sites to conduct health promotion activities for the elderly, with 1,826 care sites, or more than 90% of the nation's total, reached in 2014.
3. Older people were encouraged to join local township or village teams to compete in national contest for elderly health promotion. In 2014, more than 2,400 teams and 100,000 seniors, or over 4% of the total senior population, competed in nationwide competitions.

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. By 2014, Chiayi City, Taoyuan, Hsinchu City, Nantou, Miaoli, New Taipei City, Yilan, Tainan, Taipei, Kinmen, and changhua all applied to join the WHO Global Network of Age-Friendly Cities and Communities. Also, at the 2014 Healthy City and Age-Friendly City Awards Ceremony, there were 121 awards presented from 518 entries.
2. In 2014, the MOHW launched a project to popularize age-friendly health care institutions by improving the environment and quality of such institutions through four major standards: management policies, communication and service, care procedures, and physical environment. By 2014, there were a total of 104 health care institutions (including one public health center and two long-term care institutions) that were certified as age-friendly, with the number of certified institutions expected to increase to 200 in 2015 and 500 in 2018.

Section 3 Prevention of Major Chronic Diseases

1. Prevention of Major Chronic Diseases

(1) Use of multiple channels to educate members of the general public on prevention of metabolic syndrome has raised the recognition rate of waist warning values from 3% in 2006 to 46.0% in 2014. Local health departments and NGOs cooperated to educate people on the prevention of the "3-highs" (hypertension, hyperglycemia, and hyperlipidemia). Also, the establishment of a 3 levels of chronic disease prevention system and service network (see Figure 3-6) encouraged cities and counties to work with medical care institutions in their jurisdictions on providing 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 and established 514 diabetes support groups. According to the diabetes health promotion institution quality control survey, in the five years between 2006 and 2011, the percentage of diabetes patients with less than 7% hemoglobin A1c levels rose from 32.3% to 34.5%. Patients with well-controlled blood pressure rose from 30.9% to 37.7%, and patients with well-controlled blood lipids rose from 33.3% to 51.5%

(3) For kidney disease prevention, the MOHW strengthened publicity and educational campaigns and established 166 kidney disease health promotion institutions that provided better case management. According to data from the National Health Insurance Administration, the crude rate of dialysis over the past six years has risen from 413.5 people per 100,000 population in 2009 to 439.3 people in 2010, 431.3 people in 2011, 445.3 people in 2012, 457.3 people in 2013, and 454.9 people in 2014. The age-standardized rate, however, has stabilized.

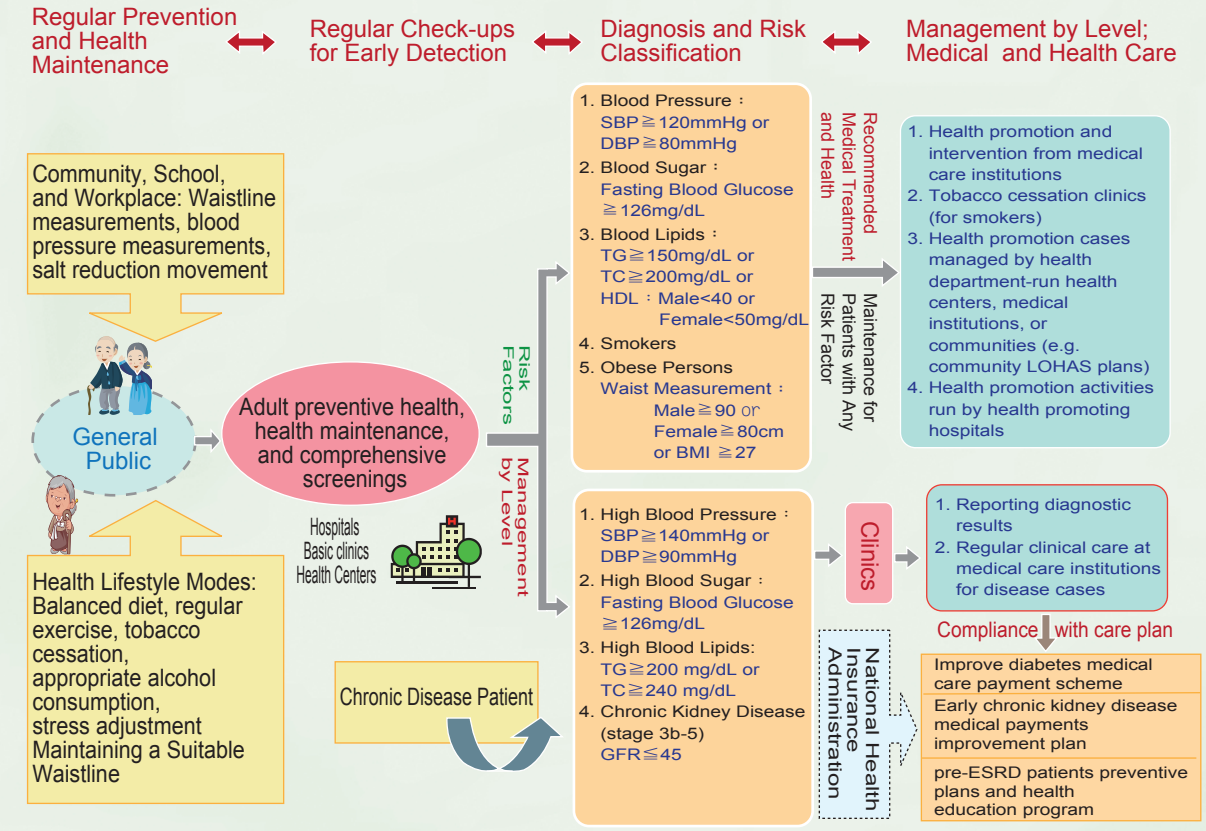
(4) In order to provide widespread blood pressure reading services, blood pressure measurement services are provided not only in hospitals but also in approximately 2,500 public locations. The MOHW also developed County-wide Chronic Obstructive Pulmonary Disease (COPD) pilot program and holistic health management models for cardiovascular disease Care to strengthen control over the 3-highs and prevent or reduce functional loss and death.

2. Menopause Health

(1) In order to provide accurate health information to women undergoing menopause, the MOHW established a special toll-free hotline. In 2014, the service was used 7,026 times.

(2) In order to raise knowledge of osteoporosis, the MOHW cooperated with the Taiwanese Osteoporosis Association in holding 63

Figure 3-6 Chronic Disease Control System –3 Levels of Chronic Disease Control Service Network



community osteoporosis health education events. These included use of the WHO fracture risk assessment tool on more than 4,000 participants. Those who were shown to be at high risk of fracture received health guidance, referrals, and follow-up.

Section 4 Cancer Prevention and Control

In order to reduce the cancer mortality rate, from 2014 to 2018 the MOHW is implementing the 3rd Phase of the National Cancer Prevention and Control Program. The three new major points include: 1. More attention paid to prevention of other causes of cancer beside smoking and areca quid chewing, such as obesity, poor diet and insufficient exercise; 2. Continuing to promote effective cancer screening, especially for oral and colorectal cancer, detecting and removing Health Promotion Administration, Ministry of Health and Welfare premalignant lesions, and preventing their development into cancer; 3. Promoting the "Cancer Navigation Plan", every life counts ensuring. Highlights of cancer occurrence, mortality, and key strategies are described as follows:

1. Cancer Incidence and Mortality by year

Since 1982, cancer has been the first leading cause of death in Taiwan. Its mortality rate gradually rose before peaking in 1997 then for the next 10 years remained steady. In 2008, the rate fell slightly, to 133.7 deaths per 100,000 population, and it currently fluctuates between 130 and 132. An increase in the cancer standardized incidence rate from 111 people per 100,000 population in 1982 to 300 people per 100,000 population in 2012 can be attributed to aging of the population, the adopting of western lifestyle habits, and the promotion of screenings for four major cancer types by the Health Promotion Administration.

2. Control of Cancer Risk Factors

Smoking, lack of exercise, unhealthy diets and excessive alcohol consumption are the 4 major common risk factors behind the cancer. The MOHW advocates that people should live a healthy lifestyle such as quitting smoking and betel quid chewing, stopping drinking as well as managing healthy weight and diet. Furthermore, the MOHW promotes betel quid prevention and control in all perspectives to reduce the incidence of oral cancer.

3. Cancer Screenings

(1) In 2010, Taiwan became the first country in the world to fully subsidize screenings for cervical cancer, breast cancer, colorectal cancer, and oral cavity cancer, with its subsidized oral cavity cancer screenings unique in the world. In 2014, there were 5.238 million screenings conducted for these four diseases, which led to the detection of 51,489 precancerous lesions and 11,785 cancerous tumors. Screening rate, cancer deteation rate, five-year survival, and other data from 2014 are shown in Tables 3-1~3-3.

(2) In 2014, there were 225 medical care institutions involved in the project of enhancing the quality of cancer screening and diagnosis in hospitals. Among the 225 institutions, 153 were certified to perform mammography, 130 were certified to perform pap smear facilities and 45 offered outpatient screening for the 4 major cancers. Besides, the institutions set up the alert system of outpatient screening, formed the single window referral services of positive test cases, cooperated with local health departments in community-based screenings,carried out patient health education in hospitals and conducted betel quid cessation classes.

(3) To promote the quality of cancer screenings, medical institutions were examined and verified for certified pap smear facilities, certified mammography facilities and certified fecal occult blood test facilities. In 2014, there were 116, 206 and 129 institutions certified, respectively. Moreover, dentists, otolaryngologist, physicians have received cancer screening training to enhance the quality of oral mucosa examination.

4. Improving the Quality of Cancer Care

(1) Since 2008, cancer care accreditation had been offered to hospitals that treat at least 500 newly diagnosed with cancer each year. By the end of 2014, a total of 55 hospitals were qualified.

(2) In 2014, the MOHW subsidized six NGOs to provide direct service for cancer patients, so the patients and their families could receive comprehensive care and support.

Table 3-1 Screening Volume, Rate, Precancerous Lesions, and Cancer Cases for Four Major type of Cancer, 2014

Cancer Type	Screening Volume	Screening Rate(%)	Precancerous Lesions	Cancer Cases
Cervical Cancer	2.178 million	73.5	10,890	4,220
Breast Cancer	0.802 million	38.5	-	3,680
Colorectal Cancer	1.252 million	40.7	36,229	2,490
Oral Cavity Cancer	1.006 million	54.3	4,370	1,395
Total	5.238 million	-	51,489	11,785

Notes: Basis for Screening Rates

1. Cervical Cancer: The rate of women aged 30-69 who were screened in the past three years (telephone survey).
2. Breast Cancer: The rate of women aged 45-69 who were screened in the past two years.
3. Colorectal Cancer: The rate of people aged 50-69 who were screened in the past two years.
4. Oral Cavity Cancer: The rate of betel quid chewers (including those who quit) or smokers aged 30 and older who were screened in the past two years.
5. Precancerous Lesions: Morphologically atypical tissues that are benign but are more likely to develop into cancer.

Table 3-2 Cancer Detection Rate for Four Major Types of Cancer, 2014

Cancer Type	Cancer Detection Rate (Estimates Based on 100% Follow up of Positive Cases)		
	Precancerous Lesions	Cancer	Total
Cervical Cancer	1/90	1/341	1/71
Breast Cancer	-	1/175	1/175
Colorectal Cancer	1/23	1/349	1/21
Oral Cavity Cancer	1/181	1/570	1/137

Notes: Basis for Detection Rates

1. Precancerous Lesions (Based on 100% Follow-up Rate): Precancerous lesion cases/number of screenings.
2. Cancer (Based on 100% Follow-up Rate): Cancer cases/number of screenings.
3. Total (Based on 100% Follow-up Rate): Precancerous lesions + cancer cases/number of screenings
4. 1/Cancer Detection Rate: For every positive case, number of patients screened

Table 3-3 Five-Year Survival Rate for Four Major Types of Cancers, 2014

Unit: %

Stage	Breast Cancer	Cervical Cancer	Colorectal Cancer	Oral Cavity Cancer
Stage 0	97.7	96.9	85.5	76.7
Stage 1	95.7	88.2	81.3	77.4
Stage 2	89.1	67.7	71.3	68.3
Stage 3	72.3	55.0	59.1	54.7
Stage 4	25.7	18.1	11.4	33.2

Source: Taiwan Cancer Registry database (includes carcinoma in situ), 2008~2012

(3) In 2014, the MOHW subsidized hospitals to establish cancer resource centers. There were 61 hospitals that established one-stop service by combining resources from both inside and outside the hospital, and offered the comprehesive service approximately 150,000 people per year.

(4) The Cancer Patinet Navigation plan was implemented in 2014 and offered services to more than 90,000 newly diagnosed patients.

5. Promoting Hospice and Palliative Care and Ensuring Patient Rights

(1) In 2014, the MOHW provided subsidies to 80 hospitals to establish standard procedures and quality control mechanisms for diagnosis disclosure in cancer patients. By educating people on the importance of telling the truth of their condition when faced with cancer, the patient rights to know were better protected.

(2) Continued promotion of hospice and palliative care services led to an increase in the percentage of terminal cancer patients receiving hospice care within one year of death from 7.4% in 2000, when the "Hospice and Palliative Care Act" was passed, to 50.6% in 2012.

Chapter 5 Health Communication, Information, and Surveillance

Section 1 Consolidation of Health Education Resources to Improve the Capabilities of Related Professionals

Health education resources were integrated to make people better understand Taiwan's health education policies. Through health education, recognition of health issues will promote the health awareness and knowledge.

1. Health education in 2014 was set by several important issues: understanding of dementia, oral cavity health, reasonable medical treatment and medication, prevention of drug abuse, and food safety. Through integrated promotion activities, people gained a better understanding of these issues and their health will be better managed.
2. Agencies under the supervision of MOHW, promoted health education advocacy to increase general recognition of health-related topics through a combination of diverse resources, sustainable promotions, and complete packaging.
3. In order to advance execution capabilities of health educators, the MOHW held workshops based on two topics: "advocacy experiences sharing & self-review" and "improving functionality." In 2014, there were 160 professionals who attended four workshops on these topics.

Section 2 Health Information

By using information and communications cloud technology, the MOHW has closely integrated health management and mobile services. Through the launch of its "health care cloud," it has become possible for more people to use mobile channels to obtain accurate health information and preventive health services, thereby achieving better health promotion.

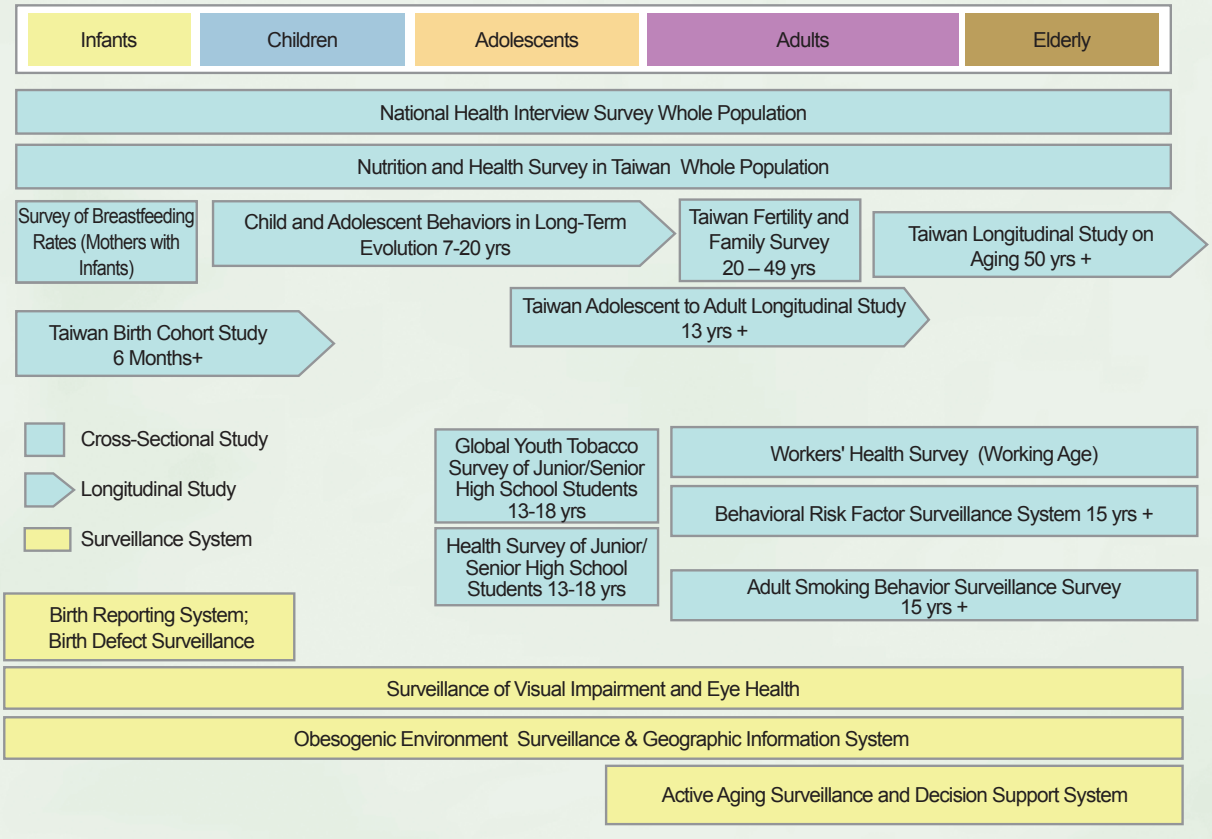
1. Completion of the Health Promotion Helper platform and app (http://wellness.hpa.gov.tw/) in 2014 provided a convenient, smart health management tool. Besides personalized interactive health information, the Health Promotion Helper provides record and management tools for health factors (such as exercise, food, work, and rest) and health check-ups, health risk assessments and recommendations, and health alerts. It helps people to cultivate a healthy new way of life. Among the 3,200 trial users there was a satisfaction rate of over 85%.
2. Completion of a preventive health record platform in 2014 made it possible for people to gather and check personal information related to prenatal check-ups, health check-ups, and cancer screenings.
3. Upon completion of the government's open information platform, there were 60 sets of health data initially available. Also, for the 2014 Health Promotion Cloud Value-Added Application Excellence Award, there were 34 winners chosen from among 63 entries with value-added innovations.

Section 3 Health Surveillance

To inform adequate policy making for health improvement 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 health of the whole population and people of different age groups, national health surveys are conducted regularly. Using data from the 2013 Nutrition and Health Survey in Taiwan, the MOHW was able to update data of nutritional status and non-communicable disease of the people. A longitudinal study aims to investigate health behavior of the adolescent to adult was intitiated and piloted in the year. (Figure 3-7).
2. To improve the framework and efficacy of the 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 new coding system and the International Classification of Diseases codes. Statistical analysis of unintentional injuries was strengthened by better utilization of the existing data. Also, a suggested framework and indicators for oral health surveillance was developed by a professional team.
3. The MOHW developed multiple and diverse mechanisms to disseminate the surveillance and survey results, including a convenient and user-friendly on-line query system based on data from the health surveys and birth reporting. A total of 700 health indicators are available from the website.

Figure 3-7 Major Health Monitoring Surveillance and Surveys



4 Health Care

With rapid changes underway to medical, social, and economic environments, the assurance of safe medical care has become a major challenge for Taiwan's health system and health providers. Key issues 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 health and quality of life.

Chapter 1 Health Care Systems

Promulgation of the "Medical Care Act" in 1985 led to the launch of the Medical Care Network Project, which divided Taiwan into 17 health regions. Subsequent planning of the health workforce and facilities set the stage for the balanced allocation of resources and improvement of regional care quality. The project, which took place in four stages over a period of two decades, gradually led to a sufficient number of hospital beds and improved quality of care.

In coordination with post-SARS (Severe Actute Respiratory Syndrome) reform of the health system, the Holistic Health Care Plan was enacted between 2005 and 2008. It emphasized safety in a patient-centered medical environment and developed community-based health care systems. To brace for the impact of the aging population, fewer children, and changes of disease patterns, the New Generation Health Navigation Project was enacted between 2009 and 2012. This plan enhanced holistic health care for all based on the principles of suitability, accessibility, continuity, and comprehensiveness. Also, since 2013 the MOHW has conducted a plan for providing greater equality in health care. Through administrative restructuring, it combines health care delivery systems to build a public health andcare services network that is localized, seamless, and integrated. Current health care systems are illustrated in Figure 4-1.

Section 1 Medical Care Resources

In order to promote balanced development of medical care resources, the MOHW established a regional medical care system in accordance with the "Medical Care Act" and the Medical Care Network Project. Relying on local assistance, it assessed regional health needs to aid distribution of medical care resources and implement plans for raising care quality. Highlights in 2014 were as follows:

1. Current Status of Medical Institutions

In 2014, there were 22,041 medical institutions in Taiwan, 7,866 pharmacies, 1,230 nursing institutions, 18 blood donation institutions, 10 pathology institutions, and 1,355 other medical institutions (such as midwifery practices and medical laboratories). Table 4-1.

2. Current Status of Hospital Beds

There were 161,491 beds in medical care institutions (including general beds, special beds, specially designated beds, and beds

Figure 4-1 Current Health Care Systems

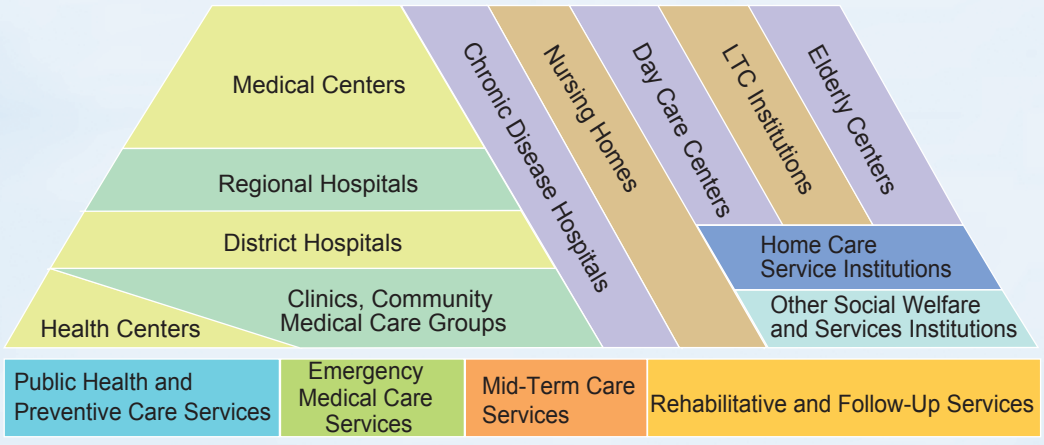


Table 4-1 Status of Medical Institutions, 2014

Type of Medical Institution		Quantity
Medical Care Institutions	Hospitals	497
	Clinics	21,544
Pharmacies		7,866
Nursing Institutions	General Nursing Homes	487
	Psychiatric Nursing Homes	35
	Home Care Practices	507
	Post-Natal Nursing Institutions	187
	Day Care Institutions	14
Blood Donation Institutions	Blood Donation Centers	6
	Blood Donation Stations	12
Pathology Institutions		10
Other Medical Institutions	Midwifery Practices	26
	Medical Laboratories	418
	Medical Radiological Institutions	61
	Physical Therapy Practices	76
	Occupational Therapy Practices	13
	Mental Counseling Clinic	50
	Psychotherapy Clinic	28
	Speech Therapy Centers	17
	Dental Technology Centers	658
	Hearing Centers	7
	Home Respiratory Care Practices	1

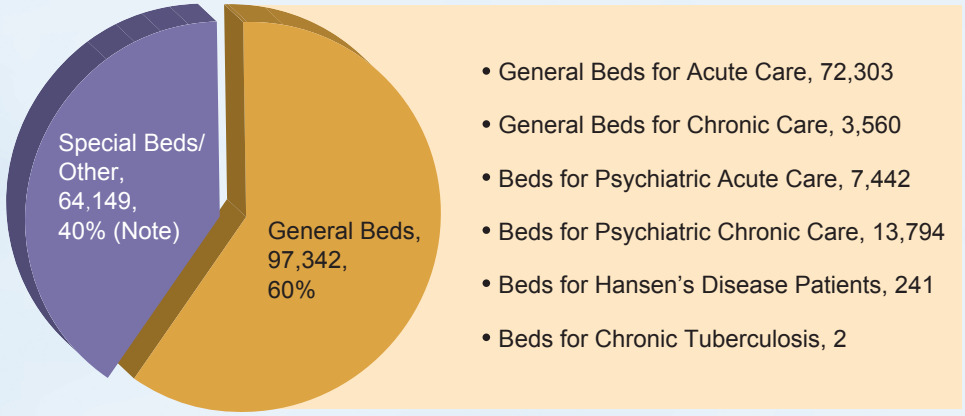
in clinics), with general beds for acute care, general beds for chronic care, beds for psychiatric acute care, and beds for psychiatric chronic care included among general beds in hospitals. For every 10,000 people, there was an average of 68.91 beds (Figure 4-2).

Section 2 Emergency Health Care and Rescue

The MOHW reinforced development of the national emergency medical care and rescue network to actively promote integrated response mechanisms.

1. Fortified the capacities of the six Regional Emergency Medical Operation Centers (REMOCs). By monitoring intra-regional emergency health situations and resource status, the centers support major cross-county (city) disaster responses.
2. By 2014, 34 hospitals qualified as severe-level hospitals, 82 hospitals qualified as moderate level, and there were 43 sub-regions that had at least one hospital designated for moderate level emergencies or above. Progress in these areas shows that hospitals are gradually increasing their capacity for emergency and acute care, and in the process ensuring more people of quality emergency care.
3. An improvement project in areas with insufficient emergency medical care resources included establishment of three treatment models: emergency health care stations in tourist zones, evening and holiday first-aid

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



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

stations, and enhanced emergency capabilities of hospitals. In 2014, incentives fostered implementation in 20 areas.

4. An incentive project launched in 2013 has encourage academic medical centers to provide emergency care support on outlying islands and in areas with insufficient medical care resources. There were 19 such centers participating, providing 17 areas on outlying islands and remote regions with a total of 67 acute and critical care doctors (the centers provided 51 doctors and local hospitals hired the remaining 16). By making quality medical care services and resources accessible to a wider range of people, the project has improved emergency and intensive care associated with strokes, cardiovascular disease, trauma, perinatology (including premature births), and other conditions.
5. Since 2008, the MOHW has provided emergency care training classes for cardiopulmonary resuscitation and automated external defibrillator (CPR & AED) use. An amendment to the Emergency Medical Services Act on January 16, 2013, which included a revision to Article 14-1 and the addition of Article 14-2, led to the expansion of AEDs in public places and the certification of safe locations (required AED installation and 70% of employees having completed CPR and AED training). Through the end of 2014, participation in the training had reached 25,000 person-times. There were 39.1 AED machines for every 100,000 people, or about 9,000 machines, including 4,762 AED registered on a special website. Also, there were 1,277 locations that were designated as "safe locations" after installing AEDs.

Section 3 Intermediate Care Services

Intermediate care is intermediary between intensive and 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 patients are evaluated to determine suitability, and either the patient or his or her family grants approval, intermediate care lasting three-to-six weeks can begin. During this period, guidance is offered on returning home and arrangements are made for home care. Once services are ended, a case manager handles follow-up procedures.

Each of Taiwan's 22 cities and counties offers intermediate care, and by 2014, intermediate care

was available at 21 hospitals overseen by the MOHW. These hospitals designated 343 beds for the service (including nursing home type beds and hospital room beds) and admitted a total of 813 patients, with 375 patients, or about 46%, discharged and able to return home. Preliminary results suggest that intermediate care led to significant advances in the areas of body function, cognitive function, nutrition indices, and satisfaction rates.

In order to help patients get better function on their own so they can return home, the National Health Insurance Administration launched a "Post-acute Care pilot project program "to help patients improve their incapacitating condition in their golden periods of treatment. Stroke patients prioritized under the program were given a customized rehabilitation and therapy plan shortly after the onset of their condition. The plan enabled patients to regain the capacity for self-care more quickly by reducing loss of function.

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 near death, in lieu of curative- and rescue-oriented care. Patient consent is a prerequisite.

From 2006, a special project has sought to raise willingness of medical care institutions and the general public to participate in hospice and palliative care while encouraging NHI holders to record consent on their NHI IC cards. Through 2014,there were 274,371 people who had signed a document expressing their willingness to undergo hospice and palliative care along with their wishes in relation to life-sustaining treatment. Each person's choices were recorded on his or her IC card (Figure 4-3).

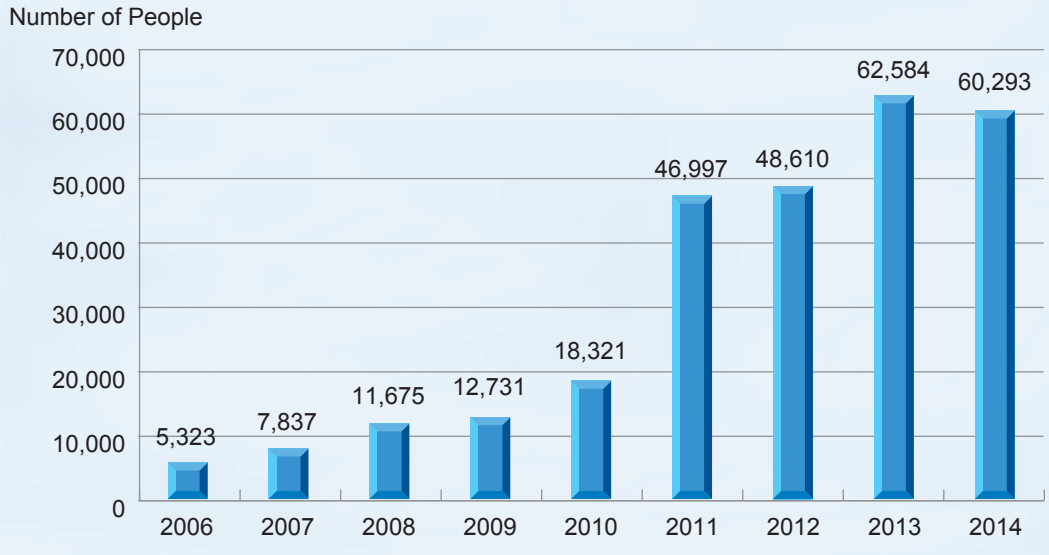
By 2014, there were 50 hospitals that served hospice inpatients and 75 that provided home services, with a total capacity to provide end-of-life care to more than 25,000 people each year. In April 2011, a pilot hospice joint care program began that offered patients the chance to remain with their original medical team while hospice care providers moved between departments to offer treatment. By 2014, these joint services had expanded to 96 hospitals and were used by approximately 20,000 cancer patients. Such programs contributed to an increase in the percentage of terminal cancer patients receiving hospice care within one year of death from 7.4% in 2000 to 50.6% in 2012.

Section 5 Oral Health Care

1. Better Dental Care for the Disabled

(1) Dental care services for the disabled continued with subsidies for five model centers (National Taiwan University Hospital, Shuang Ho

Figure 4-3 Number of People Who Recorded Hospice and Palliative Care Intentions on their IC Cards



Hospital, Chung Shan Medical University Hospital, Kaohsiung Medical University Hospital, and Mennonite Christian Hospital) and 24 hospitals to implement a comprehensive oral care project for people with special needs in 2014.The project includes encouraging hospitals to hold special dental out patient service, building support and building support and transfer networks between hospitals and social welfare organizations, and offering special training for dentists and caregivers. In 2014, such services were provided 30,111 person times.

(2) Among cities and counties nationwide, a total of 89 hospitals were designated to provide special dental outpatient service in accordance with the outpatient management law for the disabled.

2. Subsidized Dentures for Lower-to-Middle-Income Seniors

A plan to subsidize dentures for lower-to-middle-income seniors that was implemented on January 1, 2009, offers dentures to lower-income households, lower-to-middle-income households, recipients of living allowances for lower-to-middle-income seniors, recipients of living subsidies for lower-to-middle-income disabled persons, recipients of full placement subsidies from any level of government, and seniors who qualify for at least 50% subsidized daily care and living care expenses from any level of government. From 2009 to the end of 2014, more than35,000 people benefitted. Additional assistance to aid chewing function of seniors from lower-to-middle-income households arrived in 2013 when denture maintenance subsidies were increased.

Chapter 2 Mental Health and Psychiatric Care

Section 1 Mental Health Promotion Strategies and Achievements

1. In order to make people better understand and pay much attention on mental health issues, in 2014 the MOHW produced four promotional leaflets. In October, to mark World Mental Health Day, the ministry solicited mental health videos and home remedies for easing anger and pressure, and it held an online poll to choose top10 Taiwan songs that represent both encouragement and healing. These online activities and messages which people engaged are more than 180,000 person-times.
2. To promote primary prevention of mental health and achieve the vision of greater well-being and mental health for all people, the MOHW built a locally based mental health network and contract with 12 local health bureaus to implement a pilot plan for launching of this network. Achievements are made including the establishment of local mental health promotion task forces, network coordinating meetings and 181 spotlight activities were held, which had a total attendance of 18,127 participants and an average satisfaction rate of 95%. A network map was completed and various mental health and education resources were also outlined and distributed.
3. By expanding resources and participation from private sectors, further advancement will be made in the development, integration, and practice of mental health. The MOHW had been promoting and implementing the Mental Health Promotion Plan, which included subsidies for 21 organizations to carry out on mental health promotion targeting schools, premarital couples, workplaces, indigenous communities, long-term care patients, communities, and mass media. The goal was to promote the awareness of mental health issues for all the people.
4. Launch of a toll-free, 24-hour suicide prevention hotline (0800-788-995) provided professional counseling. In 2014, hotline services were used 73,341 person-times, with rescues or assistance provided during the course of 530 person-times in emergent situations.
5. By integrating suicide prevention resources, diverse prevention services were offered, including suicide case reporting, outreach visits, and crisis management. In 2014, there were 29,047 person-times reported suicide attempts, which led to 208,802 person-times outreach visits.
6. In 2014, there were 3,546 deaths by suicide, with a standardized mortality rate of 11.8 per 100,000 population, a decrease of 1.7% compared to 2013. In a WHO suicide report, Taiwan had already ranked in medium suicide

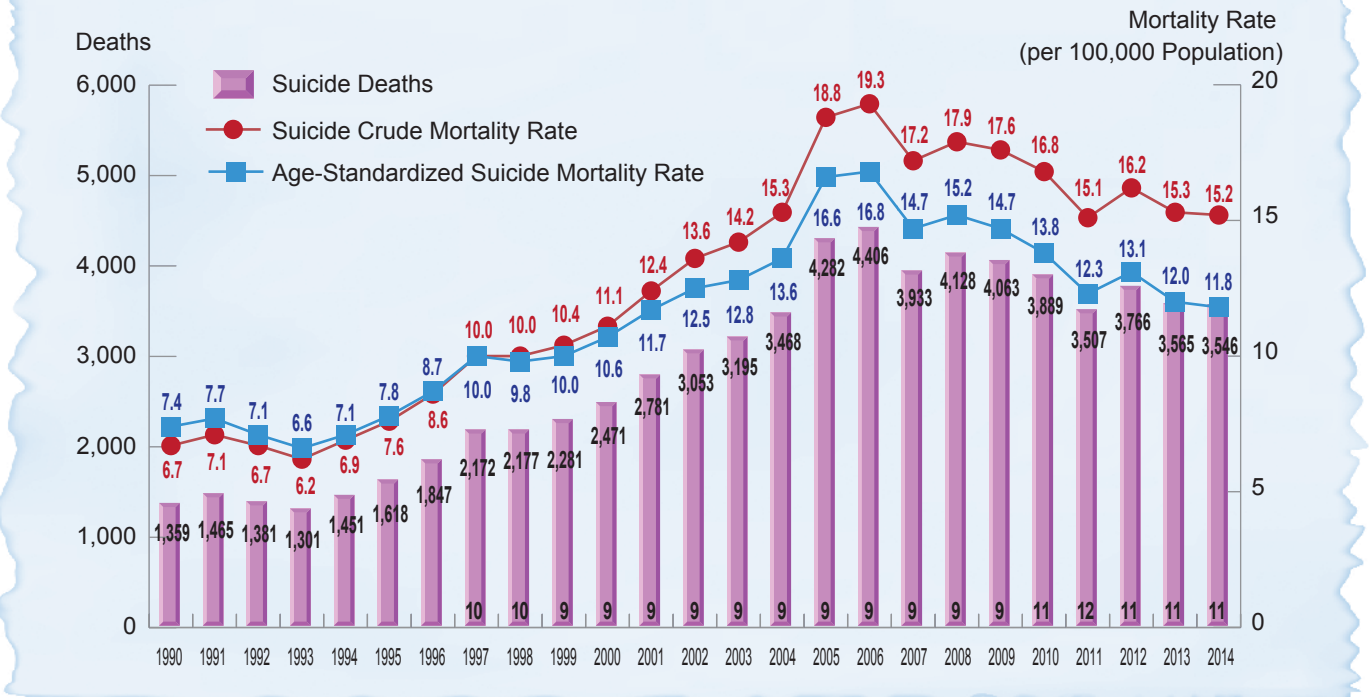
prevalence countries (standardized rate of 6.5 to 13 deaths), showing the suicide prevention policies had begun to achieve positive results (Figure 4-4).

7. Several unfortunate events, such as random killings on the Taipei Metro, a deadly plane crash in Penghu, and deadly gas explosions in Kaohsiung, led the MOHW to revise its response mechanisms and SOPs for handling mental health issues in the wake of major disasters and public safety problems. People who qualified for treatment were expanded from victims and relief providers to include members of the general public, and agencies responsible for mental health were assigned to contribute to disaster response duties.

Section 2 Psychiatric Health Services

1. In order to provide an integrity health care for psychiatric patients, a six areas of regional psychiatric care network was established. Designated core hospitals were responsible to: 1. Serve as regional psychiatric care units by promoting regional mental health and psychiatric care networks, 2. Cooperate with local health departments to help improve service quality of psychiatric care institutions improve service quality, 3. Develop professional mental health and psychiatric care services, 4. Promote education and training programs for health professionals.
2. In 2014, there were 440 psychiatric care institutions that equipped total of 21,236 beds (including 7,442 beds for emergency psychiatric patients and 13,794 beds for chronic psychiatric patients), or 9.06 beds per 10,000 population. There were also 69 daytime psychiatric rehabilitation institutions (3,433persons), 122 psychiatric rehabilitation institutions that offered accommodation (5,118 beds), psychiatric day care centers (total capacity of 6,376 people), and 35 nursing care institutions (3,295 beds).
3. In order to contact and follow-up mental patients, MOHW subsides were offered for local governments to hire a total of 96 outreach associates. In 2014, there were 714,617such person-times of visits made for 141,801 psychiatric patients.

Figure 4-4 Taiwan Suicide Deaths and Mortality Rates, 1990-2014

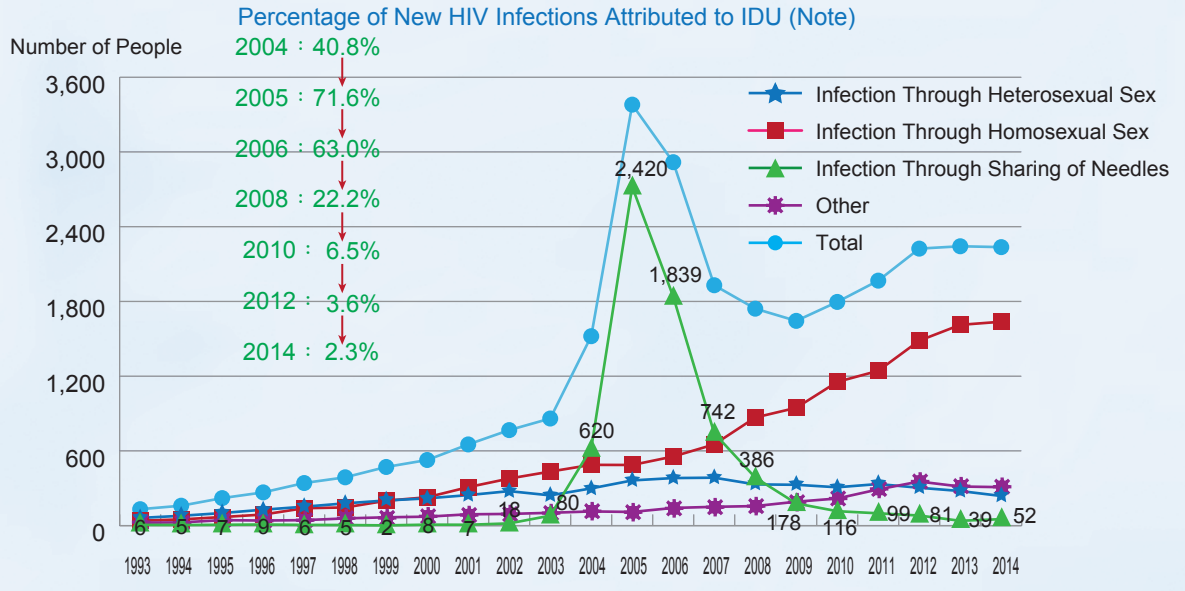


4. The Taiwanese Society of Psychiatry was contracted to handle the mandatory hospitalization and treatment of patients with serious mental illness. In 2014, there were 766 applications accepted (comprising 718 applications for mandatory hospitalization and 48 for mandatory community care).
5. Service quality at psychiatric care institutions is evaluated through accreditation mechanisms, inspections, and follow-up guidance. In 2014, inspections were carried out at 15 psychiatric medical care institutions (including psychiatric teaching hospitals), 83 psychiatric rehabilitation institutions, and 16 psychiatric nursing care institutions. Irregular follow-up and guidance was completed at 25 psychiatric rehabilitation institutions.
6. The MOHW has published a series of mental health promotional manuals that take into account the mental health care needs of the general public and holistic care planning. There were 10 booklets completed in 2014: "Childhood Anxiety," "Mental Health and Growth in Youths," "Mental Health and Nutrition," "Mental Health and Alcohol," "Bipolar Disorder," "Breaking Free from OCD," "Mental Health and Sex," "Mental Health and Dementia," "Approaches for Helping Mental Health Patients," and "The Road to Recovery for Mental Health Patients – Friendly Partners."

Section 3 Control of Drug Addiction

1. Subsidized alternative therapy for drug addiction was introduced in 2006 under a special plan to reduce HIV transmission by needles sharing of needles. In 2014, there were 150 alternative therapy institutions designated nationwide that treated a total of 41,017 patients. Effectiveness was shown by a decline in the number of new HIV cases among drug addicts from 2,420 in 2005 to 52 in 2014 (Figure 4-5)
2. A total of 1,714 employed staffs in 158 designated drug addiction treatment institutions, including psychiatrists, pharmacists, nurses, clinical psychologists, occupational therapy specialists, and social workers. As drug addicts who voluntarily sought help received addiction treatment, emergency services, hospitalization, and post-discharge follow-up aimed at preventing relapses, core hospitals in the

Figure 4-5 No. of HIV Infections by Routes of Transmission, 1993-2014



Note: By introducing alternative methods, there has been a gradual reduction in HIV infections caused by the sharing of needles among drug addicts.

mental health network conducted continuing education and training to raise professional capacity. Another plan "Subsidize private organizations that endorse group drug addiction therapy", eight organizations were founded in 2014 that support on developing treatment models and providing social rehabilitation models.

3. An alcohol addiction treatment plan targeted specific groups, such as domestic violence offenders, high-risk family members, and people who voluntarily asked for assistance. Hospitalization, clinical treatment, mental consultation, and awareness education were provided. In 2014, a total of 1,078 people are provided these services.
4. In 2014, the Taoyuan Mental Hospital, MOHW, was contracted to complete a handbook on treatment of patients with alcohol-related problems. Besides providing health workers with recommendations, it offer referral and consultation mechanisms. For non-health professionals, it provides general principles for identifying alcohol addiction problems, so early referral and intervention could be made.
5. In 2014, the Taiwanese Society of Addiction Science was contracted to develop a series of digital and interactive training materials on the hazards of Class 3 and Class 4 drugs. It also applied on continuing education and training materials for professionals who contact with drug users (with general and professional versions available). These educational products improved the effectiveness and quality for professionals on their education and training.
6. In order to help drug addicts change their behaviors and make better life when go back to their communities, funds from the lottery system were allocated to subsidize social workers for local governments and NGOs. These workers then offered family support services, such as outreach visits, daily life support, family activities, and resource referral. In 2014, 20 local governments and NGOs were subsidized and 138,589 person-times were benefit from the funds.

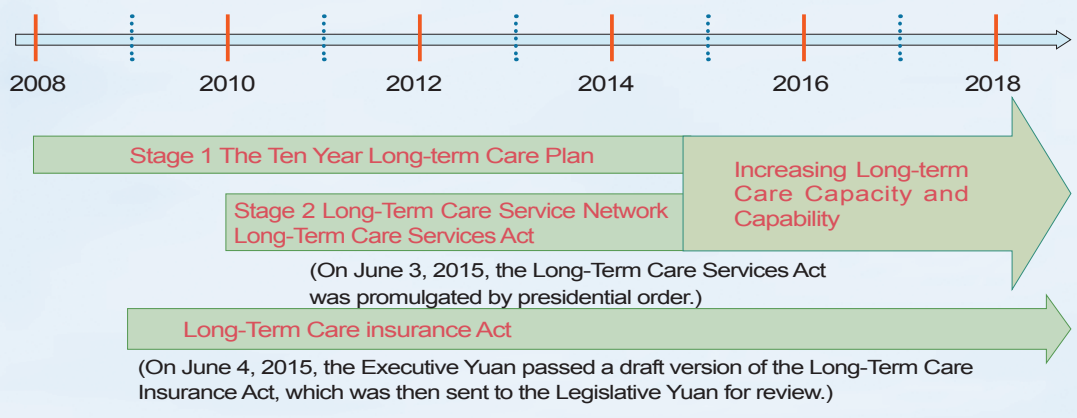
Chapter 3 Long-Term Care Service Systems

Taiwan's policy blueprint for implementing long-term care (LTC) is based around two proposed laws: the Long-Term Care Services Act and the Long-Term Care Insurance Act. With this blueprint in mind, since 2008 the government has implemented a series of plans, including the "The Ten Year Long-term Care Plan" and the "Long-Term Care Service Network Plan." To further strengthen and consolidate the LTC system, the MOHW also is scheduled to implement the Increasing Long-term Care Capacity and Capability Plan form November, 2015 to 2018 (see Figure 4-6).

Section 1 Universal Long-Term Care Services

In order to build a comprehensive LTC system, a three-stage program was established as follows:

Figure 4-6 Long-Term Care Planning Chart



1. Stage 1: Implementation of "The Ten Year Long-term Care Plan"

(1) Continued Implementation of the 10-Year LTC Plan: Development of a community-based aging-in-place network .

a. Raising the Service Usage Rate: Usage among the elderly who lost functional ability rose from 2.3% in 2008 to 33.2% in 2014, a 14.2-fold increase.

b. Accelerating Resource Expansion

a) In areas with insufficient elderly welfare institutions, the focus was on subsidizing the establishment of institutions by private organizations. In areas with sufficient resources, the focus was on providing the guidance and improvements needed to raise institutional service quality.

b) Overall service capacity climbed by 84%, with the biggest gains in day care service. Its institutions rose from 31 in 2008 to 170 in 2014,over five-fold growth (Tables 4-2, 4-3).

c) In December 2014, there were 105,449 beds available at LTC institutions, comprising 38,249 beds at general nursing homes (85% occupancy), 59,280 beds at LTC and elderly centers (76.4% occupancy), and 8,200 beds at veterans' homes.

(2) Making LTC a More Feasible Option for the Economically Disadvantaged: An analysis of the case socioeconomic data of cases under LTC, taken over a five-year period, shows that lower-to-middle-income households account for 12% of all households receiving assistance (and just 4% of the total population). Lower-income households account for 14% of all households receiving assistance (and just 1% of the total population). Based on these figures, the economically disadvantaged population receives a relatively high amount of assistance.

2. Stage 2: Implementation of an LTC Service Network Plan

(1) Implementation of an LTC Service Network Plan

An LTC service network plan, drafted with the intent of promoting diverse and balanced LTC resources, has fostered a universal service network that brings LTC to communities across the nation (including remote areas). The plan divides the nation into large (22), medium (63), and small (368) LTC regions based on service needs. It includes incentives for resource development and focuses on community-based, localized resource development. Items already completed in 2014 were as follows:

Table 4-2 Services Provided by Institutions Offering LTC Home-Care and Community-Based Care

Unit: Institution

Item/Year	2008	2009	2010	2011	2012	2013	2014
Home Care Service	124	127	133	144	149	160	168
Day care Center	31	39	66	78	90	120	150
Household Entrusted Services	4	16	23	16	17	20	22
Nutrition Meals for the Elderly	166	204	201	159	169	190	209
Transportation Service	31	42	43	39	43	42	41
Home nursing Care	487	495	489	451	498	478	486
Home (community) rehabilitation	62	88	113	112	111	191	143
Respite Care Services	102	114	311	474	527	651	1,549
Total	1,007	1,125	1,379	1,473	1,604	1,852	2,788

Notes:1. Declines in elderly nutrition meals and transportation services in 2011 were attributed to adjustments in local government planning and implementation. There was no impact to overall service capacity.
2. Home nursing care data is from the medical affairs management system of the MOHW and is collected every six months.
3. By the end of 2014, there were 170 daily care service units, including 150 daily care centers and 20 day care service points.

Table 4-3 No. Of Persons Receiving LTC Services

Unit: Persons

Item/Year	2008	2009	2010	2011	2012	2013	2014
Home Service	22,305	22,017	27,800	33,188	37,985	40,677	43,331
Day Care	339	618	785	1,213	1,483	1,832	2,344
Household Entrusted Services	1	11	35	62	110	131	146
Assistive Device Purchases/Rentals and Handicap Friendly Improvements to Residences	2,734	4,184	6,112	6,845	6,240	6,817	6,773
Nutrition Meals for the Elderly	5,356	4,695	5,267	6,048	5,824	5,714	5,074
Transportation Services (Persons times)	7,232	18,685	21,916	37,436	46,171	51,137	54,284
LTC Institutions	1,875	2,370	2,405	2,755	2,720	2,850	3,127
Home nursing	1,690	5,249	9,443	15,194	18,707	21,249	23,933
Community and Residential Rehabilitation	1,765	5,523	9,511	15,439	15,317	21,209	25,583
Respite Care Services	2,250	6,351	9,267	12,296	18,598	32,629	33,356

Notes: 1. Assistive Device purchases/rental and handicap friendly improvements to residences as well as transportation services refer to the accumulated number of people who provided service during the year. Other items refer to the number of service members at the end of December.

2. Assistive Device purchases/rental and handicap friendly improvements to residences, as well as elderly meals and LTC institutions were attributed to adjustments in local government formulated a budget to implement.

a. There were 170 day care institutions and 22 dementia community service centers established.

b. Service centers are provided to ease LTC resource shortages in remote areas. There were 66 such centers already completed by 2014 and 89 were forecast to be completed by the end of 2016.

c. Promotion of Telecare

a) In order to build a comprehensive, smart care service system that will increase usage of LTC and spur development of the health care industry, the MOHW approved the establishment of 970 community-based service footholds for biometric measurements by 12 local health departments in 2014. There were 1,900 live-alone elderly persons who used these for telecare services.

b) The MOHW announced draft guidelines governing security and maintenance of telecare personal data on November 10, 2014.

c) Besides forming an alliance of diverse companies to install equipment for the measurement and transmission of biological data, the MOHW provided the scope and procedures for examination and measurements, with 21 companieshandling 96 cases. App authorization was also granted to eight companies.

d) In conjunction with a 2014 international exhibition on elderly people, from June 19 to 22, 2014, cloud health management tools were on display for trial. There were 402 people who downloaded or renewed on site the telecare app and completed registration.

(2) Adoption of the Long-Term Care Services Act: Legislative Yuan Passes Third Reading of Long-Term Care Services Act on May 15, 2015, then was promulgated by Presidential Order on June 3, 2015 and shall become effective after two years of promulgation.

a. Planning of LTC Service Financing

a) The Ten Year Long-term Care Plan, which authorized spending of NTD4.8 billion /year, already entered its eighth year. Between NTD150 and NTD600 million has been spent annually on LTC resource establishment,

with the remaining funds used to subsidize basic services for the disadvantaged people.

b) The Long-Term Care Services Act stipulates to establish a Long-Term Care Service development fund of at least NTD12 billion over five years that will be used to comprehensive LTC services and human resources. There will be a review of the amount and sources of the fund two years after the act implementation to ensure financial stability.

c) Implementation of the Long-Term Care Insurance Act will create a social insurance mechanism that fosters mutual assistance. The draft act was sent to the Legislative Yuan for review on June 4, 2015.

b. In order to explain the primary content of the Long-Term Care Services Act and provide a platform for communicating different views, the MOHW carried out the following publicity measures:

a) In June 2015 the MOHW completed the first version of an Dummies of Long-Term Care Services Act manual, which it placed on the LTC act link on the MOHW website. More publicity plans will follow in the future.

b). An LTC Facebook fan page continues to address related issues. In the future, updated "Dummies of LTC" manuals and a Long-Term Care Services Act Q&A will be posted on the page.

c). Each of the nation's 22 city and county governments was invited to discuss issues pertaining to local responsible departments, LTC Corporate institutions, subsidies for LTC resource development, and conversion of LTC institutions and personnel on June 2, 2015.

Section 2 LTC Professional Training

1. For uniform, continuous, and complete LTC training, course plans were designed for LTC health workers and management staff of care centers. To eliminate worker shortages, goals included training 30,912 care service workers, 2,628 social workers, 5,668 nursing practitioners, and 2,128 physical and occupational therapists by 2016.

2. Results of LTC Professional Training

(1) Enrollment from 2010 to 2014 in a three-phase course covering medical LTC topics was 28,901. From 2007 to 2014, there were 729 care management workers, and from 2003 to 2014 there were 10,189 care service workers who were trained.

(2) Enrollment in 96 localized LTC staff training classes carried out in remote regions (including mountainous areas and outlying islands) between 2011 and 2014 was 2,745.

3. Expansion and Retention of the Care Service Workforce

(1) Better Training and Salaries for Care Workers: A professional workplace training system encouraged more middle-to-advanced aged workers and people seeking a second career to join the LTC service industry. Since July 1, 2014, the care service fee was adjusted to NTD200 per hour, with the minimum hourly wage set at NTD170 an hour. Also, to help care service providers defray costs, subsidies for operational fees were added. These were applied to cover overtime, vacation, on-the-job training wages, and other benefits employers were required to cover under labor regulations. By providing an incentive to hire more care service providers, the measures paved the way for capacity growth.

(2) Raising Quality and Effectiveness of Workers in Elderly Welfare Institutions: In 2014, there were three on-the-job training sessions provided to presidents (directors) of the elderly welfare institutions and social workers. Attendance reached 96 for presidents (directors) and 130 for social workers. Public and private resources were combined to conduct professional training and research related to care for the elderly dementia patients along with on-the-job professional training for workers in the elderly welfare institutions. There were four such sessions in 2014 with attendance reaching 160.

Section 3 Better Quality Through Integration of LTC Institutional Management

For better service quality of nursing homes and the elderly welfare institutions, accreditation is conducted in accordance with the "Nursing

Personnel Act" and the "Senior Citizens Welfare Act." After inviting the Ministry of the Interior and the Veterans Affairs Commission to join in integrating LTC institution accreditation standards in 2013, the MOHW reviewed and revised these standards based on the implementation progress in 2014.

Through 2014, there were 460 nursing homes evaluated (including 135 in 2014), with 64 rated as outstanding (13.91%), 185 as excellent (40.22%), 181 as good (39.35%), and 30 not qualified (6.52%). There were also 1,063 elderly welfare institutions which must be checked by competent authorities each year and undergo onsite evaluations every three years. In 2013, the MOHW evaluated 127 of these institutions, with 17 rated as outstanding (13.4%), 63 as excellent (49.6%), 40 as good (31.5%), and seven as fair or lower (5.5%).

Chapter 4 The Medical Manpower

Section 1 Current Status of the Medical Manpower

1. According to the licensing system for professional medical workers, there are 14 laws and regulations governing the management of medical workers: 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.
2. In 2014, there were 271,555 practicing medical workers, including 62,295 physicians (western and Chinese medicine doctors and dentists), 33,162 pharmacists, 9,132 medical technologists, 5,774 medical radiological technologists, 142,708 registered nurses, 149 midwives, and 2,304 dieticians. Compared to 2001, there were 18,810 more physicians, 8,271 more pharmacists, 2,590 more medical technologists, 2,662 more medical radiological technologists, 59,945 more registered nurses, 369 fewer midwives, and 1,526 more dieticians. See Table 4-3 in Appendix 2 for the number of practicing medical workers and the number of practicing medical workers per 10,000 population, as of the end of December 2014.

Section 2 Training of Medical Workers

In order to raise the quality of the medical workforce, each year the MOHW carries outtraining plans, cultivation plans, and workplace training. Results were as follows:

1. Mechanisms in place to regulate the training of medical workers include a general quota of 1,300 medical students to be enrolled each year and special tools to manage other categories of medical workers. These include the requirement that medical training programs apply to the Ministry of Education prior to establishment. Future planning of the physician work force will focus on balanced distribution of resources and include regular assessments.
2. Over more than three decades of the government-sponsored physician system, gradual improvements were made to the physician shortages that plagued public hospitals, remote regions, and outlying islands. With phased implementation leading to the fulfillment of policy goals, starting in 2006 recruitment for 40 government scholarships was gradually reduced before being eliminated in 2009, and the annual number of locally trained government-sponsored physicians rose from between six and nine each year to 27.
3. Post-graduate general medical training is offered to strengthen holistic care concepts and capabilities of physicians while improving training quality of resident physicians. In July 2011,a post-graduate year (PGY) program was launched, with a total of 128 hospitals approved to conduct the program (consisting of 40 training hospitals and 88collaborating hospitals) and participation by 1,395 students in 2014.
4. To ensure patients' safety, there are post-graduate clinical training programs which is a link between schools and clinical education in order to enhance oral health care quality. There were 374 medical care institutions that were approved to conduct training project (83 hospitals and 291 clinics), with 729 dentists participating in 2014.

5. Specialty training has been offered since 2006 to raise professionalism and care quality of nursing practitioners. The program was divided into internal medicine and surgery, with the internal section subdivided into internal, pediatric, and neurologic groups in 2012, and an OB/GYN group added to the surgery section in 2013. Through 2014, there were 5,026 specialty nursing practitioners who completed the program (2,670 internal medicine practitioners and 2,356 surgery practitioners).
6. Due to the importance of clinical training for raising the quality of new medical professionals, subsidies have been offered since 2007 to offset teaching fees. In 2014, there were 2,187 approved training plans at 133 participating hospitals. A total of 25,792 medical workers were trained, and 76.52% of medical workers received training within two years of obtaining their license.
7. A continuing education system for 14 types of medical workers mandated a certain number of hours in continuing education every six years as a prerequisite for license renewal to ensure up-to-date professional skills.
8. In order to better assess clinical skills of medical students while improving quality of clinical education, since 2010 assistance has been provided to teaching hospitals in establishing the software and hardware needed for clinical capability assessments. Also, an amendment to the Enforcement Rules of the Physicians Act paved the way for assessment testing to take place at 25 teaching hospitals. Since 2013, more than 1,300 medical school graduates have passed the Objective Structured Clinical Examination (OSCE), which tests doctor-patient communication, physical examinations, and other health care techniques. Only by passing the OSCE could graduates advance to the second stage of the doctor's exam.
9. In order to build a clinical training system for Chinese medicine doctors and foster oversight function, in 2009 the MOHW began to plan the Scheme for the Training of Responsible Physicians in Chinese Medical Care Institutions. Through the end of 2014, the scheme assisted 31 training hospitals that accepted a total of 383 new Chinese medicine doctors. Following the formal launch of the plan in 2014, all candidates who would like to become supervising physicians have to be required to undergo two years of training at an MOHW-approved hospital.
10. Implementation of the Project to Enhance Professional Competence of Chinese Medicine Practitioners has included holding 15 conferences based on both Chinese medicine and Chinese-western medicine. Also, there have been 2,150 nursing practitioners who have taken basic curricula in Chinese medicine nursing practices.

Section 3 Nursing Reform

1. Near-term and long-term plans announced on May 10, 2012, named six major objectives and 10 strategies for improving the working environment for nurses. Implementation results in 2014 were as follows:

(1) Reducing the Workload of Nurses

a. Reducing the Nurse-Patient Ratio: The MOHW has announced trial hospital evaluation standards relating to the nurse-patient ratio in three daily shifts. Besides stricter standards for daytime hours, there are new standards for evening and late-night shifts. In 2015, these will formally become part of hospital evaluations.

b. Launch of a Mechanism to Link Inpatient Insurance Payments to the Nurse-Patient Ratio: Promulgated on August 13, 2014, this plan used NTD400 million from a NTD2 billion plan to improve NHI hospital nursing care to turn the average monthly number of care staff assigned to the three shifts in general emergency rooms into a payment item. This served as a pilot mechanism for linking inpatient insurance payments to the nurse-patient ratio.

(2) Raising Salaries and Benefits for Nurses

a. NHI budgeted NTD2 billion for use in increasing the nursing workforce, raising nighttime shift fees for nurses, and raising salaries and benefits.

b. According to the Ministry of Labor data, nurses had an average salary of NTD43,296 in 2013, an 8.08% increase compared to the NTD40,060 average in 2010.

(3) Raising Retention of Nurses through Workplace Environment Improvements

a. Bringing Back Inactive Nurses: Guidance mechanisms for returning to the workplace, flexible nursing resource management models, and standards for excellent workplaces were introduced to improve the work environment for nurses and raise job satisfaction. In 2014, there was one workshop, 20 explanatory meetings, and four events to promote achievements.

b. Ensuring Worker Rights: From January 1, 2014, Article 84-1 of the "Labor Standards Act" was no longer applied to nurses (eliminating designated responsibilities).

c. Guaranteeing the Safety of Medical Workers: On January 29, 2014, the President announced an amendment to Articles 24 and 106 of the Medical Care Act. Revisions provided methods for preventing and handling violence in hospitals to ensure a safe work environment for medical workers.

(4) An 'Elite' Nurses Plan for Remote Regions

a. In order to solve nursing shortages and strengthen health care resources in remote areas, on June 19, 2014, the Executive Yuan approved an "elite" nurses plan to encourage nurses to work in remote regions. Recruitment began in 2015, with an estimated 200 nurses to be trained in remote regions over four years.

b. Besides study subsidies, this plan guaranteed a job after graduation, with state-financed nursing students dispatched to hospitals in 30 remote regions to serve as clinical nurse specialists for at least four years.

2. By the end of 2014, there were 147,818 registered nurses, an increase of 11,403 when compared to before the reforms.

Section 4 Medical Specialist System

1. Following a June 9, 2010, amendment, Article 3 of the "Rules of Specialization and Examination for Medical Specialists" designated 23 physician specializations: family medicine, internal medicine, surgery, pediatrics, OB/GYN, orthopedics, neurosurgery, urology, otolaryngology, ophthalmology, dermatology, neurology, psychiatry, rehabilitation medicine, anesthesiology, diagnostic radiology, radiological oncology, anatomical pathology, clinical pathology, nuclear medicine, emergency medicine, occupational medicine, and plastic surgery. Article 4 designated three dentist specializations: oral and maxillofacial surgery, oral pathology, and orthodontics. Through the end of 2014, physicians had passed specialist examinations 48,024 person-times.

2. In order to balance distribution of specialists while creating a stronger, better training environment, 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 (or 2,339 in total). Medical specialization associations were entrusted to designate hospitals that offer specialist training and to manage enrollment capacity. As time progressed, however, it became apparent that there was too large of a gap between the aforementioned limits and the number of resident physicians (1,300), which affected the distribution of specialists. Therefore, in 2013, the annual limit was reduced to 1,670, and in 2014 it was lowered again to 1,550.

Chapter 5 Health Care Quality

Section 1 Quality of Medical Care Services

With a view to better quality, the MOHW has created 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. Highlights in2014 were as follows:

1. Patient Safety and Quality of Medical Care

(1) Stipulated the "2014-2015 Taiwan Patient Safety Goals for Hospitals" (Table 4-4).

(2) The Taiwan Patient Safety Reporting System was established to create a safe culture for patients. In 2014, the 6,204 health care institutions that participated in the system reported a total of 62,000 cases.

(3) Regulations associated with safe hospital environments were stipulated under the Hospital Accreditation Standards. They included safety of the environment and equipment, patient orientation services and management,

Table 4-4 Taiwan Patient Safety Goals for Hospitals, 2006 - 2015

Year /Total Items	2006-2007	2008-2009	2010-2011	2012-2013	2014-2015
	8 Major Performance Objectives	8 Major Performance Objectives	9 Major Performance Objectives	10 Major Performance Objectives	8 Major Performance Objectives
1	Improving safe use of pharmaceuticals	Improving safe use of pharmaceuticals	Improving safe use of pharmaceuticals	Improving safe use of pharmaceuticals	Improving safe use of pharmaceuticals
2	Implementing infection control at medical care institutions	Implementing infection control at medical care institutions	Implementing infection control	Implementing infection control	Implementing infection control
3	Improving surgical accuracy	Improving surgical safety	Improving surgical safety	Improving surgical safety	Improving surgical safety
4	Raising patient identification accuracy	Preventing patient falls and lowering degree of injury	Preventing patient falls and lowering degree of injury	Preventing patient falls and lowering degree of injury	Preventing patient falls and lowering degree of injury
5	Preventing patient falls	Encouraging reporting of abnormal situations and data accuracy	Encouraging reporting of abnormal situations	Managing patient safety in the event of abnormal situations	Managing patient safety in the event of abnormal situations
6	Encouraging reporting of abnormal situations	Improving communication between medical care workers	Improving communication between medical care workers	Improving communication between medical care workers	Improving communication between medical care workers
7	Improving patient handoff communication and safety	Encouraging patients and family members to carry out patient safety tasks	Encouraging patients and family members to carry out patient safety tasks	Encouraging patients and family members to carry out patient safety tasks	Encouraging patients and family members to carry out patient safety tasks
8	Raising public participation in patient safety	Improving tube safety	Improving tube safety	Improving tube safety	Improving tube safety
9			Enhancing hospital fire prevention and response	Enhancing hospital fire prevention and response	
10				Improving suicide prevention among hospitalized patients	

management of medical care quality, safe use of medicine, anesthesia and operations, and infection control.

2. The Hospital Accreditation System

Relying on the core values of patient-centered care and prioritizing patient safety, reforms were made to the hospital accreditation and teaching hospital accreditation systems.

(1) Through 2014, accreditation was granted to 424 hospitals, 124 teaching hospitals, 45 psychiatric hospitals, and 10 psychiatric teaching hospitals (Tables 4-5).

(2) Drafting of hospital accreditation standards and conducting of test evaluations took place in dentistry, hospice and palliative care, and Chinese medicine.

(3) In April 2014, announcement of procedures and evaluation standards for the accreditation of Chinese medicine hospitals was conducted. By the end of 2014, there were 36 Chinese medicine departments affiliated with hospitals and 4 Chinese medicine hospitals that were accredited (Table 4-5). Also, in accordance with the consolidation of hospital accreditation mechanisms, by the end of 2015 Chinese

Table 4-5 Hospital Accreditation Results, 2014

Hospital Accreditation Results	Hospital Accreditation, Excellent			Hospital Accreditation, Qualified	
	Medical Centers	Regional Hospitals	District Hospitals	Regional Hospitals	District Hospitals
Quantity	19	78	49	3	275

Teaching Hospital Accreditation Results	Doctors and Medical Personnel Teaching Hospital Accreditation, Qualified (Medical Centers)	Doctors and Medical Personnel Teaching Hospital Accreditation, Qualified	Medical Personnel (Not Doctors) – Teaching Hospital Accreditation, Qualified
Quantity	19	98	7

Psychiatric Hospital	Psychiatric Hospital Accreditation		New Psychiatric Hospital Accreditation	
	Qualified	Excellent	Qualified	Excellent
Quantity	28	10	6	1

Psychiatric Teaching Hospital Accreditation Results	New Psychiatric Teaching Hospital Accreditation, Qualified	Doctors and Medical Personnel– Psychiatric Teaching Hospital Accreditation, Qualified
Quantity	3	8

Chinese Medicine Hospitals Accreditation Results	Chinese Medicine Hospitals		Chinese Medicine Departments Affiliated with Hospitals	
	Qualified	Excellent	Qualified	Excellent
Quantity	1	3	24	12

medicine departments affiliated with hospitals have been included as part of hospital accreditation.

(4) Hospital accreditation, medical and health inspections, and certification of training institutes for specialist medical practitioners were integrated. By the end of 2014, this had cut the total number of required evaluations by 444 (to 239), reducing the disruption of day-to-day affairs at medical care institutions.

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

Taiwan has promoted voluntary, non-remunerated blood donation since 1974. It has maintained a voluntary, unpaid donation rate of at least 5% and kept 100% of its national blood supplies based on strictly altruistic donations, putting it in the ranks of other nations with advanced blood supplies.

In order to strengthen 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 enzyme immunoassays, from February 2013 they were expanded with support from NHI to include full implementation of nucleic acid amplification testing for HIV and hepatitis. This brought Taiwan's blood testing in line with international standards while ensuring safe blood products.

Since 2009, inspections made to primary care institutions have contributed to improved management, safety, and image quality of equipment capable of producing ionizing radiation. According to the Atomic Energy Council data from June 2013, there were 7,262 primary care institutions with equipment capable of producing ionizing radiation. By December 2014, on-site guidance and inspections were completed at 1,279 of these institutions.

Section 3 Improving Efficiency and Quality of Organ Donation and Transplantation

Nations around the world face a shortfall of organ source supply, and Taiwan is no exception, with more than 8,000 patients awaiting organsat the end of 2014 and only 700 to 800 patients a year able

to receive a transplant. In order to promote organ donation, expand sources, and aid distribution, the MOHW established the Taiwan Organ Registry and Sharing System in 2002. Measures such as this have made Taiwan's organ donation rate number two in Asia and its organ transplant success rate competitive with developed countries in the west. Details are as follows:

1. On Dec. 21, 2011, an amendment to the "Human Organ Transplantation Act" stipulated that organ donor willingness must be indicated on NHI IC cards and that this indication shall carry equal weight to the paperwork donors must submit. Authorization under regulations governing organ distribution was expanded, and new rules required that donor examination reports be submitted to the hospital receiving the organ, so the status of the organ could be fully understood prior to transplantation.
2. At the end of 2012, new SOPs for the donation, transplantation, and allocation of organs made several steps in the verification of test results between medical groups repetitive, in order to ensure accurate transmission of patient information.
3. In June 2013, linking of the Taiwan Organ Registry and Sharing Center with follow-up systems for HIV and Hansen's disease and case data for Creutzfeldt-Jakob disease was completed. This enhanced accuracy of registered data.
4. In 2013, integration of hospitals involved with the northern, central, southern, and eastern Taiwan organ donation networks was completed. New unified approaches to the solicitation of organ donors, as well as the removal, distribution, and transport of organs, led to improved quality and effectiveness.
5. Establishment of the Regulations Governing the Transplantation and Allocation of Human Organs provided a legal basis for the factors and methods used in the transplant and distribution of organs. One factor used to promote organ donation as a public service with personal benefits was the inclusion of having a spouse or third-degree relative who donated organs following death as a qualification for priority recipient status.
6. A draft amendment to regulations governing the transplantation of human organs completed review by the Legislative Yuan's Social Welfare and Environmental Sanitation Committee on May 14, 2014. Some revisions were retained for further negotiation between ruling and opposition parties.

Section 4 Smart Health Care

In accordance with the Executive Yuan's Cloud Computing Applications and Industry Development Program, the MOHW launched Taiwan Health Cloud, which will be built between 2014 and 2016 and consists of four "sub-programs": a medical care cloud, a care cloud, a health promotion cloud, and a communicable disease control cloud. By using information and communication industry technology, it provides customized, convenient, and highly efficient cloud health services that promote overall health of the people. Tasks completed in 2014 included the following:

1. Continued promotion of EMR has led 343 hospitals, 51 health centers, and 192 clinics to be connected with the EMR Exchange Center.
2. In order to promote self-health management, in September 2014 the MOHW established "My Health Bank" system. People can use their "password-registered NHI card"or "Citizen Digital Certificate", to download personal medical information via internet. It helps medical information can more convenience be shared between patients and physicians, and ensures the safety and effectiveness of medical care.
3. In July, 2013, the complete NHI Pharma Cloud System was launched to assure patients a safer, higher-quality environment for medication. Physicians and pharmacists who use the system to check patients' medication records can prevent duplicate prescription and administration of medicines. By the end of 2014, there were already 5,761 hospitals that had used the system to check a total of 19.48 million records from 6.44 million different patients.
4. In cooperation with 12 local health departments, the MOHW established 970 community-based service stands for biometric measurements. In addition, there were 1,900 live-alone elderly

persons who used these telecare service at home.

5. The MOHW completed the Health Promotion Helper platform and app, which serve as a foundation for holistic health management mobile cloud services, so people can input health-related data and check preventive health records. Among the 3,200 trial users there was a satisfaction rate of over 85%.
6. A total of 40 hospitals have participated in the automatic interface for infectious disease notification and laboratory data submission. Of all the reported cases nationwide, 35% are attributed to automatic reporting, This is considered an efficient mechanism and simplify the reporting process of communicable diseases for hospitals.

Chapter 6 Health Care in Remote Regions

Section 1 Strengthening Localization of Health Care on Outlying Islands and in Remote Regions

In order to protect the right to medical care of people who live on outlying islands and in remote regions, the MOHW seeks to provide seamless medical care. Measures taken to strengthen local medical care functions included the following:

1. An integrated delivery system was launched to improve NHI effectiveness in mountainous regions and on outlying islands. Hospitals formulated plans and dispatched manpower and resources to remote regions to provide specialized and emergencycare, evening clinics at fixed locations, and mobile medical service points. These measures contributed toward implementing the "doctors move, patients stay put" principle to further strengthen local medical care.
2. As part of an MOHW mission to raise hospital care services at institutions on outlying islands to the level of a regional hospital, construction continued on the Kinmen County Comprehensive Medical Building as well as a new medical building for Lienchiang County Hospital. In 2013, the Cardiac Catheterization Room of Penghu Hospital opened, and in January 2013 services officially began at the Psychiatric Building of Kinmen Hospital.
3. Through improvements to facilities and equipment, the MOHW provided better care environments and health services to residents of remote regions. It continued to build and renovate health centers (rooms) in remote regions and on outlying islands. An improvement project repaired the central air facilities in the old medical building of Lienchiang County Hospital. Another proposed project to raise quality of emergency care at the Dawu Township health center and the South Link region contained plans to establish a South Link emergency medical care center at Dawu Township, Taitung.

Section 2 Improving Health Information Networks and EMR in Remote Regions

1. Building Health Information Networks for Remote Regions

   As mobile clinics continued to bring medical care deep into remote indigenous villages, a new user-friendly registration system offered additional languages to enhance convenience. By the end of 2014, medical information systems were established at 59 health centers in 15 counties, including Hsinchu, and there were 332 mobile medical stations that provided assistance in 8,669cases.
2. EMR Interoperability Plan for 48 Remote Regions and Outlying Islands

   In order to improve medical information in remote regions while building a framework for cloud services, EMR reading systems were built in 48 remote health centers in 2013, including the center in Fuxing District, Taoyuan City.

3. Mobile Medical Services

   Mobile medical services are used to solve treatment challenges caused by inconvenient transportation in mountain and remote regions. Physicians who provide mobile services are able to rely on cloud platforms to examine patients' medical records and images. Besides improving treatment quality, these services save

time and money for people who previously had to leave their villages for care.

Section 3 Support from Medical Centers and Tri-Services Emergency Medical Evacuations

In order to strength enemergency treatment and care services on outlying islands, in 2013 a project was launched that offered incentives formedical centers to support emergency treatment and care services on outlying islands and in areas with insufficient medical resources. Currently, Taipei Veterans' General Hospital supports Kinmen Hospital, Kaohsiung Chang Gung Memorial Hospital and Chi Mei Medical Center support Penghu Hospital, and Far Eastern Memorial Hospital and Wan Fang Hospital support critical care physician resources at Lienchiang County Hospital.

1. An aeromedical review mechanism was established in 2002 to maximize effectiveness of emergency rescue and care resources. Besides dispatching specialist physicians, outlying island emergency evacuation SOPs set by the National Aeromedical Approval Center were used in the delivery of 24-hour emergency health consultations as well as evaluations relating to air ambulance needs and coordination of aircraft and Coast Guard vessels. These steps provided an effective system for reviewing and improving air ambulance services.
2. Adhering to the principles of "doctors move, patients stay put" and seamless medical care, local medical care services were strengthened, with aeromedical services provided in a complementary role. If aircraft were insufficient due to time or other constraints, assistance was obtained from the Airborne Service Corps or the Ministry of National Defense. In 2014, there were 236 air evacuations (comprising 47 by private firms, 187 by the Airborne Service Corps, and two by the Ministry of National Defense), a decrease of 1.67% compared to 2013. Opening of the Cardiac Catheterization Room of Penghu Hospital on December 4, 2013, reduced the proportion of patients needing airborne services for cardiovascular services from 51% of all patients to 13%, showing the overall improvement to health care quality.
3. For people from mountainregions or outlying islands requiring treatment for serious or emergency illnesses or injuries but who were in stable enough condition to arrange their own travel, subsidies were available to cover half the costs associated with sea or air transportation.

Section 4 Improving Health Care in Areas with Insufficient Resources

1. Guaranteed Funding for Areas with Insufficient Medical Resources

   An NHI-associated project launched in May 2012 sought to improve health care services in areas with insufficient resources. Funding of NTD500-800 million was provided annually to community hospitals that play a primary role in providing urgent medical care to mountain regions, outlying islands, and remote areas. The funding subsidized 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 2014, there were 40 hospitals designated to handle emergency and rescue services in areas with insufficient resources. By offering a 30-50% increase in emergency diagnosis and examination fees and guaranteeing a full NTD1 payment for emergency cases under NHI's pay for points system,these hospitals were encouraged to add and improve emergency care.
3. An NHI program for increasing dental resources in underserved areas included a NTD280 million special fund in 2014 to provide fixed-location clinics and mobile medical services, helping to bridge the treatment gap that exists between urban and rural areas. In 2014, there were 35 dental clinics under the plan operating in 35 villages and townships, and there were 18 medical teams (and 280 institutions) that offered mobile services in 124 townships and villages.
4. Another program sought to increase NHI western medicine resources in underserved

areas by encouraging primary care clinics and district hospitals (or larger) to provide health care and health maintenance services,ensuring the right to medical care of residents in remote areas. In 2014, incentives were offered to three11clinics to open practices in three4townships and villages. Also, there were 177 medical care institutions that offered mobile services to 125 townships and villages (including 135 primary care clinics that served 92 townships and villages and 42 hospitals that served 33 townships and villages).

Section 5 Training and Retaining Staff on Outlying Islands and in Remote Areas

In order to balance distribution of medical resources in remote regions and train local medical care workers, since 1969 the MOHW has conducted a health worker cultivation program that targets indigenous regions and outlying islands. Through 2014, a total of 869 health workers were trained under the program, including 463 doctors, and the historic retention rate of government-sponsored physicians who completed their required service time remained above 70%. To solve difficulties in recruiting nursing professionals, in 2013 an "elite" nurses plan was formulated to assign 200 nurses to be trained in remote regions over four years. Enrollment began in 2015. Also, to encourage health workers to remain in remote regions and contribute to a localized health care system, subsidies continued to be offered for health workers to open practices and undergo additional training in mountain areas and outlying islands. In 2014, these subsidies contributed to the opening of nine practices and additional training for two health department workers.

Chapter 7 Health Care for Target Groups

Section 1 Health Care for New Immigrants

1. Besides helping new immigrants join the NHI system, a special plan was formulated to support reproductive health, reproductive health consultations, and reproductive health management for foreign and mainland Chinese spouses. The plan also included health management cards, which offered guidance in the areas of family planning, breastfeeding, prenatal health, prenatal check-ups, and prenatal nutrition. In 2014, the usage rate of these cards reached 99.2%. Also, starting from January 1, 2014, in line with prenatal standards for citizens, foreign and mainland Chinese spouses received subsidies for 10 prenatal checks, Group B streptococcus screening, one ultrasound, and two health education guidance consultations.
2. In order to protect the reproductive health of new immigrants who have not yet joined the NHI system, since 2011 subsidies for prenatal check-ups have been provided to foreign spouses of Taiwanese citizens. In 2014, there were 14,292 such subsidies offered.
3. New immigrants benefited from a special plan in which local health departments trained interpreters to assist in providing reproductive health information. In 2014, there were 335 interpreters who participated, with coverage extending to 17 cities and counties and 210 health centers.
4. In order to provide reproductive health information to people from a wide range of backgrounds, in November 2013 the MOHW published a total of 50,000 copies ofthe "Children's Health Booklet" and the "Maternal Health Booklet" in five language pairings: Chinese-English, Chinese-Vietnamese, Chinese-Indonesian, Chinese-Khmer, and Chinese-Thai. Besides having local health departments distribute the books to medical care institutions, PDF versions were available for new immigrants and their families in the publications section of the Health Promotion Administration website.

Section 2 Health Care for Rare Disease Patients

1. A total of 204 rare diseases were announced by the end of December 2014, along with 87 drugs and 40 nutritional supplements for sustaining life. Rare diseases were brought within the scope of serious diseases, reducing some of the care burden of patients.

2. A distribution center for nutritional supplements and drugs for rare disease patients provided 37 life-sustaining supplements and 10 urgent drugs. Subsidies for care fees for rare disease treatments not covered under the "National Health Insurance Act," including diagnostic exams, therapy, drugs, supplements, and home medical care equipment, were also provided and used 2,268person-times in 2014.
3. Besides providing reproductive genetics services (prenatal genetics testing, neonatal screenings, hereditary disease examinations, and genetics counseling), reproductive genetics counseling centers which specialize in hereditary and rare disease were established at 13 medical centers. Also, a reproductive genetics counseling website was created to provide additional information on hereditary and rare diseases.
4. Strengthening Education and Advocacy of Rare Disease Prevention: In 2014, besides 28 explanatory meetings held for patients, patient groups, businesses, and medical care institutions, subsidies were provided to patient groups to conduct advocacy activities. One such project, centered around film screenings of a movie that portrayed challenges faced by rare disease patients and their families, sent DVDs to a total of 200 medical care institutions, health departments and centers, and MOHW departments. There were 20 post-screening activities for patients and their families, and five "love and rock" rare disease special events held at major medical care institutions in northern, central, and southern Taiwan. Other special public screenings and post-screening advocacy events were held in three cities and counties.
5. In order to expand care and guarantees for rare disease patients, the MOHW cooperated with the Legislative Yuan and NGOs to draft an amendment to the Rare Disease Prevention and Medication Act, which passed its third reading on December 30, 2014, and was promulgated by presidential order on January 14, 2015. The sound legal environment created by the Act has allowed the MOHW to support and improve medical care and family life for patients of rare diseases. Professional outreach visits provide rare disease patients and their families with psychological support, reproductive and childrearing care, and consultations. For supportive care and palliative care not covered under the National Health Insurance Act, subsidies are offered. When rare disease patients need treatment, schooling, or home care, assistance with related organizations is arranged. Decisions on NHI reimbursements for rare disease medications are made in conjunction with committees that specialize in rare diseases and drug reviews. Pharmaceutical companies, meanwhile, are required to continue to provide rare disease drugs for the duration of authorization unless circumstances beyond their control prevent them from doing so. When they fail to continue supply in accordance with regulations, to terminate authorization they must pay a fine of between NTD100,000 and NTD500,000.

Section 3 Groups with Special Health Needs

1. Health Care for Polychlorinated biphenyls (PCB) Poisoning Patients

(1) Contaminated rice bran oil led to a PCB poisoning outbreak in Taiwan. Since PCB poisoning can be passed to the next generation through the placenta or breast milk, since 2005 the special treatment provided to PCB poisoning patients was also furnished to children born after January 1, 1980, to mothers affected by the outbreak (these children are known as second-generation PCB poisoning patients). Through the end of 2014, 1,776 PCB poisoning patients had benefited from this plan, including 1,272 first-generation patients and 504 second-generation patients.

(2) In accordance with guidelines for providing health care services to PCB poisoning patients, the MOHW continued to provide subsidies for NHI copayments for outpatient (and emergency)services and regular health examinations, special clinics, and regular outreach visits. For first generation patients, additional subsidies covered NHI copayment inpatient expenses. Between January and October of 2014, there were 12,068 person-

times of subsidies provided to cover outpatient (and emergency) service copayments and 51 person-times of subsidies to cover inpatient copayments. There were also 614 free health examinations provided and one PCB poisoning health care education and training event for staff of local health departments (centers).

(3) In order to guarantee the health care rights of patients affected by the PCB contamination scandal, the legal protections relating to the health care of victims were raised when the Yu Cheng Patients Health Care Services Act was promulgated by presidential order on February 4, 2015.

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

(1) The "Act of Human Rights Protection and Compensation for Hansen's Disease Patients", which passed its third reading in the Legislative Yuan on July 18, 2008, required competent authorities to change the terms "leprosy" and "leprosy patients" mentioned in other laws and regulations to "Hansen's disease" and "Hansen's disease patients". As of the end of December 2014, a task force that ensures the human rights of Hansen's disease patients had met a total of 25 times.

(2) The MOHW continued the implementation of a Directly Observed Treatment Short-course (DOTS) for Hansen's Disease Patients Project by local health departments in order to provide high-quality care for Hansen's disease patients.

(3) As of the end of December 2014, six hospitals were designated to diagnose and treat Hansen's disease: National Taiwan University Hospital, MacKay Memorial Hospital, Taichung Veterans General Hospital, National Cheng Kung University Hospital, the Penghu Branch of the Tri-Service General Hospital, and Lo-Sheng Sanatorium.

3. Human Rights Protection and Care for HIV Patients

The MOHW's continuing commitment to ensure the human rights and health care of HIV patients is shown in part by its introduction of Zidovudine (ZDV/AZT) medication in 1988 and free provision of highly active antiretroviral therapy (HAART) since 1997. Highlights of the MOHW's effortsin 2014 are as follows:

(1) Human Rights Protection

a. Following the promulgation of the "Regulations Governing the Protection of Rights of HIV Patients" in 2007, a system was established for HIV patients to file rights violation complaints. By 2014, nine violations were found.

b. Between the 2007 promulgation of the "Directions Governing the Review of Applications of Stay or Residence for HIV-Infected Individuals" and 2014, 48 applications were approved.

(2) Health and Care

a. On February 5, 2005, provision of fees associated with HIV/AIDS patient treatment was switched from NHI to the generalgovernment budget, with patients benefitting from free anti-HIV drugs. In 2014, there were 57 hospitals designated for the treatment of HIV/AIDS, and there was a patient coverage rate of 90.4%.

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 2014, there were 56 hospitals designated for the treatment of HIV/AIDS that participated by providing health education and consultation services. There were an accumulated 17,512 cases and 11,685 patients enrolled.

c. Tracking and management by local health departments (centers) and case managers encouraged regular treatment among patients to improve their quality of life. It also strengthened consultations, examinations and tracking among the partners of HIV/AIDS patients.

d. Subsidies were provided to NGOs that assisted with acceptance and care, treatment arrangements, emergency placement, and provision of case management services. In 2014, placement was offered in 200 cases and case management services were provided to 367 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 to relevant regulations to meet global trends and disease control needs must be made accordingly, in order to construct a solid framework for communicable disease control that can ensure the health and wellbeing of the people in Taiwan..

Chapter 1 Communicable Disease Control System

In order to prevent the occurrence, transmission, and spread of communicable diseases, the Communicable Disease Control Act and related regulations were 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 healthcare 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. Major amendments made in 2013 due to organizational restructuring and operational needs are described as follows in Table 5-1. In 2014, to strengthen prevention and control efforts, a total of 14 amendments were made to 12 related regulations and legal orders, including legally binding announcements, as shown in Table 5-1.

2. Communicable Disease Control Framework

Communicable disease prevention is a joint effort involving the central and local governments. The Centers for Disease Control (Taiwan CDC) is the highest authority in Taiwan responsible for the formulation, examination, and approval of communicable disease control strategies. Local health bureaus formulate and implement their own action plans to execute strategies established by Taiwan CDC.

3. Laboratory Technical Framework

The Center for Research, Diagnostics and Vaccine Development of Taiwan CDC is responsible for laboratory testing and research of communicable diseases. It has established eight laboratories for virus testing and seven laboratories for tuberculosis bacilli testing, certified 271 institutions for communicable disease testing, and designated institutions foravian influenza A(H7N9) testing. It has also formulated the "National Plan for the Quality Management of the Collection and Transportation of Specimens of Communicable Diseases" to ensure the quality, timing, and safety of specimen collection and transportation.

4. Command Framework

The National Health Command Center was established in 2005 to gather health-related information from central and local government agencies and other institutions. This information was then provided for comprehensive outbreak response and made available to command officials to use as a reference for decision-making. Taiwan implemented the International Health Regulations to interact with countries from around the world when reporting or responding to major outbreaks and public health emergencies of international concern.

Section 2 Communicable Disease Control Medical Network

The establishment of the Communicable Disease Control Medical Network in 2003 divided the nation into six medical care regions responsible for coordinating regional disease prevention and medical care resources. There were 134 isolation hospitals and responding hospitals designated for the admittance and treatment of communicable disease patients requiring isolated care (Figure 5-1). Besides conducting periodic inspection of negative pressure isolation rooms, hospitals were requested to formulate communicable disease emergency response plans and execute them. In 2014, 193 educational training sessions and 28 drills were carried out.

Table 5-1 List of Revised Regulations and Legal Orders Issued for Communicable Diseases, 2014

Issue Date(s) of Amendment	Name of Regulations/ Legal Order	Objective of Amendment
Jan. 9	Regulations Governing Inspection of the Implementation of Infection Control Measures in Medical Care Institutions	To address the practical needs of infection in healthcare settings and issues related to multiple drug resistant or ganisms, the name of these regulations was amended to the "Regulations Governing Inspection and Implementation of Infection Control Measures in Medical Care Institutions." Articles related to infection control in healthcare settings and the scope of inspections by competent authorities were also revised.
Jan. 9	Regulations Governing Collection and Review of Relief Fund for Victims of Immunization	To ensure people's right to relief and optimize the use of relief funds for vaccine injury, related articles were amended. The "Amount of Compensation for Vaccine Injury" was included as an attachment and the cap on medical care subsidies was raised.
Jan. 15	Regulations Governing the Management of the Health Examination of Employed Aliens	To streamline the process relating to the regular health examination for employed Group C foreign workers and to lift the restriction on tuberculosis testing for Group C foreign workers after receiving treatment, related articles and attachments were revised.
Jan. 15	Regulations Governing the Designation and Management of Hospitals for the Health Examination of Employed Aliens After Entry	In accordance with the amendment to the "Regulations Governing Management of the Health Examination of Employed Aliens," articles related to references and procedures for the regular health examination for Group C working foreigners were amended. Designated hospitals are required to submit the results of the health examinations to local competent health authorities.
Jan. 21	Operational and Compensation Regulations for the Designation and Expropriation of Quarantine and Isolation Sites and Drafting of Personnel	In accordance with J. Y. Interpretation No. 690, which stipulated that an adequate compensation mechanism should be established for compulsory quarantine, an amendment was made to Article 10 to include persons who have been assigned to care for children at a quarantine site as subjects eligible for compensation. An exclusion clause was also added.
Mar. 11	Regulations Governing Management of Infectious Biological Materials and Collection of Specimens from Patients of Communicable Diseases	The name of the seregulations was amended to the "Regulations Governing Management of Infectious Biological Materials" for the following reasons: to bring biosafety management in Taiwan's laboratories up to international standards, to meet domestic needs, to respond to an amendment to the "Communicable Disease Control Act" that revised the definition of infectious biological materials, for risk management, and because regulations governing the collection of specimens from patients with communicable diseases were already included in the Regulations Governing the Management of Laboratory Diagnosis for Communicable Diseases and Laboratory Testing Institutions. Also, the full regulations were revised, with key changes as follows:Assigning auditing and monitoring responsibilities to local competent health authorities. 1. Assigning auditing and monitoring responsibilities to local competent health authorities. 2. Added management of biotoxins. 3. Established a risk group mechanism for management of pathogenic microorganisms.
May 26	Regulations Governing Payments for Expenses of Laboratory Testing, Prevention and Treatment of HIV	Amended Article 8 to include documents caregivers must submit when applying for prophylaxis fees.

Issue Date(s) of Amendment	Name of Regulations/ Legal Order	Objective of Amendment
Jun. 4	Communicable Disease Control Act	Amended Articles 2, 23, and 51. Added the necessary actions for the central competent agricultural authority to take when major outbreaks of zoo notic diseases occur in animals. Also added the operating procedure sand the exemptions for testing and procuring pharmaceuticals during emergency.
Jun. 27 Aug. 1 Aug. 8	Announcement: Categories of Communicable Diseases and Preventive Measures for Categories IV and V Communicable Diseases	Carried out three amendments for the following reasons: • Consolidated and removed H5N1 influenza (Category I) and H7N9 influenza (Category V), which were included as novel influenza A virus infections under Category V. • Revised the name of complicated influenza (Category IV) to severe complicated influenza. • Revised the name of Ebola virus hemorrhagic fever (Category V) to Ebola virus disease.
Jul. 18	Announcement: The scope of communicable diseases to be reported were outlined in Article 19 of the Emergency Medical Services Act	Removed H5N1 influenza and H7N9 influenza and added novel influenza A virus infections.
Sep. 29	Regulations Governing Awards for the Control of Communicable Diseases	For greater uniformity in the monitoring and prevention of various avian influenza subtypes, an amendment to Article 5 eliminated a bonus for reporting the first case of H5N1 influenza of the season.
Dec. 23	Regulations Governing Quarantine at Ports	In order to abide by the general spirit of the International Health Regulations (IHR 2005), amendments were made to disease prevention measures in place at normal times and at times of heightened awareness. The regulations were also amended in accordance with the changes made to Taiwan's shipping policies.

Figure 5-1 Communicable Disease Control Medical Network

Region	Name of Responding Hospital
Northern Region	Sinwu Branch, Taoyuan Hospital, MOHW (capacity for 34 negative pressure isolation beds)

Region	Name of Responding Hospital
Central Region	Taichung Hospital, MOHW (capacity for 20 negative pressure isolation beds)

Region	Name of Responding Hospital
Southern Region	Tainan Hospital, MOHW (capacity for 22 negative pressure isolation beds)

Region	Name of Responding Hospital
Taipei Metro politan Region	Heping Hospital, Taipei City Hospital (capacity for 29 negative pressure isolation beds)

Region	Name of Responding Hospital
Eastern Region	Hualien Hospital, MOHW (capacity for seven negative pressure isolation beds)

Region	Name of Responding Hospital
Kaohsiung -Ping tung Region	Pingtung Hospital, MOHW (capacity for nine negative pressure isolation beds)

At the end of 2014, there were six Communicable Disease Control Medical Network regions with a total of 134 isolation hospitals, including six responding hospitals and six collaborating hospitals.

Section 3 Disease Surveillance and Investigation Mechanisms

The purpose of disease surveillance is to quickly detect the occurrence of diseases and the emergence of abnormal situations, to facilitate the monitoring of long-term trends, and providea reference for policymaking. The number of notifiable disease cases in 2014 is shown in Appendix II. The status of disease surveillance and outbreak investigation isas follows:

1. **Diverse Surveillance Systems for Communicable Diseases**

   Besides establishing diverse reporting and surveillance systems for communicable diseases (School-Based Disease Surveillance System, Surveillance System for Populous Institutions, Real-Time Outbreak and Disease Surveillance System, and syndromic surveillance using the NHI Data and Pneumonia/Influenza Mortality Surveillance) data from emergency departments , NHI database, and death records are also collected for more comprehensive disease surveillance. These systemsare used to gather and conduct conventional analysis on information related to domestic and international outbreak situations.

2. **Integration of Disease Reporting Systems**

   The MOHW continues to integrate reporting systems, including the Notifiable Disease Surveillance System and the Symptom Surveillance System, as well as the linking of the Outbreak Investigation System and the Central Communicable Disease Follow-up and Management System, in order to achieve a single window for disease reporting.

3. **Investigation of Outbreaks**

   Investigation is needed when sudden communicable disease outbreaks of unidentified origin occur. In 2014, the MOHW investigated 447 suspected cluster outbreaks, including the administration of post-exposure rabies vaccine for humans bit by rabid Formosan ferret badger, an outbreak of salmonella in Tamsui, New Taipei City, and a norovirus cluster infection in travelers to South Korea.

Chapter 2 Control of Major/Emerging Communicable Diseases

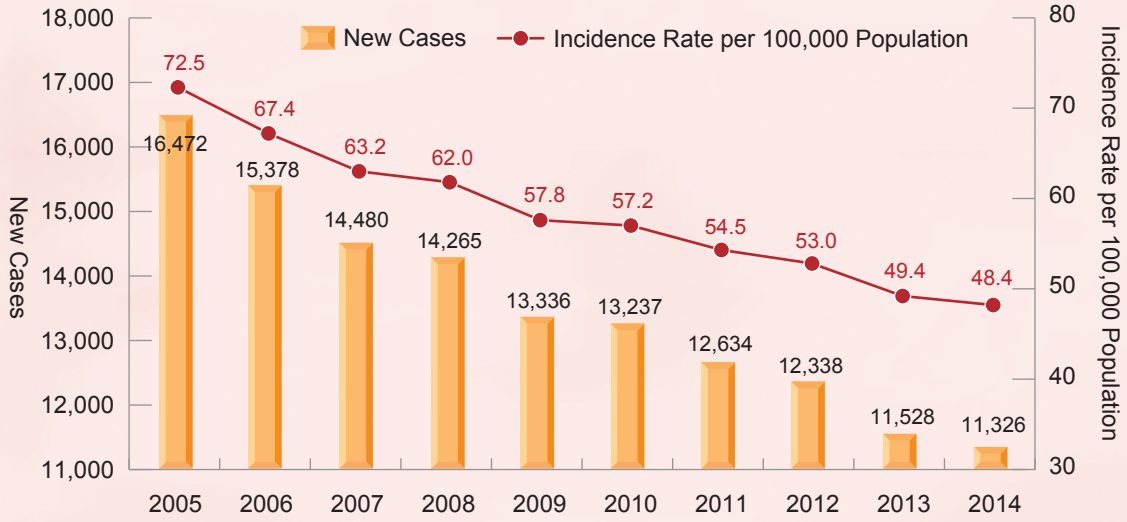
Significant progress made in terms of communicable disease control in Taiwan can be attributed to improvements in environmental sanitation and hygiene and measures against communicable disease. Communicable diseases eradicated in recent years include smallpox, malaria, and polio. Nevertheless, frequent international travel has increased the risk of emerging and re-emerging infectious disease transmission, posing challenges to prevention and control of infectious disease.

Section 1 Tuberculosis Control

In 2014, there were 11,326 confirmed TB cases in Taiwan (Figure 5-2), The results of implementing the National Mobilization Plan to Halve TB in 10 Years are as follows:

1. More than 90% of the patients who tested positive on TB smears or culture tests participated in the Directly Observed Treatment, Short-course (DOTS).
2. From 2012, patients treated under a dedicated medical treatment and care system for multidrug resistant TB (MDR-TB) had a 24-month treatment success rate of 70%.
3. Improved contact investigation led to an average of 10.5 contacts investigated for each confirmed TB case in 2014.
4. The Directly Observed Preventive Therapy (DOPT) was implemented in conjunction with the Latent TB Infection Treatment Program. In 2014, 5,500 people participated in DOPT.
5. To actively identify TB cases, the MOHW conducted nationwide TB screening via mobile chest X-ray vans. In 2014, there were 318,895 screenings that led to 326 diagnosed cases.
6. By offering subsidized hospitalization and living expenses for patients with chronic TB infection, the MOHW encourages long-term, isolated care to prevent further transmission.
7. Since June 2013, the MOHW has been promoting management principles governing HIV/TB cooperation models, including routine

Figure 5-2 Reported TB Cases, 2005-2014



HIV screening for TB patients aged between 15 and 49.During January and December 2014, the HIV detection rate among this target group was 88%.

Section 2 Communicable Diseases of the Enteric Tract

1. Enterovirus

With six cases of severe enterovirus 71 (EV 71) infection, including one death confirmed in 2014, the outbreak was milderthan that in 2013.Prevention and control strategies implemented include disease surveillance, increased environmental sanitation and hygiene inspection activities at schools/nurseries and public locations frequented by children, commissioning of a plan for strengthening enterovirus control, extended community health education, establishment of a medical care network for severe infections, and smoother transfers between responsible hospitals. The guidelines for treatment of EV71 were revised and provided to healthcare workers for reference.

2. Hepatitis A

Since June 1995, the MOHW has been providing hepatitis A immunization to preschool children in 30 mountain villages and nine villages in lowland areas adjacent to the mountain regions. This has decreased the incidence rate of hepatitis A in mountainous villages from 90.7 to 0.5 per 100,000 population.

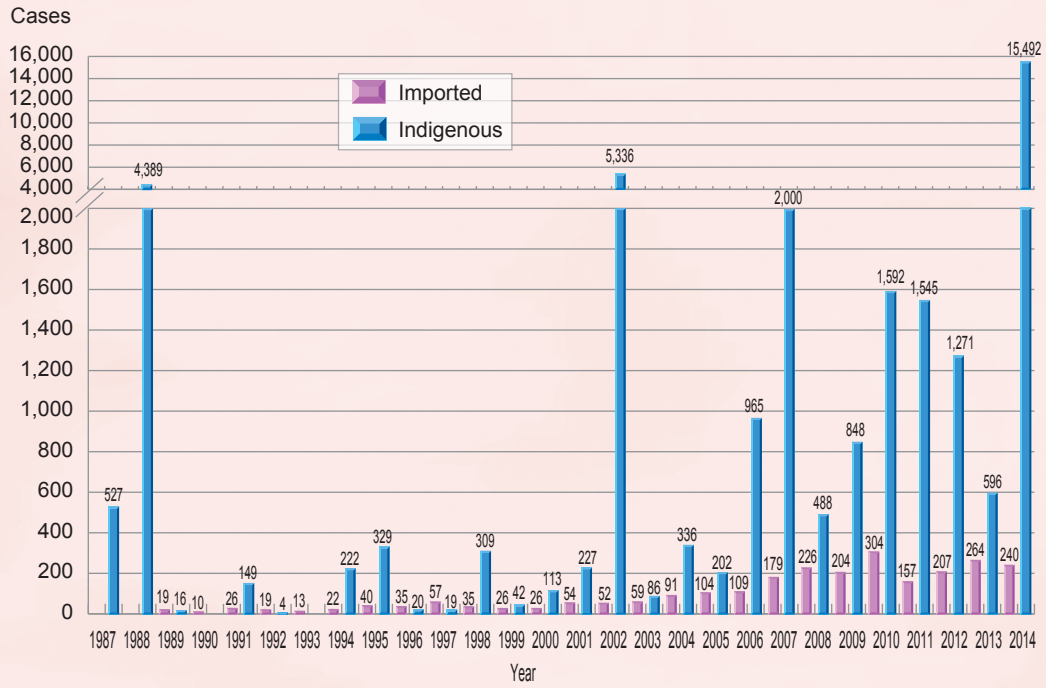
Section 3 Vector-Borne Communicable Diseases

1. Dengue Fever

In 2014, there were 15,732 confirmed cases of dengue fever, comprising 240 imported cases and 15,492 indigenous cases (including 21 deaths). It was the worst indigenous dengue outbreak in years due to a combination of factors, including an increase in global dengue incidence, temperature rise and increased precipitation. In addition, there were 136 cases of dengue hemorrhagic fever, all of which were indigenous(Figure 5-3).

In 2014, major strategies for dengue prevention and control included the revision of the guidelines for the prevention and control of dengue fever. The general public was educated through various channels. Community mobilization was used to eliminate vector breeding sites, such as peridomestic water containers. Vector control teams were formed to direct local prevention and control efforts and in bound travelers to Taiwan were screened

Figure 5-3 Incidence of Dengue Fever, by Year



for fever and asked for their travel and contact history at international ports and airports. When necessary, samples were taken to enhance disease monitoring

2. Japanese Encephalitis

Japanese encephalitis is prevalent between May and October and peaks in June and July. In 2014, there were 18 confirmed cases.

3. Malaria

The MOHW continued to implement strategies to control malaria, including disease surveillance, reinforcing health education, and warning people to avoid being bitten by vectors when traveling overseas. In 2014, there were 19 imported cases.

Section 4 Communicable Diseases Transmitted by Blood or Body Fluids

1. HIV/AIDS

Between 1984 and the end of 2014, there were28,710 reported cases of HIV among Taiwanese people. Of those infected, 12,564 developed full-blown AIDS and there were, 651deaths. In 2014, there were 2,236 new infections, with 95% of the new patients having contracted the disease through sex, 84% of whom were men who became infected through sex with other men. Prevention and control strategies as well as achievement highlights in 2014 are as follows:

(1) In order to reinforce HIV prevention strategies targeting men who have sex with men, the MOHW continued to commission the operation of five community centers for homosexuals, which served people an average of about 3,400 times a month. Each of the nation's cities and counties organized homosexual community stations to provide a friendly environment for people of all genders and a variety of health services. LINE, Facebook, and other social networks were utilized to improve the rate of HIV intervention and services forhomosexuals.

(2) Taiwan CDC formed a special alliance with local governments, educational institutions, and NGOs topromote HIV prevention. Events were organized at schools across the nation.

(3) Through the end of 2014, a special project to prevent HIV among intravenous drug users

led to the following results: 156 medical care institutions that provided substitution therapy, 865 clean need lesyringe and health consultation service stations, and 413 needle syringe vending machines. The needle and syringe return rate was 96%.

(4) Commissioned 43 medical care institutions to carry out a plan for offering free and anonymous HIV screenings and consultations. In 2014, there were 37,808 people who were screened, with a positive incidence rate of 2%. Between May and October 2014, the MOHW carried out the "Peer Teacher Training Program." There were 244 peer teachers recruited who encouraged 31,058 people to be screened for HIV,18 of whom tested positive.

(5) In order to prevent mother-to-child transmission of HIV, the MOHW launched a universal HIV screening program of pregnant women and provided pre-exposure prophylaxis (PrEP). Since the launch of the universal screening program in 2005, there were 94 new cases of HIV detected in pregnant women, including 23 cases of foreign women and seven cases detected in 2014.The positive incidence rate was 3.12/per 100,000 population. The trend in annual HIV case reports since 2006 is shown in Figure 5-4.

2. Sexually Transmitted Diseases

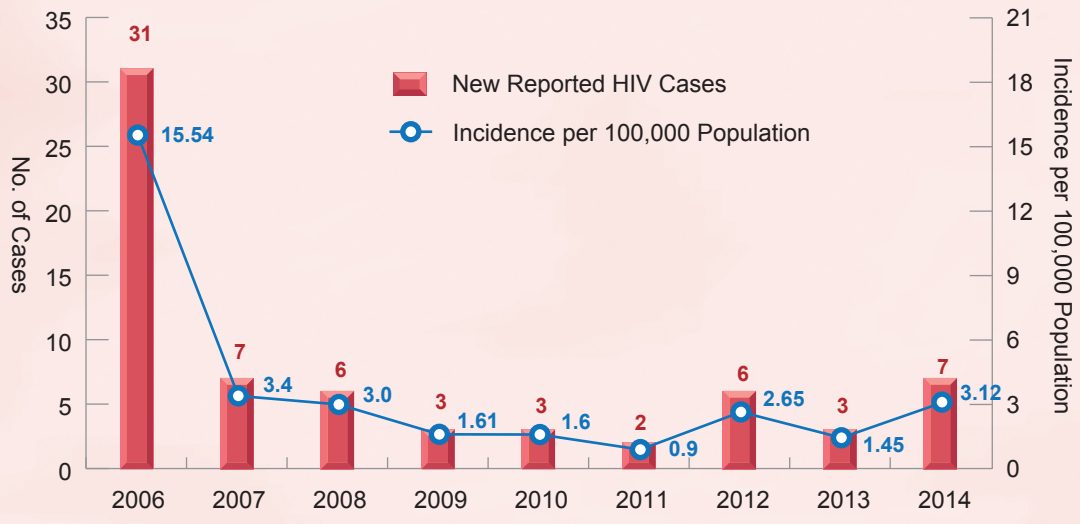
The MOHW commissioned relevant medical associations to conduct a program for improving and evaluating the quality of clinical treatments for HIV and sexually transmitted diseases (STDs). Measures to raise the willingness of patients with STDs to receive treatment included the training of specialized physicians in each special tyassociation. Recommendations were made of physicians who run STD friendly clinics, with a total of 1,229 physicians recommended by the end of 2014. An additional program to promote HIV screening among patients with STD sled to 118,202 patients screened in 2014, 0.27% of whom tested positive.

3. Hepatitis B and C

(1) The screening of pregnant women for hepatitis B during prenatal care visits and the immunization of newborns against hepatitis B dropped the carrier rate of children at age 6 from 10.5% before these measures were implemented to approximately 0.8%.

(2) There were approximately 2,500,000 adult carriers of hepatitis B in Taiwan and 400,000-700,000 adult carriers of hepatitis C. To treat patients who were already infected, in October

Figure 5-4 New HIV Cases and Positive Incidence Rate Under Universal Screening Program for Pregnant Women, by Year

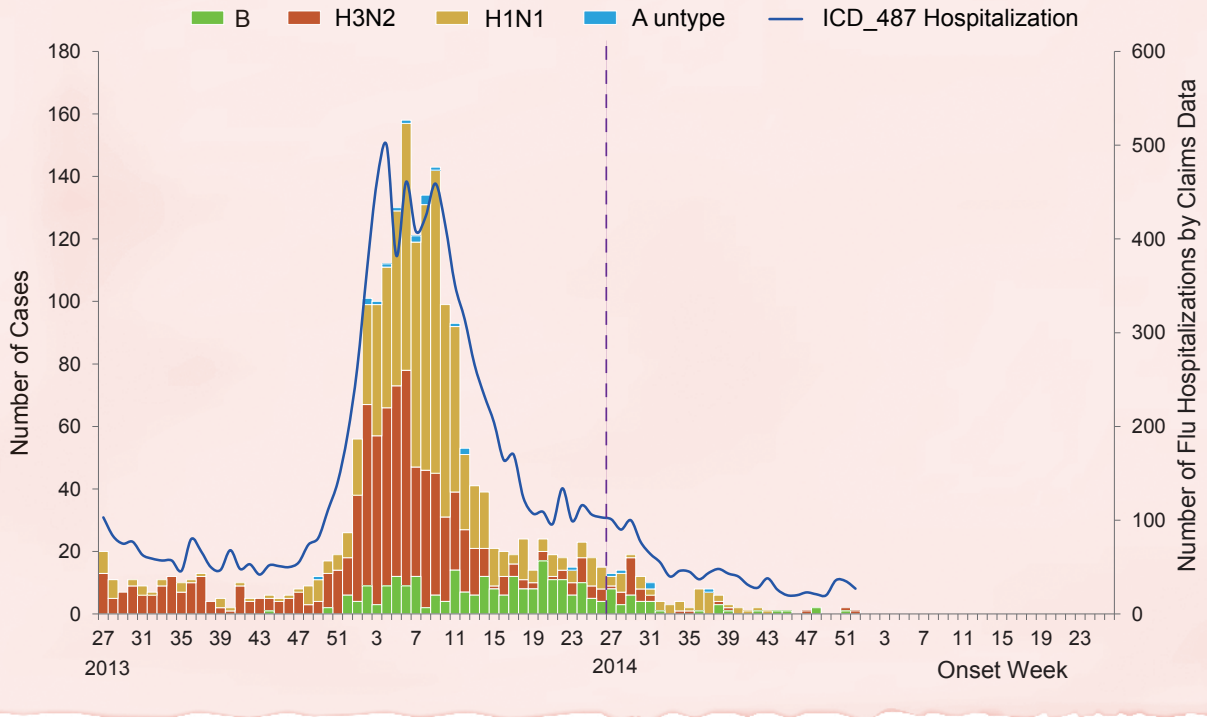


2003 the MOHW launched a pilot program to improve NHI services for chronic hepatitis B and C patients. By the end of 2014, there were 168,499 hepatitis B patients and 80,144 hepatitis C patients who participated in the program.

Section 5 Seasonal Influenza Prevention and Control

1. In order to monitor the severity of influenza and identify potential virus variations and emerging viruses, in August 2014 the name of influenza-related complications was revised to severe complicated influenza. Between January and July 2014, there were 1,677 confirmed cases of influenza-related complications (reports made upon hospitalization), including 162 deaths, which accounted for a mortality rate of 9.66%. During August and December of the same year, there were 57 cases of severe complicated influenza (reports made upon admittance to ICU), including 14 deaths, which accounted for a mortality rate of 24.56%. For a closer look at the number of flu cases, Figure 5-5.
2. An annual influenza vaccination program is launched each year in October. Following adjustments made in 2014, the following groups of individuals were eligible for government-funded vaccinations: elderly people aged 65 and above; 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 nursing institutions; health and disease prevention workers; poultry and livestock workers; patients aged between 50 and 64 with diabetes or cardiovascular, pulmonary, vascular, liver, or kidney ailments; HIV patients; and pregnant women. No diagnosis fee was charged for elderly receiving the vaccine, which also applied to infants and toddlers.
3. Maintained a sufficient stockpile of influenza antiviral to accommodate 10-15% of the total population. The eligibility for subsidized influenza immunizations was expanded from December 1, 2014, to April 30, 2015, and the number of locations that distribute antivirals was also expanded to more than 3,200. These changes were made in response to disease prevention needs during peak influenza season and the novel influenza A virus outbreak.

Figure 5-5 Confirmed Cases of Severe Complicated Influenza



4. On weekends and holidays from January 18 to February 9, 2014, including the Lunar New Year holiday, there were 37 medical care institutions across Taiwan that ran a special influenza clinic. A total of 348 such clinicsvisited by 3,160 patients were estimated to have diverted 5.55% of patient traffic away from emergency rooms during the Lunar New Year holiday period.

Section 6 Control of Emerging Communicable Diseases

Measures taken by Taiwan following the outbreak of Ebola virus in West Africa in 2014 included the following:

1. When the WHO announced the West Africa Ebola outbreak in March 2014, the Taiwan CDC immediately issued a press release and notified medical care authorities. It provided updates on the latest international disease outbreak information and health care to the general public and medical workers to heighten vigilance.
2. In August 2014, the WHO declared the Ebola outbreak in West Africa as a "Public Health Emergency of International Concern."The Taiwan CDC then formed the Task Force for Ebola Virus Disease Emergency Response.
3. In August 2014, the Taiwan CDC dispatched two medical officers to Nigeria to assist Taiwanese businesspeople and overseas staff with disease prevention. In November of the same year, another two doctors were sent to the United States to participate in the Ebola Safety Training Course. Taiwan also supported the Ebola aid efforts in West Africa by providing 100,000 surgical masks and 100,000 sets of personal protective clothing and equipment(PPE).
4. Four major strategies were further strengthened: outbound health education, inbound quarantine, domestic preparedness and response/drills, and international collaboration. Specifically, they included comprehensive improvements in quarantine measures, the issuance of travel history declaration cards to passengers on high-risk flights, completion of procedures for responding hospitals to receive and treat patients, and infection control training for frontline health care workers, such as safe donning and removing of PPE.

Section 7 Control of Imported Communicable Diseases

In order to prevent the importation of communicable diseases, quarantine measures were implemented with regard to ships, aircraft, and people. Agencies responsible for port-related affairs cooperated by establishing a health safety taskforce, which oversees international ports to prevent the importation and exportation of communicable diseases. The implemented measures are as follows:

1. **Quarantine**

   In 2014, a total of 21,707,379 people entered Taiwan. Of these, 15,280 were identified as symptomatic by the non-contact infrared thermometer diagnostic stations run by the Taiwan CDC at the airport/ports and 123 were later confirmed to be infected with notifiable communicable diseases.

2. **Control and Prevention of Communicable Disease Related to Travel**

   Travel clinics provided counseling to travelers about appropriate vaccines and preventive medication. In 2014, travel clinics at 26 contracted hospitals served patients 18,693 times.

Chapter 3 Communicable Disease Preparedness and Response, and Infection Control

Biological disasters that occurred in recent years have demonstrated the importance of pandemic-related preparedness, stockpile supply management, nosocomial infection control, and response mechanisms for bioterrorism events.

Section 1 Pandemic Influenza Preparedness and Response

1. Pandemic influenza preparedness operations are carried out pursuant to the National Influenza Pandemic Preparedness Plan. These operations adopt the approach of "Four Major Strategies and Five Lines of Defense," as outlined in the preparedness plan.

2. The MOHW continued to oversee local governments in implementing a ban on the sale of live poultry at traditional markets. In June 2014, the announcement of an amendment to Article 23 of the Communicable Disease Control Act provided the legal basis for preventing the spread of zoonotic infectious diseases.
3. The various names used for novel strains of influenza can result in problems when physicians report cases and cause confusion among the general public. Therefore, in July 2014, the MOHW consolidated H5N1 influenza, H7N9 influenza, and other strains of avian in fluenzaas novel influenza A virus infections and designated them as Category V communicable diseases.
4. A review of influenza preparedness strategies led to adjustments in terms of vaccine stockpiles, the Communicable Disease Control Treatment Network, and PPE. In July 2014, National Influenza Pandemic Preparedness Plan Phase 2 was amended.

Section 2 Management of Disease Control Supplies

1. To prepare for biological disasters, the MOHW set up a three-tiered system of stockpile management comprising of the central competent authority, local competent authority, and medical care institutions, and established a safety reserve of medical masks. The national stockpile is monitored closely via the management information system.
2. The MOHW entrusted the management of its central warehouse to a professional logistics service provider to ensure the proper management and effective distribution of stockpiles in times of emergency. In order to ensure a central stockpile of PPE that is frequently renewed, during non-outbreak periods the firm replaces old equipment and during outbreaks it maintains sufficient supplies.

Section 3 Nosocomial Infection Control

In order to ensure safety of patients by reducing the occurrence of nosocomial infections, the MOHW established and implemented nosocomial control policies for medical care institutions. Highlights from 2014 were as follows:

1. In response to the Ebola virus outbreak in West Africa, the Taiwan CDC formulated special infection control measures and guidelines for medical care institutions. In addition, a video that described the procedures for the donning and removal of PPE when faced with potential Ebola virus contacts was provided. Changes and additions were made to the recommendations for the use of PPE as well as the infection control guidelines for Middle East respiratory syndrome coronavirus (MERS-CoV). New infection control measures and guidelines were also introduced for medical institutions in response to scabies.
2. The MOHW continued to promote the Taiwan Nosocomial Infections Surveillance System (TNIS).More than 440 hospitals participated in the system. The Taiwan CDC regularly publishes annual and seasonal reports concerning nosocomial infection surveillance in Taiwan. In 2014, it added an online search function as part of its commitment to make government information more transparent.
3. The MOHW provided assistance to help hospitals reinforce the implementation of nosocomial control measures. Hospitals were encouraged to conduct pro-active surveillance and laboratory testing and relevant infection control guidelines were formulated to reduce the incidence of multiple drug resistant organisms and improve medical care quality. The MOHW conducted on-site hospital infection control inspectionsat 424 hospitals, 418 (98.6%) of which passed the preliminary inspection.
4. Seven demonstration hospitals from different regions and another 103 hospitals were selected to participate in a central line quality improvement plan. The adoption of bundle measures lowered the incidence of central line associated bloodstream infections.
5. A nationwide antimicrobial stewardship program included cross-office and cross-department cooperation and management in the hospital. Both internal and external inspections promoted the reasonable use of antibiotics, reducing the risk of infection among patients.
6. In 2014, the MOHW began to conduct infection control inspections for general nursing homes, post-natal care homes, and psychiatric nursing

homes, and completed the inspections of 456 institutions, including of 328 general nursing homes, 111 post-natal care homes, and 17 psychiatric nursing homes, with a pass rate of 99.7%, 100%, and 100%, respectively.

Section 4 Research and Laboratory Testing

1. In 2014, there was a total of 112,018 specimens sent to the Research and Diagnostic Center for testing. Among them, 25,993 contained a pathogen or tested positive for a related antibody, yielding a positive rate of 23%.
2. In 2014, platforms used for monitoring emerging and re-emerging communicable diseases revealed two cases of imported H7N9 influenza. Genetic analysis showed a large discrepancy in the internal protein genes of the H7N9 virus, indicating that the virus continues to evolve.
3. The construction of Pulse Net Taiwan was continued to facilitate rapid confirmation and comparison of food borne pathogens. The network also assists with controlling the spread of outbreaks and serves as an international surveillance platform.
4. Cooperation continued with Japan's National Institute of Infectious Disease, Japan's Research Institute of Tuberculosis, the US Centers for Disease Control and Prevention, the National Health Research Institutes, and domestic hospitals designated for sentinel surveillance.
5. The first-year plan to consolidate and improve the surveillance and protection network for food borne illnesses and related pathogens was initiated in 2014. By implementation of this plan and tracing the source of infection, the occurrence of a Sapovir us cluster infection that was suspected to have originated in food imported by a chain restaurant was identified. Through a joint international effort, the infection source of a cluster of norovir us infection among Taiwanese travelers to Korea was uncovered.
6. The accreditation system for institutions qualified to diagnose communicable diseases continued to be implemented. In 2014, 66 institutions were accredited for 236 items.

Section 5 Management of Laboratory Biosafety

1. As of December 2014,there were 505 units in Taiwan that stockpiled or used Level 2 or above infectious agents, 370 of which applied to the Taiwan CDC for the establishment of biosafety committees and 135 of which applied for the designation of biosafety personnel. Details are shown in Table 5-2:
2. In 2014, the Taiwan CDC commissioned the Joint Commission of Taiwan to improve the quality of inspections for nosocomial infection control and laboratory biosafety. Biosafety inspections were carried out at 19 biosafety level 3 (BSL-3) laboratories, one BSL-4 laboratory, and 12 TB negative pressure laboratories that are responsible for TB identification and drug sensitivity testing.
3. The laboratory biosafety techniques, standards, and guidelines formulated in 2014 included the "Laboratory Biosafety Management: A Compilation of Regulations and Administrative Guidance," guidelines for the safe handling of laboratory specimens from cases of viral hemorrhagic fever, regulations governing notification standards and the handling of accidental leakages of infectious materials and goods, and regulations governing the management of the import and export of

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

Type	Government Agencies	Medical Institutions	Academic Research Institutions	Others	Total
Biosafety Committee	15	148	51	156	370
Designated Biosafety Personnel	20	27	2	86	135

infectious biomaterials, communicable disease specimens, and related biological materials. Additionally, in order to improve biosafety techniques of laboratory workers, there were eight biosafety training classes held in 2014, with a total attendance of 644.

Chapter 4 Immunization

Section 1 Current Immunization Status and Trends

Besides routine, subsidized immunizations for children shown in the schedule in Table 5-3, children in mountainous regions and other high-risk areas also receive hepatitis A immunization. The government actively maintains high immunization rates by implementing proactive health promotion activities through city and county health centers and contracted hospitals, urging parents to get their children vaccinated and follow-up tracking activities. Immunization coverage rates of routine vaccines for children are shown in Figure 5-6.

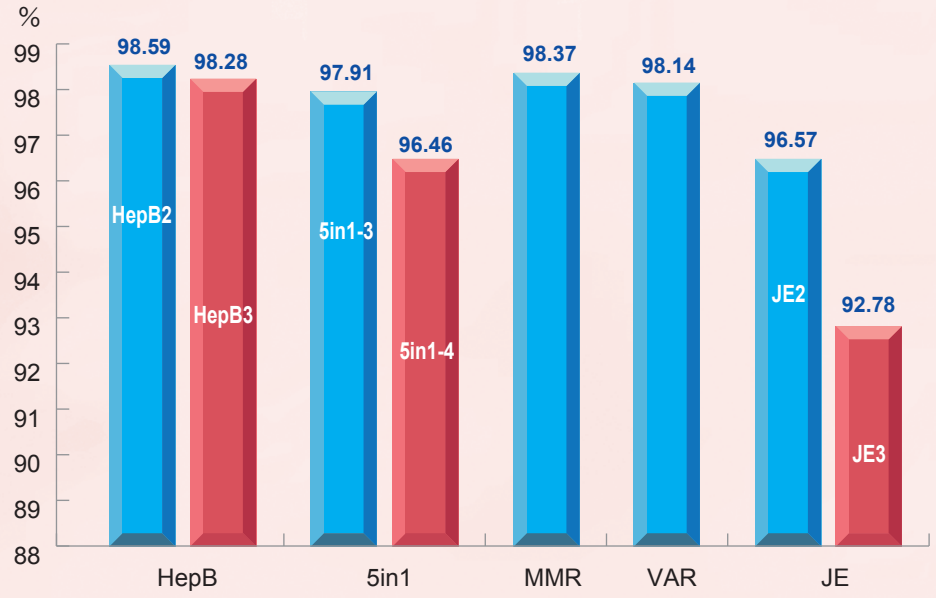
1. In 2010, a fund to procure vaccines and carry out immunizations was established in accordance with Article 27 of the Communicable Disease Control Act. The fund, which paved the way for a stable supply of routine vaccinations and the gradual implementation of new immunization policy recommendations by the Advisory Committee on Immunization Practices, is responsible for providing children with high-quality new vaccines.
2. In 2014, besides continuation of the routine vaccination policy from the previous year, pneumococcal conjugate vaccine (PCV) was included for children between the ages of 1 and 2.
3. In order to relieve victims of immunizations, the government created a mechanism to review

Table 5-3 Immunization Schedule

Age	Vaccine
Within 24 hours of birth	● HBIG 1
	● HepB 1
After 24 hours of birth	● BCG
1 month	● HepB 2
2 months	● DTaP-IPV-Hib 1 (5-in-1)
4 months	● DTaP-IPV-Hib 2
6 months	● HepB 3 ● DTaP-IPV-Hib 3
1 year	● MMR 1 ● Varicella
1 year and 3 months	● JE 1, JE 2 (two-week gap)
1 year and 6 months	● DTaP-IPV-Hib 4
2 years and 3 months	● JE 3
Between 5 years and 1st grade	● Tdap-IPV ● MMR 2 ● JE 4

Notes:
1. If mothers are hepatitis B carriers (HBeAg positive), their babies 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, 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, 2014



Source: National Immunization Information System, December 2014

Note: HBV-B (hepatitis B vaccine), 5-in-1 (diphtheria, tetanus, pertussis, haemophilus B, and polio vaccines, or DTaP-IPV-Hib), MMR (measles, mumps, and rubella combined vaccine), VAR (varicella vaccine), and JE (Japanese encephalitis).

applications for emergency relief. This provided legal assistance for patients who believed they were injured as a result of immunization.

Section 2 Development and Manufacture of Serum Vaccines

In order to record nearly a century of evolution as well as research and development of publicly manufactured vaccines, in December 2014 the Taiwan CDC published the book "100 Years of Glory and Century of Continuity – A Centennial History of Government-Manufactured Vaccine Production in Taiwan." This commemorates the hardships of those who launched the system for vaccine production and laid a solid foundation for 100 years of public health and disease control.

1. Production of Biological Products

(1) In 2014, the Taiwan CDC produced 314.5 liters of horse-derived antivenin horse serum and maintained aperiodic supply of vaccines, toxoids, and antivenins, totaling 525,436 doses. Income earned from the sale of these products was NTD42,619,100.

(2) The National Horse Farm for Anti-Venom Production, which started operations in February 2014, offers a comprehensive range services: raising of horses, establishing farm SOPs, validation of clean rooms forserum collection, compilation of GMP documents for plasma collection factory and equipment, and related GMP training for personnel.

2. Development of Biological Products

(1) Enterovirus genetic monitoring data was used to build an EV-71 viral strain library with 15 strains from four subtypes: B5, C2, C2like and C5. Strains were then selected after analyzing C2-subtype vaccines that could neutralize the following subtypes: B4, B5, C2, C4, C5.

(2) Quality assurance methods and acceptable quality levels for snake venom were established. The venom species is identified by high-performance liquid chromatography and double immune-diffusion testing. The causes of death of cage-raised snakes were examined and analysis was carried out using milking techniques in order to reduce the risk of harm or injury to both handlers and the snakes.

6 Management of Food and Drugs

The primary purpose of the work carried out by the Food and Drug Administration (FDA) is to protect the health of consumers. To achieve this goal, key working points in 2014 included creating sound legal standards and review mechanisms, implementing the food source management , building comprehensive quality chain monitoring systems, advancing national laboratory responsibilities and capabilities, building risk management systems, and improving consumer protection and communication channels. The overall goal was to provide an environment where consumers could eat at ease and be ensured of safe medicines.

Chapter 1 Management of Food

The TFDA takes reference from international norms and continues to amend food-related laws and regulations, strengthen food source management, supervise production flows, and raise hygiene awareness amongst food service personnel. As it rebuilds public confidence in the security of the nation's food and restores normal market mechanisms, the TFDA relies on team work to build an environment where people feel safe when eating.

Section 1 Food Regulatory Standards and Product reviews

1. In order to strengthen management of food safety, the TFDA carried out a comprehensive review of food sanitation regulations and enforcement challenges. It used legal and regulatory amendment to build a comprehensive food safety management system, actively promoting amendments to the Act Governing Food Safety and Sanitation, as described in Table 6-1.
2. Amendments and additions in 2014 to food management regulations and standards are shown in Table 6-2.
3. With regard to registrations of specific food, licenses issued by the end of 2014 are described in Table 6-3.

Section 2 Management of Food Product Source

1. **Promotion of the Food Safety Control System (Hazard Analysis and Critical Control Point, HACCP)**

   The HACCP system was used in designated food businesses to prevent the occurrence of food hazards (Table 6-4). Professionals with vocational certification were encouraged to enter the food businesses, and food businesses designated to require enforcement of food safety control system (HACCP) shall establish a Food Safety HACCP team with at least one team member to be a professional with vocational certification, in accordance with the Regulations on Placement and Management of Food Businesses Employment of Professionals with Vocational or Technical Certification. The task forces guaranteed safe food manufacturing processes.

Table 6-1 Amendments to the Act Governing Food Safety and Sanitation, 2014

Date	Objective of Amendment
Feb. 5	The law's name was amended to the "Act Governing Food Safety and Sanitation" (original name was the Act Governing Food Sanitation) in order to emphasize a commitment to safe management. Besides more severe fines, major management mechanisms that were introduced included mandatory food businesses registration, establishing a traceability system for products, hiring of professionals with vocational or technical certification, addition of compensation for consumer harm, guaranteeing the working rights of whistleblowers and reducing their legal responsibility, addition of a three-tier quality control system for food safety, and establishment of a food safety protection fund.
Dec. 10	Steps were taken to improve the effectiveness of food safety management and provide consumers with more sound guarantees included establishing the Food Safety Board by the Executive Yuan, requiring designated food businesses shall be equipped with laboratories, public announcing food businesses shall use electronic uniform invoices that could serve as a tool for upstream tracking, implementing a system that the food or food additive factory shall be independently established and shall not engage in non-food manufacturing, processing, or preparation at the same address and the same factory, requiring that food businesses offer evidence when major violations occurred, introduction of more severe fines and penalties, and stripping of ill-gotten gains.

Table 6-2 Amendments/Additions to Food Safety and Sanitation Management Regulations and Standards, 2014

Date	Name of Regulation/ Standard	Objective of Amendments
Jan. 28	Regulations for Application of Health Food Permit	Added regulations for when in case of failure to file a permit extension application before the permit expiration date, permit holders may apply for a new registration application within six months following the permit expiration date.
Feb. 24	Regulations on Placement and Management of Food Businesses Employment of Professionals with Vocational or Technical Certification	Food businesses designated by the central competent authority in a public announcement to require enforcement of food safety control systems shall place professional with vocational certification, responsible for food safety control. Catering and bakery businesses designated by the central competent authority in a public announcement shall have a certain percentage of professionals with technical certification to ensure safe food manufacturing processes.
Mar. 7	Regulations Governing Food Allergen Labeling	Clearly stated the requirements to provide conspicuous labeling on prepackaged food products that contain shrimp, crab, mango, peanuts, milk, egg, and products thereof.
Mar. 11	Regulations on Food Safety Control System	a. Clearly specified the scope of food safety control systems, including items and implementation. b. Designated that at least one member of the HACCP team shall be professional with vocational certification and that an internal audit shall be carried out at least once a year, to ensure effective operation of food safety control systems.
Apr. 15	Regulations on Nutrition Labeling for Prepackaged Food Products	Designated a standard format for labels on prepackage food products. Sugar content has been included as a item.
Aug. 21	Food Businesses shall mandatorily conduct tests and meet the minimum testing cycle and other relevant matters	Clearly specified the food business category, scale, test frequency, and items of mandatorily conduct test.
Sep. 3	Regulations Governing the Establishment of the Advisory Committee on Genetically Modified Foods	Clearly stated the organization, meeting, procedures, scopes, and rules and regulations of the Advisory Committee on Genetically Modified Foods.
Oct. 16	Regulations Governing the Category and Scale of Food Businesses May Commence Its Business Operation after Applying for Registration and Date of Implementation	Clearly stated that factory registration, business registration, or company registration by food manufacturers, processing, food services, import, and retail businesses shall complete food business registration before December 31, 2014.
Oct. 24	Edible oil manufacturers shall do tests and meet the minimum testing cycle and other relevant matters	Clearly specified the business scale, test frequency, and items of mandatorily conduct test for edible oil.
Oct. 27	Food Businesses that Shall Establish Traceability Systems for Food and Other Relevant Products	Clearly specified the food business category, scale and enforcement date.
Nov. 7	Regulations on Good Hygiene Practice for Food	Based upon Central Regulation Standard Act to ensure compliance to the legal form, set hygiene standards for the personnel, operation sites, sanitation management of facilities and quality assurance system of food businesses.

Date	Name of Regulation/ Standard	Objective of Amendments
Dec. 26	Health Care Effects Specified in the Health Food Control Act	Formulated the Health Care Effects Specified in the Health Food Control Act, included liver protection, anti-fatigue, modulation of blood lipids, modulation of blood sugar, modulation of immunity, bone health protection, maintaining dental health, aging delay, enhancing iron absorption, improvement to gastrointestinal function, supporting blood pressure modulation, reducing body fat formation, helping modulate allergic constitution, and other similar texts and phrases describing effects.
Jan. – Dec.	Standards for Pesticide Residue Limits in Foods, Standards for Veterinary Drug Residue Limits in Foods, Standards for Specification, Scope, Application, and Limitation of Food Additives, and food sanitation standards	Accumulated Standards: 4,335 MRLs for 354 pesticides; 1,389 MRLs for 135 veterinary drugs; scope, limitations, and specifications of usage for 800 food additive items; 36 food sanitation standards.

Table 6-3 Number of approved licenses issued, 2014

Food Categories Subject to Registration	Accumulated Permits Granted
Imported Foods in Tablet or Capsule Form	8,201
Domestic Vitamin Products in Tablet or Capsule Form	1,607
Food Additives	6,178
Infant and Follow-Up Formula	193
Formulas for Certain Diseases	155
Genetically Modified Foods	74
Vacuum-Packed Ready to Eat Soybean Foods	133
Health Foods	288

Table 6-4 Number of compliance audits carried out according to the HACCP, 2014

Product Category	Businesses Inspected
Aquatic products	200
Meat Processing Industry	138
Dairy products Processing Industry	12
Box meal factories	191

2. Border Inspection of Food Products

(1) Article 30 of the Act Governing Food Safety and Sanitation 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 foods, genetically modified food raw materials, food additives, food utensils, food containers or packaging, and food cleansers designated by the port offices of the TFDA."

(2) In 2014, inspection applications were completed for a total of 616,286 batches of food imports, of which 48,704 were examined and tested, for a sampling rate of 7.9%. Approximately 1.4% failed to meet regulations and were either withdrawn or destroyed.

3. Checking International Warnings

In 2014, a total of 419 international food safety alerts were checked and 267 food consumer Red and Green Lights alerts were published. By keeping consumers and businesses updated, the TFDA was able to maintain safety of the domestic food environment.

4. Management of Food Additives

(1) Managing Registration of Food Additives: Announced the Regulations Governing the Registration of Food Businesses and setting up a fadenbook (mandatory registration) data system for food additives (http://fadenbook.fda.gov.tw/). By the end of 2014, there were 2,203 manufacturers, importers, and vendors of food additives that had registered a total of 102,053 food additive products.

(2) Bringing Food Additive Classifications in Line with International Standards: Continued to collect relevant international standards for food additives from the United Nations Codex Alimentarius Commission (CAC) as well as the United States, the European Union, and Japan, in order to reorganize the system in Taiwan and bring it in line with international standards. Using a "positive list" approach, by the end of 2014 there were 800 food additives. For each, the scopes of use and limitations were specified.

Section 3 Safety Chain Surveillance for Foods

1. On-site inspection of Registered Food

In 2014, there were on-site inspections of health foods, domestic vitamin products in tablet or capsule forms, and food additive manufacturers and vendors. Results are shown in Table 6-5.

2. Post-Market Surveillance

Post-market surveillance of food products is conducted lovingly with local health departments to ensure compliance with health standards. Results from 2014 are shown in Table 6-6:

3. Special Inspections and Testing

In 2014, for 18 key policy items, high-risk foods, and areas of public scrutiny the MOHW guided and cooperated with local health departments in carrying out inspections and testing samples. A related task force for joint food safety inspections and prohibitions carries out inspections at upstream suppliers and manufacturers of common food products that could have a major impact on people's health. In 2014, these inspections focused on Lunar New Year foods, rice, eggs, meat factories, foods that contain starches, seafood products, and edible oil factories and manufacturers.

Table 6-5 Outcomes of On-Site Registration and Market Approval Food Products, 2014

Type	Inspected Companies	Outcome
Health Food Manufacturers Plants	26	No major non-compliance was found. Defects were corrected before follow-up audits.
Domestic Vitamin Products in Tablet or Capsule Form Manufacturing Plants	40	No major non-compliance was found. Defects were corrected before follow-up audits.
Food Additive Manufacturers and Dealers	73	No major non-compliance was found. Defects were corrected before follow-up audits.

Table 6-6 Outcomes of Post-Market Surveillance, 2014

Surveillance Item	Outcome		
	Total sampled	Qualified	Qualified Rate (%)
Pesticide Residues in Packaged Fruits and Vegetables	2,528	2,205	87.2
Veterinary Drug Residues in Livestock and Aquatic Products	830	794	95.7
Mycotoxin Contamination in Commercial Foodstuffs	461	449	97.4
Heavy Metal Contents (Lead, Cadmium) in Fruits and Vegetables from Markets	170	170	100
Heavy Metal Contents (Lead, Cadmium, and Mercury) in Rice	200	200	100
Pesticide Residues in Rice	207	207	100

Note: Local health departments conducted follow-up investigation of products that failed inspection.

Section 4 Food Safety and Sanitation Management

1. Food Service Management

In order to improve sanitation and self-management capacities of domestic food services, active promotion of rating system of food service management takes place. Based on inspection results, food services can be awarded a rating of "excellent" or "good." They then receive "excellent" or "good" food service sanitation assessment certifications (logos) valid for two years. Between 2010 and 2014, there were 10,732 food services assessed and certified. In the future, the rating system of food service management will be promoted continuously in order to enhance domestic food self-management capacity.

2. Popularization of a Registration System for Food Businesses

Following promulgation of the Regulations Governing the Registration of Food Businesses on December 3, 2013, in 2014 the MOHW continued to inform food additive businesses, food manufacturing and processing businesses, food service, import businesses, and retail businesses with factory registration, business registration, or company registration of the need to register. The registration system represents a major reform in Taiwan's food safety laws. By the end of 2014, active support from local health departments and food businesses had led to the registration of 158,562 food businesses.

Chapter 2 Management of Drugs

The main objective of drug management is to ensure public health. With this goal in mind, the MOHW reforms drug policy to accelerate the review process, assist the development and competitiveness of pharmaceutical industry, regulate the source and distribution of medicinal products. In addition, investigation of illegal drugs and controlled drugs management are taken to provide an environment of drug safety.

Section 1 Drug Regulations/Standards and Product Inspections

1. Improving Regulations and Standards

The MOHW continues to revise and formulate drug management regulations and standards to bring them in line with domestic needs. It also considers regulation harmonization with international standards. Related amendments/additions from 2014 are described in Table 6-7.

2. Managing Inspections and Registration of Drugs

(1) Inspection and Registration of Drugs Before Commercial Sale: Reviews including drug/toxicology testing, pharmacokinetics (PK/PD/BA/BE) testing, and clinical trial are conducted in order to ensure that drugs are effective and safe. In 2014, there were 315 new domestic clinical trial applications and 2,486 applications for revisions. The number of applications for clinical trial increased by 20% compared to 2013. By the end of 2014, a total of 2,008 approved medicinal products had conducted BA/BE studies in Taiwan, and 1,895 of them were domestic products. By the end of December 2014, 26,683 pharmaceutical licenses were issued, comprising 2,717 active pharmaceutical ingredients and 23,966 pharmaceutical finished products.

(2) Reform of Drug Review Mechanisms included building professional review capability and core review capacity, streamlined review mechanisms and enhancing transparency, quality and time liness. By the end of 2014, a record 135 new drugs received approval (29 domestic and 106 imported).

Section 2 Medicinal Product Sources Management

1. Promotion of PIC/S GMP

(1) As part of plans to elevate the quality of drug manufacturing and to meet international standards, in 2007 Taiwan announced to adopt the GMP standard of Pharmaceutical Inspection Convention and Pharmaceutical Inspection Co-operation Scheme (PIC/S). By the end of 2014, there were 98 domestic GMP-Compliant western medicine manufacturers. By January 1, 2015, all of Taiwan's western medicine manufacturers had implemented PIC/S GMP, as shown in Table 6-8.

(2) Taiwan officially became a PIC/S member in January 2013. Utilizing the PIC/S platform reduces repeat inspections and export costs. It brings Taiwan's drug manufacturing industry in

Table 6-7 Amendments/Additions to Regulations and Standards Governing Drug Policy Management, 2014

Date	Name	Summary of Changes
Feb. 14	Regulations for Registration of Medicinal Products	In response to practical needs, definitions for bio-similars were added, and categorized such pharmaceutical products as genetically engineered drug according to their characteristics. Amended Attachment 6 Information Documents to be Attached for the Registration of Biopharmaceuticals in Article 41.
Jul. 7	Announced the "Guidelines for the Nonclinical Pharmacology/Toxicology Studies for Medicinal Products Applications (Fifth Edition)"	In response to regulatory advances in international medicine, specification contents were revised to include risk assessments for delayed ventricular repolarization time, toxicological kinetics testing, and immunotoxicity testing guidelines and relevant segments. Chapter V, Specifications for Non-Clinical Study of New Anti-Cancer Drugs was added in accordance to medical research needs and international trends.
Sep. 17	Clinical Trial Application Procedures and Review Standards for Human Cell Therapy Products	These standards were established in order to ensure that clinical testing for human cell therapy products is scientific, safe, and in accordance with ethical standards and to ensure the rights of those who are tested. The information required for related applications were described and served as a reference for those carrying out such tests.
Dec. 12	Prioritized Review Mechanism for Inspection of New Drugs/Expedited Approval Mechanism for New Drug Inspection and Registration	Amended the definition of new drugs in Article 7 of the Pharmaceutical Affairs Act (new compositions, new therapeutic compounds, or new method of administration) to accelerate R&D and commercialization of new drugs to meet the medical treatment needs.
Dec. 22	Standards and Recognized Inventory of the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH)	In order to provide suitable procedures and a reference for firms engaged in drug R&D and manufacturing, ICH standards and recognized inventory were established. These detailed key ICH standards, scope of applicability, and overseas data that could serve as a reference for firms engaged in preparation of technical data.

Table 6-8 Pharmaceutical Manufacturers Compliant with PIC/S GMP, 2014

Product Type	Inspection Type	No. of Manufacturers
Medicinal Product	Domestic Pharmaceutical manufacturer	98
	Foreign Pharmaceutical manufacturer	870
	Foreign Pharmaceutical manufacturer with on-site inspection	246

Note: Data for foreign manufacturers with on-site inspection is accumulated from 2002 to December 31, 2014.

line with international standards, paving the way for expansion into the global market.

2. Strengthening Management of Active Pharmaceutical Ingredients

(1) Enhanced Manufacturing Quality Management of Active Pharmaceutical Ingredient Manufacturers: Management of upstream suppliers was introduced to ensure manufacturing quality of pharmaceutical ingredients. Complete implementation of the PIC/S guide to GMP for active pharmaceutical ingredients was scheduled to begin on January 1, 2016, with 21 pharmaceutical manufacturers having already applied for certification by 2014.

(2) Established the Drug Master File (DMF) system to strengthen the management of active pharmaceutical ingredients. From October 2009 to December 31, 2014, there were 3,037 DMF applications concluded, with 2,089, or 69%, approved.

Section 3 Quality Chain Monitoring for Drugs

1. Management of Drug Distribution

In order to improve quality management of entire drug supply chains, implementation of a Good Distribution Practice (GDP) system for drugs began in 2011. The system focused on four concepts: maintenance of drug quality, handling emergency drug recall events effectively, correct delivery to clients within a reasonable period of time, and prevention of counterfeit drugs from entering the drug supply chain. These advances ensured safety and effectiveness of pharmaceutical products for consumers. By the end of 2014, there were 95 related gap assessment visits made to pharmaceutical manufacturers, agents, and logistics firms.

2. Monitoring of Drugs Quality

Based on post-market medicinal products management policy, six medicinal products and one Chinese medicinal product were tested in 2014. Of the 372 samples tested, 98.1% met standards, as illustrated in Table 6-9. A total of 845 quality defects were reported, and monitored 656 international drug quality alerts. When tests revealed that drugs failed to meet standards or contained major flaws, recalls would be requested. Results are shown in Table 6-9.

3. Suppressing Illegal Drugs, Foods, and Cosmetics

(1) Integration of Cross-Agency Resources to Improve Suppression of Illegal Drugs

On March 22, 2010, the Executive Yuan began implementation of a project dedicated to improving the suppression of illegal drugs and broadcasting stations. It investigated for counterfeit drugs, foods adulterated with drugs, and Chinese medicine adulterated with drugs. It also continued monitoring of illegal advertisements for food, drugs, and cosmetics products. Results were as follows:

a. Seizure of Illegal Drugs: On average, drug investigations were over 1,500 times per month. The detection and seizure rate of illegal drugs decreases from 27.22% in 2010 to 1.20% in 2014 (Figure 6-1).

b. The rate of illegal advertisements related to drugs, cosmetic or food products decreases from 13.93% in 2010 to 5.14% in 2014 (Figure 6-2).

(2) Post-market surveillance for Drugs, Foods, and Cosmetics or Marketplace

a. In 2014, there were 721 cases involving illegal drugs. Among these, 508 cases were referred to the courts and 37 administrative sanctions were fined a total of NTD865,000.

b. In 2014, there were 3,068 cases relating to illegal food, drug, and cosmetic advertisements and were fined a total of NTD94,089,000.

(3) In 2014, the MOHW carried out five joint inspections of medicinal and cosmetic products. It uncovered violations at 142 businesses and issued total fines of NTD2.118 million. Results are shown in Table 6-10.

Table 6-9 Results of Drug Quality Surveillance 2014

Type	Project title	Number of finished piece	Number of Qualified piece	Qualified Rate (%)
Drugs	Surveillance on the Quality of Antidiabetic, NSAIDs , Hypnotic and Antibiotic Preparations in Taiwan	90	87	96.7
	Post-market surveillance of varicella and MMR live attenuated vaccines	148	148	100
Chinese Medicine	Post-market quality surveillance and testing for foreign materials in Traditional Chinese Medicine preparations	134	130	97.0
Total		372	365	98.1

Figure 6-1 Detection and Seizure Rate of Illegal Drugs, 2010 – 2014

Figure 6-2 Illegal Advertisement Rate for Food and Drugs, 2010 – 2014

Table 6-10 Results of Joint Inspections of Illegal Drugs and Cosmetics, 2014

Month	Inspection Theme	Result
March	Drug Inspections (Prescription drug, Department of health)	Inspected 31 pharmacies and drug stores, betel quid stands, and internet cafes, 12 of which were in violation.
April	Pharmacist Inspections(Prescription drug, Controlled Drugs)	Inspected 618 pharmacies, medical cosmetic shops, and clinics, with a total of 75 violations found at 73 businesses.
June	Inspection of Western Medicine Oral Solutions Containing Alcohol	Inspected 105 betel quid stands, with 14 stands found to sell betel quid adulterated with western medicine oral solutions containing alcohol.
August, September	Drug Inspections	Inspected 173 pharmacies, clinics, and hospitals, 21 of which were in violation.
October	Antibiotic Inspections(Prescription drug, Misbranded or Defective Drugs)	Inspected 41 pharmacies, 22 of which were in violation.

(4) In 2014, illegal pharmaceutical additives to weight loss or virility products were monitored. A total of 109 capsules, tablets, and powdered foods were sampled from drugstores, pharmacies (chemists), and distributors. Of these, two were found to have pharmaceutical contents. Another three were found to contain ingredients not indicated on the label. All these cases were transferred to the local health bureaus for further handling.

Section 4 Management of Drug Safety

1. Strengthening Drug Safety Control

Reporting system and monitoring mechanism were established in order to strengthen drug safety control strategies. Integration with reporting databases allows cases to be prioritized based on risk, which aids with health protection and resource sharing. Outcomes are shown in Table 6-11.

Table 6-11 Outcomes of Drug Safety Control, 2014

Drug Safety/Control Systems	Summary of Outcomes
Adverse Drug Reactions Reporting System	Received 11,399 adverse drug reaction reports.
Drug Safety Active Assessment System	Completed eight drug safety analysis reports.
Therapeutic Inequivalence Reporting System	There were 413 reports (2011-2014), with one suspected case.
Drug Product Quality Defect Reporting System	Received 845 reports, with 150 high-risk cases. Fourteen drug product recalls were initiated within these cases.
Batch Release for Biological Products	381 batches of biological products were applied for batch release in Taiwan. Among them, 377 batches (12.61 million doses) were released, but 8 batches (about 53,385 doses) were rejected due to the failed test or the cold chain failure during transportation.

2. Continued Monitoring of Drug Safety Market Information

The "Real-Time drug safety information monitoring and delivery platform" was established. In 2014, a total of 823 domestic and international drug safety and quality warnings were monitored. A total of 103 domestic medicinal product recall alerts, 36 consumer red and green light information, nine news releases, and 12 drug risk communication letters were released, and four drug safety text messages were published.

Section 5 Management of Controlled Drugs

The "Controlled Drugs Act" was formulated to strengthen management of controlled drugs required for medical and scientific purposes. Schedule, license, and distribution management systems were established to prevent abuse and illegal use.

1. Management of Controlled Drugs

(1) Schedule Management: Controlled drugs are classified into four schedules based on potential for habitual use, dependence, abuse, and danger to society. Additions and amendments in 2014 are described in Table 6-12.

(2) License Management: By the end of December 2014, there were 14,857 institutions with registration licenses to handle controlled drugs and 49,059 people with licenses to use controlled drugs.

(3) Management of Distribution

a. In 2014, written permission was granted 1,833 times for controlled drugs to be manufactured, imported, exported, or used for medicinal, educational, research, or experimental purposes.

b. In 2014, on-site auditing of 17,057 institutions took place, of which 304, or 1.78%, were found to have committed a violation. Each was dealt with in an appropriate manner.

Table 6-12 Additions and Amendments to the Schedules of Controlled Drugs, 2014

Date	Schedule	Name of Controlled Drug
Apr. 24	2	Added Oripavine
Apr. 24	3	Added Noroxymorphone
Apr. 24	3	Added Fluoromethcathinone, 1-Fluorophenyl-2-methylaminopropan-1-one, FMC
Oct. 6	2	Added Benzylpiperazine, BZP
Oct. 6	3	Added 1- (5-fluoropentyl) -1H-indol-3-yl, 2,2,3,3-tetramethylcyclopropyl, and methanone, XLR-11
Oct. 6	3	Added 2- (4-bromo-2,5-dimethoxyphenyl) -N- [(2-methoxyphenyl) methyl] ethanamine, 25B-NBOMe

2. Drug Abuse Prevention Network

Regular collection and analysis of domestic drug abuse trends takes place to provide a reference for use by drugs abuse prevention agencies (institutions). Training program for drug abuse counselors sessions took place and an anti-drugs education resources centers were established. Drug abuse prevention advocacy continued and multimedia channels were used to strengthen drug abuse prevention network services.

Section 6 Management of Chinese Medicine

1. After implementing the GMP system for Chinese medicine in 2005, at the end of 2014 there were 99 Chinese medicine GMP manufacturers. Also, 49 manufacturers were subjected to follow-up inspections in 2014 based on the "Regulations of Medicament Manufacturer Inspection."
2. In order to enhance management of traditional Chinese medicine preparations, on December 26, 2013, the MOHW announced limits on abnormal materials for 22 kinds of traditional Chinese medicine preparations, including Ten-Wang-Pu-Sin-Dan. The new rules took effect on July 1, 2014.
3. On August 1, 2012, a new border management system was introduced for 10 types of Chinese medicine materials with high imports, including Jujube Fruit. In 2014, there were 2,298 pieces of import testing applications, totaling 10,857 tons. All kinds of imported goods met the standards. Testing is required of Jujube Fruit, Astragalus Root, Angelic Root, and Licorice root. There were 51 pieces of batches of test results satisfactory.
4. Chinese medicine inspections conducted by health agencies in 2014 are described in Table 6-13.

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.

Section 1 Medical Device and Cosmetics Regulations and Product Review

1. Regulatory environment and international regulatory harmonization

Regulations governing medical devices and cosmetics and related announcements in 2014 are described in Table 6-14.

2. Review of Medical Devices, Cosmetics and Advertisements

(1) According to the different characteristics and level of risk, the TFDA classifies medical devices into 3 classes, 17 categories, and more than 1,700 items. By the end of 2014, 46 domestic preclinical testing guidance documents were developed, 1,002 medical device international standards and 90 medical device guidance documents were recognized.

(2) In 2014, a total of 113 cases of registration review for innovative medical devices with no similar items were completed, which required

Table 6-13 Chinese Medicine Inspections, 2014

Item	Inspection Results
Investigation of Illegal Advertisements for Chinese Medicines	Health agencies issued 407 administrative penalties and levied fines of NTD53,968,000.
Inspection of Packaging Labels of Commercial Chinese Medicine Materials	Inspections of 4,600 items yielded a pass rate of 99.7%.
Testing of Commercial Chinese Medicine Materials for Heavy Metals, Pesticide Residue, and Aflatoxin	A total of 246 items were tested, 3 of which failed to meet standards, yielding a pass rate of 98.7%.
Testing for Adulteration of Traditional Chinese Medicines with Western Medicines	All 121 items that were tested met standards.

Table 6-14 Amendments and revisions to relevant regulations governing medical devices and cosmetics, 2014

Date	Name of Regulation/Standard	Content Summary
Jan. 2	Revised the draft of the first point promulgated in the Registration Requirements of Mail-Order Purchases of Medical Devices by Pharmaceutical Companies	A total of three Class 2 medical devices, namely body fat analyzers, condoms, and tampons can now be purchased through mail-order. Stronger requirements have been imposed upon the pharmaceutical companies to provide consumer reminders to read product manuals prior to use and the responsibilities of the companies in providing regular calibration.
Jan. 8	Amendments to Regulations Governing Maximum Residual Amounts of Heavy Metals (Lead and Arsenic) as Impurities in Cosmetics"	Residual lead or arsenic impurities in the final product should not exceed 10 ppm and 3 ppm respectively.
Feb. 21	Promulgated the revisions to a number of articles in the Regulations of Medicament Manufacturer Inspection	The TFDA signed an Exchange of Letters on the Technical Cooperation with Liechtenstein, which would simplify medical device GMP applications and shorten the time-to-market for the country's medical device manufacturers.
May. 15	Amended Guideline for the Use of Preservative Ingredient and Dosage Limit Requirement in Cosmetics	Amended the usage limits and published additional reminders for the use of Methylisothiazolinone and Mixture of 5-Chloro-2-methyl-isothiazol-3(2H)-one and 2-Methyl- isothiazol-3(2H)-one with magnesium chloride and magnesium nitrate.
May. 20	Promulgated new technical guidances for Household Blood Sugar Monitoring Systems and nine other in-vitro diagnostic devices	To strengthen management of in-vitro diagnostic devices (IVD), the TFDA established technical guidance for nine IVDs, providing manufacturers with a reference when conducting product research and development and when preparing application and registration documents and information.
Sep.5	Promulgated revisions to Regulation for Registration of Medical Devices	(1) Clearly stated that pre-clinical testing and the original manufacturer's quality control documents must include safety and functional test data, and that the responsible testing lab must comply with relevant operational practice. (2) Clearly stated that Class 3 medical devices must comply with the requirements prescribed in the Essential Principles and Summary of Technical Documentation for Medical Device Safety and Functions.
Sep. 22	Promulgated amendments to Attachment 1 of Article 3 and Attachment 2 of Article 4 in the Regulations for Governing the Management of Medical Device	To achieve the goal of international harmonization, the amendments of Taiwan's medical device regulation items are timely made, among which is the revision to medical device category, type, and item of a stair climber.
Oct.22	Promulgated the Reference Guide for Nano-Medical Devices Identification	Provides a reference for businesses researching and developing nano-medical devices.
Dec. 19	Promulgated Good Submission Practice for Medical Device Registration	Provides support for manufacturers in establishing capabilities for internal preparation of registration documents for medical devices, and improves the quality of submitted documents, thereby enhances case approval rate and efficiency

an average review duration of about 178 days, a 10% reduction from the duration incurred in 2013. The review time is similar to that of the global leading countries.

(3) For domestically made medical devices in 2014, a world-leading total of six innovative medical devices and 22 Class 3 medical devices were approved.

(4) The registration data from 2014 for medical devices and cosmetics are shown in detail in Table 6-15.

Table 6-15 Registration data for medical devices and cosmetics, 2014

Items	Medical Devices		Cosmetics	
	Medical Device Registrations	Medical Device Advertisements	Medicated Cosmetic Registrations	Cosmetic Advertisements
Total Number of Applications	5,221	258	1,900	1,449
Total Number of Concluded Cases	5,218	225	1,562	1,286
Valid licenses: 37,798 for medical devices, 14,671 for medicated cosmetics				

3. Establishment of Quality Medical Device Clinical Trials Environment

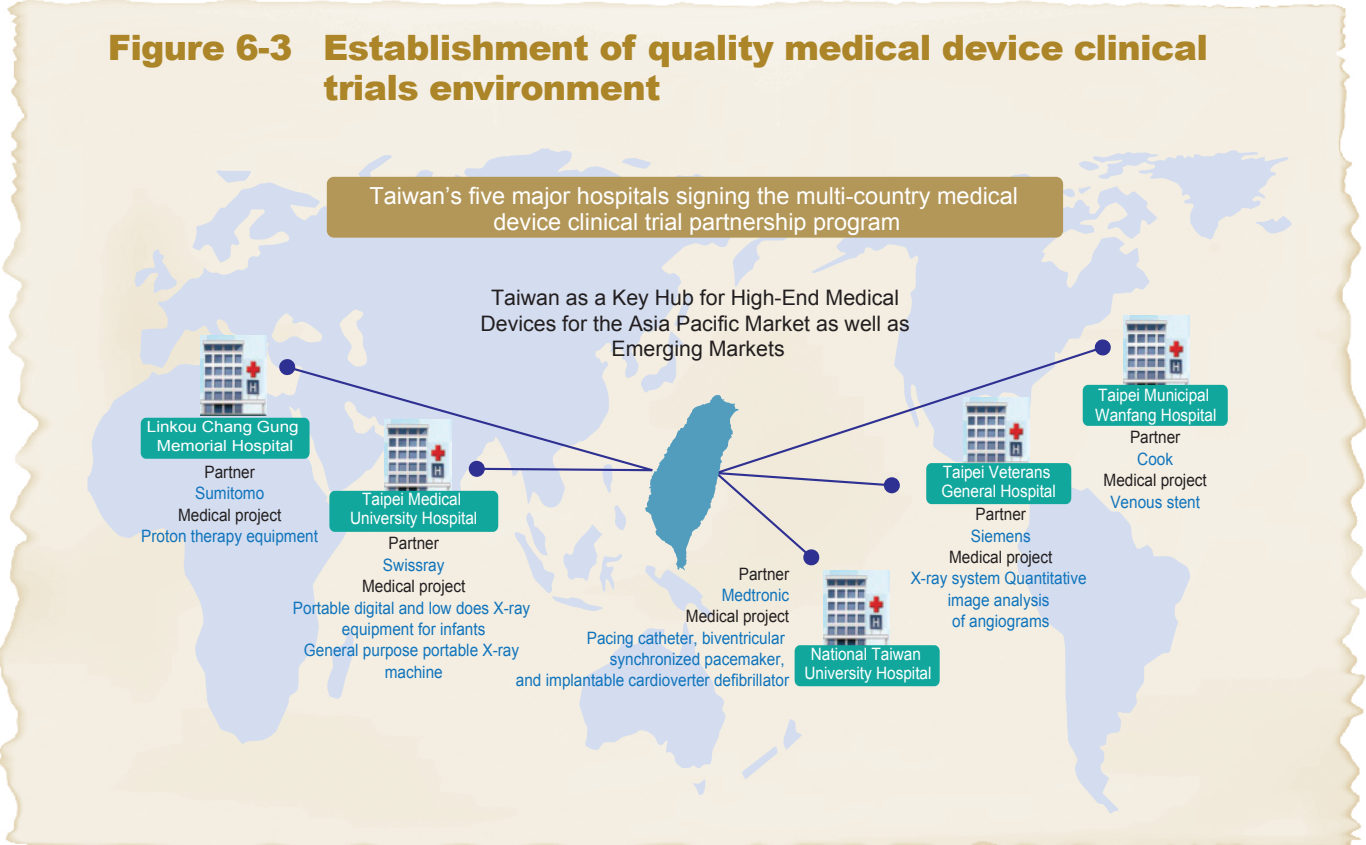
(1) In 2014, clinical trial applications were reviewed with an average review time of 38 days, a 30% reduction from 54 days in 2012.

(2) From 2012 to 2014, the number of multi-country and multi-center clinical trials for medical devices increased from 1 to 5.

(3) High ranking medical device clinical trial professionals were trained. Ten doctors had been selected and dispatched to the United States and Japan to undergo one month of medical device clinical trial training.

(4) The signing of multinational cooperation agreements on medical device R&D was promoted. Five major Taipei hospitals (Chang Gung, Wanfang, Taipei Medical University Hospital, Veterans General Hospital, and National Taiwan University Hospital) signed multi-country medical device clinical trial partnership programs with major international corporations (Sumitomo, Cook, Swissray, Siemens, and Medtronic) helping to convert Taiwan into an important hub for entering the Asia Pacific market and other emerging markets. (see figure 6-3)

Figure 6-3 Establishment of quality medical device clinical trials environment



4. Comprehensive Regulatory Consultation Network for Medical Devices and Cosmetics

(1) A legal counseling center for medical devices was established. A total of 16,276 inquiry calls were received in 2014. Training of 48 seed regulatory personnel was completed and namelist of the trained personnel had also been published online for public access in order to expand the scope of services provided.

(2) A three-step consultation network was implemented. By the end of 2014, the TFDA had successfully assisted 13 domestically manufactured medical devices through to approval, 9 cases entering the clinical trial, and transferred 3 academic research and development outcomes to the industry, which included clinical trials for the world's first high-end treatment of cartilage defects, clinical trials for the first innovative negative pressure sleep apnea treatment device, and approval for the first domestically made one-step artificial dental implant.

(3) A consultation hotline to assist with the Cosmetics Products Notification Portal was established and answers to frequently asked questions were listed on the TFDA website. There were more than 9,000 calls related to cosmetics placed to the hotline and approximately 60 interviews with related firms.

Section 2 Medical Device and Cosmetics Source Control

1. Manufacturers of Medical Devices and Cosmetics That Met the Good Manufacturing Practice

All medical device manufacturers were brought under the regulation of medical device GMP. The voluntary cosmetic GMP was also promoted. Statistics relating to manufacturers of medical devices and cosmetics that met the GMP regulation by the end of 2014 are shown in detail in Table 6-16.

2. Promotion of the Cosmetics Products Notification Portal

The TFDA is promoting the Cosmetics Product Notification System to align with international standards with countries like the United States as well as the EU and ASEAN member states which do not require pre-market reviews. In 2013, the TFDA established the Cosmetics Product Notification Portal. In 2014, a total of three training seminars were held while 1,102 products have been registered online by 138 cosmetic companies.

Section 3 Quality Chain Monitoring of Medical Devices and Cosmetics

1. Post-market Quality Surveillance of Medical Devices and Cosmetics

Results of quality surveillance projects for medical devices and cosmetics products are shown in Table 6-17. Nonconforming products were officially reported to the local health bureau 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, the TFDA conducted joint inspection with the local health bureaus. Results are shown in Table 6-18.

Section 4 Safety Management of Medical Devices and Cosmetics

1. Medical Device Safety Management

In 2014, a total of 331 global vigilance reports were received from the National Competent Authority exchange program (NCAR) of the International Medical Device Regulators Forum (IMDRF). There were also a total of 1,454 safety alerts received from the Safety Alert Dissemination System (SADS) of the Asian Harmonization Working Party (AHWP).

Table 6-16 Manufacturers of medical devices and cosmetics that met the GMP regulation, 2014

Item	Valid GMP compliance letters for domestically made medical devices	Valid quality system documentation compliance letters for imported medical devices	Valid voluntary cosmetics GMP
Item/Manufacturer	565 Items	3,057 Items	30 Manufacturers

Table 6-17 Medical device and cosmetics quality surveillance results, 2014

Project title	Total Cases No.	Inspection Items			
		Quality[1]		Package labeling	
		Conforming No.	Nonconforming No.	Conforming No.	Nonconforming No.
Survey on the quality of surgical gowns in Taiwan [2]	8	4	3	8	0
Survey on the quality of marketed medical masks	25	21	4	25	0
Hepatitis B surface antigen and antibody assay performance surveillance	22	22	0	21	1
Sterility surveillance for medical-use sterile phlegm removal device and tracheostomy tube	83	80	3	26	57
Sterility surveillance for catgut or absorbable suture	69	69	0	40	29
Sterility surveillance for urethral catheters	9	9	0	9	0
Total number (Percentage)	216 (100%)	205 (94.9%)	10 (4.6%)	129 (59.7%)	87 (40.3%)
Quality monitoring of marketed cleansing cosmetics containing nonylphenol and nonylphenol polyethoxylene glycol ether	80	79	1	74	6
Microbiological inspection of marketed cosmetics	149	143	6	112	37
Quality monitoring program for whitening and AHA containing cosmetics	137	137	0	114	23
Quality inspections for commercially available nail polish, cosmetics containing essential oils, and lipsticks	154	133	21	111	43
Total number (Percentage)	520 (100%)	492 (94.6%)	28 (5.4%)	411 (79.0%)	109 (21.0%)

Notes: 1. For surgical gowns and marketed medical masks, passing criteria would depend on whether or not if the item is capable of meeting the registered specifications.
2. There is one specimen that is not included within the scope of the quality surveillance criteria for surgical gown liquid protection.

As for the result of medical device safety monitoring, Taiwan's ADR Reporting System received a total of 1,401 cases of defective medical devices and 209 cases of adverse device reactions. A total of 3,058 domestic and global safety alerts were actively monitored. The TFDA flagged 93 of these alerts as potentially affecting the domestic public, and translated them into summaries for announcement.

2. Cosmetics Safety Management

Since May 2014, the cosmetic products adverse events (PAE) Reporting System was expanded to enhance the reporting of adverse reactions. In 2014, 105 cosmetic PAEs were reported. Additionally, 407 safety alerts were monitored and 62 consumer Red and Green Light alerts were issued to serve as a reference for consumers and others.

Chapter 4 Management of National Laboratories and Risk

Continued improvements to national laboratory functions led to new testing techniques in line

Table 6-18 The statistical analysis for joint inspections on medical devices and cosmetics, 2014

Medical Devices	Inspected counties / cities No.	Medical, aesthetic dental, and orthopedic clinics No.	Product Labeling		
			Inspected cases No.	Violations No.	Violation Rate (%)
Hyaluronic Acid Dermal filler	5	12	27	5	18.5
Surgical Sutures	5	28	71	5	7.0
Dental and bone implants	5	11	19	8	42.1
Hyaluronic acid implants for joint cavities	5	12	23	7	30.4
Total	5	40[1]	140	25	17.9

Cosmetics	Inspected counties / cities No.	Stores/ street vendors audited No.	Product Labeling		
			Inspected cases No.	Violations No.	Violation Rate (%)
Nail polish	9	87	277	19	6.9
Cosmetics containing essential oil	9	87	183	9	4.9
Lipstick	9	87	237	15	6.3
Total	9	87[2]	697	43	6.2

Notes:1. A single clinic may undergo two or more product audits.
2. For each audited store/street vendor, checks for all three categories were performed.

with international trends. A primary task was the addition of more high-precision testing equipment to advance development of testing techniques while supporting administrative management of testing technology. The MOHW also promoted risk and crisis management mechanisms. By building a comprehensive food and drug safety management system, it was able to reduce risks and hazards while lowering the impact of incidents that did occur.

Section 1 Missions and Functions of National Laboratories

1. Expansion of Testing Capacity

(1) In order to advance national laboratory function and develop diverse, accurate and fast testing capacity, the MOHW purchased four precision instruments and equipment. Technical documents were also composed for use by various fields.

(2) Conduct a series of conferences related to non-target and unknowns screening for strengthening analytical capabilities.

2. Testing Services

(1) Basic Testing: Registration testing for medical devices, cosmetics, health foods, special nutrition supplements, and food additives; lot release for biologics, including five such food incidents (including tainted oil incident and the use of dimethyl yellow in soy products), two medicines incidents (including the news on formaldehyde contents in e-cigarettes), and three cosmetics incidents (including the detection of Pseudomonas aeruginosa in shower foam).

(2) Cooperative Testing: Assisted local health agency with testing, with 2,275 such items tested in 2014.

(3) Collaborative Testing: Providing support for paid or commissioned tests as well as testing for forensic purposes for illegal pharmaceutical products, controlled drug and narcotics, and pharmaceutical adulterants in prescriptive Chinese herbal medicines and food products. In 2014, there were 3,053 such tests conducted.

3. Establishment and Promotion of Testing Methods

(1) There were 18 official analytical methods for food items were published. In addition, 60 and 10 recommended analytical methods for food products and cosmetics were published, respectively.

(2) In response to food safety and adulteration incidents, the Method of Test for Polyaromatic Hydrocarbons in Oils and Fats, the Method of Test for Acrylamide in Oils and Fats, the Method of Test for Dimethyl Yellow and Diethyl Yellow in Food, the Method of Test for Animal-Derived Ingredients in Tainted Oils and Fats - Qualitative Test of Swine, Chicken, Bovine, Ovine and Fish Ingredient, and the Method of Test for Animal-derived Ingredients in Food - Qualitative Test of Zeus faber Ingredient have been developed.

4. Preparation and Supply of Standard

Candidate standard of the HBV genotype C DNA were prepared to establish the national standards which can be provided to the manufacturers and blood centers for the development and quality control of the molecular diagnostics to advance the biotechnology industry.

Section 2 Risk Management and Emergency Response Mechanisms

1. Promotion of an Organizational Risk Management Mechanism

(1) Organizational Risk Management and Crisis Management: A risk management and crisis management task force was established to integrate risk management and crisis management into everyday procedures and decision-making. Establishment of an emergency response mechanism controlled and lowered the impact of potential crises.

(2) Risk Management and Crisis Management Education and Training: In 2014, conducted educational training courses on the emergency response handbook, related procedures, and case studies. These strengthened risk management and crisis control of related units while fostering a culture of risk management.

2. Strengthening Crisis Response

In 2014, emergency response mechanisms were initiated following the discovery of tainted edible oils and illegal use of dimethyl yellow. For each incident, testing improvements were made and after action reports were completed to serve as a reference for future crisis management.

A food and health volunteer provides accurate food safety information.

A promotional vehicle entered a local community to provide information on food safety and correct use of medicine.

Chapter 5 Risk Communication and Consumer Protection

In order to prevent public panic from inadequate or incorrect information, effective strategies of risk communication have to be established to strengthen public understanding, trust, and confidence. Through the Food Safety and Protection League and the Food Health Volunteer Training Program, these were other measures to increase knowledge of food policies for the general public.

Section 1 Providing Consumers with Immediate Information

1. A professional section and a children's section have been added to the Food and Drug Consumer Service Network, providing more diverse and convenient knowledge services to satisfy public needs and requirements.
2. The "Food Fans" Facebook group used a combination of health education and advocacy posts, a food knowledge examination, and other games and activities to provide consumers with educational health information. There were already more than 20,000 fans of the group.
3. The TFDA established the drug safety education learning website to provide educational materials and lesson plans on correcl drug usage. The website was browsed by more the 400,000 visitors.
4. A medical device safety and quality warning platform was established to quickly announce relevant warnings. A special webpage for the advocacy of medical devices was also created to gather information related to medical device awareness activities and printed advertisements. Experts and scholars were interviewed for the introduction of special columns and articles on medical devices.
5. Continued to provide assistance and encouragement for medical care institutions to report abuse of controlled drugs. These data were compiled into monthly reports on drug abuse cases and testing statistics along with seasonal newsletters.

Section 2 Consumer Communication and Advocacy

1. The Food Safety and Protection League was formed by gathering passionate university and college teachers and students who were majoring in subjects related to food and nutrition. Members passed on accurate food safety and health knowledge to students at junior high schools and elementary schools.
2. Recruited more than 1,500 Food Sanitation Volunteers from across the country. Whenever incidents such as the edible oil scandal arose, these volunteers would enter communities and provide accurate food safety information to members of the general public.
3. New regulations contained in the "Act Governing Food Safety and Sanitation" (such as rules for listing ratios of the main ingredients on food labels and the registration of food enterprises) were published to consumers through the media. There were also 18 scientific-based food safety educational articles published in the nation's major newspapers in order to enhance people's understanding of food safety and risk. An exposure of 64,312 times in the media was estimated to reach a total of 20 million people.
4. To create a supportive environment for proper use of medicinal products. TFDA established 22 health education resource centers for safe medicine, and 520 community based drug counseling stations in medical institutions nationwide. TFDA works with 112 correct drug use centers and seed schools across 18 counties and cities to help promote education for proper drug use.
5. Continued to cooperate with the Ministry of Justice and the Ministry of Education on the implementation of an anti-drug abuse educational campaign. Also, for the first time, with the Health Promotion Administration to conduct a joint educational campaign to prevent hazards associated with the use of addictive substances. By working with other government departments, the MOHW was able to expand the reach of its drug abuse prevention advocacy.

7 Social Insurance

In order to guarantee assistance for individuals and families who face economic crises owing to birth and old age, sickness and death, injury and disability, loss of function and unemployment, the government has used social insurance to build a safety net based on the principles of self-sufficiency, mutual assistance, and sharing risk. This part describes National Health Insurance, National Pension, and Long-Term Care Insurance (planning underway).

Chapter 1 National Health Insurance

The core value behind the establishment of Taiwan's National Health Insurance (NHI) was to ensure "health care equal rights" and "economic equal rights". The emphasis on "health care equal rights" sought to address the problem of people falling into poverty because of illness; the focus on " economic equal rights" was to prevent people from falling ill because of poverty. Launched in 1995, NHI system has become as a critical pillar and guardian of social stability and public safety in Taiwan over the past 20 years.

Section 1 Current Status of NHI

In order to make health care sustainable, in 2013 the government implemented the second-generation NHI. Its visions- to raise quality, care for the disadvantaged, ensure sustainability, and serve as an international benchmark- were formulated with the objectives of guaranteeing universal health care and fair treatment. Reforms included linking financial revenues and expenditures, raising the financial burden 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 to the NHI system to ensure their rights to health.

By the end of 2014, total enrollment in the NHI was 23,622,000 persons, and the enrollment rate exceeded 99% of Taiwan's population. Approximately 93% of the nation's medical care institutions were contracted by the National Health Insurance Administration (NHIA) to accept NHI, 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 come from other sources, including Public Welfare Lottery profits and the Health and Welfare Surcharges on Tobacco Products. As the end of 2014, the cumulative surplus of NHI was NTD 126 billion, equivalent to about 2.92 months of NHI system's expenditures. It balanced the legally contingency reserve fund, showing that the NHI system was rather stable in finance.

Section 2 Convenient Access to Health Care through Universal Coverage

In 2014, there were 357.01 million outpatient visits and 3.20 million hospital admissions. Averages per person included 15.2 clinical visits and 0.14 hospital stays, and the average length of hospitalization of 1.3 days.

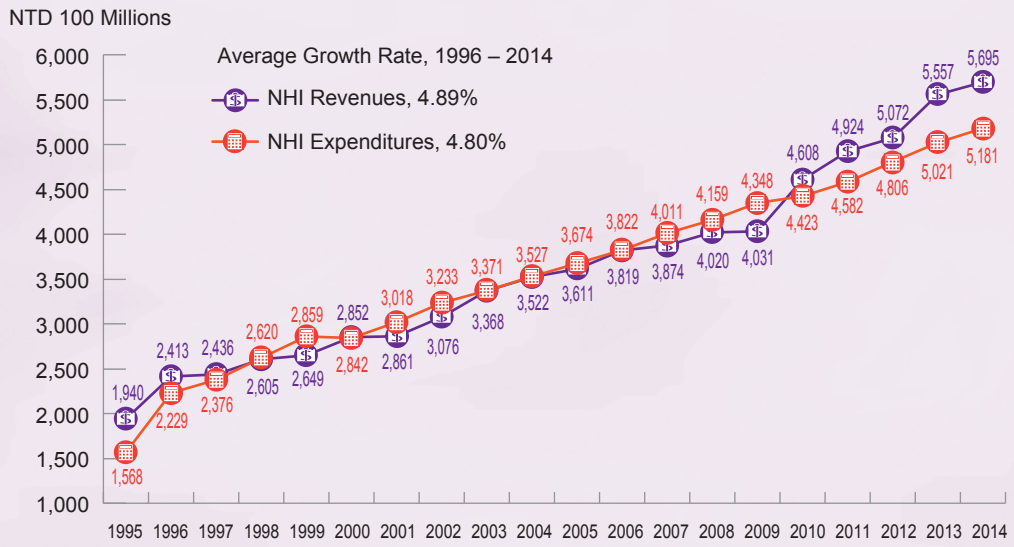
At the end of 2014, there were 20,603 contracted medical institutions, accounting for 93.22% of the nation's total medical institions. Insured persons could receive suitable care wherever they chose. While oversea if they required treatment for an emergency illness or injury, they also could qualify for either a partial or full reimbursement of accrued fees.

Section 3 Improving Finances by Linking Revenues and Expenditures

Rising medical fees can be attributed to population aging, advancement of medical treatments and medicines, and demands for higher quality medical care. The impact of these fee hikes has been exacerbated by sluggish insurance revenues growth, attributed to the slow increases in payroll-related amounts that stagnant salaries in a weak economy bring. Facing these fiscal problems, the MOHW adjusted premium rates in 2002 and 2010, and succeeded in improving NHI finances by eliminating the gap between revenues and expenditures, as shown in Figure 7-1.

Upon the launch of second-generation NHI on January 1, 2013, the following reforms were

Figure 7-1 NHI Revenues and Expenditures, by Year



implemented in order to maintain fair distribution of the insurance premium burden and balance finances through expansion of the premium base:

1. The NHI Supervisory Committee and the NHI Medical Expenditure Negotiation Committee were merged into National Health Insurance Committee, which contributed to build a mechanism to link revenues and expenditures, thereby achieving financial balance.
2. Earnings outside of the insured payroll-related amount, such as large bonuses, salaries for part-time work, incomes from professional practice, stock earnings, interest earnings, and earnings from rentals, were subjected to supplementary insurance premiums. This was in line with the principle that premiums should be paid based on capacity.
3. For the group insurance applicant (employer), when the total amount of salary paid exceeds the insured payroll-related amount for that month, a supplementary premium should be calculated based on the difference. This ensures a fairer burden among employers.
4. The government's financial responsibility was increased through the stipulation that its insurance premium burden shall not be lower than 36%.

Section 4 Promotion of Diverse Payment Systems

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

Since July 2002, the NHIA has used a global budget payment system. It has also begun to rely on payment micro strategies, such as case payments and pay-for-performance, in order to change diagnosis and treatment behaviors, so it can improve medical treatment service quality. Other changes include more efficient use of medical resources, which keeps treatment costs down, and implementation of the Taiwan Diagnosis Related Groups (Tw-DRGs) system on January 1, 2010. Since July 1, 2014, the second stage Tw-DRGs system has been underway.

On January 1, 2012, a pilot capitation payment system was launched. This arrangement provides greater profit incentives to hospitals and doctors that enhance health promotion, allowing patients to benefit from more holistic treatment and care services. By the end of December 2014, eight teams implementing this pilot system were caring for approximately 200,000 patients.

A pilot program plan to build higher quality post-acute care models that spread across different departments was launched in 2014. It started with stroke patients by establishing individualized medical care plans to be conducted during the golden rehabilitation period. The goal was to minimize loss of function, so patients could return to their former way of life.

By the end of 2014, a total of 39 medical teams from 129 hospitals and 22 upstream hospitals are participating in the program. Among the 1,626 accepted patients, 87% showed functional progress, and their Activities of Daily Living scale(ADLs) performance progressed from severe dependence to functional independence, and 83% returned home, and there was a satisfaction rate of 84%.

Section 5 Disclosure of Information to Raise Quality

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

Patients benefit from transparent information on the cost of self-pay 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 consumer.

Section 6 Care for the Disadvantaged and Remote Regions

1. Subsidies for the Economically Disadvantaged

(1) Besides 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 2014 is described in Table 7-1.

(2) Medical 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. But those who cannot afford their premiums and facing economic difficulty could receive support of NHI card unlocking. In December 2014, there were 835,000 cases of people in arrears on their premium payments, including more than 790,000 of them could still receive medical care.

(3) Use of feedback from Public Welfare Lottery for the Disadvantaged: Assistance provided in

Table 7-1 NHI Premium Payment Assistance Measures, 2014

Item	Beneficiaries	Total Assisted	Total Contribution
Premium Subsidies	Low-income households, low-to middle-income households, near-poor households , unemployed veterans, unemployed laborers and their families, disabled persons, unemployed indigenous peoples who are under the age of 20 or 55 or above	3.04 million persons	NTD23.957 billion
Relief Fund Loans	People who meet Standards for Identifying the Underprivileged and the Destitute for National Health Insurance Purposes	3,045 cases	NTD190 million
Payment by Installments	People unable to pay their premium arrears at one time	117,000 cases	NTD3.166 billion
Charity Donation Referrals	People unable to pay their premiums	10,337 cases	NTD24.75 million

2014 included payment of NHI premium arrears and fees associated with treatment. More than 70,000 cases of people were subsidized exceeding NTD430 million in total.

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 this plan to solve problems associated with insufficient medical care resources in mountainous regions and on outlying islands. By 2014, there were 26 contracted medical institutions participating in a total of 50 locations. They had served more than 450,000 people and achieved average overall satisfaction of 95%.

(2) Plan for Improving Medical 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 nearby areas with insufficient resources were encouraged to provide 24-hour emergency treatment, internal medicine, surgery, OB/GYN, pediatrics, and hospitalization services. Through 2014, there were 74 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 payment of expenses when receiving treatment for issues related to the illness or injury. Through the end of December 2014, there were approximately 970,000 such certificates granted (covering more than 910,000 people, or about 3.87% of NHI beneficiaries). Fees associated with major illnesses and injuries were approximately NTD167.9 billion in 2014 (accounting for 27.3% of total health care expenditures).

(2) From a legal standpoint, rare diseases are treated like major illnesses or injuries. Patients are eligible for a Major Illness/Injury Certificate, which exempts them from copayments, and drugs designated by the MOHW as necessary for the treatment of rare diseases are fully covered by NHI. Through the end of December 2014, there were 9,666 rare disease patients obtained a certificate. Fees associated with rare diseases were approximately NTD3.390 billion in 2014.

Section 7 Using Technology to Raise Efficiency

Following advances in cloud and virtual technology, in 2013 the NHIA began to move its public platforms from self-maintained servers to virtual hosts. By the end of 2014, there were approximately 200 such platforms using virtual hosting services, reducing the electricity, maintenance, and manpower costs associated with running servers. Whenever a public platform suddenly faced high-volume connection or service needs, flexibility offered by virtual hosts dispersed or reduced traffic to lower waiting times.

NHI cards store extensive information; besides records of major illness and injury, they indicate drug allergies and clinical records (including prescriptions, testing, and examinations). Doctors use this information as a reference to improve patient safety. NHI cardholders can also indicate their willingness to donate organs and register for hospice and palliative care along with do not resuscitate orders. If the insured person is unconscious or unable to communicate, family members can understand his or her wishes and allow for a dignified death.

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". Through the end of December 2014, 135,000 group insurance applicants had already used the system. Each month, there were approximately 1.3 million online applications are made to change information, accounting for more than 70% of such changes.

Following the launch of the supplementary premiums in 2013, the NHIA provided a standalone "Supplementary Premium E-reporting System" to facilitate recordkeeping by those who pay the premiums. Additional information and reporting channels provided online and through other media further simplified reporting procedures. Through the end of March 2015, the online system was used close to 27 million times to apply for deduction information related to supplementary premium payments in 2014. This accounted for more than 90 percent of all such applications, demonstrating the system's contributions to administrative efficiency.

In July 2013, the NHIA established "NHI Phama Cloud system" that physicians and pharmacists use to check patients' medication records. This

prevents duplicate prescribing and administration of medicines, and minimizes the risk of unfavorable drug interactions. By the end of December 2014, there were already 5,761 medical institutions that were using the system, including 26 medical centers, 84 regional hospitals, 364 district hospitals, 4,152 local clinics, 1,132 pharmacies, and three home care service institutions. A total of 19.48 million records for 6.44 million patients were checked.

Also, to improve the general public's understanding of personal health and treatment conditions, "My Health Bank" was completed on September 25, 2014. The system is available on the NHI website, and allows people to use their NHI card or Citizen Digital Certificate to apply for, check up, and download. "My health Bank" offers the insured which they can safely and conveniently access details of their doctor visits over the previous days with "password registered NHI card" or "Citizen Digitial Certificate." They can get personal clinical and hospitalization data, the dental health data, allergies, organ donor and hospice/palliative care intentions, and immunization records. "My Health Bank" can also be used to check and download personal NHI card status and records as well as insurance fee and premium records. By allowing people to quickly and conveniently obtain personal NHI treatment data, My Health Bank makes self-health management easier. It also bridges the information gap between physician and patient, to make treatment safer and more effective.

Chapter 2 National Pension

Taiwan established National Pension (NP) on October 1, 2008, as a new form of social insurance. Citizens aged between 25 and 65 years old who are not participating in related social insurances for military personnel, civil servants and teachers, laborers, and farmers should participate in the NP. By providing basic economic safety for beneficiaries and their families when the insured person becomes old or faces maternity, disability, or death, the NP system has become an indispensible part of the nation's social safety net.

Section 1 Status of NP

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 protection. Highlights in 2014 were as follows:

1. Insured: There were 3,584,020 insured persons in December 2014. Among them, 13.91% were members of low income households, disabled persons and people whose income did not reach a certain threshold, and 86.09% were general people including workers awaiting employment and housewives. For more details, Table 7-2.
2. Premium Rate: 7.5%
3. Insurance Burden: In principle, the government should pay 40% (NTD518 monthly) of NP insurance fees. For insured persons whose

Table 7-2 NP Beneficiaries and Payment Ratios, December 2014

Classification	Insured Persons	Ratio (%)
General Insured Persons	3,085,741	86.09
Low-Income Household	77,315	2.16
Persons with Severe or Extremely Severe Disability	98,456	2.75
Persons with Medium Disability	77,866	2.17
Persons with Mild Disability	66,018	1.84
Middle-low income persons (Under 1.5-fold minimum cost of living)	126,404	3.53
Middle-low income persons(Under 2-fold minimum cost of living)	52,220	1.46
Total	3,584,020	100.00

income does not reach a designated threshold or who are disabled, the government's share is increased to 55% (NTD713) or 70% (NTD907). For low income households and people with a severe or greater disability, the government's share is 100% (NTD1,296).

4. Monthly Insurance Amount: According to the "National Pension Act," the NP monthly insurance amount shall be adjusted in accordance with the consumer price index (CPI). The CPI reported by the Directorate-General of Budget, Accounting and Statistics in 2014 did not reach the threshold required for adjustment, so the monthly insurance amount remained at NTD17,280.
5. The insureds premium payment Rate Paid by the Insured: From the start of NP insurance (October 2008) to December 2014, the total premiums receivable by insured persons were NTD191.3 billion. Through March 11, 2015, NTD108.0 billion of this amount had been paid out, or 56.46% of accumulated payments. (Female 58.4%, male 41.6%)
6. Benefits

(1) Insurance Benefits: include old age pension payments, maternity payments, disability pension payments, funeral payments, and surviving family pension payments.

(2) Other Benefits: Old age basic guaranteed pension payments, disability basic guaranteed pension payments, and aboriginal pension payments.

(3) NP benefits paid in 2014 are described in Table 7-3.

7. Financial Status of the National Pension Insurance Fund: Through the end of 2014, the accumulated value of the fund was NTD193 billion. Investments and earnings are described in Table 7-4.

Section 2 System Reform

1. Major Legal Revisions: Numerous revisions were made to the "National Pension Act" in order to make NP fairer and more rational. Highlights are described in Table 7-5:
2. Challenges and Responses

Challenges to NP: Increase the NP insurance premium payment rate, strengthen policy communication strategies, adopt suitable collection measures and fines for spouses of insured persons in arrears, fair coverage and pension payments for citizens who are living abroad, and improve risk management and portfolio diversity for the NP Insurance Fund and etc.Faced with the above challenges, the MOHW introduced the following strategies:

Table 7-3 NP Benefit Recipients and Payment Amounts, 2014

Payment Type		Recipients (People)	2014 Payment Amounts (NTD1,000s)
Insurance Payments	Old Age Pension Payments	571,334	22,492,557
	Maternity Payments	18,676	330,134
	Disability Pension Payments	5,464	240,294
	Funeral Payments	18,132	1,566,777
	Surviving Family Pension Payments	55,936	2,382,973
	Subtotal	69,542	27,012,735
Other Payments	Old Age Basic Guaranteed Pension Payments	728,187	31,321,729
	Disability Basic Guaranteed Pension Payments	21,740	1,244,072
	Aboriginal Pension Payments	35,091	1,439,082
	Subtotal	785,018	34,004,883
Total		1,454,560	61,017,618

Note: Recipients of lump sum payments are accumulated over the course of the year. Data for yearly pension payment recipients are accumulated till the end of the year.

Table 7-4 Investments and Earnings of the National Pension Insurance Fund, as of December 2014

Investments	Amount at End of December 2014 (NTD1,000s)	%	Accumulated Earnings, Current Fiscal Year (NTD1,000s)	Annual Earnings Rate (%)
A. Domestic Operations	118,236,435	61.97	7,143,731	6.12
1. Cash Equivalents	32,428,361	17.00	366,143	0.84
(1) Bank Deposits	26,525,918	13.90	348,290	0.84
a. Demand Deposits	78,518	0.04	10,322	0.66
b. Check Deposits	0	0.00	0	0.00
c. Time Deposits	26,447,400	13.86	337,968	0.85
(2) Short-Term Loans	1,150,702	0.61	729	2.77
(3) Short-Term Instruments	4,751,741	2.49	17,124	0.81
2. Equity Securities	69,208,931	36.27	6,508,450	10.91
(1) In-House Management	46,736,047	24.49	4,890,339	13.09
(2) Mandated Management	22,472,884	11.78	1,618,111	7.26
3. Debt Securities	16,599,143	8.70	269,138	2.02
(1) Corporate Bonds	7,299,143	3.83	102,030	2.17
(2) Bank Debentures	9,300,000	4.87	167,108	1.93
B. Foreign Operations	72,568,784	38.03	3,503,406	5.90
1. Cash Equivalents	7,523,969	3.94	390,719	9.19
2. Equity Securities (In-House Management)	17,124,146	8.97	606,947	7.53
3. Debt Securities (In-House Management)	47,920,669	25.12	2,505,740	5.32
(1)Foreign Negotiable Securities	22,286,044	11.68	1,862,733	8.79
(2) Bond Funds	25,634,625	13.44	643,007	2.48
Subtotal	190,805,219	100.00	10,647,137	
Subtotal (Weighted)				6.05

(1) Continue review of NP enrollment and payment qualification standards, in order to make the NP system fairer and more reasonable, and to implement the legislative purpose to ensure the basic economic security of the disadvantaged .

(2) Oversee the Bureau of Labor Insurance to carry out the actuarial management of NP. In accordance with actuarial result, the MOHW will review whether premium rate adjustments are needed to ensure the long-term financial security of the NP Insurance Fund.

(3) Strengthen measures to raise the insured's premium payment rate and improve policy communication, and also oversee the Bureau of Labor Insurance to conduct the collection of NP arrears.

(4) Oversee efforts conducted by the Bureau of Labor Insurance to provide assistance to the insured persons in arrears for applying payment by installments and delayed payments, and also to the spouses of insured persons in arrears, who have reasonable cause for arrear, to apply for canceling fines, in accordance with

Table 7-5 Major Revisions to the National Pension Act

Date	Amended Articles	Main Amended Objectives
Aug. 13 2008	Amended Articles 6, 7, 30-32; deleted Articles 52, 54	Ensured the original rights of farmers by separating their insurance from NP. Eased the deadline for retired laborers to participate in NP insurance.
Jun. 29. 2011	Amended Articles 1, 2, 6, 7, 12 – 14, 30 – 32, 34, 40, 42, 50, 53, 59; changed the name of Section 2, Chapter 4; added Articles 13-1, 18-1, and 32-1	Strengthened protection of the disadvantaged and improved the overall pension system including expansion of the range of people covered, revision of premium collection and insurance period calculation rule, eased requirements for receipt of guaranteed basic pension, added maternity payments, and conditional elimination of joint responsibility for fines for spouses.
Dec. 21. 2011	Added Article 54-1	A mechanism was created that linked the monthly insurance amount to the rate of consumer price index growth. This ensured that pension payments were sufficient to guarantee basic economic security when costs of goods rise.
Dec. 26. 2012	Amended Article 31	Requirements for receipt of payment were eased for the old age basic guaranteed pension payment, the disabled basic guaranteed pension payment, and aboriginal pension payments in response to annual adjustments to current land value. Those who lost qualification due to adjustments to current land value prequalified starting from January 2012.
Jan. 8. 2014	Amended Article 55	To prevent NP payments from becoming the object of mortgage or compulsory execution, thereby affecting basic economic security of the payments recipients, payments recipients under this Act are eligible for opening a specific account in a financial institution with the proving documents provided by the insurer. The specific account is only for depositing NP payments, and the deposit in the specific account shall not be the objects of offset, mortgage, guarantee or compulsory execution in order to strengthen the function of the NP Insurance to ensure the basic economic safety for recipients.

the "Scope of the reasonable causes of the National Pension Act"

(5) Use online events, social networking sites, and e-newsletters to strengthen general understanding of the NP system.

(6) Ask the Bureau of Labor Funds to review and adjust NP Insurance Fund portfolio and investment strategies by way of diversifying asset allocation to improve investment performance.

In order to create a more sound pension system in the country, the Executive Yuan established a special reform group to improve public pension system and followed the concepts of financial stability, social fairness, generational inclusion, and pragmatism. The MOHW will continue to operate in accordance with the Executive Yuan's policy instruction and widely gather opinions to amend the National Pension Act.

Chapter 3 Planning Long-Term Care Insurance

Changes to the composition of Taiwan society and medical advances have lowered the fertility and mortality rates. The overall population is quickly becoming aged, which is leading to greater demand for long-term care (LTC). 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. For these reasons, building a comprehensive LTC system has already become a key component of Taiwan's social security system.

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) Conducting National LTC Need Surveys

a. LTC Need Surveys are conducted as part of LTC insurance system planning to learn functional disability rates at the national and city/county level, to analyze LTC need of those with loss of function, and to understand the resource need and problems of caregivers. Besides contributing to an LTC basic database, these findings serve as a reference for analyzing future LTC needs, developing LTC service systems, determining the scope of LTC insurance, and calculating premium rates.

b. For to continue to understanding functional disability status and to grasp changes and trends in LTC need. After Taiwan's National LTC need Survey in 2010 and 2011, another Taiwan's National LTC Need Survey conducts in 2014 and 2015. It will be completed in 2016.

(2) Development of 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: 1. Activities of daily living and instrumental activities of daily living; 2.Communication skills; 3. Special and comprehensive care needs; 4. Cognition capabilities, mood, and behavioral patterns; 5.Home environment, household support, and social support; and 6.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.

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 to conduct preliminary planning.
Jul. 2009	Acting in accordance with an Executive Yuan request, the Department of Health 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 conducting system planning and related legislative tasks.
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 "Long-Term Care Insurance Act" was sent to the Legislative Yuan for review.

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 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.

(3) Planning LTC Insurance Benefits and Payment Systems

a. Benefits systems: At the end of 2013, the MOHW completed the first draft version of the LTC Case-Mix System (LTC-CMS). This will serve as a reference when setting future LTC insurance benefit standards. In 2015, 10-year case study empirical data was gathered. In response to feedback from LTC workers and expert meetings, the LTC case classification system was recalibrated.

b. Payment systems: Planning of LTC insurance payment systems is based on the benefit item and benefit group. For home services, community services, and institutional residential services, payments are assessed on a case-by-case basis. For different service items, different expenditure groups were established. For example, for rental of medical devices, payments are assessed by the day (month). In order to establish reasonable payment standards that reflect labor costs and to help LTC institutions provide high-quality services, since 2012 the MOHW has used surveys to gather cost data from LTC institutions. This information is then analyzed to serve as a reference for payment standards.

(4) Planning LTC Insurance Financial Mechanisms

a. LTC premium is shared by the government, employer, and the insured, with the government to shoulder at least 36% of the budget, in line with standards used in the National Health Insurance Act.

b. Several mechanisms were introduced to ensure financial accountability scheme of LTCI. Besides adopting a mechanism to link revenues and expenses, an LTC insurance committee must review proposals for balancing finances and benefits scope before the competent authority announces implementation. A formula was established to adjust premium rates every three years to ensure actuarial balance over a 25-year valuation period, and contingency reserve fund is sufficient to last at least three months.

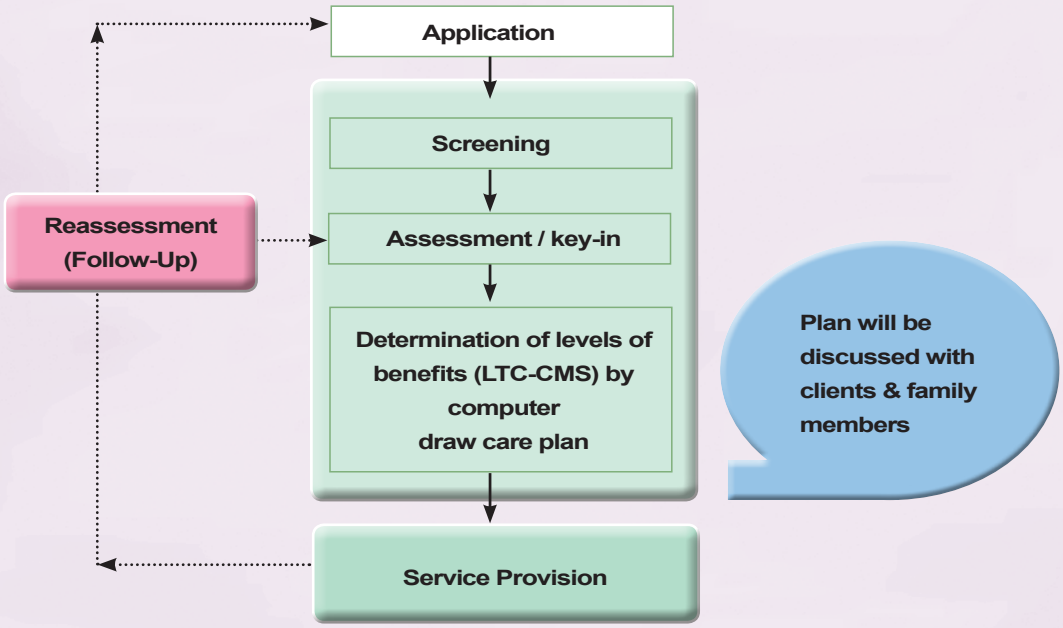
(5) Planning an LTC Insurance Care Management System

Key Tasks for LTC Insurance care management include assessment visit, drafting care plans, approving care plans, connect service, regular follow-up and re-assessment, and assisting insured in applying for re-approval. The insurer must establish service center across the country. See Figure 7-2.

Section 3 Legislation and Advocacy

1. Between July 2009 and May 2015, the MOHW held 220 experts' consultations meetings to discuss insurance finances, underwriting, organizational system, payments and

Figure 7-2 LTCI service delivery process



expenditures, care management, and other issues. There were 405 discussions and other activities to share LTC insurance mechanism ideas with members of the general public. Opinions were also solicited from employers as well as the disabled, older people, women, and other care groups.

2. In order to understand the general public's views toward introducing LTC insurance and expectations toward premiums, there were 15 telephone surveys conducted between March 2010 and December 2014. Each of the surveys, which targeted residents 20 years old and above of the Taiwan area (including Kinmen and Matsu), had at least 1,073 valid questionnaires. A summary of results follows:

(1) Views Toward Government Planning of LTC Insurance: 70-80% of respondents were supportive of the government planning an LTC insurance system. At least 70% of respondents in each age group expressed support.

(2) Views Toward the Government's Timetable for LTC Insurance:The number one response, at approximately 40%, was "the sooner the better". It was followed by "within two years", expressed by 20% of respondents. "Three or four years" and "later than four years" were each favored by between 8% and 14% of respondents.

(3) Monthly Premiums Tolerance, Expressed as a Fraction of NHI Premiums: 14-20% of respondents were willing to pay between 1 and 1/2 of what they pay for NHI premiums, 17-21% were willing to pay 1/3-1/4, 16-31% were willing to pay 1/5, 7-15% were willing to pay 1/6-1/9, and 9-11% were willing to pay 1/10-1/20.

(4) Views Toward Family Caregivers Receiving Care Allowances: 66-71% of respondents expressed support; 19-23% were opposed.

A draft version of the Long-Term Care Insurance Act was approved by the Executive Yuan on June 4, 2015, then sent to the Legislative Yuan for review. As a new form of social insurance, however, more communication with the general public is needed for a consensus to be reached. Once the draft act passes and an LTC insurance system is successfully introduced, Taiwan's social safety net will take a big step toward becoming complete.

8 Social Welfare Services

Since its founding on July 23, 2013, the Social and Family Affairs Administration has been responsible for planning and implementing welfare service policies that focus on women, children and youths, the elderly, and the disabled. It advances the rights, well-being, and benefits of all people. By combining household and community resources, it provides appropriate care for disadvantaged groups to achieve the visions of guaranteed rights, supportive households, a friendly society, and overall progress.

Chapter 1 Children and Youths Welfare

At the end of 2014, Taiwan's children and youths population was 4,149,792, or 17.70% of the total population. Faced with the challenge of people having fewer children, in the Population Policy White Paper (approved by the Executive Yuan in 2013), emphasis was placed on cooperation between related agencies to promote child-friendly environments. Measures to ease the lower birth rate included promoting the value of marriage and families and related supplementary measures, such as friendly work environments, sound social environments, support systems for child care, and financial support. Related measures are shown in Figure 8-1.

In terms of legal revisions, an amendment promulgated on November 30, 2011,replaced the Children and Youths Welfare Act with The Protection of Children and Youths Welfare and Rights Act. This was in response to social, population, and family environment changes and based on the Convention on the Rights of the Child. It provided a legal basis for protecting freedom of expression,

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

No Wealth Exclusion | Partial Wealth Exclusion | Vulnerable Groups

Item \ Age	0	1	2	3	4	5	6
Economic Support Measures	Child-care subsidy for employed parents with qualified childcare providers						
	Allowances for Unemployed Parents with children under 2 years old						
	Special Pre-school Childhood Deductions						
				Preschool Subsidies			Free Tuition Plan for 5 Year Olds
	Assistance for Families in Hardship (Living Allowances for Children, Children nursery Allowances)						
	Living Subsidies for Children of Low Income and Low-to-Middle Income Families						
Low-Cost High-Quality Child Care Measures	Public-privately collaborative infant centers			Non-Profit Preschools			
	Resource Centers for Childcare						
	Centers of Family Childcare Services						
Friendly Workplace Measures	Allowances for Unpaid Parental Leave						
	Family Care Leaves						
Preventive Healthcare Measures	Medical Care Subsidies for Children Under 3						
	Intervention and Transportation Subsidies for Children with Developmental Delays						
	NHI Subsidies for Children and Youths of Low-to-Middle Income Households						
	Children's Preventive Healthcare Services						
Personal Safety Protection Measures	Three-Level Preventive Measures						

Source: Social and Family Affairs Administration, MOHW

the right to development, freedom of social participation, the right to information, the right to culture and leisure, and freedom from economic exploitation. In response to international progress and to demonstrate Taiwan's commitment to protecting the rights of children, on June 4, 2014, the "Implementation Act of the Convention on the Rights of the Child" was announced by presidential decree. This provided a legal basis for children in Taiwan to be assured of rights in line with international standards.

Section 1 Welfare Subsidies for Children and Youths

1. **Allowance for Unemployed Parents with children under 2 years old.**

   These allowances, which targeted families with a marginal tax rate of under 20% over the most recent year and with at least one parent who did not work due to childrearing needs, were monthly subsidies of NTD2,500-5,000. In 2014, there were 258,436 children (133,903 boys and 124,533 girls) who benefitted from their families receiving a total of NTD5,110,130,000.

2. **Emergency Living Assistance for Children and Youths from Disadvantaged Families**

   Families with children and facing hardship, at high risk, or dealing with economic difficulties qualified for monthly emergency living assistance payments of NTD3,000 per person. These helped vulnerable families get through economic crises. In 2014, the payments assisted 8,750 families, including 12,452 children and youths (6,201 boys and 6,251 girls). Additionally, there were 32,941 visitations made (16,300 to boys and 16,641 to girls), guidance was provided to 1,524 children classified as being from high-risk families (724 boys and 800 girls), and 639 children entered into protective services (387 boys and 418 girls). Assistance totaled NTD169,494,645.

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

   Assistance was offered to guarantee the rights to NHI resources for children and youths of low-to-middle income families. Through the end of December 2014, there were 140,745 people who benefited (72,222 boys and 68,523 girls). Assistance totaled NTD1,276,914,187.

4. **Medical Care Subsidies for Children Under 3 Years Old**

   Subsidies were available to cover co-payments associated with outpatient and inpatient services for children under 3 years old. In 2014, these subsidies provided free treatment 12,849,730 times and reduced the financial burden on families by a total of NTD1,892,926,761.

5. **Medical Care Subsidies for Children and Youths of Low-Income and Disadvantaged Households**

   In order to provide children from disadvantaged families with suitable medical care, payment assistance was offered for the following: NHI arrears; intervention, training, and evaluation fees for children with developmental delays; nursing and meal fees during hospital stays; and hospitalization copayments. Through the end of December 2014, there were 2,460 people who benefitted (1,400 boys and 1,060 girls), with subsidies totaling NTD84,099,080.

Section 2 Maintaining the Rights of Children and Youths

1. **Building Platforms to Discuss the Welfare and Rights of Children and Youths**

   Established the Promotional Team for Children and Youths Welfare and Rights(Executive Yuan) and the Promotional Team for Children and Youths Welfare and Rights (MOHW). These groups carried out negotiations, research, reviews, and consultations in relation to children and youths welfare policies, the Convention on the Rights of the Child, and the convention's enforcement act.

2. **A Safety Plan for Children and Youths to Prevent Accidents and Injuries**

   In 2007, the Children and Youths Safety Implementation Plan was formulated to promote personal, home, traffic, school, play, water, and employment safety for children and youths. Also, the Promotional Team for Children and Youths Injury Prevention meets every six months to discuss ways to provide safe, worry-free environments for children and youths to grow.

3. **Protecting the Rights of Stateless Children and Youths and Those Without Household Registration**

   The MOHW regularly follows up on children

and youths without household registration or who are stateless. Through the end of 2014 it had registered 47 such cases, with 25 already concluded through the assistance of local governments and other public departments. Two educational and training classes were held and a book featuring case studies was compiled to improve the practical capabilities of social workers. The objective was to guarantee the schooling, home care, and medical care rights of children and youths without household registration or who are stateless, in accordance with Article 22 of "The Protection of Children and Youths Welfare and Rights Act."

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

(1) Carried out a variety of children and youths rights advocacy events in cooperation with local governments and Non-Government Organizations (NGOs). In 2014, subsidies were provided to 75 organizations to hold 375 such events, with total attendance of 75,238 participants (35,235 boys and 40,003 girls)

(2) Taiwan Girls' Day is held on October 11 each year to encourage building better environments for girls to grow.

(3) Assistance was offered to local governments to cultivate children and youths representatives. Stronger social participation and free expression among this segment of the population raised overall citizen participation and knowledge.

Section 3 Placement Services

1. Better Promotion of Institutional Placement Services

(1) By encouraging, guiding, and commissioning NGOs to pair children and youths with institutions specializing in placement and education, the MOHW assisted children and youths from families facing grave misfortune or who were deprived of parents, impoverished, or in need of care. By 2014, there were already 124 such institutions (see Table 8-1).

(2) Formulated a budget to subsidize professional service fees, facilities and equipment costs, educational assistance, and research and training. In 2014, these subsidies totaled NTD66,179,100.

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

According to paragraph 2, Article 84 of The Protection of Children and Youths Welfare and Rights Act, authorized agencies shall conduct accreditation of placement and education institutions for children and youths. In the most recent accreditation (including Taipei City evaluations in 2011 and joint central government evaluations in 2012), there were 109 institutions evaluated, with all institutions that rated only "fair" having passed re-inspection in February 2014. Details are shown in Table 8-2.

3. Promoting Foster Care Services

Provided guidance to local governments and commissioned NGOs to conduct foster care services, with assistance including recruitment, screening, and training of suitable foster families. By December 2014, there were 1,289 households registered to serve as foster care homes, 303 reserve foster care homes, and 1,743 children and youths receiving foster care (see Table 8-3).

4. Building a National Children Placement and Follow-up Management System

After developing a national case management system for placement and follow-up of children

Table 8-1 Institutions Specializing in the Placement and Education of Children and Youths, 2010-2014

Year		2010	2011	2012	2013	2014
Number of Institutions		115	120	123	126	124
Approved Number of Beds		4,554	4,577	4,816	4,985	4,991
Children	Boys	1,815	1,837	1,858	1,842	1,818
	girls	1,804	1,772	1,691	1,700	1,683

Source: Social and Family Affairs Administration, MOHW

Table 8-2 Accreditation Results for Institutions Specializing in Placement and Education of Children and Youths, 2011 and 2012

Rating	Taipei Evaluations (2011)	Joint Central Government Evaluations (2012)	Subtotal (Institutions)	Ratio (%)
Outstanding	6	26	32	29.36
Excellent	8	47	55	50.46
Good	2	16	18	16.51
Fair	0	4	4	3.67
Poor	0	0	0	0.00
Subtotal	16	93	109	100.00

Source: Social and Family Affairs Administration (MOHW), Department of Social Welfare (Taipei City Government)

Table 8-3 Foster Care Homes and Children, 2010-2014

Year		2010	2011	2012	2013	2014
Families (Households)		1,260	1,243	1,248	1,275	1,289
Children	Boys	968	937	927	899	847
	Girls	937	865	908	905	896

Source: Social and Family Affairs Administration, MOHW

and youths, starting in January 2014 the MOHW assisted related agencies and workers in handling placement and follow-up information. The system has aided recordkeeping and follow-up of cases accepted and concluded by placement institutions and foster homes, which has raised service quality. Statistics forms have also been produced that help social workers to evaluate service effectiveness and raise administrative efficiency.

Chapter 2 Welfare for Women and Family Support

Section 1 Women's Welfare

At the end of 2014, there were 11,735,782 women in Taiwan, accounting for 50.08% of the total population. In order to better accommodate the increasingly diverse roles and service needs of these women, since 1991 Taiwan's social welfare budget has included a special women's welfare fund. Also, to promote communication between domestic and foreign women's groups, on March 8, 2008, the Taiwan Women's Center was launched.

Changes have been made to administrative mechanisms and policies to eliminate and prevent women's problems. By focusing on women, these increase the rights and capabilities of women and strengthen women's welfare. Key achievements were as follows:

1. Support services that sought to boost women's welfare and empowerment were offered in combination with private organizations. These not only raised women's capabilities but also created more opportunities for fair development. In 2014, the services were offered 8,985 times.
2. Strengthened functionality of 20 women's welfare service centers across the country. By linking government and private resources, the centers offered women's welfare, women's rights, parental education and guidance, legal services, and learning services. The centers also provided women's welfare and rights services that were diverse, community-based, and comprehensive.
3. Operated and managed the Taiwan Women's Center, which serves as a platform for popularizing women's welfare, women's rights, and gender mainstreaming. The center also increases interaction between women's

organizations (both domestic and international) and public and private agencies. In 2014, there were 11,431 visits made to the center and 54 organizations used its premises (a total of 289 times). Domestic organizations and foreign guests visited on 69 occasions (with total visitors reaching 1,687), and online traffic exceeded 1.3 million.

4. Advanced the women's dream pavilion concept by subsidizing establishment of pavilions by the New Taipei City and Pingtung governments in 2014. The pavilions serve as a platform for empowering women's groups and cultivating exchanges between different groups. Besides encouraging women to participate in social and public affairs, the pavilions host exhibitions and foster localized empowerment mechanisms and operation models. Observation and study conferences were also held at the city and county level to expand the women's dream pavilion experience and create additional opportunities for sharing resources.

Section 2 Services for Disadvantaged Families

1. Welfare Services for Single-Parent Families

(1) Subsidized NGOs in carrying out case management, after-school care, empowerment plans, and various supportive welfare services for single-parent families.

(2) In 2014, there were 42 single-parent family service centers established across Taiwan and 141 subsidized plans for single-parent families. We also subsidies temporary childcare fees as well as tuition and miscellaneous fees on studying high school, vocational high school, and college for 315 single-parents. These subsidized plans were used by 10 male single-parent and 305 female single-parent (male: female ratio of 1:30.5).

2. Welfare Services for Families With Foreign Spouses

In accordance with a Ministry of the Interior has formulated care and guidance measures for foreign and Mainland Chinese spouses, in 2014 NGOs received subsidies to hold lifestyle adaptation classes for foreign spouses. There were 35 the Foreign Spouses Family Service Centers established across Taiwan, 92 community service centers for foreign spouses, and 105 special plans.

3. Community Care Services for Children from Disadvantaged Families

In order to improve care and guidance for disadvantaged families, and in particular their children, has formulated special community care service plans. In 2014, NGOs received subsidies to conduct 126 related plans, which included social work case management, community promotions, the programming of after school care service, basic guidance for household affairs, parental education, and family activities.

4. Intervention Services for Children and Youths from High-Risk Families

(1) Combining with police administration, educational administration, household administrations, health and other agencies, the MOHW carries out screenings of children and youths from high-risk families. Referral and care mechanisms provide preventive services to strengthen household capacity.

(2) In 2014, subsidies distributed to 83 NGOs, engage 224 social workers. They screened 34,764 families, with assistance provided to 24,334 households and 34,323 children and youths.

Section 3 Daycare and Early Intervention Services

1. Services for Families with Daycare Needs

(1) Childcare subsidies for employed parents with qualified child-care providers：For both parents (or guardians) or the 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 2014, there were 62,744 children who benefited from a total of NTD1,251,947,003 in subsidies.

(2) Daycare Services

a. Families childcare services: Nationwide Centers of Family Childcare Services are established to assist childcare providers passing the license examination, to provide the pre-job trainings and on-the-job seminars and to hold promotions and onsite visiting. In the end of 2014, 41,849

childcare providers who joined 70 Centers of Family Childcare Services Agencies cared for 59,982 children.

b. Infantcenters Services: Local governments are supervised to guide infant centers with legallicenses. In the end of 2014, there were 659 legally registered infant centers that were caring for 14,845 children.

c. Community-based Family Support Services: Local governments are supervised to set public-privately collaborative infant centers by the non-profit way with community related resources.At the end of 2014, there were 72 public-privately collaborative infant centers that opened and cared for 2,275 children. Furthermore, local governments also institute community-basically childcare resource centers where parents could use related material and have parental courses and guidance. At the end of 2014, there were 87resource centers for childcare opened and provided services 990,000 times.

2. Early Intervention for Children with Developmental Delays

(1) Home-Based Intervention Services: Help was available for children with developmental delays who had insufficient family support, were located in remote areas that lack intervention resources, or faced economic problems that prevented them from enrolling in kindergarten, intervention institutions, or medical care institutions. These children qualified for home-based intervention services provided by the intergration of various relevant specialists of institutions, organizations or colleges. In 2014, there were 1,779 children who benefitted.

(2) Subsidized Intervention Fees: Intervention and transportation fee subsidies were available to children with developmental delays. These were worth up to NTD5,000 monthly for children from low-income families and up to NTD3,000 monthly for other children. In 2014, there were 39,299 children who benefitted from total subsidies of NTD341,332,325..

(3) Community-Based Intervention Services: In 2014, subsidies were provided to eight cities and counties to promote community-based intervention services in 34 townships and villages. These combined professionals in the areas of health administration, special education, and social administration that provided convenient intervention to areas that lack intervention resources.

Section 4 Services for Families with Special Needs

1. Children and Youth Adoption Service Providers

(1) In order to eliminate private sale of infants and reduce the occurrence of families that terminate adoption agreements, unless there is a direct family/stepfamily relationship, all adoptions must be carried out by approved children and youth adoption service providers or companies.

(2) Through the end of 2014, there were nine institutions (with 13 service points) approved to provide children and youth adoption services, six of which were qualified to provide international services. In 2014, these institutions matched 347 children (155 adopted domestically and 192 adopted overseas) with adoptive parents.

2. Assistance for Families in Hardship

(1) Emergency living assistance, living allowances for children, nursery allowances, medical subsidies, litigation subsidies, education allowances for children, and career development loans were available to help families in hardship.

(2) In 2014, there were 19,033 families that used these benefits 139,513 times (120,803 for females, 18,710 for males), with total subsidies exceeding NTD429,780,000.

3. Custody Rights of Under aged Children

(1) Local governments dispatch social workers to conduct interviews and assessments when custody disputes arise due to divorce, then issue recommendations to the court hearing the custody case.

(2) Family mediators help couples that are divorcing find common ground to settle their disputes. In 2014, nine subsidized NGOs (12 projects) and eight district courts cooperated with 9,238 such negotiations.

4. Support Services for Teen Pregnancies

(1) Established a teen pregnancy hotline (0800-25-7085) and a teen pregnancy support

website (http//www.257085.org.tw) to provide assistance and consultation to minors who became pregnant. In 2014, these services were provided 924 times, there were 32,752 visits made to the website, and 333 consultation letters were received.

(2) Provided placement services for minors who became pregnant and their children. By the end of 2014, there were six institutions that specialized in placement and nurture that were able to assist a total of 60 such young mothers at a time. Each city and county provided case management services and assisted with financial subsidies, health care, childcare services, and referrals for foster care and adoptions services.

Chapter 3 Welfare for the Elderly

Taiwan officially became an aged society in 1993. In light of the challenges this brings, the MOHW adopted a three-pronged policy approach: economic security, health maintenance, and lifestyle care. It promoted measures that meet the psychological, social, educational, and leisure needs of older people. It also implemented the Senior Citizens Welfare Act, and built friendly environments conducive to the health, safety, and lifelong learning of older people in accordance with Executive Yuan-approved "Population Policy White Paper – Countermeasures for an Aging Society." Such policies sought to aid the vitality, dignity, and autonomy of older people.

A nationwide tour by Chung Yeung ambassadors

Section 1 Economic Security for the Elderly

1. Monthly living allowances of NTD3,600-7,200 are offered to guarantee the economic security and basic lifestyle of low-to-middle income older people. In 2014, there were 122,423older people who received a total of more than NTD9,384,590,000 in subsidies.
2. Monthly special care allowances worth NTD5,000 were offered to low-to-middle income persons who had to sacrifice employment to care for an elderly family member. In 2014, there were 9,077such allowances worth a total of NTD45,000,000.
3. In order to help older people turn their home and land into monthly cash payments, a pilot reverse mortgage mechanism (which allows the elderly to convert equity in their home into cash) was launched on March 1, 2013. The Taipei City Government also commissioned the Institute for Physical Planning and Information to evaluate the effectiveness of an experimental public welfare project for using homes to support the elderly in Taipei. Findings were used to assess potential adjustments to the reverse mortgage mechanism.

Section 2 Health Care for Older People

1. In order to reduce the economic burden of NHI premiums and medical copayments on older people with economic problems, NHI premiums are fully subsidized for low-to-middle income elderly persons aged 70 and above. In 2014, these subsidies were provided to 79,216people.
2. Daily subsidies of NTD1,800, with an annual limit of NTD216,000, are offered to pay hospitalization and nursing fees of seriously ill low-to-middle income older people who are in the care of MOHW-commissioned placement institutions. In 2014, four institutions received these subsidies.

Section 3 Lifestyle Care for Older People

1. In recognition of the many contributions Dr. George Mackay made to the poor in Taiwan, starting from June 1, 2011, discounted public transit was availableto foreigners who met the following qualifications: had lived in Taiwan at least 20 years, 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, was at least 65 years old, was formally recognized forlong-term dedication or special contributions to Taiwan. Through the end of 2014, a total of 223 foreigners qualified.

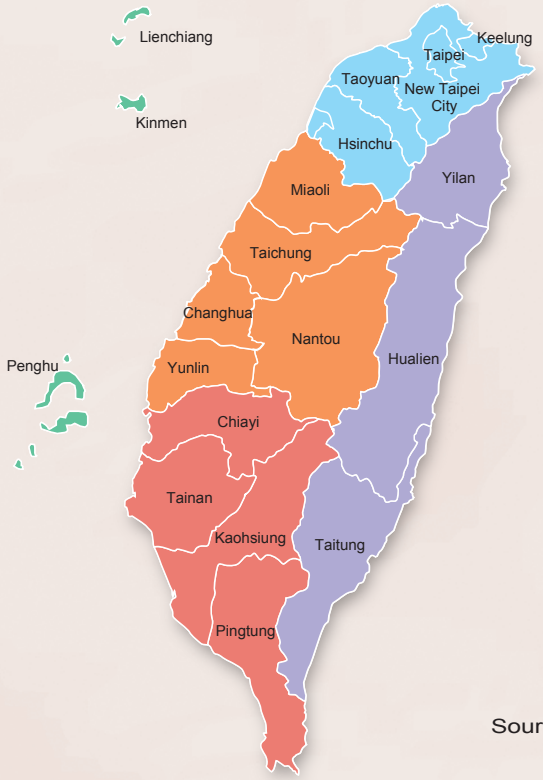
2. Care for older people living alone included 24-hour emergency assistance services to provide immediate help to older people with emergency needs. Also, establishment of a center for following-up missing elderly people helped reunite families. Between the center's founding in October 2011 and the end of 2014, it located 1,202older people out of 2,072 reported as missing.
3. Subsidies were provided to establish a private elderly consultation service center that operates a hotline for the elderly. Answers to a wide variety of questions were available by calling 0800-228585. The hotline handled close to 600 calls per month on average.
4. Through a combination of cross-departmental resources and the gathering of local governments, experts, and NGOs, planning of a second phase plan for friendly care services for older people took place. Following the first phase plan, which emphasized active aging, friendly older people, and blending of generations, the second phase plan focused on healthy aging, aging in place, smart aging, vigorous aging, and continuing education. It included 84 action measures. Also, to meet the needs of an "aged" society, which was expected within 10 years, a special white paper was issued following consultations with the general public. Developmental action strategies focused on providing healthy, prosperous, active, and friendly lifestyles for older people.
5. Local governments cooperated with village offices and community organizations to establish 1,969 community care points (see Figure 8-2). Local residents who served as volunteers provided outreach visits, phone calls,

Figure 8-2 Distribution of Nationwide Community Care Points

Central Region	
Miao	73
Taichung	207
Nantou	72
Changhua	117
Yunlin	60

Outlying Islands	
Kinmen	9
Lienchiang	7
Penghu	21

Southern Region	
Chiayi County	67
Chiayi City	23
Tainan	303
Kaohsiung	196
Pingtung	130



Northern Region	
Keelung	55
Taipe	68
New Taipei	214
Taoyuan	123
Hsinchu County	42
Hsinchu City	30

Eastern Region	
Yilan	61
Hualien	39
Taitung	52

Source: Social and Family Affairs Administration, MOHW

referrals, food services, and health promotion activities. There were more than 210,000 people served.

Section 4 Social Participation by Older People

1. Besides special schools, retirement age research, and welfare activities, such as conferences, health lectures, sporting events, croquet competitions, and singing contests, older people benefitted from discounts on public transit, entry into health and leisure centers, and admission into cultural and educational facilities. They were also encouraged to participate in more outdoor activities to promote physical health. In 2014, there were354,201 older people who benefitted from the schools and activities offered.
2. Mobile senior culture, health, and leisure tourswere made possible by the subsidized purchase of 18 multi-functional tour care buses by 16 cities and counties. These helped older people access not only welfare services and health consultations but also leisure, culture, and entertainment activities. In each city and county, there were about 35~36 of these tours each month with average attendance of 1,100-1,200.
3. For Senior Citizens' Day, the 2014 Family Walk took place. Older people with outstanding performances in talent competitions from 2010 to 2013 were invited to join a special senior variety group that went on tour from September 22 – October 2, 2014, to perform for children and youths, older people, correctional institutions, and community care points across Taiwan.They promoted active ageing, generational blending, and other ideas that showed how older people can lead wonderful lives.

Chapter 4 Welfare for the Disabled

Taiwan's welfare policy for the disabled is based on the actual needs of disabled persons as well as the "People with Disabilities Rights Protection Act" and a white paper on protecting the rights of people with disabilities. Besides introducing mechanisms to evaluate the needs of disabled persons, Taiwan is working harder to guarantee the economic security, diverse continuous services, and the living environment of the disabled while advancing their social participation.

Section 1 Guaranteeing the Rights of the Disabled in Line with International Practice

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). In order to establish a legal basis for the CRPD in Taiwan, on August 1, 2014, the Legislative Yuan passed the "Act to Implement the Convention on the Rights of Persons with Disabilities," which was announced by Presidential Order on August 20, 2014, and implemented beginning on the International Day of Persons with Disabilities on December 3, 2014. The MOHW has already planned related measures to implement regulations contained in the Convention.

A drum performance featuring members of a senior citizens Taiko troupe in Yuemei Community, Daxi

2014 grandparents happy Walking Festival

2. A new system for evaluating the needs of people with disabilities was formally implemented on July 11, 2012. It adopted the WHO's International Classification of Functioning, Disability and Health (ICF), in particular its use of body structures, body functions, activities and participation. The spirit of ICF was to use professional teams to identify the disabled and their needs. A single channel was also created for people to receive personalized, diverse welfare services. In 2014, there were 224,013 people who applied for disability identification, with 200,647 people qualified and 217,728 who underwent needs assessment.

Section 2 Economic Security for the Disabled

1. For greater economic security, disabled persons with qualifying household income and property levels received monthly living subsidies of NTD3,500, NTD4,700, or NTD8,200. In 2014, there was more than NTD20,527,740,000 in such living subsidies offered (benefitting 350,526 people).
2. Day care and residential care subsidies for disabled persons exceeded NTD7,065,410,000 in 2014 (benefitting an average of 39,199 people each month).

Section 3 Life Care for the Disabled

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

In order to promote lifestyle quality and social participation among the disabled, services offered included home care, independent lifestyle support, lifestyle reconstruction, day care, family foster care, and community housing. In 2014, there was NTD878,750,000 spent on these services to provide benefits to people 3,884,842 times. There were also 97 service stations for community housing and 105 service points for community day care.

2. Home Support Services for the Disabled

In order to provide diverse care channels for households with a disabled person and reduce the burden on caregivers, household services included emergency and short-term care as well as support for caregivers. In 2014, there was NTD64,733,409 spent on these services to provide benefits to people 111,669 times.

3. Institutional Care Services

At the end of 2014, there were 273 welfare institutions for the disabled that had a total of 23,454 beds. They were serving 18,967 people (consisting of 11,533 males [60.8%] and 7,434 females [39.2%]), leaving more than 4,000 beds vacant. Key service items included early intervention, day care, art and learning, inpatient care, and welfare. The MOHW assisted institutions in reducing scale and becoming more community based, to make services more accessible and convenient for the disabled.

Section 4 Assistive device Resources and Services for the Disabled

1. Conducted a nationwide joint meeting to facilitate integration of assistive device resources and services for the disabled. Further progress came through the establishment of a related web portal.

2. Assistive device Services at the Local and Central Levels

(1) Establishment of a Central Assistive device Resource Center: Commissioned establishment of resource promotion centers for multifunctional Assistive device, orthotic and mobility devices, and communication and information Assistive device. The centers provided consultations, education and training, website maintenance, exhibitions, and promotional activities while also helping local assistive device centers to raise their professional capacities.

(2) Subsidized and guided establishment of assistive device centers by local governments. These provided accessible, convenient service channels that offered assistive device evaluations, consultations, publicity, and maintenance services. There were 26 such centers located across Taiwan.

3. Subsidized assistive device fees for the disabled. In 2014, there were 75,318 such subsidies handed out worth a total of NTD728,950,000.

4. Assessing effectiveness of assistive device services provided by local governments: according to regulations contained in a law governing integration, R&D, and services relating to assistive device for the disabled, from October 6 – November 27, 2014, the MOHW assessed service effectiveness of each city and county.

5. An annual budget of NTD6 million subsidizes medical rehabilitation and assistive device center plans for at least 10 hospitals located across Taiwan. The purpose is to provide assistive device consultations, analysis, and customized design, so the disabled are able to live independent, autonomous lives.

6. A comprehensive plan for subsidizing medical assistive device for the disabled was implemented on July 11, 2012. Through the end of 2014, these subsidies were provided 18,711 times (68% to males, 32% to females), with total subsidies worth NTD122,201,743.

Section 5 Social Participation by the Disabled

1. Funding is offered to private organizations that hold leisure, entertainment, research and study, and other activities for the disabled. These subsidies can be used to create or enhance web pages, facilities, and equipment used by the disabled. In 2014, there were 704 such subsidies that benefitted a total of more than 30,000 people.

2. Before Mid-Autumn Festival, the general public and enterprises were encouraged to purchase festival-related goods produced by disabled welfare organizations.

3. Activities held in conjunction with International Day of Persons with Disabilities included a special awards ceremony to present Golden Eagle awards to outstanding disabled persons.

4. Subsidies were offered to conduct guide dog training and advocacy programs. There were 39 guide dogs in service and 122 younger dogs in training.

5. Carried out several measures to provide parking for the disabled and methods to identify qualified users. Already established 16,235 parking spaces for the disabled, distributed special license plates, and issued more than 270,000 disabled parking permits.

6. Cooperated with related departments and municipal and county (city) governments to offer discounts for disabled people to use public transit and enter scenic areas, health and recreation spots, and cultural/educational facilities.

7. In order to promote barrier-free spaces for the disabled to easily move, and thereby increase social participation, since 2008 the MOHW has used revenues from the public welfare lottery and donated resources to assist in the purchase of special "Rehabus" buses by municipal and county (city) governments. In 2014, there were 1,554 of these buses in Taiwan that had an accumulated ridership of 3,685,718.

8. Assisted municipal and county (city) governments in establishing channels for sign language interpreting and setting standards for service scope and procedures, with the goal of increasing social participation by people with hearing problems. There were a total of 277 people working with the MOHW as sign language interpreters.

9 Social Assistance and Social Work

In order to provide suitable care for the destitute, the vulnerable, and those facing difficult periods in their lives while slowing the rise in the income gap, Taiwan's social assistance measures operate under the principles of "active care, respect of needs, and aiding self-sufficiency." Related regulations are regularly reviewed. Unemployment benefits and welfare services are combined to ensure that people receive the assistance they need.

By establishing a social work service system, the MOHW has raised the professionalism of social workers, ensured the rights of beneficiaries, and provided greater oversight to the usage, pay, and safety guarantees of social workers employed by local governments. Community development has raised community awareness, social welfare, health promotion, and cultural inheritance. By encouraging participation in volunteer services, the spirit of assistance has flourished. Consolidation of social worker resources has made people more willing to participate in public affairs, which has contributed to growth in social welfare and higher quality of life.

Chapter 1 Emergency Assistance for Low (middle-low) Income Households

Section 1 Current Status of Assistance

The goal of social assistance is to care for low-income and middle-low-income households and to provide emergency assistance to those facing critical or disaster situations, with the objective of making recipients more self-sufficient. Social assistance guarantees a basic lifestyle standard for the disadvantaged and helps people to overcome difficulties.

Before a 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 wealth, or assistance from family members. In order to ease the impression of the working poor and to further encourage self-sufficiency among beneficiaries, the lowest living index was relaxed and legal guarantees were extended to middle-low-income households. Adjustments were made to the lowest living index calculation methods based on the disposal income ratio method, in line with established practice in most European Union and OECD nations. Besides bringing the assistance program in line with international standards, this allowed it to more closely adhere to the purpose of the poverty line. Based on the revised calculation methods, the lowest living index for low-income households in Taiwan Province rose from NTD9,829 to NTD10,244. The lowest living index for the past five years is shown in Table 9-1.

At the end of 2014, cities and counties had evaluated and approved public care for 149,958 low-income households (with 357,722 people) and 114,522 middle-low-income households (349,130 people). A total of 706,852 vulnerable people were included under the government's scope of care, an

Table 9-1 Minimum Cost of Living, 2010-2014

Region Year	Taiwan Province	Taipei	Kaohsiung	New Taipei City	Taichung	Tainan	Fujian Province	
							Kinmen	Lienchiang
2010	9,829	14,614	11,309	10,792	-------	-------	7,400	
2011 (January-June)	9,829	14,794	10,033	10,792	9,945	9,829	7,920	
2011 (July-December)	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	

increase of 150,043 households, or 155% more people (430,724 people), compared to before the amendment (Figure 9-1).

According to the Report on the Low-income and Middle-income Family Living Condition Survey,2013 , the five main reasons for poverty among low-income and middle-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 financial providers. Figure 9-2.

Section 2 Living Support

Living support for low-income households is an important part of social assistance. When the average income among household members is below the lowest living index and the household wealth is below the yearly threshold announced by central government or municipal authorities, the government provides continuing economic support. According to the Report on the Low-income and Middle-income Family Living Condition Survey, 2013 , the leading social assistance service measures in order of importance to low and middle-low-income households were: living assistance, NHI subsidies, miscellaneous school expense subsidies, and living assistance for the disabled (Figure 9-3). These show that most government social assistance for low-income households was continuing and frequent.

Local governments currently offer living support, student living assistance, and children living assistance to low-income households. Related relief measures are available for each assistance type. 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 subsidy from the competent authority that is no more than 40% of the original amount in cash. In order to prevent excessive welfare payments affecting a recipient's willingness to work, Article 8 of the Act states that the amount of assistance granted by the government and received by each person each month under this Act or other Acts shall not exceed the basic wage of the current year announced by the government. Highlights of key living support measures provided to low-income households in 2014 are illustrated in Table 9-2.

Besides cash payments, services that local governments must provide based on need include nutrition subsidy for puerperas and infants (including nutritional subsidies for newborns of single mothers), procreation subsidy, prioritized placement in social housing, housing rent subsidies, subsidies

Figure 9-1 Beneficiaries of New Social Assistance Regulations

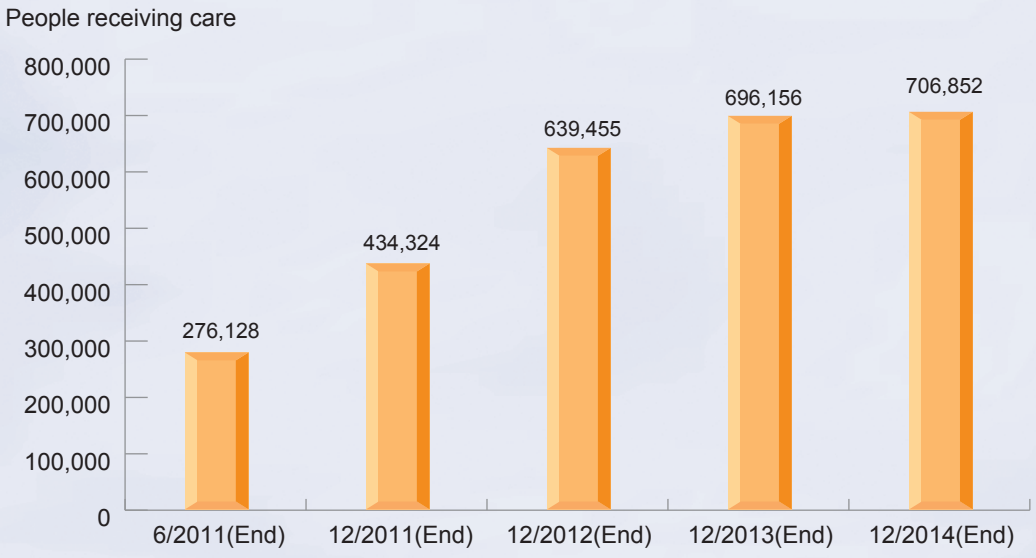


Figure 9-2 Five Leading Causes of Poverty Among Low-income and Middle-low-income Households, 2013

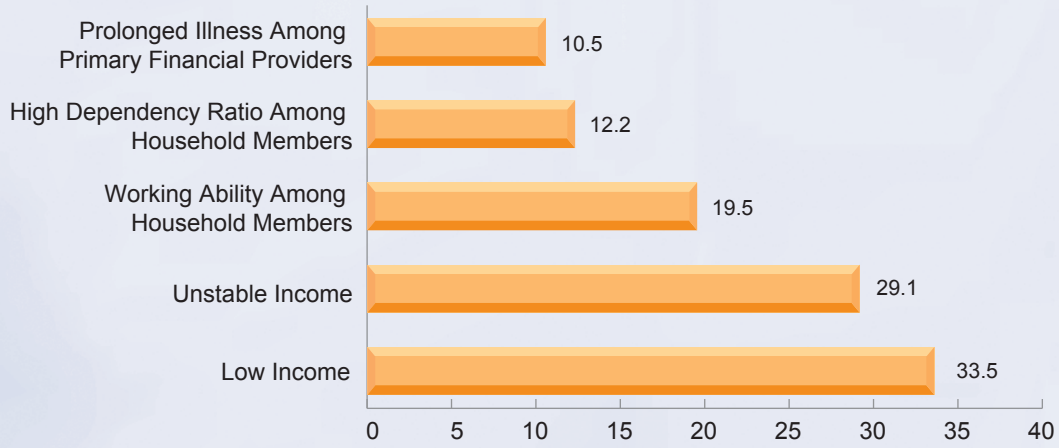


Figure 9-3 Type of Social Assistance Provided to Low-Income and Middle-low-income Households

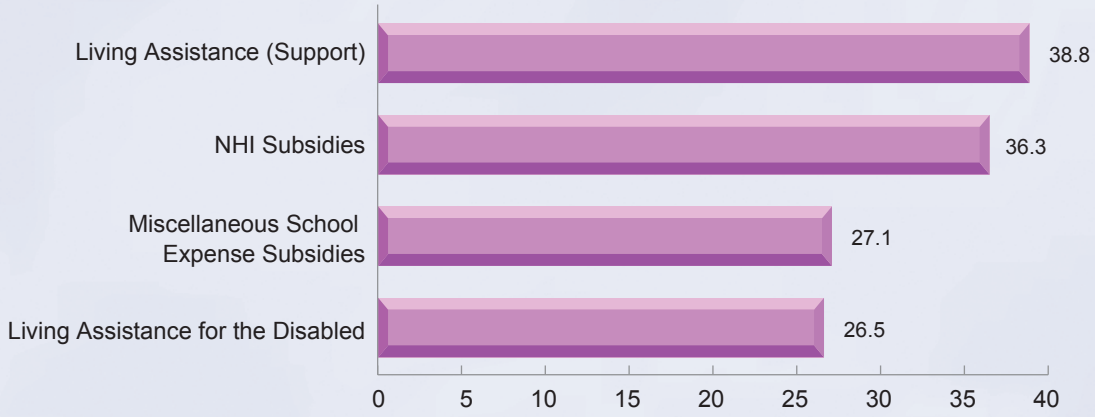


Table 9-2 Key Living Support Measures Provided to Low-Income Households, 2014

Subsidy Item	No. of Subsidies	Total Subsidy Amount (NTD)
Family Living Subsidies	1,292,475	NTD 6,255,748,408
Student Living Subsidies	689,307	NTD 4,067,654,800
Work Relief Programs (Including Middle-low-income Households)	23,985	NTD 373,091,163
Holiday Greeting	777,529	NTD 520,627,390

for the basic repairs of a residence, Loan interest subsidies for purchasing a residence or building a residence, student healthy lunch subsidies, and subsidies for hospitalization of the injured or sick. These measures guarantee that the basic needs of low-income and middle-low-income households are met.

Section 3 Medical Subsidies

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

1. NHI Subsidies: Article 19 of the Public Assistance Act states: "The insurance premium for low-income households to cover NHI shall be paid from the budget of the central competent authorities. As for the insurance premium for middle-low-income households to cover NHI, this shall be paid by themselves and 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 2014, NHI premium subsidies totaled more than NTD5,768,240,000.
2. Copayment Fee Subsidies: In order to reduce the health care burden faced by low-income households, Article 49 of the National Health Insurance Act states: "When low-income households receive medical care, the care expenses to be borne by them shall be paid out of the central competent authority budget." In 2014, subsidies for these expenses (including clinical and hospitalization fees) totaled NTD2,008,100,000.
3. Subsidies for Medical Care Not Covered by NHI: In order to satisfy health care needs of low and middle-low-income households, local governments established related laws and regulations governing subsidy standards for medical Care fees. In 2014, there were 4,260 such subsidies worth a total of NTD89,873,420.

Section 4 Work Benefits and Promoting Self-Sufficiency

In order to promote self-sufficiency among low-income and middle-low-income workers, Article 15 of the Public Assistance Act states: "For persons in low-income and middle-low-income households who are able to work, municipality and county (city) competent authorities shall, according to needs, provide employment services, vocational training, business initiation aid, or work relief 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 them career counseling, loan interest support for establishing careers, subsidies for transportation when job seeking, temporary childcare, and allowances for daytime care within the job seeking or vocational training period, and other services and subsidies for obtaining employment. Participants in vocational training programs can also apply for special living allowances to help pay for family expenses during their schooling period, eliminating one area of concern.

In 2014, there were 38 subsidized projects in which local governments and NGOs assisted in helping people become more self-sufficient and break free of poverty. The total value of 48,060 such subsidies was NTD16,421,680.

Section 5 Emergency Relief

1. The Public Assistance Act provides timely assistance to people who are mpoverished due to emergency situations.
2. 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.
3. To further strengthen care for the disadvantaged, an immediate care plan was introduced for the delivery of emergency relief. When impoverishment resulted from an accident befalling a family's primary financial provider, assistance was granted following visits and confirmation by the local neighborhood office, private charitable organizations, and the local township (village/city/district) office.
4. Related achievements from 2014 are described in Table 9-3.

Table 9-3 Emergency Relief Achievements, 2014

Type	Beneficiaries (People)	Relief Payment Amount (NTD)
Emergency Relief from Municipal and County (City) Authorities	42,232	NTD253,490,910
Emergency Relief from the MOHW	1,039	NTD14,135,000
"Immediate Care" Emergency Relief	16,218	NTD231,878,003

Chapter 2 Assistance for the Homeless

In 1991, as authority over measures for the homeless switched from police agencies to social administration agencies, management gradually shifted from police suppression to social guidance. Current sheltering and guidance for the homeless is based on three service levels: emergency, transitional, and stabilizing. Suitable services and guidance, which take into account basic human rights and regional differences, help the homeless to rebuild and adapt their lives.

Section 1 Analysis of the Homeless Issue

According to local government data, there were 2,533 homeless persons registered for assistance services at the end of 2014, more than 70% of whom stayed in Taipei, New Taipei City, Taichung, Tainan, Kaohsiung, or Taoyuan. There were seven cities and counties with 50 or fewer homeless persons, and there were no registered homeless persons in Kinmen, Lienchiang, and Penghu. The data show a significant gap between different localities, with most homeless people concentrated in areas of high urbanization.

According to an MOHW-commissioned 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 a junior high school education or lower. Most were single, with 47.4% never married and 46.9% divorced, living apart, or having lost their spouse to death. 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.

Section 2 Homeless Assistance Measures

According to Article 17 of the Public Assistance Act, local governments shall formulate autonomous measures to assist homeless people based on the homeless population and the scale of its needs. Assistance measures were as follows:

1. Shelter and Placement Services: Municipal and county (city) governments were taking additional steps to offer professional assistance with arranging placement. Besides helping the homeless to locate family and friends, for those with no home to return to, roaming the streets, or unwilling to accept institutional placement, flexibility was provided in offering temporary placement locations, such as homeless shelters. There were 10 public homeless shelters (including seven that were privately operated).
2. Lifestyle Maintenance Measures: In order to ensure a secure lifestyle for the homeless, the government and related institutions cooperated with private organizations to conduct outreach. This included basic lifestyle maintenance measures, such as warm meals, showers, warmth, barber services, clean clothes, sleeping bags, and health care. In order to encourage local governments to carry out homeless assistance measures, the MOHW has arranged related subsidies for municipalities and counties (cities).
3. Measures to Promote Self-Reliance: In cooperation with the competent authority overseeing labor, professional training was provided to homeless persons with the ability and desire to work. Each homeless person's unique traits were considered when negotiating with relevant units to create job opportunities. Work relief programs raised self-sufficiency, and consultation services increased independence and encouraged the homeless to return to their families and live a more normal social life.

4. Care in the Cold: On November 10, 2014, the MOHW issued a plan for strengthening care for the vulnerable when the weather is cold and during the Lunar New Year holiday period. Whenever the Central Weather Bureau issued a cold weather warning for temperatures below 10° C, local governments and NGOs launched cold weather care services to provide the homeless with warm meals and clothes as well as information on temporary shelters.
5. Work Achievements: In 2014, local governments provided assistance to homeless persons 222,573 times, including care services 199,064 times, placement and shelter services 1,632 times, assistance returning to family 407 times, referral for welfare services 3,297 times, referral for employment services or professional training 3,792 times, and other care services 5,929 times.

Chapter 3 Disaster Relief

The higher frequency of disasters that climate change has brought in recent years has led to a greater focus on disaster relief. Constant changes and advances are made in reducing and preparing for disasters, and response and restoration once disasters hit. Reviews and improvements are also made to the role of social administration. For disaster relief, the primary duties of the MOHW's Department of Social Assistance and Social Work is to provide shelter and placement services for disaster victims, to prepare necessary living supplies, and to provide reassurance 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 the disadvantaged groups, in accordance with the "Disaster Prevention and Protection Act." In 2014, there were 5,797 shelters for disaster victims nationwide that had a total capacity to serve 1,965,317 people.
2. In order to quickly consolidate goods and deploy staff when a disaster arrives, in December 2011 the government built a management system for its integrated network of livelihood products and volunteers. Further progress arrived in 2014 when the MOHW tasked municipal and county (city) governments with assisting operations and training by township (village, city, district) offices and volunteer groups. The MOHW also held six education and training sessions for central and local disaster control members.
3. Built a "regional alliance, fast assistance" model for social administration workers. Local governments were separated into five geographic areas: northern, central, southern, eastern, and outlying islands. Cities and counties in each area assist each other when disasters occur to provide fast relief and assistance, trauma guidance, 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 determine deaths, missing people, and major injuries. It then instructs senior officials to begin procedures for issuing condolence payments.
2. After checking related documentation, local governments distribute disaster relief payments to qualified people. Families of the dead or missing receive NTD200,000 and those who are severely injured receive NTD100,000. In addition, the MOHW 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 2014: After Typhoon Fung-wong struck in September, the MOHW issued a NTD200,000 consolation payment to the family of a dead victim.

Chapter 4 Social Work

Section 1 Social Work System

Countries around the world are implementing professional social work systems. Through the end of December 2014 in Taiwan, there were 8,035 people nationwide who passed the examination for social work specialists and 4,471 people who were professional social work specialists. By the end of December 2014, there were 11,537 full-time social workers assigned to social welfare tasks in public and private agencies (for the number of social workers from 2010 to 2014 Figure 9-4), which is the equivalent of one per 1,993 people.

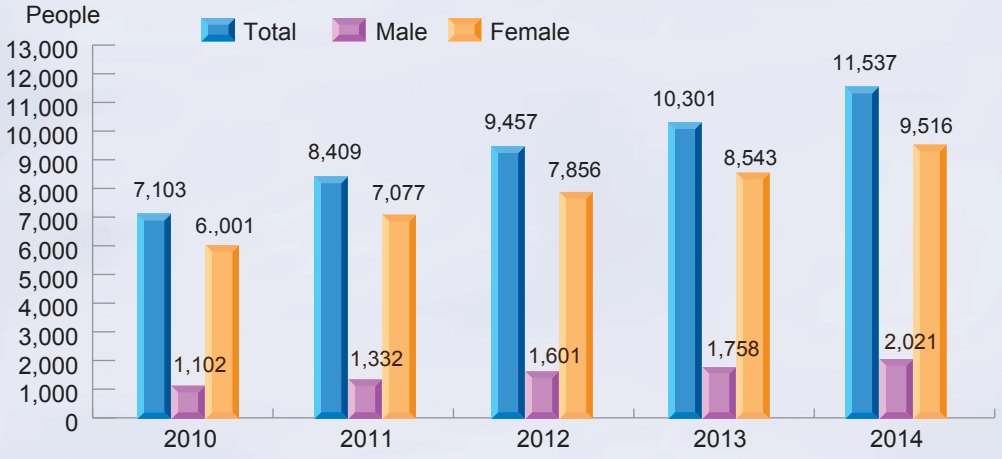
In order to build a professional social work system, the following measures were conducted:

1. Since some professional and technical social work positions do not have a test through the Ministry of Examination, the MOHW reviewed practical experience and seniority of social workers. By December 2014, there were 62 committee meetings that reviewed a total of 9,261 social work seniority application cases.
2. Formulated a plan to honor outstanding social workers, with the MOHW and NGOs selecting winners based on recommendations from public and private agencies. On April 2, 2014, there were 125 outstanding social workers honored for Social Work Day.
3. In accordance with updated regulations governing continuing education and professional licensing of social workers, in 2014 review and certification of 1,683 continuing education cases took place.
4. In accordance with regulations governing the distribution, selection, review, and continuing education of specialty social workers, there were 330 social workers who applied to be tested in 2014. Among them, 273 qualified to take the exam and 217 passed, as announced on April 30.
5. For better management of social worker resources, in May 2013 an outside organization was commissioned to establish a national social worker database, which was completed in May 2014.

Section 2 Plan for Strengthening the Social Work Workforce

Throughout Taiwan, local governments are faced with insufficient workforces for handling social work. Therefore, on September 14, 2010, the Executive

Figure 9-4 Full-Time Social Workers Assigned to Social Welfare Tasks in Public and Private Agencies, 2010-2014



Source: Number of Full-Time Professional Social Workers, Department of Statistics, MOHW Form 9-3

Yuan approved a plan for local governments to increase deployment and use of social workers. Between 2011 and 2016, the plan was estimated to add 1,462 social workers (in 2011, there were 366 contracted workers added, and from 2012 to 2016 there were plans to add 1,096 full-time social workers). From 2017 to 2025, another 394 full-time social workers were expected to fill vacancies. Between 2010 and 2016, the total number of social workers in public agencies was estimated to increase from 1,590 to 3,052. As for the 366 contracted social workers added in 2011, the central government provided a 40% subsidy for them to provide direct services related primarily to youth protection, domestic violence, sexual assault prevention, and social assistance for the disabled, older people, and women.

Following implementation of this plan, the population per government-employed social worker fell from 14,549 to 7,580. This has lowered the case burden on front-line social workers, allowing them to provide better investigations and guidance for cases involving youth protection, domestic violence, sexual assault, and vulnerable families. More than 60% of social workers were formally incorporated, ensuring proper use, promotion, and reasonable salary. By creating a system for gaining long-term experiences in specialized areas, social workers were able to build greater 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, regulations. To strengthen social worker safety, on April 1, 2015, the Executive Yuan approved a social worker professional safety program that sought to create friendly work environments through safe employment, secure services, and stable management.

In order to continue to strengthen the safety of social workers, measures planned by the MOHW included the following:

1. An application to receive subsidies from the 2014 public welfare lottery was submitted to carry out a plan for guaranteeing the personal safety of social workers. This assisted local governments in continuing to strengthen pre-employment and on-the-job safety training. Besides enhancing risk awareness and capabilities, social workers received better protective facilities and equipment.
2. In order to continue to strengthen the safety of social workers, at the end of 2013 a study on the drafting of social worker safety legislation was commissioned. After completion in July 2014, this was used as a reference for setting the scope of social worker safety and sub-laws.
3. In 2014, research was formulated to examine social worker supply, demand, and safety. This was to contribute toward planning of a social worker safety handbook that would serve as an essential tool for primary-level social workers.

Chapter 5 Welfare Resources Network

Section 1 Community Development

1. Community development in Taiwan adopts a civil association model in accordance with the "Regulations on Community Development Work." In terms of construction and social welfare, it is focused on three major areas: community public facilities, welfare production, and psychiatric ethics. The overall goal is to improve welfare within the community.
2. An important part of community development involves using social power to promote community welfare services. Subsidies were offered for communities to issue publications and hold activities, which consolidated community awareness. Bringing people together promoted interaction within communities and raised quality of life. Achievements included the following:

(1) Establishment of Community Activity Centers: At the end of 2014, Taiwan was home to 3,898 community activity centers that provided a location for community development associations to hold meetings; for local children, women, and older people to engage in activities; and for residents to rest or gather.

(2) Building Welfare-Based Communities: Conducted flagship plans, community manpower cultivation, disaster prevention and

preparation advocacy, and community proposal cultivation. In 2014, subsidies provided in 277 cases totaled NTD19,374,000.

(3) Holding Nationwide Observation and Study Activities: Nationwide observation and study events in 2014 focused on communities with outstanding performances, community customs and entertainment, and community-based welfare. In these three categories, total attendance reached 413, 2,912, and 1,211 people, respectively.

(4) Conducting Community Development Accreditation: In 2014, community development accreditation was carried out on 13 city and county governments in northern Taiwan and community development associations within their jurisdictions. Taipei, New Taipei City, Taichung, Yilan, Taoyuan, Miaoli, and Nantou all earned outstanding marks. Excellent marks were given to Hsinchu County, Hualien, Keelung, Hsinchu City, and Kinmen. Yongxing Community, in Nantou County's Nantou City, and 33 other community development associations earned superb, outstanding, or excellent marks or individual category honors. Events held to honor these communities were attended by 1,219 people.

Section 2 Charitable Collections

In order to manage charitable work and achieve suitable use of social resources, on May 17, 2006, the government announced the Charity Donations Destined for Social Welfare Funds Implementation Regulations. The scope of the regulations covered social welfare activities, educational and cultural affairs, social charity, international humanity rescue, and other relevant programs recognized by central government agencies. Also, to provide a legal basis for charitable organizations to seek charity donations, the Charity Donations Act – Implementation Regulations and the Charity Donations Destined for Social Welfare Funds Implementation Regulations – Permission Regulations were promulgated on December 25 and 27, 2006, respectively. In 2014, there were 344 permits issued to a total of 289 groups, with total funds collected surpassing NTD917,050,000.

Each year an accounting agency audits charity drives approved by the MOHW in order to raise financial accountability and effectiveness of organizations seeking donations. The audits also examine the use and flow of funds. In 2014, audits were carried out in 131 cases, including 122 cases from 2013, eight ongoing drives for major international and domestic disasters, and one special case of concern by related competent authorities.

Special conferences are held to increase professional knowledge of those who carry out charitable drives, to improve practical work ability of charitable organizations, and to familiarize such organizations with related laws and regulations. In 2014, there were two such conferences with total attendance of 156 people. Training courses related to charitable drives were attended by another 62 people.

The establishment, expansion, and upgrade of a public charity management system was carried out to raise accessibility of the current system, simplify procedures for organizations to apply for charitable drives, and carry out follow-up reference activities, with a new system going online on January 9, 2015. Four related training classes attended by a total of 230 people were held across Taiwan in December 2014.

Section 3 Volunteer Services

To effectively combine private capacity, encourage people to help others, and provide sound development of volunteering services, the Volunteer Service Act was promulgated on January 20, 2001. The act designated the definition and scope of volunteer service, responsibilities of competent authorities and related units, rights and obligations of volunteers, and measures to advance volunteering. Better integration of social worker resources facilitated full use of volunteer services.

Incentives introduced to accelerate development of volunteering included distribution of gold, silver, and bronze awards for outstanding health and welfare volunteers as well as medals in a nationwide volunteer awards ceremony. To encourage greater participation, volunteer training and other related activities by NGOs were subsidized in line with procedures governing social welfare subsidies. A national volunteer service information platform and a management system for disaster material resources and volunteer networks were also established to help local governments in disaster

zones announce updated information and assist with matching assistance to areas in need of disaster relief. In a 2014 national competition to select outstanding volunteer teams, there were 15 teams awarded and five units that won special category awards.

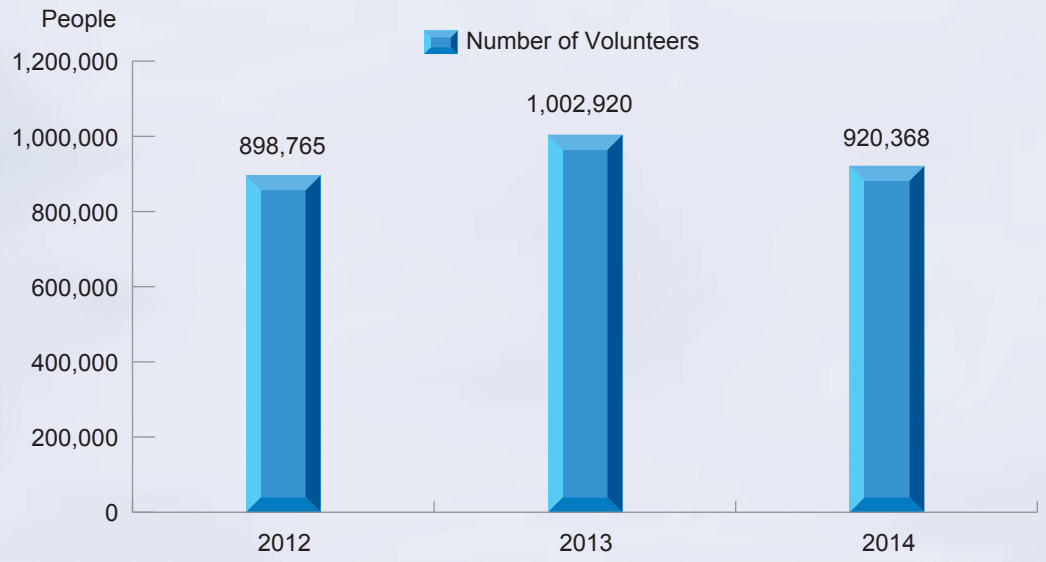
Total volunteers increased from 898,765 in 2012 to 1,002,920 in 2012 before retreating to 920,368 in 2014 (see Figure 9-5). In 2014, there were 316,591 male volunteers (34%) and 603,777 female volunteers (66%), for a male-female ratio of approximately 3:7, and there were 53,829 health volunteers and 240,150 social welfare volunteers.

Section 4 Welfare Consultations Hotline

In order to assist families and individuals facing hardships, the MOHW combined public and private services and resources to launch the 1957 welfare consultation hotline. By dialing 1957 on a mobile phone or landline, toll-free, people can access a single channel for free welfare consultations, reporting, and referrals.

1. Operation of the hotline, which was launched in 2006, was commissioned to the Taiwan Fund for Children and Families on September 1, 2010. The fund employed 35 professional social workers (including one administrator) who, from the hours of 8 am to 10 pm daily, offered consultations and assistance to people facing hardships or in need of welfare services.
2. In 2011, the hotline was integrated with single-channel welfare services offered by each municipality and county (city) government to build a hotline reporting system. When responders received a call that required reporting or transfer, they could use the system to notify local social welfare departments. After accepting the case, the departments dispatch social workers for visits or related services. Central and local governments consolidate their resources to build strong social safety nets with numerous levels of protective mechanisms. A hotline knowledge bank was also created that consolidates welfare and safety network resources and links to related networks specializing in employment safety, suicide prevention, school safety, and public safety.
3. From 2010 to the end of December 2014, there were 271,039 calls to the hotline. Reports were issued to municipal or county (city) governments in 2,761 cases (in 2014 there were 54,656 calls, with 568 cases reported to municipal or county [city] governments).

Figure 9-5 Number of Volunteers



10 Prevention of Violence and Protective Services

Safety issues consolidated under the authority of the MOHW included domestic violence, sexual assault, and sexual harassment, along with protection of the elderly, the disabled, children and youths, and the prevention of child and youth sexual transactions. Oversight was assigned to the Department of Protective Services, while responsibility for handling offenders fell under the auspices of the Department of Mental and Oral Health. Organizational restructuring consolidated social and health administration, allowing for better distribution of duties and integration of resources.

Chapter 1 Prevention of Sexual Harassment and Gender Violence

Sexual Harassment Prevention Act formally went into effect on February 5, 2006, and each year approximately 400 sexual harassment complaint investigations are received. In order to lead the community in paying attention to violence prevention topics and to commend workers engaged in preventative tasks, this division established the "Purple Ribbon Award" to affirm the achievements on behalf of people in all walks of life.

Section 1 Sexual Harassment Issues Analysis

In 2014, in all of the related departments a total of 550 sexual harassment complaint cases were investigated (383 tenable, 72 untenable, and 95 others). Of these cases, at 88.34%, the majority was investigated by police departments, followed by the offenders' departments, which investigated 10.93% of cases. Around 95% of the victims were women and 90% of the offenders were men. The main type of complaint, accounting for 48.34% of the total (233 cases), involved unwanted kisses, hugs, or touching of the breasts, buttocks, or other private areas of the body. This was followed by "humiliating, degrading, hostile, or harassing comments or attitudes" (such as sexually explicit language, staring at the chest area, or shaming figure or clothing) at 27.59% (133 cases). The two major types of relationships in cases were "strangers" at 68.38% (320 cases) followed by "friends" at 8.55% (40 cases). The most common place of infraction was the workplace, at 47.06%, followed by "through technological equipment (such as the Internet, cell phone text messages etc.)" at 15.55% (See Figures 10-1 to 10-4).

Figure 10-1 Sexual Harassment Appeal Cases Investigated by Relevant Agencies, 2014

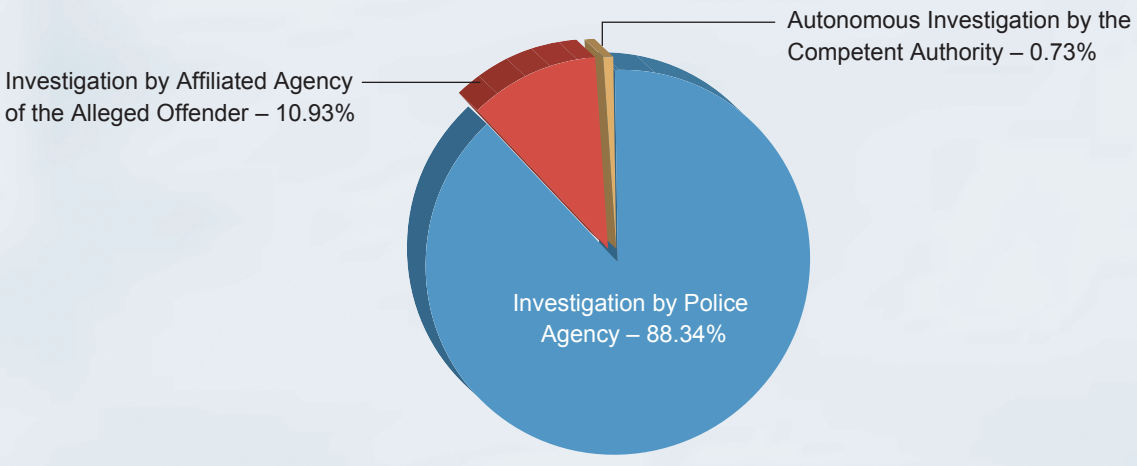


Figure 10-2 Types of Sexual Harassment Appeal Cases, 2014

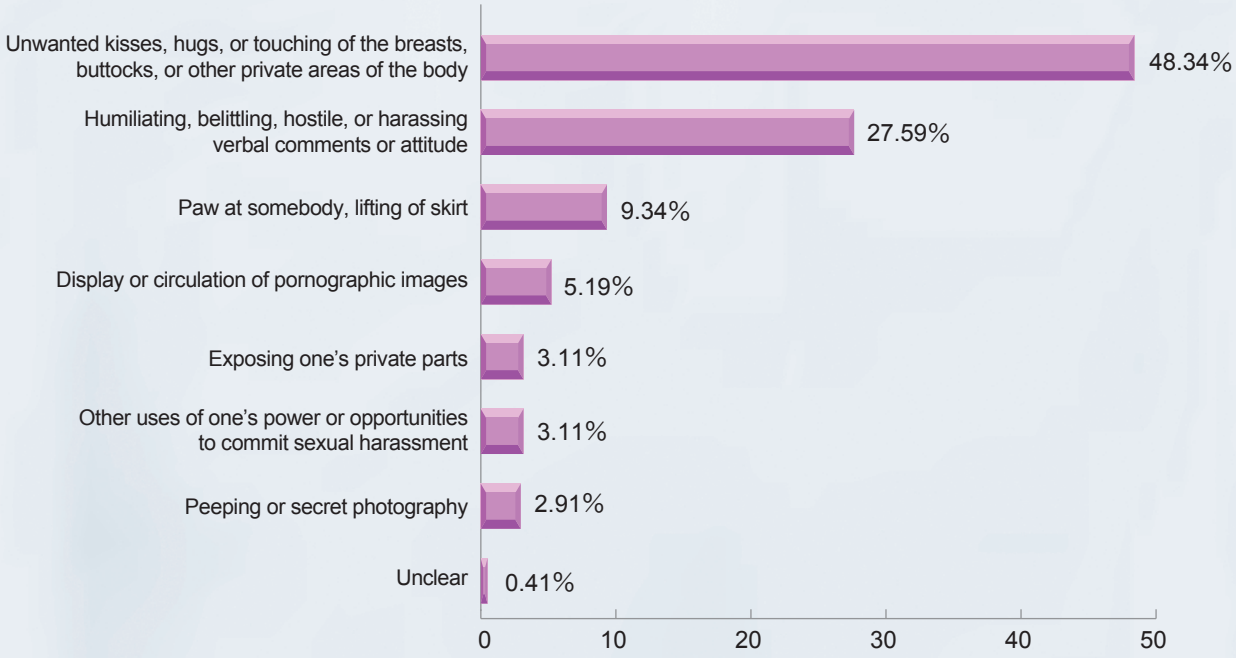


Figure 10-3 Relationship Between Alleged Offender and Victim in Sexual Harassment Appeal Cases, 2014

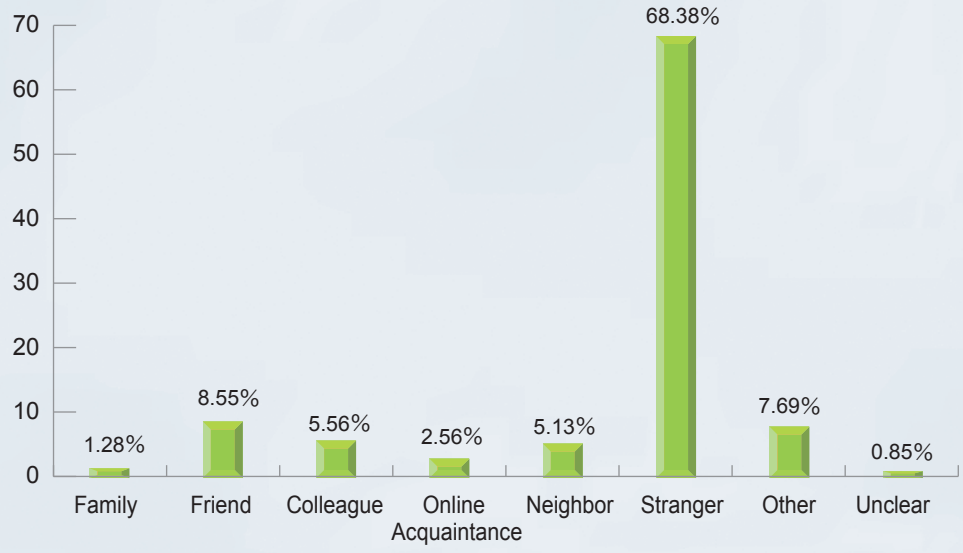
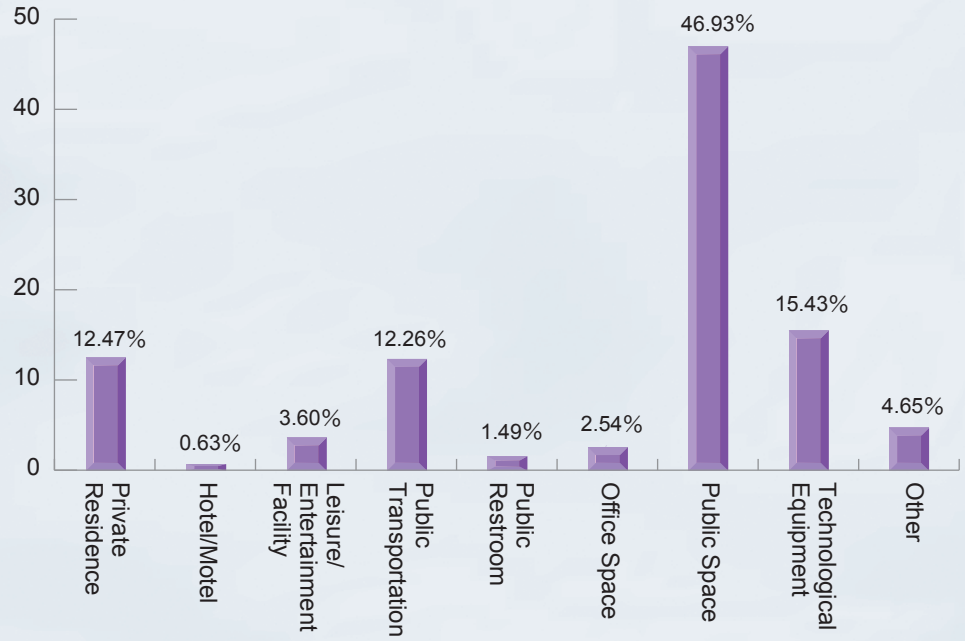


Figure 10-4 Location of Sexual Harassment Appeal Cases, 2014



Section 2 Quality of Sexual Harassment Prevention and Education

1. "The Workplace Sexual Harassment Prevention Service Plan" was established using "The Sexual Harassment Incidences and Complaint Investigation Index" and "The Sexual Harassment Case Handling Handbook" as supplementary tools. In August and September 2014, professional training was held in four venues in northern, central, and southern Taiwan, and an estimated 400 participants attended, including social welfare, police administration, education, labor affairs, and medical personnel.
2. There were 40,000 copies of "The Workplace Owner Sexual Harassment Considerations Guide" and "Sexual Harassment Victims Rights Manual" published and distributed, and on December 30, 2014, each city and county assisted in forwarding them to all social welfare, police administration, civil affairs, health, education, labor affairs, business affairs, tourism, transportation, and cultural (news) government departments.
3. In 2014, 11 local governments received assistance to hold "The Competitive Program for the Construction of Sexual Harassment Prevention Systems" to provide services to victims of all sexual harassment cases, sexual harassment prevention education advocacy in each field, guidance and checking for preventative measures, and professional training for practitioners for a total of 221,801 participants. Sexual harassment prevention and education advocacy was held for a total of 1,502 businesses, including the liquor industry, the transportation industry, religious groups, and medical care institutions.
4. The Sexual Harassment One-Stop Reporting Window for Three Laws Service Seminar was held in 2014 and 2015. The seminar was convened several times, with the Ministry of Labor, Ministry of Education, Ministry of the Interior, local governments, and related professional scholars. A resolution was made for suspected violations of Article 25 of the Sexual Harassment Prevention Act, whereby police authorities receive reports at a single window and handle investigation transfers.

Administrative complaints are handled by complaint channels set forth in three laws governing sexual harassment prevention. Administrative complaints related to the Act of Gender Equality in Employment, the Gender Equity Education Act, and the Sexual Harassment Prevention Act are handled by integrated complaint mechanisms, and processes and time limits for transfer of jurisdiction are set forth in the "Standard Operating Procedures for Jurisdiction Transfer for Complaints by Victims of Sexual Harassment" in order to provide each local government and relevant ministry with handling procedures.

Section 3 Prevention of Gender Violence

1. Maintaining the Taiwan Against Gendered Violence (TAGV) Resource Network and Publishing the TAGV Newsletter: Widespread attention placed on gender violence, discussion and greater awareness of violence prevention culminated in the November 21, 2013, launch of Taiwan's first anti-gender violence online library, called Taiwan Against Gender-Based Violence (http://tagv.mohw.gov.tw/). As of December 2014, the website contained 14,921 volumes of data and had been reached by more than 1.4 million visitors. As for the TAGV newsletter, which was first published in September 2014, three issues had been published as of December 2014.
2. Holding the First Annual "Purple Ribbon Award": The Purple Ribbon Award is an international symbol of gender violence prevention and an award for people active in protective work for women and children, the elderly, and the disabled in order to inspire more people to become engaged in gender violence prevention.
3. In 2014, the annual "Gender Violence Prevention and Protection Services Theses Presentation" recognized one PhD thesis and four Master's theses. A special presentation was held on November 24, 2014, with a total of 165 social welfare, police administration, health administration, and psychological counseling practitioners and academic personnel in attendance.

Section 4 Cross-Departmental Network Integration

1. Establishing an Inter-Departmental Communication Platform: In 2014, six group meetings for the promotion of domestic violence and sexual assault prevention were convened to review the current state of gender violence prevention and protection service networks while also addressing suggestions to improve coordination of multi-disciplinary networks and intervention strategies.
2. Holding the 2014 Gender Violence Prevention and Protection Services Camp: The camp was held on March 3 and 4, 2014, with merit of award recognitions for 2013 municipal and county (city) governments' promotion of domestic violence and sexual harassment prevention occupational activities evaluations. There were 300 central and local network staff employees in attendance.
3. Holding the 2014 Forum to Cultivate Local Civil Society and Promote Protection Occupational Activities: A total of five forums were held in northern, central, and southern Taiwan, and civil society delegates were invited from municipal and county (city) government protective services programs. There were a total of 153 participants who provided suggestions about each important working plan for the MOHW and difficulties with experiences cooperating with local governments in order to increase the quality of protection work services.

The 1st Purple Ribbons Awards Ceremony

Chapter 2 Prevention of Domestic Violence

Asia's first "Domestic Violence Prevention Act" was promulgated on June 24, 1998. Each year, there are approximately 100,000 domestic violence cases reported with an average yearly increase of 10%. In order to extend victim protection, domestic violence incidence reporting measures and treatment, benchmarks have been announced in order to comprehensively promote domestic violence prevention network services.

Section 1 Status of Domestic Violence Reporting and Service

In 2014, the national number of family violence victims was 95,663 (68,030 female victims, comprised 71.1%, the victim population ratio was 580 victims for every 100,000 people for women; 26,312 male victims comprised 27.5%, and the gender of 1,321 victims was unknown, the victim population ratio was 225 victims for every 100,00 people for men). The combined victim population ratio was 409 victims for every 100,000 people (see Figure 10-5). Compared to 2013, with a family violence victim count of 110,103 people (76,396 female victims, comprising 69.4%; 31,796 male victims comprising 28.9%, and 1,911 people of unknown gender), this was a reduction of 13.11%. The primary reason for the reduction in the number of victims was amendments to the definition of child protection statistics (in 2013, the child protection victim included abuse of children by family members and non-family members as incidences of inappropriate behavior). Of these victims, those suspected of or confirmed as handicapped numbered 6,348 victims, comprising approximately 6.64%; the analysis of reported case types shows victims of "intimate partners" as having the largest number at an estimated 49,560 victims (86.57% female victims); followed by "violence between non-intimate family members" numbering 24,515 victims (60.05% female victims); "harm towards children and adolescents" numbered 18,737 victims (46.15% female victims); and "elderly abuse" numbered 2,851 victims (61.66% female victims) (see Figure 10-6). Municipality and county (city) governments provided family violence victim protection assistance for 1,127,819 victims and paid NTD533,600,044, primarily to subsidize asylum resettlement, emergency living assistance, psychological rehabilitation assistance, medical assistance, and legal and court fees.

Figure 10-5 Rates of Domestic Violence, by Year

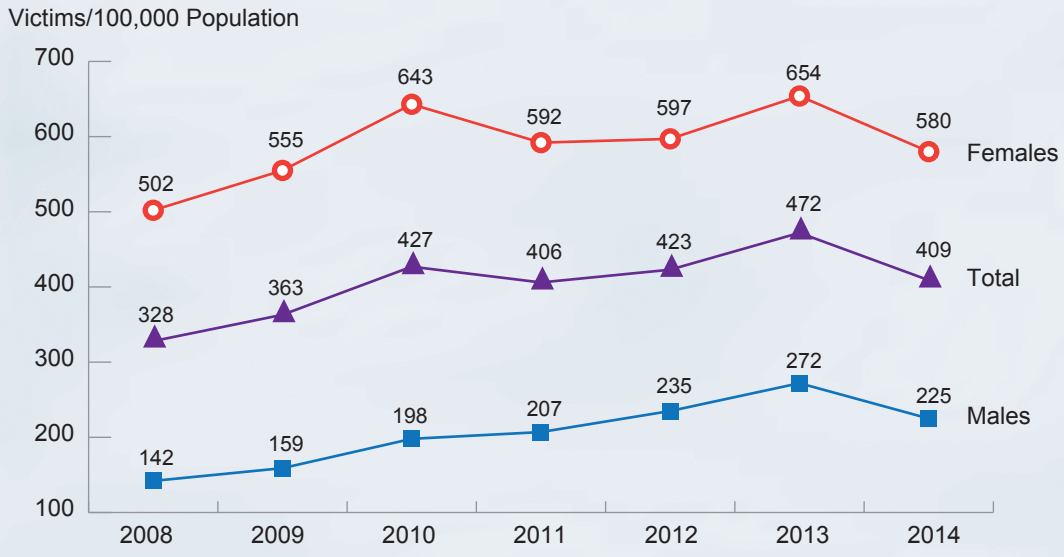
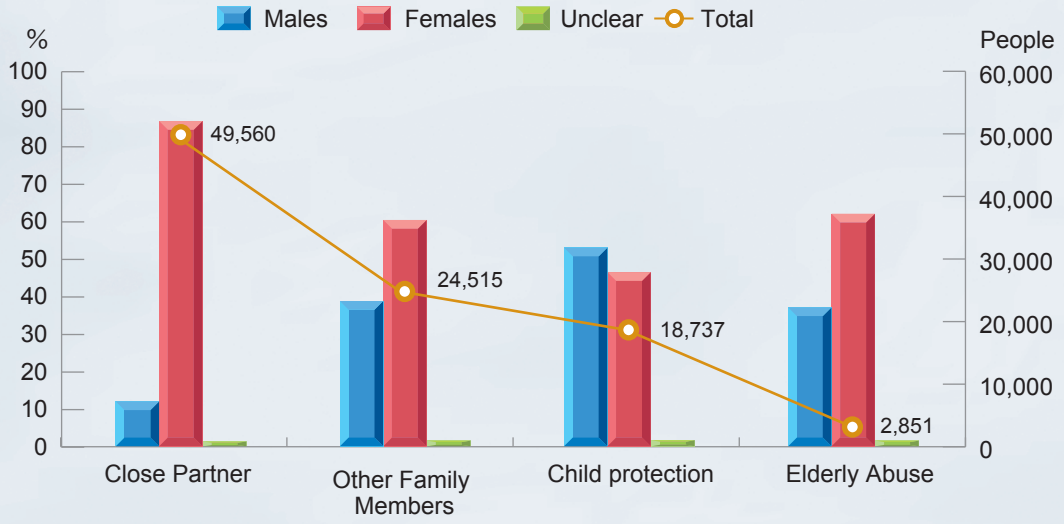


Figure 10-6 Reported Victims of Domestic Violence in 2014, by Gender



Certain provisions of the "Domestic Violence Prevention Act" were amended and passed by the Legislative Yuan on January 23, 2015, and announced by the President on February 4. A total of 33 articles were amended (including revisions to 25 articles and the addition of eight new articles). Changes focused on the following:

1. Children, adolescents, and non-cohabitating close relations and domestic violence witnesses are to be included within the scope of companions under protective orders.
2. The period of validity shall be extended for general protective orders and limits on the number of extensions will be abolished.
3. It is stipulated that central competent authority shall establish funding to strengthen tasks to prevent domestic violence and sexual assault.
4. The media will be restricted from funding to report or document identity information of victims or their underage children in order to protect victims' right to privacy.
5. When people are not bound by judicial authorities, the judiciary will immediately notify county and city police administrations and the Center for the Prevention of Domestic Violence and Sexual Assault and provide victims with real-time notifications.

Section 2 Safety and Protection Network Against Domestic Violence

1. Continued to promote the Safety and Protection Network against Domestic Violence Plan:

(1) Convened regular review meetings to survey the state of each municipality and county (city) government's implementation of the Safety and Protection Network Against Domestic Violence Plan and research the common or systematic problems that each of the central administrations' face during promotion.

(2) In 2014, held one administrative workshop, two professional development workshops, three group supervision events, and two high-risk case observation seminars, with a total of 496 participants in attendance. In 2014, all municipal and county (city) government agencies held a total of 132 risk assessment-related education training workshops for a total of 9,777 employee trainees in police administration, health, and social welfare related prevention network.

(3) In 2014, establishment of a multi-faceted evaluation index was commissioned for high-risk crises case removal in accordance with the Safety and Protection Network against Domestic Violence in order to assist each preventive network affiliate to objectively assess risk factors in high-risk cases, and on these grounds analyze whether high-risk cases require crises removal.

2. The Taiwan Intimate Partner Violence Danger Assessment (TIPVDA): As of December 2014, the reported domestic violence cases in which the danger assessment was applied numbered 93%, which was a 13% increase from 2013.

Section 3 Diverse Intervention Services in Domestic Violence Cases

Using social welfare funds and repayments from the national lottery, diverse treatment services were established for domestic violence victims, including 11 victim shelter services, 14 judicial assistance programs, 44 victims' counseling services, caring counseling and connection resource services, three aboriginal tribal domestic violence victims case care counseling services, four victims' employment counseling services, 10 violence witnessing care counseling for children and adolescents and psychological counseling programs, and seven personal safety programs for recent immigrants, with total subsidies amounting to NTD68.64 million.

Section 4 Domestic Violence Prevention Quality and Education

1. Strengthening Cooperation Mechanisms for the Safety and Protective Network Against Domestic Violence: Each quarter the Serious Domestic Violence Incidences Case Studies Conference was convened in order to discuss cases in which domestic violence incidences caused serious injury or death, to observe the current state of the Safety and Protective Network Against Domestic Violence operations, and to propose recommendations for improvements in inter-professional network coordination and intervention strategies based on discussions and observations.

2. Domestic Violence Report Form Training, Casework Forms, and Case Assessment Procedures: In 2014, three conferences were convened to research and evaluate domestic violence case collection and handling procedures, domestic violence casework forms, domestic violence report forms, and amendments to the open case assessment index for adult domestic violence case protection and the assessment summary for domestic violence cases.

3. Case Notification Measures and Treatment Processes: The "Elderly Protection Incident Report" and "Elderly Open and Closed Abuse Case Assessment Index" were researched and drafted in order to establish a one-stop reporting window and submission procedure.

4. Provide Training for Domestic Violence Prevention Network Employees: In 2014, three batches of basic domestic violence social worker training, three batches of marital violence and child protection workshop seminars, three recent immigrants social work seminars, and three aboriginal tribe domestic violence prevention workshop seminars were held and training was completed for an estimated 150 newly hired social workers. Senior social workers and supervisors participated in training about 200 times.

5. The Application Development and Educational Outreach for Elderly Protection Case Evaluation Auxiliary Tools Program: The Taiwan Elderly Protection Assessment Tool was used to hold district education training and supervision. In 2014, one professional focus group and education training for 115 people in eastern and central Taiwan was completed.

Section 5 Prevention Awareness in the Community

1. Continued implementation of a plan to strengthen violence prevention in communities. Conducted an innovative violence prevention competition that brought the message of anti-violence into neighborhoods. The competition was split into two categories: "The Elite Group"

and "The Cutting-Edge Group." There were also 68 submissions from community or civic groups, six prizes for each of the two groups, and on December 6, 2014, there were 190 people who attended an awards ceremony where the event results were announced.

2. Establish the Foreign Spouses Personal Safety Advocacy Plan: Domestic violence prevention advocacy was carried out through publications circulated in Taiwan, with Southeast Asian languages on the cover and broadcast announcements through channels targeted at Southeast Asian audiences. In 2014, there were 15 single-page foreign-language publications printed and 600 publicity announcements broadcast.

Section 6 Intervention for Domestic Violence Offenders

1. Continued to encourage judges to issue civil protection orders to protect of domestic violence victims while overseeing intervention plans launched by local governments. In 2014, intervention was provided to 3,762 people, 1,442 of whom already completed the program. The intervention implementation rate reached 100% excluding for the people who died, incarcerated, or protection orders cancelled.
2. Preventive Services for Domestic Violence Offenders

(1) The 0800-013-999 male care hotline was established in 2004 to provide counsultation for men facing issues related to domestic conflicts and reduce the risk of violence. In 2014, the hotline totally received 18,457 calls.

(2) The profit from the National Lottery was partially used to subsidize domestic violence counterpart prevention service plans, which were co-handled by local governments and civic groups. In 2014, an allocated budget of NTD23,374,000 founded for 17 prevention plans.

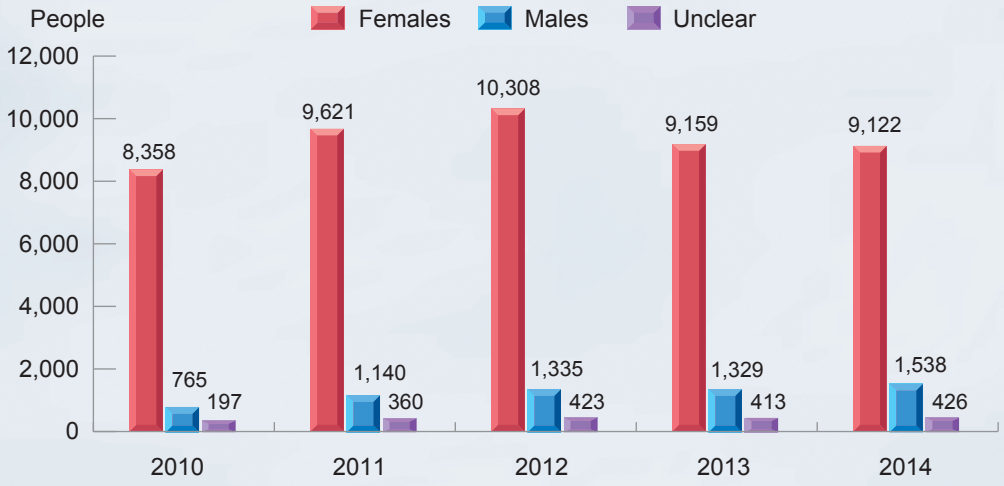
Chapter 3 Prevention of Sexual Assault

The "Sexual Assault Crime Prevention Act" was promulgated on January 22, 1997, and each year approximately 13,000 suspected cases of sexual assault are reported. In order to solve problems encountered by related agencies on promoting sexual violence prevention work, the MOHW has formulated several sexual assault case service standards.

Section 1 Sexual Assault Reporting and Other Services

In 2014, there were 11,086 reported victims of sexual assault. About 82% of the victims were women (Figure 10-7) and 54% were junior high and high school students aged 12-18. There was a high rate of victims under the age of 18 at 64%, and there were 1,100 suspected and confirmed handicapped victims, which comprised 10% of the total reported cases. About 60% of the incident locations were in private places, 84% of the suspects were male, and 33% of suspects were youths aged between the ages of 12 and 24. Of the reported sexual assault cases, 80% victim known offenders, and the two most common relationships were (former) boyfriends and girlfriends and direct or collateral blood relatives (comprising a total of 38%). The following two most common relationships were classmates (9.8%), and general friends (8.6%). Online acquaintance accounted for 6%. In 2014, municipal and county (city) government domestic violence and sexual offense prevention centers provided protection and support programmes for sexual assault victims, such as shelter arrangements, case reporting and inquiry accompaniment, economic support, injury diagnosis and treatment assistance, legal support, psychological counseling and consultations, and school transfer and enrollment services, for a total of 199,846 people and NTD109,460,000 in support funds.

Figure 10-7 Sexual Assault Cases by Gender, 2010-2014



Section 2 Diverse Intervention Services for Victims of Sexual Assault

1. Assistance for Victims of Sexual Assault: Establish standards governing services and subsidies in sexual assault cases. Protection support measures established included victim services and subsidies, counseling for all prevention centers for providing emergency assistance to victims for medical care, examinations and evidence gathering, emergency placement, psychological therapy, and legal consultations, in accordance with regulations.
2. Strengthening Sexual Assault Prevention in Indigenous Communities: On February 19, 2014, a meeting was convened to make resolutions, which included strengthening the integration of civic professional organizations and bodies, and initiating the creation of an experimental sexual assault case service model with indigenous tribes as the primary focus. The MOHW requested that the Ministry of Education include the state of sexual assault prevention education promotion in indigenous tribal areas in related evaluation indexes, urge entrusted indigenous committees to handle sexual assault cases in tribal communities, engage in three-level prevention efforts, and strengthen cultural elucidation advocacy.
3. Scheduling Control for Handling Child Sexual Assault Cases: Using the National Domestic Violence, Sexual Assault and Children-Juvenile Protection Information System, regular reminders were established to remind child care social workers of the legal processing period for each case through the information system.
4. Planning Cross-Network Cooperation for Sexual Assault Cases Involving Those Who Unwittingly or Unwillingly Enter Into Judicial Processes: In 2014, the informative public leaflet "When Pure Love Steps Into the Courtroom: Two Articles for the Uninformed (Family Edition)" was compiled. Two administrative workshops were also held to address the handling of work regulations and developing standards for those cases of sexual assault that do not enter into formal legal proceedings, with 120 participants in attendance.
5. Holding Discussion Seminars for Severe Sexual Assault Cases: In 2014, there were

five seminars convened to discuss 17 issues, including concepts of personal decision making regarding body rights for preschoolers, insisting on practical inspection tasks for teachers who are unsuitable to hold posts at all school levels, monitoring functions on anklet tracking and monitoring devices, contact coordination tasks for local police and prosecutors, and mastering timing issue resolutions for immediate investigation transfers in sexual assault cases. In addition, it was requested that all network units strengthen their handling of these issues.

6. Strengthening Sexual Assault Case Inspection Tasks and Improving Inspection Quality: In 2014, inspection certificates were provided for 3,896 sexual assault victims and 1,961 of them were sent to the Criminal Investigation Bureau for further inspection and examination.
7. Implementing the "Directions on Relieving the Victims of Sexual Assault from Repeated Statements:" In 2014, a total of 1,739 sexual assault victims were entered into relief from making repeated statements services, and through the integration of police, public prosecutor, social worker, and medical care teams, examination quality was increased and sexual assault victims were relieved from having to make repeat statements. In 2014, the final total number of deposition cases for the investigation of sexual assault in each district court prosecutor's office was 4,222 cases, with an indictment ratio of 52.13%. Court rulings elected to transfer cases to prosecutors for guilty verdicts for 2,136 people, with an 88.3% conviction rate.

Section 3 Improved Sexual Assault Prevention Quality and Education

1. Established the Sexual Assault Prevention Social Worker Training System: In 2014, professional training was held on nine occasions for basic and advanced employees and supervisors. The training focused on issues related to child sexual assault victims, especially understanding and improving counseling skills for children's physical and mental development planning. A total of 645 professional join the training programme.
2. Held Professional Training for Injury Evidence Collection: In April 2014, the MOHW coordinated with the Police Forensic Center to provide the Chang Gung University of Science and Technology Department of Nursing with eight sexual assault sampling boxes for the education criminal nursing care. Examinations held for overseas students at government expense, "Criminal Nursing Care" was recommended to be included in order to train and recruit criminal care nursing personnel.
3. Held the "Sexual Assault Prevention Film Festival:" In July 2014, in Taipei, Taichung, and Kaohsiung there were nine screenings of the Sexual Assault Prevention Film Festival followed by discussions which were attended by approximately 1,000 people.
4. Strengthened Community and Campus Prevention Education Counseling: In 2014, allowances were provided for 12 sexual assault prevention education counseling programs. As of the end of December 2014, a total of 50 educational activities were held with a total of 93,543 participants.

Section 4 Reporting System and Information Platform

1. Implementation of Mandatory Reporting and Establishing a National Protection Information System and Case Handling Procedural Management System: The e-Care program was promoted, and a sexual assault case follow-up system was implemented. In addition, an information-sharing platform was established for prevention network related personnel.
2. Establishment of the 113 Protection Hotline: In 2014, there were 159,828 calls received, including 12,315 calls that related to violence between married/divorced/cohabited couples. There were 12,065 cases involving children and youth protection and 1,396 cases of sexual assault.
3. Developing Diverse Reporting Channels: In 2014, the online domestic violence reporting network was used to report 129,798 sexual assault and child protection cases and 1,000 Internet consultation cases. In addition, the 113 protection hotline text messaging service was

added to the 113 protection hotline system, enabling hearing and speech impaired people to send text messages to call for help. Then the professional hotline workers will send the text messages back to confirm his or her personal safety.

Section 5 Therapy and Guidance for Sexual Assault Offenders

1. Coordinated the establishment of compulsory treatment institutions for sexual assault offenders who had completed criminal prison sentences. By the end of December 2014, two more psychiatric hospitals were designated by the Ministry of Justice to handle compulsory therapy – Jianan Psychiatric Center and the Yuli Branch of Taipei Veterans General Hospital – bringing the total number of designated hospitals to five.
2. Community intervention is provided for sexual assault offenders. In 2014, a total of 6,419 offenders received physical treatment and counseling, including 1,907 offenders who completed intervention services and 3,689 who were still undergoing intervention. There were four people referred for compulsory treatment, 497 uncompleted due to explained excuses, and 322 punished for unregistered.

Chapter 4 Protection of Children and Youths and Prevention of Child and Youth Sexual Transactions

In order to implement child protection tasks, a standard child protection task procedure was established. In order to adhere to Article 34 of the United Nations Convention on the Rights of a Child (CRC), which states that protected children will not be subjected to any form of sexual exploitation or sexual abuse, and to prevent and avert child and youth sexual transactions, in 2014 intensive amendments were made to the Child and Youth Sexual Transaction Prevention Act, and the name of the act was changed to the Child and Youth Sexual Exploitation Prevention Act.

Section 1 Long-Term Professional Provision System for Protective Social Workers

1. In accordance with the Executive Yuan approved "Advancing Local Government Social Workers Staffing and Deployment Program," subsidies were continued for local governments to provide protective social work personnel. In 2014, there were 508 child protection, domestic violence, and sexual assault prevention social workers who received NTD146 million in subsidy allowances.
2. All municipal and county (city) governments were required to establish the jurisdiction of protective social worker personnel planning, and beginning in 2014 a yearly report must be submitted indicating the inspection results for protective social work personnel planning. Under the "Quality Assessment and Improvement Plan for Protective Social Work Personnel Professional Services," assessment procedures will be supervised for improving professional quality of protective social work services by municipal and county (city) governments.
3. According to municipal and county (city) government statistics on child and youth protection, domestic violence and sexual assault prevention social work personnel for 2014, there were 871 public sector employees engaged in the handling of protective affairs, and there were 590 employees at civic groups which were entrusted to handle protective affairs, making a total of 1,461 employees. This is in comparison to the MOHW estimate, which stated that there were 1,444 employees, which was 17 less. This reveals that in recent years the full implementation of personnel enrichment planning on the part of local governments together with increased cooperation with civic groups and entrusting them with the handling of following up service plan for protective cases has already made up for yearly social work personnel deficiencies.

Section 2 Protection of Children and Youths

1. Implementing a Mandatory Reporting System: In 2014, municipal and county (city) governments assisted 11,583 abused children and youths. Among them, 5,301 (46%) were male, and 6,282 (54%) were female, that female is 8% higher than male. Compare to the data in 2013 there were a total of 16,322 abused children and youths, 7,616 (46%) were male and 8,706 (54%) were female, Indicating that there were 4,739 (29%) cases reduced in the total number of assisted abused children and youths.
2. In order to improve the reporting quality for children and youth protection incidences, in 2014 academic institute was entrusted to conduct a contract proposal "Decision Guidance Experiment Planning for Child Protection Mandatory Reporting" and establish a guide for child and youth protection incidence reporting and assist mandatory report personnel in carrying out accurate reporting and front-line child protection social work personnel to provide a timely intervention.
3. Supervising Municipal and County (City) Governments in Carrying Out Child and Youth Protection Services: In 2014, two group meetings were convened for severe child and youth abuse prevention incidences to review a total of 12 cases. Resolutions included requesting that local governments provide resource intervention for families with multiple problems, horizontal linkage mechanisms be strengthened, and services be reviewed regularly for combined efficiency. The resolution also called for mandatory case discussion meetings to be convened for cases which were reported multiple times, and that the suitability of related assessment and treatment be reviewed.
4. Adopting International Family Preservation and Family Reunification Models: In 2014, cooperated with Children's Research Center of NCCD In US in development of a localized structured decision-making model for children and youth protection. Since November 2014, requested that social workers conduct safety assessments when handling children's protection cases. Also commissioned R&D relating to evaluation standards and service procedures used in household intervention in children and youth protection incidents, as well as the formulation of related guidelines and handbooks.
5. Improving Professional Training and Practical Seminars for Child and Youth Protection Social Work Personnel: In April and October 2014, two events were held with 102 social workers in attendance and 51 hours of basic training. In 2014, there were two professional trainer training events for child protection and safety assessment and decision-making models, 25 education and training events, and 10 outside supervision conferences with a total of 700 social work employees completing professional training. On December 4 and 5, 2014, "Child and Youth Protection Services – An International Seminar on the Practice and Prospects for Family Treatment Models" was held.

Section 3 Medical Care Services for Child and Teenager

1. In order to set up a network for child protection and medical care services, facilitate the resources integration from health, social and network cooperation, following the experiences of developed countries in Europe and the United States, five child protection medical treatment service demonstration centers were designated in Taiwan in 2014 to integrate cross-disciplinary teams in the hospital with outside networking units.Services of medical care, follow-up after being discharged from the hospitals and social welfare aid are provided on a case oriented basis. In the end of December 2014, these services were provided 251 person-times.
2. The "Child Abuse and Neglect – Medical Staff Handbook" was amended to promote medical personnel's professional knowledge regarding the identification and referral for the abused child, and continue to establish a standardized curriculum,teaching materials, training programme and personnel certification.
3. Strengthening Counterpart Services and Service Programs in a High-Risk Family for a Child Protection Case :

(1) The "Management Information System of Psychiatric Care," "Suicide Prevention Notification System," and "Protection Information System" were linked in order to efficiently access the information of cases and their related counterpart for accurately evaluate the risks of child abuse.

(2) Referrals were implemented for the suspected mentally ill or alcoholics, and the assessment and referral were made by local government to provide adequate medical care for the cases and their family.

Section 4 Child and Youth Sexual Transaction Prevention

1. An amendment to the Child and Youth Sexual Transaction Prevention Act that passed third reading in the Legislative Yuan on January 23, 2015, focused on strengthening protection measures for victims and family intervention mechanisms. The amendment was announced by Presidential order on February 4, 2015, and the name of the Act was changed to the Child and Youth Sexual Exploitation Prevention Act. The main revisions were as follows:

(1) Expanded Scope: In addition to the scope of the original definition of sexual exploitation, it was expanded to include "causing children or youths to engage in sexual transactions or obscene behavior for others to watch," meaning using children for sexual performances to be viewed by others. In addition, the scope of sexual exploitation now includes filming or copying pictures, photographs, films, video tapes, compact disks, electronic signals, or any other materials involving child or youth sex transactions or obscene behavior as well as manufacturing materials with child sexual content. The original specifications for the enforcement of regulations regarding using children or youths for sexual service jobs such as hostesses or sexual escorts, accompaniment, or dancers as well as behavioral patterns which have caused past concern as possible sexual transactions were also added to the Act's specifications.

(2) Reasons for Victim Placement: Evaluations are made for whether or not to place victims of sexual exploitation or suspected sexual exploitation in accordance with standards for no sexual transaction or sexual transaction risk. After the amendment, the main consideration is whether the victim has resettlement needs. If there are no concerns about victims' education enrollment, employment, living adjustment, physical safety, or family protection and upbringing functions and the victims have been assessed as having no resettlement needs, parents or guardians will provide protection and upbringing. If victims are assessed as having resettlement needs, the designated authorities will provide resettlement to an appropriate location or other assistance measures.

(3) Strengthened Duties of Competent Authorities: In addition to strengthening preventive education advocacy regarding children and youths who are subjected to sexual exploitation for the current municipal and county (city) authorities, in accordance with legal regulations, authorities will accompany victims in investigations and carry out victim placement and remedial education for offenders after being released from prison. In addition to increasing existing duties, after the amendment for those requiring or not requiring placement with parents or for guardians of children and youths who have returned home, the authorities will provide follow-up counseling and assistance for at least one year or until the victim reaches the age of 20, with the goal of avoiding victims' re-exposure to sexual exploitation. In addition parents, guardians, or actual care takers of children and youths who have been subjected to sexual exploitation or are suspected to have been subjected to sexual exploitation will receive between 8 and 15 hours of parent education counseling as a means of enhancing authorities' capacities to assist families.

(4) Diverse Punishments for Illegal Behavior: For penalties for the violation of this ordinance, in addition to existing criminal penalties, administrative penalties will be increased and the competent authorities will impose punishments on those who pay to observe or seek out child and youth sex transactions or obscene behavior or those who use children or youths for sexual service jobs such as hostesses or sexual escorts, accompaniment,

or dancers. For individuals or organizations who have been sentenced for child or youth sexual exploitation, the competent authorities will provide a set amount of remedial education during the incarceration period in order to avoid repeat incidences of sexually exploitive behavior toward minors after release from prison.

(5) Penalties will be provided for the expanded scope of protection for children and youths, including child and youth sex transactions and exploitative behavior, using children or youth for sexual performances for others to watch, viewing child or youth sexual performances, producing child or youth pornographic materials, and using children or youths for sexual service jobs such as hostesses or sexual escorts, accompaniment, or dancers. Rape, intimidation, or other means of non-consensual sexual exploitation of minors will be severely punished.

2. Creating a Child and Youth Sexual Transaction Prevention Oversight Committee: In accordance with Article 3, paragraph 3 of the Child and Youth Sexual Transaction Prevention Act, which states "The competent authorities shall establish an institution of supervision and report conference on prevention of child and teenager sexual transaction together with above correlative units within six months after this Act has entered into force, termly declare and review the results of education, guidance, succor, punishment to inflictors, settlement and protection," by the end of 2014, there were 34 oversight committees convened to review the work situations for all of the relevant units.

3. Holding Events Related to Child and Youth Sexual Transaction Prevention: In 2014, subsidized civic groups held preventive advocacy training and learning, child and youth sexual transaction related work and criminal behavior remedial education, counseling services for families of dropouts and missing runaways or abducted children and youths, and group youth counseling, using a total of NTD 20,520,000 in subsidy allowances.

4. Producing and Promoting Educational Materials: Using the three themes of "Putting an end to juvenile pornography and prevention of sexual exploitation of children," "Alcohol, tobacco, betel nut, illegal drugs, or any other substances which are harmful to physical and mental health shall not be provided to children and youths," and "The promotion of Internet safety for children and youths," 30-second short promotional films were made and broadcast in order to prevent children from being exposed to sexual violence and undesirable substances.

Section 5 Internet Safety Mechanisms for Children and Youths

1. Formulating Operating Procedures and Principles for Handling Online Content Violations Relating to Children and Youths: On April 1, 2014, related procedures and principles were issued. These were available for use during case distribution and to serve as guidance and reference to iWIN Institute of Watch Internet Network institutions, municipal and county (city) governments, and the National Police Agency.

2. Implementing iWIN Internet Content for Protection Mechanism Functions: On December 10, 2014, a research conference was convened to make a resolution that for complaint cases regarding the use of Internet content as a lure, medium, or implied means of encouraging sexual transactions, case information should be sent to police and local government authorities in order to investigate and punish perpetrators and Internet media which violate this article of the Act. Internet platform companies which post content that is inappropriate for children and youths will be investigated and punished by each responsible government agency in accordance with regulations related to Article 46 of the The Protection of Children and Youths Welfare and Rights Act and violation of regulations set forth in Article 33 of the Child and Youth Sexual Transaction Prevention Act. The results of this resolution between January and December 2014 were as follows: 15,051 complaint cases, 1,544 of which were handled by local governments. The bulk of complaints concerned obscenity and pornography cases, and of these cases, 9,541 had foreign IP addresses and 1,622 had domestic IP addresses.

11 Research Development and International Cooperation

Chapter 1 Science and Technology Research in Health and Welfare

In 2014, the MOHW's budget for technological development was NTD3,995,112,000 (Figure 11-1), which accounts for approximately 2.85% of the total budget. It was primarily invested in empirical researches for food-drug management and medical/health policies, as well as in establishing an advantageous environment for the development of the biomedical industry, along with biomedical technology researches. There were a total of 657 projects or grants for research programs.

Section 1 Mission-Oriented Research

The research findings were grouped by policy into the following: "Communicable Disease Preparedness and Response Measures," "Public Health Promotion," "Food and Drug Administration," "Advanced Health Care Systems," and "National Health Insurance Reform." Further detail for these five categories are as follows:

1. Communicable Disease Preparedness and Response

(1) Communicable Disease Control

a. Studies have shown that since the MOHW implemented the policy of restricting antibiotic usage for treatment of acute upper respiratory tract infections in 2001, the resistance rate of Group A streptococcus strains to erythromycin has decreased from 50% to 10% by the end of 2014, successfully reducing drug resistance and health care expenditures.

b. It was discovered that in Taiwan, melioidosis is spread through air pollution particles, and that information has been included in the content of disease education materials. A pilot study to introduce care bundles for prevention of ventilator-associated pneumonia (VAP) and catheter-associated urinary tract infections (CAUTI) was conducted. Among the participating inpatients from the 11 hospitals in the study, a 21.10% reduction in VAP and a 28.2% reduction in CAUTI were observed.

(2) Communicable Disease Diagnostic Technology: The establishment of a rapid unknown/emerging infections disease detection technology platform has subjected four suspected cases to the identification of Ebola virus infection. All four cases tested negative for the virus, which instantly pacified the general public.

(3) Communicable Disease Surveillance and Case Reporting: Three mobile apps have been developed in order to assist front-line workers in carrying out home visits and have shown to effectively save time and labor power. In

Figure 11-1 Yearly Technological Research Budgetary Trends and Variations

addition, cloud applications, including case reporting modules based on hospital electronic medical record systems and a brand new automated laboratory automated reporting system, were developed in order to streamline and simplify case reporting procedures.

2. Public Health Promotion

(1) Healthy Birth and Growth

a. A model for active telephone consultations and intervention for mothers discharged from baby friendly hospitals/clinics was completed. Also, the Telephone Consultation Breastfeeding Handbook was developed. Therefore,the exclusive breastfeeding rate and breastfeeding confidence of mothers increased.

b. Research findings revealed that plasticizers can be transmitted to infants through the placenta. Therefore, expecting mothers are recommended to pay attention to the environment and exposure to plasticizers during pregnancy. For example, they should avoid using Type 3 plastic containers and instead select Type 5 plastic materials. They should also pay attention to ingredients in skin care products and cosmetics.

(2) Healthy Aging: The results of developing "Chronic Kidney Disease and related High-Risk Groups Intervention Management Models" revealed that participants' knowledge of kidney health care, blood pressure, and glycosylated hemoglobin control had reached a level of significant improvement. Furthermore, the first draft of the Taiwan Clinical Diagnosis and Treatment of Chronic Kidney Disease Guidelines was completed in hopes that a consensus will take shape among the people in Taiwan to increase the quality of care for chronic kidney disease.

(3) Closing the Health Gap: Study on the status of the oral cavity and related influencing factors for the physically and mentally handicapped was held in order to understand the current situation and provide an oral health policy reference as a basis for amendments to the "People with Disabilities Rights Protection Act."

(4) Health Promotion Infrastructure: The nation's birth cohort study database was established to serve as a reference for the appropriate allocation of state resources. Short scale was devised for non-clinical assessment and screening of children's development of different stages.

3. Food and Drug Administration

(1) Creating More Sound Food and Drug Management Regulations

a. In order to strengthen food product safety, labels were developed for food products which contain genetically modified ingredients. A total of six management specifications and 32 management references were created for issues such as pesticides and animal drug residue tolerances.

b. In order to improve drug safety and enhance quality, 20 drug-related management specifications were developed, the safety monitoring of 12 commercially available drug and cosmetic products were analyzed, and 45 drug products were re-evaluated for safety.

(2) Monitoring the Flow of Food and Drugs

a. In response to food safety incidences in 2014, the Method of Test for Polyaromatic Hydrocarbons in Oils and Fats, the Method of Test for Dimethyl Yellow and Diethyl Yellow in Food have been developed.

b. In order to facilitate effective administration of hamful substances in foods and adulterated foods, innovative inspection methods were researched. Four articles were written, 14 articles were amended, and 60 articles related to food inspection methods were added in order to assist in analysis and clarify facts.

c. In accordance with research and inspection results and risk assessment data, eight specialized databases related to food products and controlled substances were established to facilitate repid data comparison when responding to emergencies.

(3) Strengthening the Development and Promotion of Chinese Medicine and Pharmacy

a. Completed research for setting up standards for major constituents in Chinese medicine "Forsythia" from cross-strait. The evaluation of using "Xuefu Zhuyu Decoction" to improve glycemic control and maintenance liver function, kidney function, and CNS function in mice model for Type 2 diabetes. Executed research about drug interaction between "Shujianhuo Decoction" and Warfarin, a prescribed drug to treat cardiovascular diseases.

b. Revised editions of "A Dialogue between Physicians and Historians: Historical Heritages and Change of Chinese Medicine Academic Knowledges," "A Review of the History and Practice of the Needling Depth of Acupoints," and "History of Chinese Medicine" were published.

4. Advanced Health Care Systems

(1) Improving Medical Care Quality

The national standard for the Computer Tomography Dose Diagnostic Reference was established in order to reduce radiation dose patient suffered during CT performance.

(2) Improving the Health Care System

a. Building an International Grade Rural Health Care Digital Information Network

a) Telemedicine and Telehealth Care: On November 11, 2014, the "draft guidelines governing security and maintenance of telecare personal data" were announced. A public version of the remote health care app "TelecarePMO" was developed in cooperation with city and county health departments to establish service footholds for community-based physiological measurements and provide remote physiological measurement services for elderly people who live alone.

b) Establishing Digital Information and Communication: The "Health Information System (HIS)," "Picture Archiving and Communication System (PACS)," and "Electronic Medical Records Exchange System" were completed for use in rural mountain areas and outlying islands in order to provide rural residents with convenient access to cross-hospital medical data exchanges.

b. Analysis of the results of an investigation of long-term care services resources was completed in order to develop the evaluating indicators and to integrate the standards of various types of home services and community-based services LTC institutions.

c. A survey of the distribution of nursing graduates' careers was completed and the demand for nursing manpower was estimated for the next three years. A survey of the work content and manpower situation was also completed for clinical nurses and nurse assistant.

d. Using community oral health consultation intervention strategies and indigenous language and culture as an educational foundation model, oral cancer screening behavior and the willingness to self examine oral mucosa rate rose by over 10% for indigenous peoples in rural mountain areas.

5. National Health Insurance Reform

(1) Stabilizing Heath Care Finances: A comparison, of changing operation mechanisms and effectiveness within the range of international health insurance, was carried out in order to come up with suitable changes in the modes of national insurance payments for Taiwan and make risk assessments on their public impact. A regular premium was established with a supplementary premium monitoring module along with financial actuary modules and modules related to tax data and insurance fees.

(2) Continue Payment Reform: A term of validity was established for certifications issued to verify patients with the top 10 types of malignant tumors for the appropriate use of health care resources. In addition, professional training was carried out for healthcare professionals and on-site counselors who handle post-acute stroke patients in order to enhance the quality of post-acute care. A pilot project was proposed for research of post-acute quality care to be entered into the United States' CARE Assessment Scale in order to establish a highly credible and effective Chinese-language version of the CARE Assessment Scale.

(3) Enhanced Quality of Medical Care: A health insurance and medical service index analysis system was established along with a quality index risk adjustment method for the development of localization. Research was undertaken to create a health care quality index for the sophistication of organizations that can provide the public with a medical reference. In addition, a yearly medical public interest poll continued to be carried out (with a nearly 80% approval rate among citizens for National Health Insurance) to develop a public interest monitoring index for medical care.

(4) Enhancing Institutional Effectiveness: Information related to access of healthcare services was analyzed along with public

opinion and all patterns of current access to services in order to increase the effectiveness of healthcare services. In addition, public participation in medical care services and drug payment projects was evaluated. Also, researches related to standard payment formulations were carried out in order to provide policy proposals on "professional guidance," "financial guidance," and "democratic participation.

(5) Medical Technology Evaluations: The establishment of drug reimbursement and exit mechanisms for special materials was deliberated together with the development of better medicines and payment provisions for special materials. Technical evaluations were completed for three types of drugs targeting chronic adult spontaneous (immunological) idiopathic thrombocytopenic purpura, chronic myelogenous leukemia, and colorectal cancer, and for three types of specialized medical care materials for artificial knees, vein thrombosis rings, and peripheral vascular plugs.

Section 2 Translational Medicine Research and Industry Development

1. Technology Transfer and Licensing

In 2014, basic and applied biomedical research won 72 domestic and foreign patents, and eight cases of technology transfers were granted for research and development results, earning a total revenue of NTD5,795,848 (Figure 11-2).

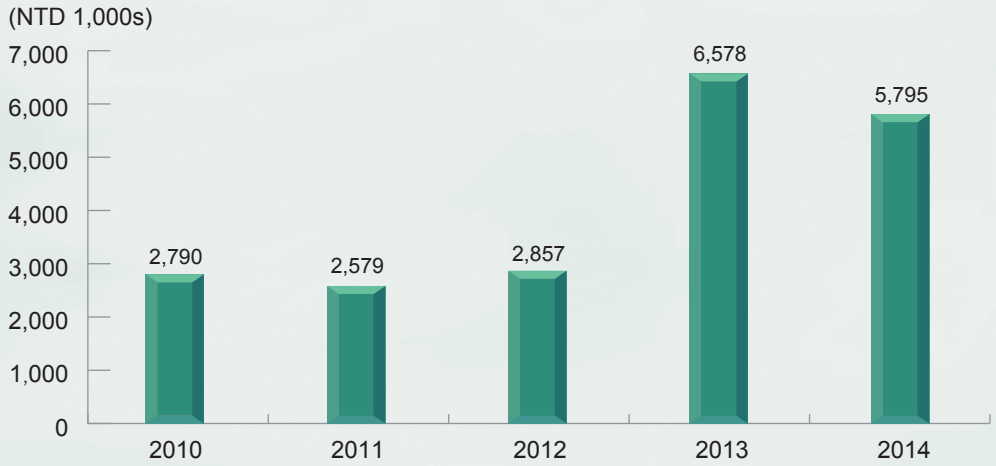
2. To Promote Innovation and Competitiveness of Clinical Trial Project

(1) Regulatory Consultation for Drug Development Process and Clinical Trials: In accordance with each case, regulatory consultation was carried out to resolve problems of pharmaceutical regulation. In 2014, regulatory queries were provided for 1,665 cases, and Index cases for regulatory were provided for 23 projects (including eight projects reached the clinical stages).

(2) Accelerating IRB Review Efficiency for Multicenter Clinical Trials: The c-IRB review mechanism was established for clinical trials of pharmaceutical products on July 1, 2013. In 2014, there were 79 cases completed, with an average review time of 8.3 days.

(3) Establishment of High-Quality Environments for Clinical Trials: Taiwan National University Hospital, Taipei Medical University Hospital, and China Medical University Hospital have been awarded Full Accreditation by the Association for the Accreditation of Human Research Protection Programs (AAHRPP). They have enhanced the quality of clinical trials and increased the trust of international companies, and promoted industrial development of pharmaceutical research and development.

Figure 11-2 Trends of Annual Incomes from Research



(4) Cooperation between cancer research centers and clinical trial centers with domestic and foreign pharmaceutical companies was promoted to carry out important clinical trials. (Figure 11-3)

3. Promoting the Second Phase (2014-2017) of the Cancer Research Project

This phase of the Cancer Research Project is focused on researching the rising incidence of breast cancer, colorectal cancer, and betel-related oral cancer, which is a Taiwan-specific problem. There were 12 cancer centers and one integrated cancer research center that were subsidized (Figure 11-3). Key results are summarized as follows:

(1) Epidemiology and Prevention

a. Colorectal Cancer: Based on endoscopy results, patients aged 40-49 with metabolic syndromes had a higher prevalence of colorectal tumors and positive detection rate in colorectal cancer screenings, and this risk was even higher than in women between 50 and 59 years old. Fecal occult blood testing was recommended for men aged 40-49 who were smokers, overweight, with high blood pressure, diabetes, or high blood fat.

b. Oral Cancer: The results indicated that people who drink over five cups of tea per day (especially green tea) have a 40% lower risk of getting upper aerodigestive tract cancer. Anti-cancer ingredients in tea leaves (or the habit of drinking tea) may become an effective drug for the prevention of upper aerodigestive tract cancers.

c. Breast Cancer: Research results provide evidence that smoking and exposure to secondhand smoke will increase the risk of breast cancer. It also shows that nicotine receptors and DNA repair gene polymorphisms have significant interactions with smoke exposure, which can affect breast cancer.

Figure 11-3 Clinical Testing Centers and Cancer Research 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

(2) Early Detection and Diagnosis

a. Colorectal Cancer: 46 sets of micro RNAs (miRNAs) related to colorectal cancer have been successfully identified for screening cancer patients from normal people with a detection rate of 88.7%. This result was much higher than 12.9% and 51.6% rates using CEA (carcinoembryonic antigen) and iFOBT (fecal occult blood reaction) respectively.

b. Oral Cancer: Optical diagnosis was carried out by using the VELscope, which provided a quick and convenient early diagnosis method. It is simple and easy to use, and no additional staining procedure is required to detect lesions. It has already begun to be used in recorded clinical cases in cooperation with the University of Malaya.

c. Breast Cancer: Standardization and quality control screening were completed for the Automatic Breast Ultrasound (ABUS); furthermore, a GPS navigation image recorder was applied to help image processing and section precision positioning in Breast Ultrasounds (BUS).

(3) Treatment and Prognosis

a. Colorectal Cancer: It was demonstrated that by using the combination of laparoscope and mechanical arm surgery for lymph node dissection, the five-year survival rate of late stage colorectal cancer patients could be increased by 40%.

b. Oral Cancer: Surgical robot technology was established to assist in endoscopic surgery, and this technology was able to effectively reduce the probability of early hypopharyngeal complications and effectively reduce the ratio of radiation therapy for early-stage hypopharynx cancer patients.

c. Breast Cancer: For stage one luminal-like breast cancer patients, the effectiveness of chemotherapy is nearly nonexistent. The prognosis of type V subtype stage two breast cancer patients are comparable with stage one patients without any risk factors. These results can be applied to reduce overtreatment of breast cancer patients.

4. Biomedical Research and Development (National Health Research Institutes)

(1) The anti-diabetic drug candidate DBPR018 has been approved by both the U.S. Food and Drug Administration and the Taiwan Food and Drug Administration for a phase I clinical trial. In May 2014 it entered a repeated-dose human clinical trial.

(2) DBPR114, a multi-kinase inhibitor has been identified as a developmental anti-cancer drug candidate. It is capable of effectively inhibiting several cancer-related kinases and has excellent growth-inhibiting effects on several types of human cancer cells. The National Research Program for Biopharmaceuticals has selected it as a developmental drug candidate.

(3) Pre-clinical study of an H7N9 flu vaccine has been completed and technology transferred to a local company, with clinical trials planned for the first half of 2015. In the study of four serotypes of dengue virus, two mouse models for protection studies have been established. These can be used to evaluate the efficacy and protection mechanisms of lipidated dengue vaccine candidates.

(4) For mutual regulation between inflammatory T lymphocyte activation and adipocytes, it was discovered that immune system disorders are key to the occurrence of metabolic disorders. Protein kinase MAP4K4 can be a potential biomarker or targeted therapy for type 2 diabetes. Our research found that phosphatase DUSP22 (also called JKAP) can become a potential biomarker or targeted therapy for autoimmune diseases (such as systemic lupus erythematosus). This research finding was featured in the Taiwan Biodevelopment Foundation's inaugural biotechnology seminar.

(5) In nanomedicine research, a novel endogenous nanocarrier (red blood cell-derived vesicles, RDV) was found to load various functional molecules, indicating it has potential as a biomedical applied material.

Section 3 Promoting Health and Welfare Data Statistical Applications

1. Management for Health and Welfare Data Service Platforms

The Collaboration Center of Health Information Application(CCHIA) is a service platform provided through government planning and management. It aims to enhance the decision quality of public health decision-making, expand

academic research and promote the quality of medical care services, and further promote general welfare of well-being. Having attained the support of the Executive Yuan from 2012 to 2015, the goal of the cloud service is planning and expanding health-related databases and actively developing databases for all types of topics. In addition to continuing to strengthen information security management operations in 2014, certification was also obtained for the latest 2013 version of the Information Security Management System IS027001.

The Collaboration Center of Health Information Application(CCHIA) 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 has undergone a critical review.

2. Service Content and Amount of Services in the Collaboration Center of Health Information Application(CCHIA)

(1) In December 2014, there were 51 databases in 14 general categories for application announcement. Each database was created consulting reference manual for users.

(2) In order to balance regional academic research needs, it was installed in the following research sub-centers: Taipei Medical University, National Taiwan University, Kaohsiung Medical University, Chang Gung University, National Yang Ming University, and Tzu Chi University.

(3) The yearly number of applications gradually rose from 135 cases in 2011 to 196 cases in 2014, which was an average annual growth rate of 10%. During the same period the number of service man-days rose from 675 in 2011 to 4,936 in 2014, which was an average yearly increase of 90%.

Chapter 2 International Cooperation

In response to globalization and as a member of the global village, 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. We will continue to participate in and contribute to the relevant international organizations in order to share our experience and promote public health.

Section 1 Participation in International Organizations

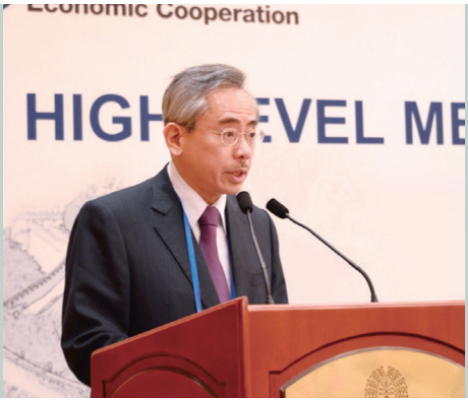
1. World Health Organization

The MOHW was invited to attend the 67th WHA as an observer. With a theme of "The Link Between Climate and Health," the MOHW shared Taiwan's climate change trends, related diseases, and policy responses. It also engaged in bilateral talks with 58 nations, including the United States, Japan, and countries in the European Union to promote mutual and multilateral international health cooperation. Taiwan has participated in six years of the WHA. (See Figure 11-4)

2. Asia-Pacific Economic Cooperation (APEC)

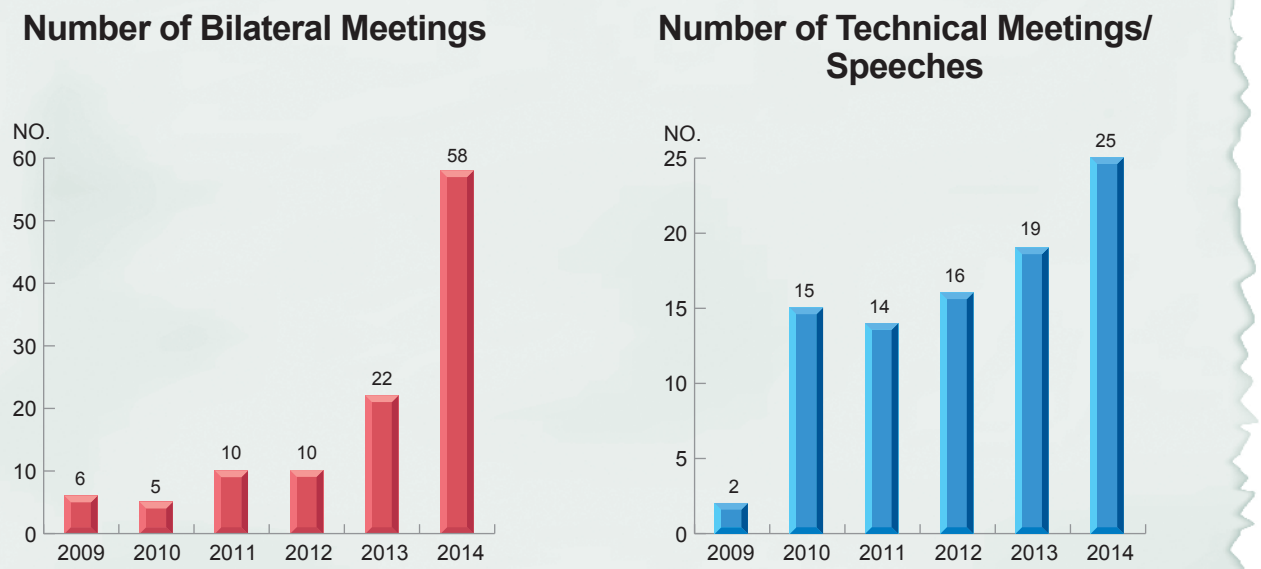
Taiwan participated in the "Fourth APEC High-Level Meeting on Health and the Economy, which was hosted by Beijing Government. Former Health Minister Chiu Wen-Ta delivered

The Taiwan delegation to attend the 67th World Health Assembly



2014 APEC conference on Health and the Economy

Figure 11-4 Progress in WHA Participation Over the past 6 years



a keynote speech at the meeting and shared Taiwan's specific actions, such as promoting the "Pilot Program to Enhance the Quality of Post-Acute Care" and "Long-Term Care Plan" to respond to future challenges related to health and economic aspects.

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

Participation in the International Council of Nurses (ICN) 2014 Fifth Annual Regulatory Approvals Forum, Tripartite Meeting, and Third Annual World Conference on Health Regulation: In May, Geneva, Switzerland hosted the Fifth Regulatory Approvals Forum, with nearly 40 nursing regulators from 22 countries and representatives from the National Nursing Association (NNA) as participants. The Tripartite Meeting had government Nursing Midwifery chiefs from 83 countries, nursing and midwifery associations' representatives, and representative lawmakers in attendance. Topics related to strengthening the nursing and midwifery workforce were collectively discussed with representatives in order to support universal health care and meet national health goals.

b. Holding International Meetings

a) The 84th Traditional Chinese Medicine Day and the 6th Taipei Traditional Chinese Medicine International Forum were hosted in Taipei on March 15 and 16, 2014.

Table 11-1 The State of International Health and Welfare Operations, 2014

International Affairs Conducted by the MOHW	2014
Participation in international conferences and research	56 events
Domestically hosted international conferences	14 events
Foreign guests/visitors	525 people from 56 countries

Experts were invited from 14 countries, and approximately 1,419 traditional Chinese medicine practitioners, exchanging publications concerning current research and development of traditional Chinese medicine as well as current research and results.

b) The 2014 Taiwan-US Health and Welfare Policy Symposium was held on May 13 and 14 in Taipei. Speakers included the commissioner of the Georgia Department of Public Health, Dr. Brenda Fitzgerald, the director of the Arkansas Department of Health, Dr. Nathaniel Smith, the Washington state secretary of health, John Wiesman, the president of the Milbank Memorial Fund, Christopher F. Koller, the director of the Arkansas Department of Human Services, John Selig, the director of the Policy and Organizational Management Program at Duke University, Pikuei Tu, and the associate director of the Policy and Organizational Management Program at Duke University, Cheryl Lin. Officials and scholars exchanged information on important health topics, challenges to future development, and the outcomes of implementing health policies.

c) The 1st APEC Conference on Health Promoting Hospitals and Health Services was held in Taipei on July 30 and 31, 2014, based on the theme "Health Care Delivery Reform in an NCD Era." There were 518 participants from seven member countries: Mainland China, Thailand, Peru, Malaysia, Korea, Singapore, and Japan. Participants shared the results of healthcare promotion in hospitals and age-friendly health care.

d) The 2014 NIH International Conference in Taiwan was held in Taipei on October 13, with "Medical Services, Drug Benefits, and Future Challenges" as its core themes. Experts and scholars from Thailand, Malaysia, Indonesia, Vietnam, the Philippines, Korea, and Japan were invited for discussions on health insurance and medical services as well as drug benefits and pricing.

e) The 2nd APEC Conference on Age-Friendly Cities and Age-Friendly Economies was held in Taipei on October 16. The vice supervisor for Health and Consumers of the European Commission, Jorge Pinto Antunes, the director of Community Development of the Melville City Council Australia, Christine Young, and the executive director of SurveyMeter Indonesia, Dr. Ni Wayan Suriastini, were invited to speak about the current state of international promotion of age-friendly cities and economy around the globe with 241 participants in total.

f) The Pacific Region Indigenous Doctors' Congress (PRIDoC) was held from November 2-6, 2014 in Hualien with "family and partnership" as its main themes. It was the first time that this congress had been held in Taiwan. Indigenous healthcare workers and experts from regions and countries such as Hawaii, Australia, New Zealand, and Canada shared their experiences with one another.

2014 Taiwan-US Health and Welfare Policy Symposium

Pacific Region Indigenous Doctors' Congress (PRIDoC)

There were 60 foreign guests from 31 countries who participated in the 2014 Global Health Forum in Taiwan

g) The Silver Linings Global Forum was held on November 17 in Taipei. Five experts from the United States, Japan, Denmark, and Hong Kong were invited to speak about topics such as innovative service models, training comprehensive personnel, developing business service models, and technological applications. Also, there were arrangements for foreign and domestic experts to share their service experiences.

h) The 2014 Global Health Forum in Taiwan was held in Taipei on November 30 and December 1, 2014, with the theme of "Healthy Society, Healthy People." A total of 60 foreign guests from 31 countries participated, including eight deputy health ministers, 34 health officials, and many internationally renowned experts and scholars. Total participation in the two-day forum was 1,037, the most ever since the first forum in 2005.

c. Visits by Foreign Guests: A total of 525 foreign guests from 56 countries attended. They shared information related to health and welfare policy, medicines, food safety, health care, technology, and bilateral cooperation. Origins of visitors are shown in figure 11-5.

(2) International Cooperation

a. The Taiwan-US 5th Cooperation Agreement was signed by the Centers for Disease Control and the US Department of Health and Human Services. Both parties will exchange and share influenza surveillance and laboratory diagnostic information and technology. Officials will be sent to the United States to study vaccine seed strain systems and models for estimating the global death toll from seasonal flu.

b. Taiwan and European quality management APIs signed an exchange of information and confidentiality agreement on May 12, 2014. The Taiwan Food and Drug Administration and the European Directorate for the Quality of Medicines & Healthcare, Council of Europe both signed to allow for bilateral information exchanges concerning pharmaceutical raw material quality, non-public proprietary information related to manufacturing, and technological documents about the latest standards and specifications.

c. Taiwan Health Inequalities Reporting Plan: In June 2014, a cooperation plan was signed with the director of the Institute of Health Equity at University College, London, Sir Michael Marmot, who is also head of the WHO's

Commission on Social Determinants of Health. In 2014, the Taiwan Health Inequalities Report was completed, as were plans to conduct joint research to improve health inequality and establish a mechanism for the long-term monitoring of health inequalities.

d. The Taiwan-Philippine Memorandum of Understanding on Health Products Management Cooperation was signed on September 12, 2014, by the Taipei representative to the Philippines, Raymond Wang, and the Manila Economic and Cultural office representative, Antonio I. Basilo, in order to establish information exchanges and cooperation in health products management.

e. The Taiwan and Korea Memorandum of Understanding for Health Insurance Cooperation was signed on November 17, 2014, by the National Health Insurance Administration and the Korean Health Insurance Review and Assessment Services. Its objective was to promote and expand mutual research cooperation on health-insurance related measures, experience and personnel exchanges.

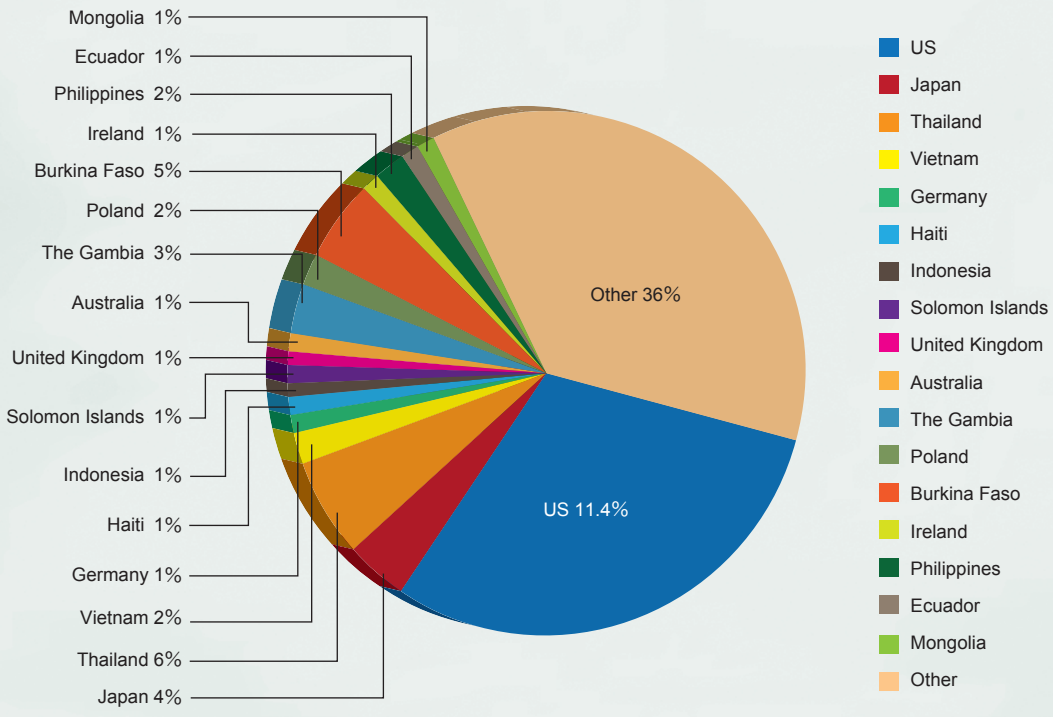
f. Cross-Strait Cooperation Agreement on Medicine and Public Health Affairs: This agreement was signed during the 6th Chiang-Chen meeting in December 2010. In accordance with the agreement, H6N1 virus strain was offered to Mainland China on March 31, 2014. And through emergency treatment processes and mechanisms, contact was established for 24 Taiwanese passengers in an incident in Fujian Province where a tour bus fell into the Jiulong River on May 23.

2. International Health Assistance

(1) Humanitarian Aid

Taiwan International Health Action (TaiwanIHA) cooperated with Japan's Association of Medical Doctors of Asia (AMDA) in 2014 to provide dental care aid in Hakkari Province, Turkey. In addition, dental clinical mission was joined by Hualien's Tzu Chi General Hospital and Badulla Hospital in Badulla, Sri Lanka. In addition to

Figure 11-5 Nationalities of Foreign Visitors, 2014



providing tooth scaling, fillings, and fluoride varnishing for approximately 200 students in two schools, dental health education and demonstrations of proper tooth brushing were provided along with medical supplies, such as dental cleaning kits, clinic materials, and mobile dental units.

(2) Medical Assistance

a. Global Medical Instruments Support & Service Program (GMISS): Collected old medical instruments from hospitals throughout Taiwan and donated them to ally countries in accordance with foreign policy. In 2014, there were 12 donation cases with a total of 1,036 donated pieces of medical equipment delivered to the Solomon Islands, Swaziland, Myanmar, Haiti, Paraguay, Sao Tome and Principe, St. Vincent and the Grenadines, Mongolia, Palau, Kiribati, and Burkina Faso.

b. Taiwan International Healthcare Training Center (TIHTC) promoted diplomatic relations by training medical personnel in overseas regions which lack medical resources. In 2014, training was provided to 106 foreign healthcare personnel in 18 countries.

c. The outbreak of Ebola Virus Disease (EVD) in West Africa, the Centers for Disease Control donated 100,000 sets of personal protective equipment to West African outbreak areas as supplies for front line epidemic prevention workers in late November 2014.

d. The 2014 National Health Cooperation Program in Africa: Assistance with the advancement of public health in Africa cover national health insurance, maternal and child health care services, AIDS prevention, parasite prevention, e-Health, medical supplies donations, and staff training.

e. In 2014, the MOHW has accepted the request from the Ministry of Foreign Affairs (MOFA) to implement the "Medical Cooperation Programs to Diplomatic Allies and Friendly Countries in the Pacific" Eight domestic hospitals are in charge of the program in eight corresponding countries, in which the "Taiwan Medical Program" and "Mobile Medical Mission" are implemented in the following four countries: Palau, Kiribati, Nauru, and Tuvalu; the "Taiwan Health Center" is implemented in Marshall Islands and Solomon Islands; and the "Mobile Medical Mission" is implemented in the Republic of Fiji and Papua New Guinea. These programs were fully funded by the MOFA.

TaiwanIHA's medical team memeber provided dental care to children in Sri Lanka

Section 3 Globalization of Medical Services

1. Medical Services Industry Background

The changes of health Insurance payment system had influenced the hospital's operation model, and with population aging, technology advancing and medical service market enlarging; the medical industry extended their service territory. They switched their services from "disease-treatment orientation" to "customer orientation". Although, our civilian's health insurance expenditure has grown every year, but comparison with other developed countries, the proportion relative to the GDP is still inadequate and could be improved further.

Through the advancement of internationalized health care services, the advantages of Taiwan's health care service and technology will emerge. This will develop Taiwan's medical industry and increase the international competitiveness of its health care service industry.

2. Medical Service Globalization Development Goals

(1) By assisting medical service provider to develop their own brand, establish their strongest features, provide various medical treatment services, as well as to emulate

industry institutionalization and organizing ability, to integrate same trade and different business in horizontal combination and vertical integration. Those can explore innovation operation strategies for medicare companies and create a more diversified environment for medical service industry.

(2) Adopt the Free Economic Pilot Zone policy to develop an international health industry, with implementation led by central policy planning and health care as a driver of the biotechnology, pharmaceutical, medical materials, information, and health industries.

3. Achievement of Promoting Globalization of Medical Services

(1) "Taiwan Medical Travel" was established to serve as a platform for information exchange and dissemination, and counseling was continued for 57 hospitals to participate in the program and create an environment that was internationally competitive. In addition to running a foreign language switchboard and online information site, counseling field visits were completed.

(2) We continually strengthen our medical service marketing strategies and promote Taiwan Brand medical care service to national and international tourism systematically.

(3) Related regulations have been eased and accommodation has been made to entry regulations for Mainland Chinese citizens to enter Taiwan. There were 51 hospitals that could apply to carry out health examinations and cosmetic medical care services for Mainland Chinese citizens.

(4) We run a pilot scheme called "Chiao-An Pilot Program" to relax restrictions for overseas compatriots, those who lived in Myanmar, Laos, and Cambodia and traveling to Taiwan for health examinations, the aesthetic medicine and medical therapy services. And up to December 2014, there were 3,013 overseas compatriot visitors in 158 compatriot groups applied the "Chiao-An pilot Program".

(5) Detailed Achievement of the promotion of international medical (see Table 11-2).

(6) In coordination with the Free Economic Pilot Zone policy to promote our international health industries, four International Health Liaison Centers, located in Taipei Songshan Airport, Taoyuan Airport, Taichung Cingcyuangang Airport, and Kaohsiung Siaogang Airport, were synchronously lunched on December 28, 2014. Those Centers will provide medical service information and appointment service to assist all foreign passengers when medical care needed.

Table 11-2 Recent Achievements in the Promotion of Medical Travel

Type \ Period	2008	2009	2010	2011	2012	2013	2014
Outpatient	63,388	78,553	96,850	92,931	115,569	123,107	174,342
Inpatient	1,102	1,818	2,157	3,105	3,845	4,293	6,078
Cosmetics	1,072	3,902	3,125	3,254	5,822	10,627	4,308
Heath Examinations	2,983	5,234	8,532	9,843	48,075	93,137	74,946
Total	68,545	89,507	110,664	109,133	173,311	231,164	259,674
Output Value (NTD 100 Million)	20.29	34.33	41.49	54.14	96.23	136.48	141.35

Appendices

Appendix 1 Health and Welfare Indicators

Table 1 Population Indicators

Year	Total Population	Population Structure			Crude Birth Rate	Crude Death Rate	Natural Increase Rate	Total Fertility Rate		Population Density
		0-14	15-64	Over 65					Adolescent Pregnancy	
	1,000s	%	%	%	‰	‰	‰	Per Woman	‰	People/Km^2
2001	22,406	20.8	70.4	8.8	11.7	5.7	5.9	1.4	13	619
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

Source: Ministry of the Interior

Table 2 Life Expectancy and Mortality Rate

Year	Life Expectancy at Birth			Under 5 Mortality Rate	Adult Mortality Rate (Ages 15-60)
	Both Sexes	Male	Female		
	Years	Years	Years	Per 1,000 Population	Per 1,000 Population
2001	76.7	74.1	79.9	8.2	116.7
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

Source: Ministry of the Interior

Table 3 Health Expenditure

Year	Economic Growth Rate	GDP Per Capita	National Health Expenditure (NHE)					NHE as % of GDP	NHE Per Capita
				Financial Agents	Financial Resources				
				Public Sector Ratio	Government Sector Ratio	Household Ratio			
							Out-of-Pocket Ratio		
	%	USD	NTD Millions	%	%	%	%	%	NTD
2001	-1.3	13,448	583,775	61.3	27.1	52.0	32.3	5.88	26,130
2002	5.6	13,750	620,674	60.4	25.7	51.6	32.5	5.96	27,631
2003	4.1	14,120	657,796	60.2	27.2	51.8	32.7	6.15	29,154
2004	6.5	15,388	705,353	58.9	25.9	52.3	33.8	6.21	31,146
2005	5.4	16,532	735,502	57.0	24.9	53.6	35.3	6.26	32,359
2006	5.6	17,026	767,432	57.3	24.8	52.5	34.3	6.27	33,625
2007	6.5	17,814	796,540	57.8	24.1	52.8	34.9	6.17	34,757
2008	0.7	18,131	819,416	57.2	23.9	53.7	35.7	6.49	35,630
2009	-1.6	16,988	862,552	57.4	23.9	52.7	35.5	6.91	37,375
2010	10.6	19,278	885,045	57.2	25.5	55.6	36.8	6.53	38,246
2011	3.8	20,939	907,829	57.2	25.3	56.2	36.7	6.62	39,141
2012	2.1	21,308	932,818	57.9	24.9	55.4	36.1	6.63	40,086
2013	2.2	21,902	962,777	58.5	23.3	54.0	35.8	6.61	41,242
2014	3.8	22,635	…	…	…	…	…	…	…

Source: Directorate-General of Budget, Accounting and Statistics; Ministry of Health and Welfare

Table 4-1 Health Facilities - Institutions

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
2001	18,265	637	593	92	501	44	2	42	17,628	9,425	2,544	5,659
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

Source: Ministry of Health and Welfare

Table 4-2 Health Facilities - Beds

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
2001	127,676	114,640	39,670	74,970	72,915	67,818	13,036	57.0	51.2	32.5	30.3	5.8
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

Source: Ministry of Health and Welfare

Table 4-3 Health Workforce - Medical Professionals

Year	Medical Professionals									
		Physicians	Chinese Medicine Doctors	Dentists	Pharmacists (Assistants)	Medical Technologists (Assistants)	Medical Radiation Technologists (Assistants)	Registered Nurses (Assistants)	Midwives (Assistants)	Dieticians
	People	People	People	People	People	People	People	People	People	People
2001	165,855	30,562	3,979	8,944	24,891	6,542	3,152	82,763	518	778
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

Source: Ministry of Health and Welfare

Table 4-4 Health Workforce - Medical Professionals Per 10,000 Population

Year	Medical Professionals Per 10,000 Population									
		Physicians	Chinese Medicine Doctors	Dentists	Pharmacists (Assistants)	Medical Technologists (Assistants)	Medical Radiation Technologists (Assistants)	Registered Nurses (Assistants)	Midwives (Assistants)	Dieticians
	People	People	People	People	People	People	People	People	People	People
2001	74.0	13.6	1.8	4.0	11.1	2.9	1.4	36.9	0.2	0.3
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

Source: Ministry of Health and Welfare

Table 5 Notifiable Diseases

Year	Confirmed Cases							
	Cholera	Novel Influenza A Virus Infections	Japanese Encephalitis	Hansen's Disease	Malaria	Measles	Meningococcal	Mumps
	People	People	People	People	People	People	People	People
2001	-	···	33	2	29	10	43	444
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

Table 5 Notifiable Diseases (Continued)

Year	Confirmed Cases						
	Pertussis	Poliomyelitis	Congenital Rubella Syndrome	Rubella	Neonatal Tetanus	Tetanus	TB
	People	People	People	People	People	People	People
2001	6	-	3	17	···	19	14,486
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

Source: Ministry of Health and Welfare

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
4. Since 2014, various subtypes of human cases of avian influenza are reported as "novel influenza A virus infections".

Table 6 Food and Pharmaceutical Affairs

Year	Incidents of Food Poisoning			Number of Pharmaceutical Firms			
		No. of Cases	No. of Deaths		Pharmacies	Dealers of Drugs or Medical Devices	Manufacturers of Drugs or Medical Devices
	No. of Outbreaks	People	People	Units	Units	Units	Units
2001	178	2,955	2	47,130	6,440	39,948	742
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

Source: Ministry of Health and Welfare

Table 7-1 Mortality Statistics - 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 Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population
2001	6.0	126,667	558.7	32,993	143.1	11,003	48.8	13,141	57.8	3,746	16.8	9,113	39.8
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	162,911	443.6	46,095	130.2	19,400	50.2	11,736	30.4	10,353	24.7	9,845	26.0

Source: Ministry of Health and Welfare

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 Mortality Statistics - Major Causes of Death (Continued)

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 Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population
2001	9,513	41.5	5,159	22.9	5,239	22.3	1,766	7.9	4,056	17.9	2,781	11.7
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	7,123	23.7	6,430	15.3	4,962	14.8	5,459	13.5	4,868	12.5	3,546	11.8

Source: Ministry of Health and Welfare

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 Mortality Statistics - Major Causes of Cancer Death

Year	Major Causes of Cancer Death									
	Cancers of the Liver and Intrahepatic Bile Ducts		Cancers of the Trachea, Bronchus, and Lungs		Cancers of the Colon, Rectum, and Anus		Cancers of the Breast (Female)		Cancers of the Prostate	
	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population	Number of Deaths	Standardized Mortality Rate Per 100,000 Population
2001	6,415	28.0	6,555	28.3	3,457	15.0	1,241	10.7	693	5.9
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	8,179	23.3	9,167	25.3	5,603	15.3	2,071	11.9	1,218	6.5

Source: Ministry of Health and Welfare

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	NHI						
	Insured	Percentage of Total Population	Health Care Indicators				
			Average Clinical Visits Per Insured Person	Average Hospital Stays Per 100 Insured Persons	Average Fees Per Clinical Visit	Average Fees Per Hospital Stay	Average Length of Hospital Stays
	1,000s of Persons	%	Times	Cases	Points	Points	Days
2001	21,654	…	13.6	12.5	752	39,101	8.8
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	9.7

Source: National Health Insurance Administration

Notes: 1. Sources of Health Care Indicators: Insured person files in the MOHW second-generation storage system, clinics, delivery institutions, and clinical records (data acquired on June 2, 2015).
2. Statistics contained in this table do not include commissioned cases.
3. In calculations based on "per insured person," insured persons refers to the average number of insured persons from the months of February, May, August, and November.
4. Clinical visits do not include reported at-home care and community psychological care, transfers and outsourced examinations, refilling of prescriptions for chronic illnesses, treatment and drugs for B/C hepatitis, delivery institutions, and care order payment amount supplementary reports.
5. Clinical cases do not include transfers and outsourced examinations, refilling of prescriptions for chronic illnesses, treatment and drugs for B/C hepatitis, delivery institutions, and care order payment amount supplementary reports.
6. Hospitalization cases do not include treatment and drugs for B/C hepatitis, and care order payment amount supplementary reports.
7. Length of hospitalization stays refers to combined time spent in acute care beds and chronic illness beds.

Table 8 Social Insurance (Continued)

Year	National Pension								
	Insured Persons	As a Percentage of Persons Aged 25-64	General Insured Persons	Low-Income Households	middle-low income persons whose incomes fail to reach certain standards		Persons with Disabilities		
					Under 1.5-fold minimum cost of living	Under 2-fold minimum cost of living	Severe or extremely severe	Medium	Mild
	1,000s of Persons	%	1,000s of Persons	1,000s of Persons	1,000s of Persons	1,000s of Persons	1,000s of Persons	1,000s of Persons	1,000s of Persons
2001	-	-	-	-	-	-	-	-	-
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

Source: Ministry of Health and Welfare

Table 9 Social Assistance

Year	Low-Income Households				Low-Middle Income Households			
	Number of Households	As a Percentage of Total Households	People	As a Percentage of Total People	Number of Households	As a Percentage of Total Households	People	As a Percentage of Total People
	Households	%	People	%	Households	%	People	%
2001	67,191	1.0	162,699	0.7	-	-	-	-
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

Source: Ministry of Health and Welfare

Note: Implementation of the new "Public Assistance Act" on July 1, 2011, eased standards for inclusion

Table 9 Social Assistance (Continued)

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
2001	9,640	10,173	4,454	10,209	96,886	39,229	21,406
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

Source: Ministry of Health and Welfare

Table 10 Social Welfare

Year	Child and Youth Welfare (Under 18)						Elderly Welfare (65 Years and Older)					
	Number of People	As Percentage of Total Population	Children Foster Care		Living Support for Disadvantaged Children and Youths		Number of People	As Percentage of Total Population	Living Allowance Subsidies for Low-Middle Income Elderly People		Special Care Allowances for Low-Middle 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
2001	5,662,521	25.3	...	...	...	...	1,973,357	8.8	181,211	982,386	-	-
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

Source: Social and Family Affairs Administration

Table 10 Social Welfare (Continued)

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	(No.)	(No.)	(People)	(Person-Times)
2001	…	…	…	44	28	431	616
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	62	40	385	1,924
2007	…	103,612	28,547	75	37	330	1,902
2008	…	107,149	30,625	58	37	331	2,987
2009	…	153,175	40,913	61	38	345	3,340
2010	…	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	73	58	469	4,256

Source: Social and Family Affairs Administration
Note: Women's welfare items compiled since 2014.

Table 10 Social Welfare (Continued)

Year	People with Disabilities										
	Number of People	Ratios of Persons with Disabilities			As Percentage of Total Population	Living Assistance		Subsidies for Day Care and Residential Care		Auxiliary Appliances Assistance	
		Under 18	18-64	Over 65							
	People	%	%	%	%	Person-Times	NTD10,000s	年底人數	NTD10,000s	Person-Times	NTD10,000s
2001	754,084	6.8	58.2	35.0	3.4	2,090,576	668,695	12,891	196,042	51,873	56,928
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

Source: Social and Family Affairs Administration

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
2001	...	...	...	...	...	...	...
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

Sources: Ministry of Health and Welfare and Municipal, County (City) Governments

Table 12 International Comparisons

Country	Population Statistics						Life Expectancy and Mortality Rate						
	Median Age	Crude Birth Rate	Crude Death Rate	Total Fertility Rate	Adolescent Birth Rate	Dependency Ratio	Life Expectancy at Birth			Infant Mortality Rate	Under 5 Mortality Rate	Adult Mortality Rate (Ages 15-60)	
							Total	Male	Female			Male	Female
	2013	2013	2013	2013	2007-2012	2013	2013	2013	2013	2013	2013	2013	2013
	Years	‰	‰	Per Woman	‰	%	Years	Years	Years	Per 1,000 Live Births	Per 1,000 Population	Per 1,000 Population	Per 1,000 Population
Taiwan	39	9	7	1.1	4	34.9	80	77	83	4	5	132	54
Japan	46	8	10	1.4	5	61.6	84	80	87	2	3	81	42
Republic of Korea	39	10	6	1.3	2	37.1	82	78	85	3	4	93	38
United States	37	13	8	2.0	34	50.4	79	76	81	6	7	128	76
Canada	40	11	7	1.7	14	46.3	82	80	84	5	5	81	52
United Kingdom	40	12	9	1.9	22	54.0	81	79	83	4	5	88	55
Germany	46	9	11	1.4	8	52.0	81	79	83	3	4	92	50
France	41	12	9	2.0	9	56.5	82	79	85	4	4	109	52
Australia	37	13	6	1.9	15	50.2	83	80	85	3	4	78	45
New Zealand	37	14	6	2.1	25	51.9	82	80	84	5	6	80	52

Sources: WHO Statistical Information System (2015), World Bank, Ministry of the Interior, Ministry of Health and Welfare"

Note: International comparisons are based on the Gregorian calendar

Table 12 International Comparisons (Continued)

Country	Health Expenditure			
	Health Expenditure Ratios		Health Expenditure per Capita	
	Health Expenditure as share of GDP	Public Health Expenditure as share of Health Expenditure	Health Expenditure per Capita	Public Health Expenditure per Capita
	2012	2012	2012	2012
	%	%	USD PPPs	USD PPPs
Taiwan	6.6	57.9	2,668	1,546
Japan	10.3	82.1	3,649	2,997
Republic of Korea	7.6	54.5	2,291	1,248
United States	16.9	47.6	8,745	4,160
Canada	10.9	70.1	4,602	3,224
United Kingdom	9.3	84.0	3,289	2,762
Germany	11.3	76.7	4,811	3,691
France	11.6	77.4	4,288	3,317
Australia[a]	9.1	68.4	3,997	2,733
New Zealand[a]	10.0	82.7	3,172	2,623

Sources: 2014 OECD Health Data, Ministry of Health and Welfare
Note: "a" means that data were from 2011.

Appendix 2 Notifiable Diseases Statistics

Table 1 Number of Confirmed Cases of Acute Notifiable Disease, 2014

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
	H5N1 Influenza (Note 3)	0	0	0
II	Diphtheria	0	0	0
	Typhoid Fever	25	6	19
	Dengue Fever	15,732	15,492	240
	Dengue Hemorrhagic Fever / Dengue Shock Syndrome	136	136	0
	Meningococcal Meningitis	3	3	0
	Paratyphoid Fever	8	0	8
	Poliomyelitis	0	0	0
	Acute Flaccid Paralysis (Note 4)	29	29	0
	Shigellosis	132	15	117
	Amoebiasis	300	103	197
	Malaria	19	0	19

Table 1 Number of Confirmed Cases of Acute Notifiable Disease, 2014 (Continued)

Category	Disease	Total	Indigenous Case	Imported Case
II	Measles	26	8	18
	Acute Hepatitis A	117	68	49
	Enterohaemorrhagic Escherichia coli Infection	0	0	0
	Hantavirus Hemorrhagic Fever with Renal Syndrome	2	2	0
	Hantavirus Pulmonary Syndrome (HPS)	0	0	0
	Cholera	4	4	0
	Rubella	7	1	6
	Chikungunya Fever	7	0	7
	West Nile Fever	0	0	0
	Epidemic Typhus Fever	0	0	0
	Anthrax	0	0	0
III	Pertussis	78	77	1
	Tetanus (Note 5)	9	-	-
	Japanese Encephalitis	18	18	0
	Congenital Rubella Syndrome	0	0	0
	Acute Hepatitis B	120	117	3
	Acute Hepatitis C	205	205	0
	Acute Hepatitis D	1	1	0
	Acute Hepatitis E	9	5	4
	Acute Hepatitis Unspecified	1	1	0
	Mumps (Note 5)	880	-	-
	Legionnaires' Disease	135	129	6
	Invasive Haemophilus Influenzae Type b (Hib) Infection	4	4	0
	Neonatal Tetanus	0	0	0
	Enteroviruses Infection with Severe Complications	6	6	0
IV	Herpesvirus B Infection	0	0	0
	Leptospirosis	98	97	1
	Melioidosis	37	36	1
	Botulism	0	0	0
	Invasive Pneumococcal Disease	587	586	1
	Q Fever	42	42	0
	Endemic Typhus	21	19	2
	Lyme Disease	2	0	2
	Tularemia	0	0	0
	Scrub Typhus	414	412	2
	Complicated Varicella	55	54	1
	Toxoplasmosis	12	12	0
	Complicated Influenza	1,721	1,713	8
	Brucellosis	0	0	0

Table 1 Number of Confirmed Cases of Acute Notifiable Disease, 2014 (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
	H7N9 Influenza (Note 3)	2	0	2
	Novel Influenza A (Note 3)	0	0	0

Notes:
1. Date of Download: Data were downloaded on October 23, 2015..
2. Day of disease onset is used as the basis of analysis for all acute notifiable diseases.
3. Since July 1, 2014, the MOHW has consolidated H5N1 influenza, H7N9 influenza, and other strains of avian influenza as novel influenza A virus infections. These were designated as Category V Communicable Diseases. At the same time, the MOHW removed H5N1 influenza (Category I) and H7N9 influenza (Category V). Data for H5N1 influenza and H7N9 influenza were complied through June 30, 2014. Data for new novel influenza A virus infection began from July 1, 2014.
4. 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.
5. Tetanus and mumpsare cases reported by the physician without laboratory testing of specimens.

Table 2 Number of Confirmed Cases of Chronic Notifiable Disease, 2014

Categories	Diseases	Number of Confirmed Cases
II	Multidrug-Resistant Tuberculosis (MDR-TB)	112
III	Tuberculosis	11,326
	Syphilis	6,986
	Gonorrhea	2,622
	（HIV Infection） Human Immunodeficiency Virus Infection	2,236
	Acquired Immunodeficiency Syndrome	1,387
	Hansen's Disease	9
IV	Creutzfeldt-Jakob Disease	0

Notes:
1. Date of Download: Data were downloaded on October 23, 2015.
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.

Appendix 3 2014 MOHW Publications

● Books

No	Title/Topic	Pubishing agency	Government Publications Number(GPN)	Publishing Month/Year
1	Maternal Health Booklet	Health Promotion Administration	1010201932	Sep. 2013
2	Children's Health Booklet	Health Promotion Administration	1010201940	Sep. 2013
3	A Review of the History and Practice of the Needling Depth of Acupoints	National Research Institute of Chinese Medicine	1010301114	Jul. 2014
4	Anti-Drug Report 2014	Food and Drug Administration	1010301691	Sep. 2014
5	The National Health Insurance Photo Book from 1995	National Health Insurance Administration	1010303039	Dec. 2014
6	2014-2015 National Health Insurance Annual Report	National Health Insurance Administration	1010303097	Dec. 2014
7	2014-2015 Handbook of Taiwan's National Health Insurance	National Health Insurance Administration	1010303206	Dec. 2014

● Periodicals

No	Title/Topic	Pubishing agency	Government Publications Number(GPN)	Publishing Month/Year
1	Journal of Food and Drug Analysis	Food and Drug Administration	2008200056	Mar. Jun. Sep. Dec. 2014
2	Taiwan Tuberculosis Control Report	Centers for Disease Control, R.O.C.(Taiwan)	2009604164	Apr. 2014
3	CDC Annual Report	Centers for Disease Control, R.O.C.(Taiwan)	2009205617	Jul. 2014
4	Health Promotion Administration Annual Report	Health Promotion Administration	2010301336	Nov. 2014
5	Taiwan Health and Welfare Report	Ministry of Health and Welfare	2010302163	Dec. 2014
6	Taiwan Food and Drug Administration Annual Report	Food and Drug Administration	2010302286	Dec. 2014
7	2013 Statistics of Birth Reporting System	Health Promotion Administration	2009502148	Jun. 2014

● Digital Publications

No	Title/Topic	Pubishing agency	Government Publications Number(GPN)	Publishing Month/Year
1	Taiwan Epidemiology Bulletin	Centers for Disease Control, R.O.C.(Taiwan)	4909902427	Jan. 2010
2	CDC Annual Report	Centers for Disease Control, R.O.C.(Taiwan)	4309902536	Jul. 2010

Appendix 4 MOHW Associated Websites

No	Website Name	Websites
1	Ministry of Health and Welfare	http://www.mohw.gov.tw
2	Centers for Disease Control, R.O.C.(Taiwan)	http://www.cdc.gov.tw
3	Health Promotion Administration, Ministry of Health and Welfare	http://www.hpa.gov.tw
4	Food and Drug Administration, Ministry of Health and Welfare	http://www.fda.gov.tw
5	National Health Insurance Administration, Ministry of Health and Welfare	http://www.nhi.gov.tw
6	Social and Family Affairs Administration, Ministry of Health and Welfare	http://www.sfaa.gov.tw
7	National Research Institute of Chinese Medicine, Ministry of Health and Welfare	http://www.nricm.edu.tw
8	National Health Research Institutes	http://www.nhri.org.tw
9	Taiwan Drug Relief Foundation	http://www.tdrf.org.tw
10	Center for Drug Evaluation, Taiwan	http://www.cde.org.tw
11	Taiwan Joint Commission on Hospital Accreditation	http://www.tjcha.org.tw
12	Food Industry Research and Development Institute	http://www.firdi.org.tw
13	The Executive Yuan Gazette Online	http://gazette.nat.gov.tw
14	Taiwan Suicide Prevention Center	http://tspc.tw
15	Health 99 Website	http://health99.hpa.gov.tw
16	Taiwan Health Promoting Schools	http://hpshome.giee.ntnu.edu.tw
17	Taiwan International Health Action	http://www.taiwaniha.org.tw
18	Taiwan International Healthcare Training Center	http://ptph.gov.tw/tihtc/
19	Global Medical Instruments Support & Service Program	http://gmiss.mohw.gov.tw/
20	Child and Juvenile Adoption Information Center	http://www.adoptinfo.org.tw
21	Health Indicator 123-Interactive Online Query System for Health Indicators	https://olap.hpa.gov.tw/

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