Taiwan

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International Health Care System Profiles

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Overview

Taiwan's National Health Insurance provides universal, mandatory coverage for all citizens and legal residents. The single-payer system, administered by the National Health Insurance Administration, is funded primarily through payroll-based premiums. The government provides generous premium subsidies for low-income households, civil servants, and other groups.

Although it spends a smaller portion of its gross domestic product on health care than other high-income countries, Taiwan achieves strong health outcomes, including a high average life expectancy. However, the health system's budgetary constraints have contributed to significant workforce shortages, and there are persistent gaps in access to care for rural communities and Indigenous populations.

HEALTH SYSTEM
BY THE NUMBERS

7.3%
Health care spending as a percent of GDP

80.2 years
Life expectancy at birth

100%
Public insurance coverage

Coverage and Access

Background and History

The origins of the modern health insurance system can be traced to the end of World War II. With medical facilities considerably damaged, health authorities focused on improving public health in the years that followed. They introduced more than 10 public insurance programs, each covering a particular group, such as government employees, farmers, and low-income households.[1]

While this system improved health outcomes, it was fragmented, and just 59 percent of the population had coverage prior to 1995.[2] In 1986, the government began a shift to a universal program. The planning process, which involved studying health insurance systems abroad, led to the merging of the various public insurance programs under a single-payer system.[3]

The National Health Insurance (NHI) Planning Team was established by the Department of Health in 1991, followed by the NHI Act in 1994 and the NHI system in 1995.[4] Subsequent reforms that were designed to make health care more financially sustainable and accessible led to the implementation of the Second-Generation NHI in 2013.[5]

The Role of Public Health Insurance

Enrollment in NHI is mandatory for all citizens. At the end of 2023, 100 percent of the population was insured under the system.[6]

The system is funded mainly through premiums paid by insured individuals, employers, and the government. The balance of revenue comes from supplementary premiums levied on non-payroll income, which were introduced under the Second-Generation NHI. This non-payroll income includes large bonuses (those exceeding four times the employee's salary), rent, interest, dividends, professional fees, and income from second and third jobs. Other sources of supplementary premiums include additional government premium subsidies, tobacco taxes, and taxes on lottery gains.[7]

The contribution ratio is based on the insured person's monthly income.[8] Premium contributions are capped at four members per household (the insured person plus three dependents). Any additional household members are covered at no cost. Caps and thresholds apply to payroll-based and supplemental premiums.[9]

There are copayments for accessing medical services, which vary by service type, provider, and individual circumstances (*see Cost Sharing and Out-of-Pocket Spending*).

Services Covered by Public Health Insurance

NHI benefits are uniform and comprehensive. They include:[10]

- Inpatient care
- Outpatient care
- Dental care
- Traditional Chinese medicine
- Pharmaceuticals
- Maternity care
- Primary care
- Eye care
- Rehabilitative care
- Palliative care
- Mental health care
- Long-term care
- Preventive care
- Home visits
- Assistive devices.

NHI doesn't cover eyeglasses or medical equipment, such as wheelchairs and hearing aids, but it does cover costly cochlear implants for children. People who need wheelchairs or artificial limbs can apply for government subsidies under the People with Disabilities Rights Protection Act, while veterans who need hearing aids or artificial limbs can receive them free of charge at veterans' hospitals.[11]

Safety Nets

The government offers a range of assistance measures for people unable to cover the cost of their premiums, as well as for those working in specific professions or suffering from chronic illness or injury.[12]

The government provides 100 percent premium subsidies for low-income households, military personnel, unemployed veterans, unemployed workers and their dependents, people with physical and mental disabilities, and unemployed native citizens under age 20 and over age 55.[13]

Exemptions from outpatient copayments apply to childbirth and certain conditions, such as cancer, as well as some population groups, including residents of remote and mountainous areas and offshore islands, veterans and families of deceased veterans, low-income households, and children under age 3.[14]

Others receive discounts on copayments. For example, outpatient copayments for people who have a disability certificate are limited to TWD 50 (USD 2). For patients in areas that lack medical resources, copayments are reduced by 20 percent.[15]

Exemptions from drug copayments are given to patients with cancer or a chronic illness and to those who have received a major illness/injury certificate for any other serious condition. Finally, the National Health Insurance Administration (NHIA) waives copayments for all lifesaving drugs for people with rare diseases recognized by the Ministry of Health and Welfare (MOHW).[16]

The government provides interest-free loans to people experiencing financial difficulty to help them cover their premiums and any unpaid copayments. In 2021, these loans totaled TWD 151 million (USD 5 million) distributed among 1,747 people.[17]

The NHIA offers installment plans to people who owe premiums of more than TWD 2,000 (USD 62) and are not eligible for relief loans. In 2021, installment payment plans totaled TWD 2.3 billion (USD 72 million) and were paid across 70,000 cases.[18]

The Role of Private Health Insurance

Private health insurance is supplementary to mandatory public health insurance. Private plans are offered by for-profit insurers, often as part of nonmedical insurance offerings such as life or car insurance. These don't cover medical services already covered by NHI, nor do they buy faster access to, or a wider choice of, specialists. Instead, such policies offer disease-specific cash indemnity provisions. Policyholders can use this money to pay for private hospital rooms or devices, such as drug-eluting stents, that NHI does not cover.[19]

There are no data available for private insurance uptake.

The Role of Government

The NHI program is administered by the NHIA, which falls under the MOHW. The NHIA is supported by six regional offices connected by a health information infrastructure. Local and municipal governments play little to no role in financing health care.[20]

The bulk of NHI-covered services are provided through a predominantly private delivery system, although some hospitals are owned and operated by municipal governments.[21]

The MOHW, which sets policy, determines how much the NHI global budget should grow each year (subject to approval by the premier's office).[22]

The NHIA's main tasks include collecting premiums, pooling risk, and paying providers, as well as overseeing the utilization, expenditures, and quality of health services. The NHIA is also responsible for coverage decisions (based on the cost-effectiveness of new drugs and treatments), provider fee-setting and fee schedule adjustments, and cost containment.[23]

Parliament plays an important watchdog role in all NHI matters. In addition to its role in negotiating any new health legislation, it must pass an amendment to the NHI Act for any premium rate increases above 6 percent.[24]

Integration and Care Coordination

The Family Doctor Integrated Care Plan

Introduced in 2003, this community-based program seeks to improve access to continuous, comprehensive medical care. Community networks comprising five or more primary care physicians and one community hospital provide patient-centered primary care, including disease management, patient health education, and preventive care. Telephone consultations with family doctors are also available 24 hours a day for those enrolled in the program.[25]

At the end of 2023, 5,590 primary care clinics (52.3%) and 7,807 physicians (45.4%) had formed 558 community health care networks serving more than 6 million people.[26]

In 2024, the NHIA upgraded the program to include care programs for diabetes, early chronic kidney disease, and metabolic syndrome. It uses digital tracking management to monitor health conditions.[27]

The Integrated Delivery System

The Integrated Delivery System (IDS) was introduced in 1998 to improve access to medical services and facilities in remote, underserved areas by increasing collaboration between large hospitals and local providers and introducing mobile specialist medical services. Over time, the IDS has gradually expanded to cover preventive health, community-based services, and chronic disease management.[28]

Long-Term Care Plan 2.0

The Long-Term Care Plan 2.0 (LTC 2.0) was implemented in 2017 to support the aging population through a community care system that integrates home hospice care and home-based medical care (*see Long-Term Care and Social Support*).[29]

The NHIA also supports care coordination by streamlining administrative processes. Its third-party payment mechanism, for example, handles medical expenses based on the NHI fee schedule, so physicians are not responsible for individual claims processing.[30]

Despite these efforts, the health care system remains fragmented, partly because each health care institution receives payments based on its share of service volume. This fragmentation increases competition and disincentivizes collaboration between providers (*see Overview of the Delivery System*).[31]

Operations and Resources

Overview of the Delivery System

The health care system comprises clinics, district hospitals, regional hospitals, and medical centers. These deliver three levels of care:

- **Primary care** is typically provided in clinics and district hospitals and is primarily responsible for monitoring and treating stable chronic diseases.
- **Secondary care** is provided in regional hospitals and offers a wider range of specialist services, inpatient care, and more advanced diagnostics.
- **Tertiary care** is typically provided in medical centers and offers highly specialized treatments, complex procedures, and advanced diagnostics.[32]

Patients can access any level of health care directly without referral, but copayments incentivize patients to seek initial treatment at lower tiers, which reduces pressure on specialist facilities (*see Cost Sharing and Out-of-Pocket Spending*).

The NHI payment system relies on a third-party payment mechanism, with the NHIA paying hospital and clinic expenses according to the NHI fee schedule.[33] The global budget payment system determines how financial resources are distributed across providers. Each year, the system sets a cap on the total available health resources for the sector, meaning that individual institutions receive payments based on their share of the total service volume. This system is efficient and effective at controlling costs from an administrative perspective, but it forces institutions to maximize volumes to ensure their financial stability.[34]

Primary Care

Primary care is provided in clinics and district hospitals. Treatment is focused mainly on preventive care and the management of acute and chronic diseases.[35]

There's no referral system, and residents are not required to have their own general practitioner (GP). However, initiatives such as the Family Doctor Integrated Care Plan encourage residents to enroll with a regular doctor or clinic (*see Integration and Care Coordination*).

In 2024, there were 270 practicing physicians for every 100,000 people — a 29 percent increase from 2014.[36]

Out-of-hours care is available at regional hospitals and medical centers, which are required to operate 24-hour emergency departments.[37]

Physicians are paid predominantly on a fee-for-service basis according to national uniform fee schedules set by the NHIA with input from industry stakeholders. Other sources of income include patient registration fees, services and goods not covered by NHI, and copayments and coinsurance. Pay-for-performance programs offer additional financial incentives for doctors based on the standard of their care for certain diseases and conditions, including cancer and diabetes.[38]

There are currently no data available for the number of practitioners employed publicly versus privately.

Outpatient/Specialist Care

Specialist care is provided in regional hospitals and medical centers. Care is typically accessed through primary care referral, self-referral, or hospital admission, depending on the severity of the patient's condition.[39]

There are currently no data available for the number of specialist medical practitioners or the proportion employed publicly versus privately.

Physician Education and the Workforce

There are both public and private medical schools, and the government limits admissions to 1,300 per year.[40] In 2021, annual tuition fees at public schools totaled TWD 78,327 (USD 2,439), while fees at private schools totaled TWD 135,829 (USD 4,298).[41]

While early specialty training is prioritized, including general medical practice in the initial years of residency, gaps in family medicine education remain. Only nine of the 13 medical schools, for instance, have dedicated family medicine departments.[42]

International students can access a range of scholarship options. The Ministry of Education has a scholarship program which pays up to NTD 40,000 (USD 1,273) each semester for tuition fees and expenses.[43]

The average salary for doctors depends on their specialty and experience. Typically, it falls in the range of TWD 1.2 million (USD 37,363) to TWD 3 million (USD 93,408) a year.[44] Attending physicians work an average of 69.1 hours per week.[45]

Hospitals

There are both public and private hospitals. Under the Medical Care Act, no for-profit hospitals are permitted. Most large-scale private hospitals are owned by foundations, and a number of small-scale private hospitals are owned by individual physicians or physician groups.[48] As of 2020, 83 percent of hospitals and 74 percent of beds were private.[49]

Hospitals derive revenues from the global NHIA hospital budget, which is divided into six regional budgets administered by NHIA regional offices. Under this arrangement, competition for revenues is intense among hospitals within each region.[50]

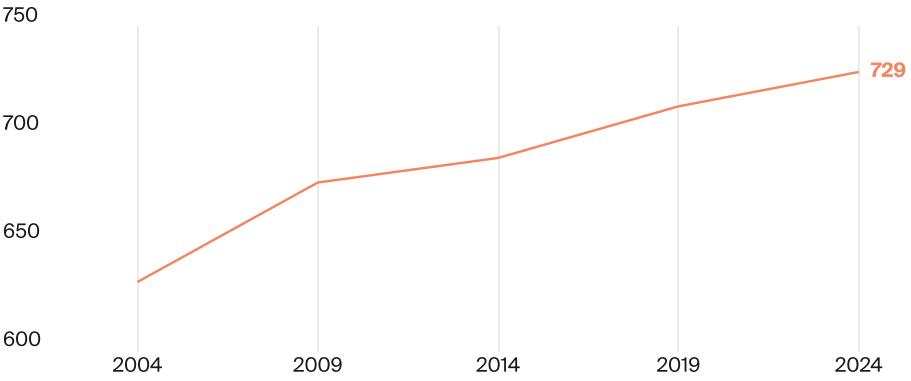
Hospitals are paid under a fee-for-service model according to uniform national fee schedules and diagnosis-related groups set by the NHIA with input from stakeholders. Hospitals also derive revenue from direct payments for non-NHI-covered services and goods, copayments for outpatient services, coinsurance for inpatient services, and registration fees collected at the time of service.[51]

HOSPITALS **BY THE NUMBERS**

In 2024, there were **626 registered nurses per 100,000 people**.[46]

In 2024, there were **729 beds per 100,000 people**.[47]

Number of Hospital Beds per 100,000 People, 2004–24



Source: Department of Statistics, "Statistics of medical care institution utilization, 2024," distributed by Ministry of Health and Welfare, accessed November 5, 2025.

Owing to strict budget considerations, hospitals are limited in their ability to hire medical staff. Over 74 percent of nurses work 40 to 60 hours per week. In 2022, the average salary was TWD 677,936 (USD 21,700).[52] Retention issues contribute to workforce challenges: in 2023, the practicing rate for nurses was about 60 percent.[53]

"The nursing shortage is serious," says Princeton University's Tsung-Mei Cheng. "In addition to low pay and long working hours, nurses feel like they aren't respected in the same way doctors are. As a result, many are leaving the profession. Policymakers are aware that this is fundamentally due to underfunding, and there's a big focus on finding ways to increase financial resources allocated to the system."

Mental Health Care

NHI covers mental health services on an outpatient basis (including day care) and on an inpatient basis for both acute and chronic mental health problems. Services are provided by public and private psychiatric hospitals, clinics, and community-based facilities. In 2023, there were 598 psychiatric care institutions: 203 hospitals and 395 clinics.[56]

The relatively high number of mental hospital beds per capita reflects a historical emphasis on institutionalization and long-term hospitalization for mental illness.[57] In 2024, there were 20,497 mental hospital beds, about 88 mental hospital beds for every 100,000 people.[58]

The Mental Health Act, implemented in 1990, has undergone significant changes to better reflect modern societal expectations and to reduce institutionalization.[59] The 2022 amendment aims to more comprehensively safeguard and care for individuals with mental illness, with greater emphasis on community mental health centers for preventive care and coordinated community support. As of 2022, 28 community mental health centers were operating.[60]

MENTAL HEALTH CARE **BY THE NUMBERS**

In 2024, there were **8 psychiatrists per 100,000 people**.[54]

In 2024, there were **88 mental hospital beds per 100,000 people**.[55]

The mental health workforce has expanded rapidly. In 2024, there were 1,974 psychiatrists, compared with 1,384 in 2010 — a 43 percent increase.[61] This equates to 8.4 psychiatrists for every 100,00 people.[62]

Despite these efforts to improve mental health care, stigma surrounding mental illness continues to deter many from seeking treatment.[63]

Long-Term Care and Social Support

Taiwan officially became an aged society in 2018, when individuals age 65 and over accounted for 14 percent of the population. The development of a comprehensive long-term care system has therefore become a national priority.[64]

LTC 2.0 expanded eligibility for services and promoted the integration of multipurpose community-based supportive services (*see Integration and Care Coordination*). At the end of 2022, there were 684 community integrated service centers, 7,432 combined service centers, and 3,758 long-term care stations. In the same year, 440,381 people were receiving long-term care services, a 13 percent increase from 2021.[65]

To meet growing demand, the MOHW has promoted workforce development through incentives such as improved pay and clearer career progression. At the end of 2022, there were 95,850 individuals employed in long-term care services, a 7.2 percent increase from 2021.[66]

The 2022 Regulations on Application and Payments for Long-Term Care Services entitle individuals who meet eligibility criteria to a personalized care plan developed by a community integrated service center. The care plan includes transportation, assistive device services, home accessibility improvements, and respite care. Once they have delivered services, providers can apply for reimbursement from the local government.[67]

Long-term care services are also available to individuals who meet eligibility criteria, such as age, disability, or functional limitations. For low-income families, the government pays 100 percent of long-term care costs.[68]

Cost and Affordability

Health Care Spending Overview

In 2023, health care spending as a share of gross domestic product was 7.3 percent,[69] which is below the 2022 averages for the Western Pacific region (8.1%) and high-income countries (8.2%).[70]

Total health expenditure has increased over time. In 2023, health spending was USD 55 billion — a 13 percent increase from 2020.[71] Per capita spending has also continued to grow, reaching USD 2,352 in 2023, 14.5 percent above 2020 spending.[72]

In 2022, government spending accounted for the largest share of health expenditure (74.5%), followed by out-of-pocket spending (21.4%) and prepaid private spending (4.2%).[73]

Pharmaceutical Spending

In 2023, pharmaceutical spending accounted for 16.1 percent of the total health care spending.[74]

The government strictly controls drug expenditure to ensure the availability and affordability of medications. In 2013, the NHIA introduced the Drug Expenditure Target (DET), which sets an annual budget. If spending exceeds the target, the DET activates a price adjustment mechanism. The following year, prices that exceed the predetermined range are subject to adjustment. While this is efficient from a cost perspective, it can limit access to more clinically effective drugs.[75]

There are currently no data available for per capita pharmaceutical spending.

Cost Sharing and Out-of-Pocket Spending

In 2023, out-of-pocket spending accounted for 38.8 percent of total health spending, above the 2022 averages in high-income countries (18.4%) and the Western Pacific region (16.8%).[76]

Most NHI services require some degree of cost sharing. Copayment levels depend on service type, provider level, and referral status. All outpatient consultations in clinics require a copayment of TWD 50 (USD 2). Copayments for appointments in hospitals or medical centers range from TWD 50 (USD 2) to TWD 170 (USD 5) if the patient has a referral. For those without a referral, the range is TWD 80 (USD 2) to TWD 420 (USD 13).[77]

Dentistry and traditional Chinese medicine have a standard copayment of TWD 50 (USD 2) regardless of the level of care required. Patients with a disability certificate are required to pay only the basic copayment of TWD 50 (USD 2) when seeking outpatient care at any hospital or clinic. Copayments are waived for 30 types of catastrophic illnesses and injuries.[78]

For inpatient care, copayments range from 5 to 30 percent for chronic illness and 10 to 30 percent for acute conditions, depending on length of stay. The copayment for each hospitalization for the same condition is capped at TWD 43,000 (USD 1,339), with an annual ceiling of TWD 72,000 (USD 2,242).[79]

Residents seeking outpatient, emergency, and home care services in areas that have been officially recognized as lacking medical resources, including mountain areas and offshore islands, receive a 20 percent discount on their copayments (*see Safety Nets*).[80]

The copayment for emergency care in district hospitals and clinics is TWD 150 (USD 5). This rises to TWD 400 (USD 12) in regional hospitals and TWD 750 (USD 23) in medical centers.[81]

Pharmaceutical copayments depend on the prescription cost. A 20 percent copayment applies to prescriptions of TWD 101 (USD 3) and over, capped at TWD 300 (USD 9) per prescription.[82]

How Are Costs Contained?

The most powerful cost-control tool is the global budget system, which caps annual spending at a predetermined level. This cap allows providers to maximize revenue while minimizing administrative costs.[83]

Although it's designed to maintain service coverage, the enforcement of a fixed budget has led to underinvestment in long-term health outcomes. For example, it does not allow for adjustments to meet evolving health care needs or technological advancements.[84]

In December 2024, Taiwan's suspension-and-resumption mechanism for Taiwanese residents living overseas was abolished to improve the financial sustainability of the health care system (*see Health Care Innovation*). This abolition is expected to generate an additional TWD 2.6 billion (USD 81 million) annually.[85]

Quality and Outcomes

Health Outcomes

In 2023, average life expectancy in Taiwan was 80.2 years, among the highest in the world.[93] Average life expectancy had increased for 10 years until 2021, when it fell for two consecutive years, largely because of the COVID-19 pandemic.[94]

That said, the aging population presents new issues. In 2023, adults age 65 and older accounted for 18 percent of the population. Chronic noncommunicable diseases are responsible for 80 percent of deaths, and older adults are particularly susceptible: 92.4 percent suffer from at least one chronic disease, and 56.6 percent suffer from three or more. Healthy life expectancy after age 65 is only 7.6 years.[95]

Addressing Health Inequities

Some gaps in health care persist in certain regions and populations. Rural areas, for example, often face limited access to primary care and specialist services in particular, leading to delayed diagnosis, inadequate treatment, and poorer health outcomes. In 2022, life expectancy in Taitung County was 76.5 years, more than seven years below that in the capital city, Taipei, where it was 83.8 years.[96]

Minority groups, including Indigenous populations and migrant workers, also encounter health care access difficulties, such as language barriers, cultural differences, and socioeconomic disadvantages. These difficulties can reduce these groups' use of health care resources and increase their health risks. In 2021, life expectancy among the Indigenous population was 73.9 years, nearly seven years below the national average.[97]

The government has introduced measures to address these issues, as discussed below.

Rural Health Care Improvement Program

In 2019, the government launched a rural health care improvement program that, between 2019 and 2023, invested nearly TWD 1 billion (USD 31 million) in upgrading primary care service capacities, expanding local medical talent pools, and improving local emergency care capabilities.[98]

HEALTH OUTCOMES **BY THE NUMBERS**

Life expectancy at birth was **80.2 years** in 2023, compared with 77.4 years for Southeast Asia, east Asia and Oceania.[86]

The maternal mortality rate was 1**4 deaths per 100,000 live births** in 2021 (compared with 48 in the Western Pacific region).[87]

In 2023, the infant mortality rate was **430 deaths per 100,000 live births** (compared with 410 in high-income countries).[88]

In 2021, the share of the population suffering from mental health disorders was **12 percent** (compared with 16% in high-income countries).[89]

In 2023, the suicide rate was **19.1 deaths per 100,000 people**.[90]

Guns were responsible for **0.1 deaths per 100,000 people** in 2023.[91]

12 percent of the population was obese in 2022.[92]

The Indigenous Peoples' Health Act

In 2018, the MOHW introduced an action plan outlining strategies to tackle disparities in Indigenous health care. Action points included government-funded training, community health development, and preventive services. In 2023, the government elevated the action plan to a law: the Indigenous Peoples' Health Act.[99]

Migrant-Worker-Friendly Medical Service Map

In 2024, the Ministry of Labor introduced a service to make it easier for migrant workers to access health care information in their native language. It is accessible via the LINE@E-LINE automated messaging service, introduced by the Ministry of Labor to help migrant workers with communication and adaptation.[100]

Other initiatives include LTC 2.0 (*see Long-Term Care and Social Support*) and the IDS, which develops alternative ways for underserved communities to access health care (*see Integration and Care Coordination*). One example is the deployment of mobile medical units equipped with facilities such as X-ray machines and blood-testing services to rural areas.[101]

Innovation and Reform

Health Care Innovation

Reforms are ongoing to improve health care accessibility, stability, and financial sustainability. In 2016, for instance, the medical referral system was reinforced by adjusting copayments for treatment across various tiers of medical care based on whether a referral is in place (*see Cost Sharing and Out-of-Pocket Spending*). The aim of variable copayments is to reduce pressure on more specialized hospitals and cut costs.[102]

In 2024, the government abolished the suspension-and-resumption mechanism, which had allowed overseas residents to temporarily suspend their NHI coverage and resume it when returning to Taiwan. Taiwanese nationals must now continue to pay their NHI premiums regardless of where they live or withdraw from the system entirely. The move is intended to make the system both fairer and more financially sustainable. It's also expected to reduce the number of overseas residents taking advantage of the system because of rising medical costs in their countries of residence.[103]

Health Care Technology

In 2024, the MOHW announced that three new centers would be established to facilitate the application of artificial intelligence (AI) in clinical settings through cross-hospital collaboration.[104]

Since 2004, residents have had access to an electronic NHI e-card containing personal, clinical, and insurance data.[105] Other initiatives include:

- **PharmaCloud** (2013): This is a cloud-based drug information system that gives doctors and pharmacists access to each patient's four-month prescription history. It also provides clinical recommendations to reduce adverse drug reactions and unnecessary prescribing.[106]
- **NHI MediCloud** (2013): This is used across hospitals and clinics and integrates PharmaCloud with data systems, including prescription histories, examination results, surgeries, allergies, and discharge summaries.[107]
- **My Health Bank** (2014): This allows individuals to access and download their comprehensive medical records from the previous three years.[108]

This profile reflects data as of January 2026. New or updated information may have become available since its release.

Notes

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