Global Budget Payment System

The global budget payment system was adopted to constrain the rapid growth in costs under the fee-for-service model and institute a system of financial accountability. Under the system, medical providers and payers negotiate overcall caps on total medical payments with the NHI system prior to the beginning of a fiscal year based on a fixed volume and range of medical services. The process is illustrated in Chart 3. The negotiated growth rates for each medical sector's total expenditures since 2006 are shown in Table 14.

If the total amount claimed for reimbursement by a sector exceeds the pre-set ceiling, point values for that sector's services may drop. If, on the other hand, a particular sector works together to reduce unnecessary treatment and strengthen preventive care measures, effectively controlling the volume of services provided, point values for its services may increase.

The global budget system was phased in between 1998 and 2002, capping overall expenditures in Taiwan's four broad medical sectors — dental (implemented in July 1998), traditional Chinese medicine (July 2000), western medicine clinics (July 2001) and hospitals (July 2002). Since the system was fully implemented in 2002, it has successfully controlled the growth of medical expenditures at below 5% a year. Chart 4 shows medical expenditure growth since 2006.

To ensure that patients' rights to care are not affected by the constraints of the global budget payment system, the NHIA and medical associations have adopted measures to jointly supervise hospitals and clinics that operate under the system and ensure that they are providing high quality care.

總額支付制度

為落實財務責任，同時避免在論量計酬支付制度下，引發醫療費用快速成長，全民健保醫療費用支付之設計，採用醫療費用總額支付制度。醫療費用總額支付制度實施之程序，是在每一年度開始前，由醫界與付費者就醫療服務內容，先協商次年適當的健保醫療費用總額。在此協定的額度下，若服務量過多，就可能導致每點點值降低；反之，若醫界間同儕合作，減少不必要醫療、加強預防保健措施有成，則因服務量可以有效控制，有可能提高每點點值。

醫療費用總額預算支付制度自 1998 年 7 月起由牙醫門診先開始實施，其後分別於 2000 年 7 月陸續推動實施中醫門診總額預算支付制度，2001 年 7 月實施西醫基層總額預算支付制度，至 2002 年 7 月實施醫院總額預算支付制度，完成全面實施醫療費用總額預算支付制度。總額預算支付制度全面實施後，有效將醫療費用成長率控制在 5% 以下。自 2006 年起之醫療費用成長率如圖 3。為確保民眾就醫權益不因總額支付制度實施而有所變更，健保署與醫療團體共同執行醫療品質確保方案，以監督醫療院所，提供更高品質的健康服務。醫療費用總額研擬程序如圖 4。2006 年起各總額部門醫療費用協定成長率如（表 14）。