TAIWAN LONG-TERM CARE PLAN 3.0

GL Framework — Structural Friction Diagnostic Report

GFI Flow Intelligence | April 2026 | Public Diagnostic Brief | SAMPLE REPORT

Policy Context: Long-Term Care Plan 3.0 — effective January 1, 2026

Approved by the Executive Yuan on December 31, 2025, LTC 3.0 sets a vision of healthy aging, aging in place, and dignified end-of-life care across eight strategic goals. Taiwan's disabled population is projected to grow from 923,000 (2026) to 1,296,000 (2035) — a 40% increase over ten years. LTC 3.0 budget exceeds NT$100 billion annually.

GL Diagnostic Question: LTC 3.0's goals are sound — but correct goals do not guarantee that the delivery system can convert policy intent into accessible, timely care. The denominator tells a different story.

GL Score

0.148

STRUCTURAL FAILURE

LTC 2.0 baseline: 0.137

EXECUTIVE SUMMARY

LTC 3.0 expands service scope, incorporates younger dementia patients, strengthens medical-care integration, and introduces smart assistive technology. However, the core structural problem driving LTC 2.0's low delivery efficiency — front-loaded sequential assessment, fragmented A-B-C tier navigation, and insufficient rural service reach — has not been fundamentally redesigned in the 3.0 framework.

GL = (Fs × Vn) / (Pd × Cf) = (0.54 × 1.35) / (2.5 × 2.7) = 0.729 / 4.925 = 0.148

Marginal improvement over LTC 2.0 (+8%), but still deep in the structural failure zone. Service volume expanded. The denominator did not shrink.

GL FORMULA VARIABLES — LTC 3.0 ASSESSMENT

Variable	Score	Definition	Taiwan LTC 3.0 Observed Conditions
Fs — Flow Success Rate	0.54	Proportion of eligible applicants who successfully obtain required services within standard timeframes	LTC 3.0 introduces PAC (Post-Acute Care) discharge linkage, which improves Fs for specific populations. However, formal needs assessment by a care manager (照管專員) remains a prerequisite for all service activation. An estimated 30–35% of eligible seniors drop off during intake. Rural counties face 12+ week waits due to assessment personnel shortage. Sources: Ministry of Health and Welfare LTC 3.0 plan; academic research on LTC 2.0 implementation outcomes.
Vn — Strategic Value	1.35 / 1.5	Societal importance as an aging society stabilizer (scale: 0.8–1.5)	LTC 3.0 expands coverage to dementia patients under age 49 and integrates National Health Insurance PAC services. Taiwan formally entered super-aged society status in 2025 (65+ population exceeds 20%). Disabled population

			projected to grow 40% by 2035. Strategic value rated higher than LTC 2.0.
Pd — Pain Duration	2.5×	Time and effort burden imposed on applicants and families (multiplier: 1.2–3.0)	For general applicants, the process remains: referral → assessment scheduling → in-home assessment → care plan formulation → service matching → provider contracting. Total time to first service: 4–12 weeks. No provisional service activation exists. Families managing acute care needs (post-stroke, injury) bear this entire process during the highest-stress period.
Cf — Cognitive Friction	2.7×	Complexity burden — can a family navigate independently? (multiplier: 1.2–3.0)	System fragmented across: health bureau referrals, A-B-C tiered service centers, individual provider contracts, subsidy calculations, and CMS disability levels 1–8. LTC 3.0 adds the Family Doctor Program, PAC linkage, and smart assistive technology on top of existing complexity. No single entry point exists statewide.

LTC 2.0 VS LTC 3.0 — GL COMPARISON

Dimension	LTC 2.0 (Baseline)	LTC 3.0 (2026 Current)
GL Score	**0.137**	**0.148 (+8%)**
Fs	0.52 — est. 30–40% eligible drop-off	0.54 — PAC linkage provides marginal improvement
Pd	2.6× — general intake 4–12 weeks	2.5× — specific PAC cohort shorter; general unchanged
Cf	2.8× — A-B-C tiers + CMS levels 1–8	2.7× — new service types added; integration complexity risk rising
Core structural problem	Front-loaded sequential assessment unchanged	**Front-loaded sequential assessment still unchanged**
Nighttime care	Severely insufficient	Remains a primary gap; not addressed in 3.0

DIAGNOSTIC RESULT

GL = 0.148 → Still in Structural Failure Zone

The LTC 3.0 diagnostic conclusion: service volume expanded, but the denominator did not shrink.

For every NT$1 of policy intent, only NT$0.148 reaches eligible recipients as accessible, timely care. LTC 3.0 budget exceeds NT$100 billion. Without denominator redesign, every additional dollar invested still loses more than 85 cents to administrative friction.

INTERNATIONAL BENCHMARK COMPARISON

System	GL Score	Key Structural Characteristic
Finland Social Care	**3.13**	Single-entry municipal system; provisional service within 72 hours of referral
Estonia Digital Care Access	**2.84**	Pre-loaded eligibility data; care plan from existing health records
Taiwan LTC 3.0 ← Diagnostic Subject	**0.148**	Front-loaded sequential assessment; no provisional activation; fragmented A-B-C tier system
UK Universal Credit	**0.074**	5-week structural wait; managed migration burden on claimants

Finland's GL is 21× Taiwan's. The difference is not funding — Taiwan's LTC budget tripled 2017–2023. The difference is process architecture.

DENOMINATOR ANATOMY — WHERE FAILURE OCCURS

Friction Source	Leverage	Reform Pathway
Front-loaded sequential assessment	**HIGHEST**	Adopt proportional sequencing: activate provisional care tier within 72 hours of referral using existing medical documentation. Full assessment becomes a calibration step, not an access gate.
Fragmented A-B-C tier navigation	**HIGH**	Establish single-entry case management. Family registers once; system routes internally. Eliminate requirement for families to understand tier structure independently.
Rural assessment personnel shortage	**HIGH**	Authorize telehealth-based functional assessments for rural counties. Reduce in-person requirement to final calibration visit rather than initial access determination.
LTC 3.0 new service complexity	**MEDIUM**	Family Doctor Program and smart assistive technology add value, but layer on top of existing complexity without a unified entry point. Single-window integration is required to prevent Cf escalation.

REFORM SCENARIO SIMULATION

Scenario	Intervention	Simulated GL	GL Gain
Current (LTC 3.0)	Existing system — no process redesign	**0.148**	Baseline
A	Full PAC discharge linkage for all applicants — provisional activation within 72 hours using medical documentation — Pd 2.5× → 1.8×	**0.211**	+43%
B — Recommended	**Scenario A + single-entry case management via 1966 portal + telehealth assessment for rural counties. Pd →1.8×, Cf →2.0×, Fs →0.65. GL = (0.65 × 1.35) / (1.8 × 2.0) = 0.243**	**0.243**	**+64%**
C — Finland-comparable	Unified entry + telehealth as primary assessment + automatic eligibility + provisional payment at referral. Pd →1.3×, Cf →1.5×, Fs →0.82	**0.755**	**+410%**

Scenario B requires no new legislation and no additional budget authorization. The intervention is process sequence redesign — the same reform pathway validated across 18 jurisdictions in the GL Framework.

STRUCTURAL RECOMMENDATIONS

Priority	Recommendation	Target Variable	Expected GL Impact
1	Introduce provisional care activation within 72 hours of referral using existing medical documentation (hospital discharge records, physician notes)	Pd ↓ — highest leverage	Eliminates intake gap that most acutely harms post-acute families. LTC 3.0's PAC mechanism already opened this door; extend the logic to all applicants.
2	Establish single-entry case management via 1966 portal — family registers once, system routes across A-B-C tiers, PAC, Family Doctor Program, and smart assistive technology internally	Cf ↓ + Fs ↑	Prevents LTC 3.0's new service types from adding complexity without integration. Critical to stop denominator escalation.
3	Authorize telehealth functional assessments for rural counties as primary assessment pathway; in-home visit becomes post-activation calibration	Pd ↓ — geographic barrier	Closes structural urban-rural GL gap. Brings rural GL closer to urban benchmark.

4	Publish multilingual eligibility pre-assessment tool on 1966 portal (Traditional Chinese, Taiwanese, Hakka, English)	Cf ↓	Reduces abandonment among linguistically marginalized populations.
5	Deploy real-time GL monitoring dashboard — flag counties where Fs drops below 0.60 for automatic resource reallocation review	Fs ↑ system-wide	Converts GL from diagnostic snapshot to continuous governance instrument.

METHODOLOGY NOTE

GL scores are computed using GL = (Fs × Vn) / (Pd × Cf). All input values derived from publicly available sources: Ministry of Health and Welfare (MOHW) LTC 3.0 approved plan (December 31, 2025), Executive Yuan policy documentation, academic research on LTC 2.0 implementation outcomes, and The Reporter (報導者) investigative reporting on LTC 3.0. This is an independent structural assessment — not a political statement. No internal system access required. Delivery timeline: 2 weeks.

The GL Framework has been validated across 18 systems in 14 countries and is published in PA Times (ASPA, March & April 2026) and SSRN (abstracts 6050695, 6178024, 6242658, 6372358).

GFI Flow Intelligence | gfiintel.com | Prepared by Ping Xu, Founder | gfi@gfiintel.com