

Universal Health Coverage: an Overview and Lessons from Asia

*Tsung-Mei Cheng, JD, MA, Woodrow Wilson School of Public
and International Affairs, Princeton University*

On December 12, 2012, the United Nations General Assembly passed a landmark resolution on Universal Health Coverage (UHC) in response to calls from a growing number of countries around the world for comprehensive health reforms towards universal health coverage. UHC became a key global health objective, and both the World Bank and WHO have urged nations to prioritize UHC to achieve sustainable development and global security.

In the two years since then, the global movement towards UHC has continued to gain momentum, culminating in the launch of the first-ever “Universal Health Coverage Day” on 12 December 2014, an effort sponsored by a global coalition whose members include the Rockefeller Foundation, the WHO, the World Bank, and more than 500 organizations from around the globe. The coalition’s main objective is to “stress the importance of universal access to health services for saving lives, ending extreme poverty, building resilience against the health effects of climate change and ending deadly epidemics such as Ebola.”¹

Why Is UHC Important?

UHC for a country may be defined as access, on equal terms, for all citizens to a specified package of the highest quality health care that country can afford without any citizens suffering financial hardship as a result. It does not preclude citizens from purchasing – with their own funds—additional, elective services such as cosmetic surgery, orthodontics, private hospital rooms, *et cetera*.

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UHC is important as a means to fight poverty in the age of deepening income inequality worldwide, recently highlighted dramatically in the important work on wealth and income inequality by the French economist Thomas Piketty in his 2014 book, *Capital in the Twenty-First Century*. Despite progress in the fight against lethal global diseases such as HIV/AIDS, malaria and other infectious diseases, each year the number of people falling into poverty due to the cost of medical care are growing. It is estimated that each year around 100 million people fall into the poverty trap because of illnesses, and that around one billion people cannot even access needed health care, paving the way for the spread of disease outbreaks around the globe,² and a vicious cycle of poverty, disease and threat to global health security

Like education, UHC is an important investment in human capital, which is necessary for economic growth and development; UHC lays the framework of opportunity for what Aristotle called “human flourishing,” an idea that has been elaborated by Nobel Prize-winning economist Amartya Sen.³

In today’s world of global mobility everyone has a stake in fighting infectious diseases wherever they arise, especially should some infectious diseases become drug-resistant. Nations go to great lengths and spare no financial resources to fight terrorism. Someday even the well off and well insured may come to realize that drug-resistant infectious diseases are biological terrorists. In a real sense, fighting this enemy should be viewed as part of national defense and global health security.

Some Caveats in the Use of the Term “UHC”

While the general goal UHC is laudable, a note of caution may be in order, because pursuing unrealistic goals will lead to inevitable subsequent disillusionment and barriers to what can be achieved realistically with a more modest agenda. It can also lead to a serious misallocation of resources.

First, UHC does not require a universally applicable package of health care services that must be covered. Access to health care in the U.S. means something very different from access to health care in Uganda. Put another way, universal access to health care in a country with a per capita GDP of \$50,000 means something different from access to health care in a country with a per capita GDP of \$2,000 or less.

Second, there is the problem that equal financial access that may be facilitated by health insurance does not necessarily mean equal physical access to high quality health care. Health insurance holds an empty promise if there are physical barriers to health care, high quality or not.

Third, it is not clear that the egalitarian precepts that are relevant and economically feasible in countries with a high per-capita income and a low inequality (or Gini coefficient), that is, a relatively equal distribution of income—as in Taiwan, for example—can arbitrarily be imposed on countries with lower GDP per capita but high Gini

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coefficients, a combination prevalent in much of the developing world, including China. A multi-tier health system with an adequate level of care for the poor may be better than an ideal, egalitarian system that cannot be achieved.

These are more than pedantic points. Far too much effort has been made by the governments of western developed countries, and by profit seeking enterprises, to bring to low- and middle-income countries highly sophisticated but also highly expensive health care that those countries simply cannot afford. It could even be said that devoting a nation's scarce public financial resources to, for example, the construction of highly sophisticated hospitals meeting modern day Western standards actually may harm the health of poor people who then are neglected, all for want of access to much cheaper primary care. Economists recognize this as the age-old concept of opportunity costs, a concept which has become increasingly familiar to health policy makers also. The opportunity cost of highly sophisticated health care within resource-constrained health systems may be high morbidity and premature death among poor people.

Health policy analysts and policy makers must be realistic when working within socio-economic constraints. Practically, in terms of global health programs, this means that the approach should be Rawlsian.⁴ It means that the concern should be mainly over how well the poorest within a country fare and less over whether the distribution of health care in countries conforms to egalitarian ideals.

A focus mainly on low-income families within countries would have two consequences.

First, it would stress the important role of public health and primary care in improving the health status of the population. Second, it would put into sharper focus the importance of the non-medical determinants of health. There is a well-known trade-off between health care proper and education, especially the education of women, as Chicago economist and Nobel laureate James Heckman would argue. A focus mainly on the plight of the poor in health care also would draw attention to the crucial importance of maternal and child health and nutrition in driving the health of populations.

Moving Towards UHC

With the preceding having been duly noted, it can be asked how best to approach UHC for specified benefit packages and in a specific social, economic and political context.

One begins this process by clearly articulating the distributional ethic that the health system is supposed to observe. As noted, that ethic is apt to depend on the degree of income inequality in a country.

Second, there has to be a clear definition on the package of benefits that is to be financed through insurance coverage.

Financing UHC

In regards to financing, one must note that neither government nor employers nor commercial health insurance companies actually ever finance anything. They may pay health care providers for health care delivered, but they will always recoup these outlays fully from private households in the forms of taxes, premiums, or reduction in take-home pay.⁵ All financing originates in private households, unless external (foreign) aid is a major source of a nation's financing for health care.

Developing a financing scheme for UHC is complex. One must consider all possible sources of financing first, and then examine the economic, administrative and ethical merits of each source.

The *major sources* of financing are taxes, premiums, philanthropy within countries, foreign aid, or self-pay by patients. Each of these major categories has several subgroups that differ quite substantially in terms of their ethical implications and behavioral effects. For example “premiums,” a major source of financing, can be based on ability to pay in the form of a fixed percentage of payroll (as in Germany) or charged per capita (as in Switzerland) or based on the individual's health status (as in the market for individually purchased health insurance in the U.S. prior to the full implementation of the Affordable Care Act of 2010 in 2014.)

Different governments may select differing financing sources based on: (a) the administrative feasibility of tapping that source (for example, collection of taxes and premiums), (b) the stability of the base for that financing, (c) the impact on the economic behavior, that is, the manner in which raising the finances might alter economic incentives within the economy, and (d) the fairness of the financing in terms of the distributional ethic posited for the health system.

There is no ideal, one-size-fits-all healthcare financing system, because each system is the product of many tradeoffs, compromises and national conditions.

The manner in which health care is financed actually is the most crucial vehicle for expressing the desired distributional ethic to govern access to a specified benefit package. Insurance coverage in effect amounts to a redistribution of purchasing power for health care in any given year. For that reason, the method of financing and risk pooling largely defines the degree of egalitarianism in financial, as distinct from physical, access of health care. The provision of physical access of health care to all segments of society is beyond the scope of this paper.

As a rule of thumb, the more egalitarian a UHC system is, the more heavily government will have to be involved in the financing of care. It requires social health insurance. A health system that relies purely on private, commercial insurers cannot ever achieve access to health care on egalitarian principles. The market constraints faced by commercial

insurance makes it incompatible with equitable access to health care and, in fact, quite natural lead to inequality. Unless they are expressly prohibited by government from doing so, commercial insurers have every financial incentives to base insurance premiums on health status and to reject relatively sick prospective clients unable to pay these “actuarially fair” premiums based on health status.

Available evidence to date shows us that countries with *social health insurance* systems, regardless of whether the health care services are delivered by publicly or privately owned facilities or a mixture of the two, provide their citizens equitable access to affordable health care services, regardless of their citizens’ socio-economic status and ability to pay.

Administering Health Insurance

There are two alternatives for organizing the financing of health care in social health insurance systems: a single-payer approach or a multi-payer approach.

Government-Run Single-Payer Systems: The administrative expense of government-run single payer systems (Taiwan, Korea, or each of the Canadian provinces) is usually the lowest attainable because these systems have common nomenclatures which facilitates the effective and efficient functioning of modern IT systems, and does not involve the cost to tax- or premium payers of marketing and profit taking. Single-payer systems also are the best platform for achieving an egalitarian distribution of financial access to health care and of the financial burden of poor health among populations.

Social Insurance with Multiple Payers: In many health systems today, including the U.S. and China, there is a trend towards separating the financing and the administration of health insurance.

In these health systems, while the government raises the financing of health care to assure an equitable distribution of the financial burden of health care among the population, the tasks of claims processing, quality monitoring and other forms of managed care, and paying provides are delegated to multiple commercial health insurers. Under the U.S. Medicare Advantage program, private insurers perform these functions for Medicare beneficiaries who prefer being served by private insurers. The U.S. Medicaid Managed Care program for the state-based Medicaid system for the poor perform these functions as well, as do the German, Swiss, and Dutch private insurers in their health systems.

The arguments made by proponents for that task delegation are that commercial insurers are more “efficient” than are government-run insurance systems and thus are able to achieve substantial savings in the use of health care. The empirical evidence bearing on this assertion, however, remains mixed and unconvincing.⁶ So far one should treat it as purely a theoretical proposition.

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Relative to government-run insurance, which has low administrative costs, reliance on multiple commercial health insurers to perform claims processing and paying providers will entail higher administrative costs for marketing, administration, and profits. In the U.S., those costs are now constrained under President Obama's Affordable Care Act (ACA) to no more than 15% of collected premiums for larger commercial insurers and 20% for small insurers.⁷

Furthermore, lacking the market clout of large, government-run single-payer insurance systems, private insurers typically must pay the providers of health care higher prices for health care. Because private insurers must pay higher prices for health care services and incur higher administrative costs, they can perform the task of administering government-financed health insurance more cheaply than can government-run insurance only if they can reduce the use of health care per insured patient below the use-rate under government-run insurance, and do so without impairing the quality of medical treatments.

Sustainability

Just as "UHC" has been a poorly defined term in health policy circles, so has the word "sustainability." What do users of the term mean by it?

There actually are two kinds of "sustainability" for health care systems: one refers to *economic sustainability*, the other *political sustainability*. A health system needs to be both *economically* and *politically* sustainable to be truly sustainable over the long run.

"Economic sustainability" means how much of its GDP a nation can afford to allocate to health care, given the many other human needs or desires, all of which seek claims on the nation's resources. Economic sustainability also could refer to the adequacy over time of the health-care workforce. The issue arises as the dependency ratio – the ratio of the sum of young dependents and the elderly to the number of people of working age – continues to rise worldwide, albeit at different rates across countries. One can only hope that labor-saving technology in health care can come to the rescue here, as most likely it will.

"Political sustainability," on the other hand, means how much the better-off in society would be willing to pay, either with taxes or community-rated health insurance premiums, to help finance the health care needs of lower income citizens who cannot afford to pay for that care with their own resources. It is an aspect of a nation's dominant social ethic, which is a product of history, contemporary culture and education.

Political leadership and support at the top are necessary for building politically sustainable health systems. For example, China's ambitious and comprehensive health reform that began in 2009, and is continuing and deepening today, would not have been possible without the sustained commitment of leadership at the top to the central value of solidarity and

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equity for all citizens, coupled with significant investments in the health care sector through public financing. Likewise, as noted above, Vietnam's ongoing efforts towards UHC would not have been possible without the support and commitment of the country's top leadership, once again coupled with significant investments in the health sector through public financing and commitment to the principle of solidarity and equity.⁸

Taiwan's well established universal National Health Insurance is thriving today, also in a fundamental way because of continued political support and commitment from the top, continued commitment to the principle of equity, accompanied by increasing government contributions to the health care sector.

Lessons from Asia

The Asian economies provide a rich pastiche of different approaches to health care systems. Experiences from, for example, Taiwan, South Korea, Hong Kong, China, and Vietnam may be informative.

Taiwan and South Korea have adopted a single payer approach, with government-run health insurance system, that manages not only the financing, but also the claims processing, monitoring of quality, fee-negotiation and payment of provider.

Both Taiwan and South Korea have tried to broaden the income base on which to levy premium to improve the fairness in financial contributions. Historically both systems have relied solely on payroll income on which to levy premiums.

In January 2013 Taiwan implemented a new, supplemental financing scheme that added a 2% premium on six additional sources of non-payroll income (interest, dividend, rental income, professional fees, income from second jobs, and bonuses) to the basic payroll based premium base, levied at 4.91% of salary and wages.⁹ This reform significantly improved not only the financial status of the NHI, turning it from a status of large deficits to one with a solid surplus, but also the fairness in financial contributions by making the well-to-do pay a larger share of the premium burden.

Of the single payer social health insurance systems in operation today, Taiwan's National Health Insurance (NHI) stands out as an example of a well-functioning system that achieves equity and social solidarity, good cost control, and administrative efficiency. Accounting for 52.2% of Taiwan's total national health spending of 6.6% of GDP (2013),¹⁰ Taiwan's NHI combines a government-administered social health insurance system with a predominantly private delivery system. It provides universal coverage to its 23.4 million citizens with a comprehensive and uniform national benefits package — primary (outpatient) care, inpatient care (including expensive cancer treatments and organ transplants), drugs, dental care, traditional Chinese medicine, dialysis, etc., without waiting lines, at an annual administrative cost of

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1.06% of the total NHI budget, and with high public satisfaction (80%).¹¹

Going forward, one might conclude that Taiwan's NHI is economically sustainable for the foreseeable future. At slightly over half of Taiwan's national health spending of 6.6% of GDP, Taiwan's NHI appears to have elbow room for growth given Taiwan's high GDP per capita (PPP) of \$41,539 (IMF 2013). In addition, the high public satisfaction the NHI enjoys and the political stability of Taiwan also make Taiwan's UHC scheme politically sustainable for the foreseeable future.

Korea's single payer National Health Insurance, while quite similar to Taiwan's single payer National Health Insurance in many respects, has not been able to control health spending growth as well. Among OECD countries, Korea has been the country with the highest rate of health spending growth.¹²

Hong Kong under British rule transplanted the idea of a NHS in the form of the Hong Kong Hospital Authority which managed both the financing and delivery of health care. In that regard it resembles the U.S. Veterans Administration system. It is "socialized medicine" in its purest form.

China can be said to be still in the early stages of moving towards UHC. Under Communist rule, prior to market reforms following reform and opening in 1978, there existed in China what might be called UHC for whatever health care benefits China could deliver at that time — primarily primary care and public health. With the market reforms that began in 1978, that system was destroyed. It gave way to a market-oriented health system in which just 55% of the urban and 21% of the rural population had any health care coverage in 2003.¹³ Those who had high income had coverage for ever more sophisticated health care. Prices for health care went through the roof, a fact also enjoyed by many manufacturers of health care products inside China and abroad.

In 2009, China began a comprehensive health reform that addressed all the important areas that needed reform, namely, health insurance expansion, establishment of the essential drug list, expansion of capacity of the health-care delivery system focusing on grassroots health care facilities and workforce, expansion and equalization of public health services, and public hospital reform. Today most of China's population has access to health insurance (more than 96% and 99-100% in some rural areas)¹⁴ for some benefit packages, although the specific health services vary significantly among provinces of varying wealth in urban and rural regions. The Chinese government's ultimate goal is to bridge this chasm in benefits coverage. At the moment, China appears to be grappling with differentiating the roles of the public and private sectors and searching for the appropriate role of the private sector, for example, engaging private commercial insurers to perform the functions of claims processing, quality monitoring, and payment of providers. It is a work in progress, through trials and errors.

It remains to be seen what China's experimentation with delegating

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the tasks of claims processing, quality monitoring and paying providers will achieve in the longer run. The original intent of China's health reform since 2009 has been to develop a "harmonious society" where "everyone enjoys equal access to basic health care and medical services."¹⁵ This would imply a roughly egalitarian health system with financing based on ability to pay, and access to health care provided on roughly equal terms. However, unless that reform effort is very closely monitored by government and kept channeled in that direction, the Chinese health care system may end up more like the U.S. system, which is a patchwork of quite distinct health insurance systems – socialized medicine for the veterans, a single payer for the elderly and the poor, and a health system substantially segmented by risk class for everyone else, and last but not least, a system that always will be very expensive and always will beget much waste.¹⁶

Vietnam, which has recently entered the ranks of lower-middle-income countries, has made significant progress towards UHC under a government-run single payer health system whose core structure relies on a national network of primary care facilities and strong emphasis on public health. It should be noted that Vietnam's ongoing efforts towards UHC and achievements so far would not have been possible without the support and commitment of the country's top leadership, once again coupled with significant investments in the health sector through public financing and a firm commitment to the principle of solidarity and equity, and competent health care bureaucracy under the ministry of health.¹⁷

Developing countries and emerging market countries seeking UHC may be well served to start with a single payer social health insurance system like Taiwan's National Health Insurance for equity, good cost control, and administrative efficiency, and allow both public and private providers to compete and deliver health-care services. Taiwan's approach followed the recommendation in 1989 of Princeton economist Uwe Reinhardt to adopt a single-payer health insurance system, a recommendation which the government adopted in 1990.¹⁸ According to Reinhardt, once the financing and administration are in the hands of government, market forces could be engaged where they are not counter-productive to the achievement of desired social goals – in Taiwan's case, an egalitarian and affordable health system.

Multi-payer social insurance systems tend to be more costly to run, as is the case with Germany's social health insurance system, the Swiss system, or the U.S. Medicare Advantage system. Offering citizens a choice of insurance carriers – as distinct from freedom choice of providers of health care—is not a free lunch, it costs money.

Summary and Conclusion

The world-wide drive by the World Bank, the World Health Organization, and hundreds of organizations devoted to the cause for UHC will entail a

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very long and very hard struggle. Health reform takes a long time in even the richest of countries (the U.S., Switzerland, the Netherlands, *et cetera*).

For one, the task is technically quite complex, as has become abundantly apparent from the passage and the implementation of the ACA, which in fact addresses only a small part of the U.S. health care system.

Second, the task faces an uphill struggle for political reasons because, however structured, UHC entails a significant redistribution of income from the well-to-do to the poor and from the healthy to the sick. People may endorse that redistribution at the rhetorical level but get serious second thoughts when it comes time to step up to the cashier's window. We have witnessed that, too, in the wake of the passage of the ACA.

As this author reported in a 2003 paper, "Taiwan's New National Health Insurance: Genesis and Experience So Far,"¹⁹ a major lesson from Taiwan shows that so-called "windows of opportunity" should not be missed in efforts to move to UHC. This is a particularly important lesson for low-and middle-income countries. In Taiwan, that window of opportunity consisted of rapid economic growth averaging 9% a year through the 1980s, a budding democratic electoral system in which health reform had become a major plank in party platforms, a powerful leader willing to expend political capital on the issue, and a highly motivated and well-educated bureaucracy willing and able to embrace the complicated task of implementing the system. This confluence of factors made it possible for Taiwan to develop the blueprint for UHC in the short period of a little of over half a decade beginning in the late 1980s, pass the NHI Law in July 1994, and commence *full* implementation in March 1995, less than a year after the law's passage and five years ahead of the scheduled implementation date of 2000.

Had Taiwan not moved up the implementation when it did in 1995, it would have run into the Asian financial crisis of 1997 which might have put the break on the full implementation of the plan, perhaps even indefinitely as economic growth in Taiwan had slowed in the years since.

For students of health policy and for health policy makers, Taiwan provides the textbook model on designing and implementing a system of UHC.

It is possible to have, or build, universal, sustainable, 21st century health care systems. The world has seen how it could be done, and also how significant progress can be made with limited resources through judicious approaches to organizing the financing and delivery of essential health care services. Indeed, barring future global financial shocks like the 2008 financial crisis, countries seeking UHC may confidently walk the path towards UHC and provide their citizens health care and the opportunity for realizing their full human potential, not even to dwell on the contributions healthy people and healthy lives can make to a country's economic growth and prosperity.

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