Medical Health Insurance Systems in Asia

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Abstract : Aging is a natural biological process which increases the risk of disease, thereby requiring medical care. This is now a global phenomenon with an urgent public health challenge and continues to accelerate rapidly. To confront this challenge, the United Nations has recommended Universal Health Coverage (UHC), adopted in all countries by 2030, as one of its Sustainable Development Goals (SDGs). In fact, however, there is a great variation of the pace at which different countries are moving toward the goal of UHC for all people. Most Asian countries are struggling to achieve this goal with rapid progressing of aging and low birthrate and often insufficient resources.

This report focuses on the medical health insurance systems in Asian countries with a large number of elderly people. We summarize the characteristics and challenges of the health insurance systems and classification of financial resources of medical health insurance, based on research reports and government records in 2008 to 2018. It is necessary to develop country-specific variations of UHC, and this can best be completed by sharing information and incorporating the most useful aspects of mutual nation's system. This process would contribute to the goal of establishing UHC on a global scale, not limited in Asia.

Key words : Universal Health Coverage, low birthrate, aging, medical health insurance

Introduction

Everyone should be equal wherever one is born in the world, but there are health disparities even in the same country or different environment where they are born. According to the 2017 Global Monitoring Report written by World Health Organization and the World Bank, "at least half the world's population still lacks access to essential health services. Furthermore, some 800 million people spend more than 10 per cent of their household budget on health care, and almost 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses[1)]." Under the condition, Universal Health Coverage (UHC) with core of right for health is aiming to achieve that "every individual and community, irrespective of their circumstances, should receive the health services they need without risking financial

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hardship[1]. ”

In the Sustainable Development Goals (SDGs) adopted at the United Nations Summit in 2015, the UHC promotion was raised in the Goal 3 (health and welfare). As of now, the degree of its achievement varies in each country: already achieved, or nominal succeeded but not actually working, and being on the target but not completed.

Rapidly declining birthrate and accelerated aging in Asia

In Asia, population aged over 65 years rated 6.7% and 13.0% in Viet Nam and Korea respectively in 2108 as shown in Talbe1[16]. Viet Nam and Korea are forecasted to become an aging society and an aged society in each soon. The doubling time to become population aging rate of 7% to 14% is estimated to 14 years in Viet Nam, 16 years in Singapore, 17 years in Korea, 19 years in Indonesia, 20 years in Thailand, Malaysia, Philippine, and 23 years in China. Within a short period of 10 to 30 years, aging will be faster in Asian countries[17, 18].

Total fertility rate (TFR) fell below the population replacement level 2.1 to 1.3 in Singapore, 1.5 in Thailand, 1.6 in China, 2.0 in Malaysia and Viet Nam with low birthrate[17]. While the aging population is increasing, it implies the declining in total and productive population, and labor force. Thus, for instance in Thailand, declining birthrate and accelerated aging goes up in the early stages of economic development. Government has to prepare for two kinds of policy, social security system for the elderly and childcare support at the same time. Actually, insufficient financial resources block to prepare for the aging and low birthrate.

Financial resources patterns of medical health insurance

Global medical health insurance systems are mainly divided into three models: the national health service (single-payer) model, the social

Table 1　Basic Statistics of the Asian Countries

	Populations (million)	Population aged over 65 (%)	Life expectancy at birth (years)		Total fertility rate
			male	female	
China	1,403.50	9.7	75.0	78.1	1.6
India	1,324.20	5.6	67.4	70.5	2.3
Indonesia	261.1	5.1	67.4	71.7	2.3
Korea	50.8	13.0	79.3	85.4	1.3
Malaysia	31.2	5.9	73.4	77.9	2.0
Philippines	103.3	4.6	66.0	72.9	2.9
Singapore	5.6	11.7	81.3	85.3	1.3
Thailand	68.9	10.6	71.9	79.3	1.5
Viet Nam	94.6	6.7	71.9	81.1	2.0

insurance (multiple-payer) model, and the private (market-based) model. The national health service model is that the government is the primary provider of medical services with financial resource from tax like England and Canada. The social insurance model is that the providers of medical services are mixed with public (primarily) and private (optionally) insurance organizations like Japan and Germany. The market model is that medical services are mainly provided by private organizations with private medical insurance premiums like America[19].

Medical health insurance systems in Asia consist of a mixture of the social insurance premiums and public expenditure, but some countries are not in Table 2. For instance, Malaysia has no public medical insurance system and manages medical health services with financial resource from tax. The medical health insurance system in Singapore is based on a fund system, managing the fund in the Central Provident Fund. In countries where the majority of workers occupy the informal labor sector and therefore have unstable incomes such as Indonesia and India, it is not a proper way to pay for fixed insurance premiums.

Medical health service is apt to be given priority for public officers, not for socially vulnerable people such as rural residents, farmers, fishermen, low-income people, and ethnic minorities. While, India has medical health insurance system called Rashtriya Swasthya Bima Yojana (RSBY) for the poor belonging to the Below Poverty Line (BPL) adopted in 2008. This system is not enough to cover the outpatient care and medical products which will be occupied the most of medical expenses with out-of-pocket payments, due to secure for only certain inpatients. Some countries have limited and small amount of public financial resources which can be reliable for the poor like Viet Nam of socialist country.

Medical health insurance systems in Asian countries

It is summarized the characteristics and tasks of health insurance systems in Asia, based on the documents in 2008 to 2018 in Table 3.

China

China has three sorts of medical insurance systems: Urban Employee Basic Medical Insurance System; Basic Medical Insurance System for Urban Residents; New Rural Co-operative Medical Care System (NRCMCS). It was announced that Urban Employee Basic Medical Insurance System and Basic Medical Insurance System for Urban Residents were integrated into Urban and Rural Residents' Basic Medical Insurance Systems in 2016[2-4, 20, 21].

Urban Employee Basic Medical Insurance System

This is a compulsory coverage for company workers in the city including urban and rural family registers, self-employed, public officers and their retirees. It is composed of two-story structure: personal account (personal savings) and fund (social insurance system). Hospitals and pharmacies which are eligible for medical insurance benefits have a system designated by the government. Medical insurance system involves two-story structure. The first floor includes benefits of basic medical expenses. The second one comprises benefits of high-cost hospitalization and visits for treatments of specific diseases. Personal accounts are used to pay for medical treatments and medication. The first and second floors are benefits from the public medical insurance fund.

[Old] Basic Medical Insurance System for Urban Residents

It is an optional coverage for non-workers, elderly, defectives, elementary students to college stu-

Table 2　Financial resource patterns of medical health insurance system

		Insurance scheme	Financial Resources		Self-pay burden	Public Hospitals
			Insurance Systems	Government Subsidizations		
China	Urban and Rural residents' Basic Medical Insurance Systems (insititutionally integrated in 2016)	Urban Employee Basic Medical Insurance System	+	—	+	—
		[Old] Basic Medical Insurance System for Urban Residents	+	+	+	
		[Old] New Rural Co-operative Medical Care System (NRCMCS)		+	—	
India		Central Government Health Scheme: CGHS	social insurance system	+		—
		Employees' State Insurance Scheme: ESIS	Social insuracne system	+	—	
		Rashtriya Swasthya Bima Yojana: RSBY	—	+	—	—
Indonesia		SJSN (Sistem Jaminan Sosial Nasional) Health	Social Insurance system	+	—	Free for the poverty
Korea		Universal Health Coverage	Social Insurance system	+	+	—
Malaysia		No public system of medical health insurance Private medical facilities with free consultations	—	—	+	—
Philippines		Philhealth	Social Insurance System	+	+	—
Singapore		Medisave	Fund System	—	—	Partially self-pay burden
		MediShield	+	—	+	
		Medifund	—	+	—	
Thailand		Civil Servant Medical Benefit Scheme: CSMBS	—	+	—	Free for low income group
		Social Security Scheme: SSS	Social Insurance System	+	+	
		Universal Coverage	—	+	+	
Viet Nam		Health Insurance	Social Insurance System	+	+	—

Table 3 Medical health insurance Systems in Asia

	Insurance scheme	Basic Act	Enforcement year	Main Administration	Financial Resources		Eligibility	Benefits	Out-of-pocket payments	Number of admitted insurance	Public Hospitals
					Insurance Systems	Government Subsidizations					
China	Urban Employee Basic Medical Insurance System	Social Insurance Act	Introduced in 1951 Renewed system in 1998	Direct controlled city , city (principle)	First Floor (Basic Medical Insurance) ·Business principle burden:total wages of employees x 8% ·Employee burden: employees' average wage last year x 2% Second Floor (Expensive Medical Insurance) : different in each reeion	–	Employers working in the city (city register+provincial register), self-employed, civil servants	First Floor: benefits for basic medical expenses Second Floor: benefits for expensive fee of hospitalization, hospital expenses of special diseases	Personcal account saving are used to pay for medical treatments and medication (benefits from public health insurance fund in both floors)	295.32 million (2016) coverage rate: 32.4%	
	[Old] Basic Medical Insurance System for Urban Residents Urban and Rural residents' Basic Medical Insurance Systems (insitiutionally integrated in 2016)	Social Insurance Act	Introduced in 2007 Renewed system in 2003	Cityiy Prefecture, city	First Floor (Basic Medical Insurance) :pay by selecting from a number of per-set premiums (insurance premiums are different in each region) Second Floor (Medical Insurance for Serious Diseases): basically no payment	Provincial government and district government subsidize a certain amount for each inhabitant every year Provincial government annually subsidizes more than 10 yuan per person	Non-workers, elderly, defectives, students, and children in the city register Rural citizens in the provincial register	First Floor: benefits for basic medical expenses Second Floor: benefits for expensive fee of hospitalization, hospital expenses of special diseases(medical insurance for seriours diseases) (First Floor: benefits from public health insurance fund Second Floor: benefits from medical insurance for serious diseases managed public-private collaboration)	Local government regulates Free	448.6 million (2016) 670 million (2016) Coverage rate: 98.8%	
India	[Old] New Rural Co-operative Medical Care System (NRCMCS)	Social Insurance Act	Introduced in 1959 Renewed system in 2003								
	Central Government Health Scheme: CGHS		1954		Social insurance system salary of an insured persion	Budget of Central Government	Senior citizens and retired personnel in Central Government bodies	Specialist consultation, hospitalization, pharmaceuticals		2.966 million (2015)	Free
	Employees' State Insurance Scheme: ESIS	The Employees' State Insurance Act	1952	Employees' State Insurance Corporation: ESIC State Government (based on the guildline of Ministry of Labour and Employment)	Social insurance systems Employer: 4.75% of the wages payable to employee Employees: 1.75% of the wages payable to an employee	Provincial Government: 12.5% subsidization for medical payment Central Government: 75% subsidization Provincial Government: 25% subsidization for all medical insurance	Employees of private formal sector Below Poverty Line: BPL Five members including a householder are secured	Medical services, sickness, maternity (payment in kind) Allowance for invalidity, family, and funeal expenses Hospitalization in the registerd hospitals, 100 rupees of carfare per hospitalizaiotn, carfare for screening and monitoring	Free Free	29.30 million (2017)	
	Rashtriya Swasthya Bima Yojana: RSBY		2008		–					36,330 households (2017)	

	Insurance scheme	Basic Act	Enforcement year	Main Administration	Financial Resources		Eligibility	Benefits	Out-of-pocket payments	Number of admitted insuracne	Public Hospitals
					Insurance Systems	Government Subsidizations					
Indonesia	SJSN (Sistem Jaminan Sosial Nasional) Health	Act on the National Social Security System	2014	Badan Penyelenggara Jaminan Social (BPJS)	Social insurance system ① Civil servants, military personnel, and police officers: for 5% premium of monthly wages, employers and insured persons pay 3% and 2% in each. ② The other wage labors: for 5% premium of monthly wages, employers and insured persons pay 4% and 1% in each ③ Non-wage labors and non-workers：the insurance premiums are different according to the hope ward of the service benefit ④ Pensioners: for 5% premium of bsic pension and family allowance, government and pernsioners pay 3% and 2% in each	Government coverage for the poverty	Entry obligation for all nations will start on January 1st, 2019 All nations (poverty, capital, labor), foreigners working over 6 months in Indonesia	Hospitalizaion, specialist consultation, medicatin, maternity, and emergency treatments	Free Self-burden: the difference over the prescribed amount in a Ministerial Ordinance	1.27 billion (2014)	not expensive for medical treatments and medication free for the poverty financial support for the central government
Korea	Universal Health Coverage	National Health Insurance Act	1977 1989 (UHC)	National Health Insurance Corporation: NHIC Health Insurance Review and Assessment Servant: HIRA	Social insurance systems Employment health insurance: capital and labors share 5.89% of monthly reward in half and 2.945% of monthy income in half Community medical insurance: accoirding to each income and property, imposed points of insurance multiply 172.7 (2013)	Public revenues General tax and tobacco tax (2012)	All people in Korea Divided into three groups: employment members, dependents, and community members	Medical allowance, medical expenses,disability allowance for security instrunments, consultation for maternity, and medical check ups	・Hospitalization: 20% payment for all medical facilities ・50% payment for meals during hospitalization ・30~60% payment for consultation ・30~50% for medication ・5% for a serious case ・10% for an incurable case	National Health Insurance: 49.662 million	
Malaysia	No public system of medical health insurance Private medical facilities with free consultations								In 1951, medical treatment fees were set up ,based on the Fees Act Patients have less self-burden , due to the help of federal budget		
Philippines	Philhealth	Republic Act No.7875	1995	Philippines Health Insurance Corporation (PHIC): Philhealth	Social insurance system Capital and labors share 2.5% wages in half	Government payment for indigenous residents Local governments payment for low-income residents	All citizens in Philippines	Hospitalization, expensive medical allowance, speicalist consultation	Self-burden: excess cost for hospitalizaion of diseases regulated comprehensive payment Self-burden: excess cost per medical consultaion, excluded from comprehensive payment	80.67 million (2013)	

	Insurance scheme	Basic Act	Enforcement year	Main Administration	Financial Resources		Eligibility	Benefits	Out-of-pocket payments	Number of admitted insuracne	Public Hospitals
					Insurance Systems	Government Subsidizations					
Singapore	Medisave	Central Provident Fund Act (Chapter 36)		Central Provident Fund Board	Reserve fund system Capital and labors accumulate a certain percentage of the salary in a worker's personal account	–	Employment nations, permanent residents in Singapore, and self-employed over a certain income, and Singapore seaman of foreign nationality	Hospitalizaion, chronical diseases, expensive inspections, and expensive medical allowance	Free	3.42 million (2012)	20~30 per condultation available for general people reduced treatment fee for over 65 yrs or more and children
	MediShield	Central Procident Fund Act (Chapter 36)	2014	Cetral Provident Fund Board	Annual insurance fee is set up, according to the age	–	All Medisave members join in	Hospitalization, chronic diseases, expensive inspection, and medical allowance (support for tne expensive or long-term medical allowance over the coverage of Medisave,	Setting the maximum on the amount of insurance claims depending on the hospitalizaion days and surgery	–	
	Medifund	Medical and Elderly Care Endowmen t Schemes Act (Chapter 173A)	1993	Medifund Committee	–	The National Treasury for all costs	Nations in Singapore	Hospitalization, specialist consunltation, and nursing	Free	587,481 (2012)	
Thailand	Civil Servant Medical Benefit Scheme: CSMBS	Imperial Ordinance	1980	Central Accounting Breau in Ministry of Finance	–	Tax resources	Public servant and retired personnel in government bodies	Payment in kind with all-inclusive coverage	Free in general Self-burden: hospitalization in a private hospital Repayment: mecial facilities with no registeration	4.97 million (2012) Coverage rate: 8%	30 baht of personal payament per consultation free for low income group
	Social Security Scheme: SSS	Social Security Act	1991	Social Security Office in Ministry of Labour	Social insurance system Capital and labors share 10% wages in half	Government additional subsuduzation: 2.75% of wages payable to an insured person	Compulsory registered: insured personnel in private business aged 15 to 59 Voluntary registered: farmers and the self-employed	Payment in kind: consultaion, nursing, medication, transportation Cash payment	Defective allowance in social insurance scheme: free consultation within the fixed limits	14.04 million (2016) Coverage rate: 21%	
	Universal Coverage	National Health Security Act	2002	National Heath Security Office (NHSO)	–	Tax resources	Voluntary registed: farmers and self-employed, inapplicable to CSMBS or SSS	Main treatment for acute symptoms Available for activites of disase prevension No cash payment	30 baht payment per consultation and hospitalizaion	48.62 million (2012) Coverage rate: 3/4	
Viet Nam	Health Insurance	Health Insurance Act (25/2008/QH12) Health Insurance Act (46/2014/QH13)	2009 2015	Ministry of Health: MOH Viet Nam Social Security (VSS)	Social insurance systems ① Labor-management contributions: labors in the private companies, and civil servants ② Social insurance contributions: social insurance recipients of retirement allowance, and unemployment insurance recipients ③ Voluntary contributions: persons engaged in the agriculture, forestry, and fisheries industries, and self-employed residents	① Full contribution from government: officers, the poverty, minorities in a socially and economically difficult situation, under 6-year-old children, revolutionary contributors and their families ② Partial contribution from government: students, and quasi-low-income residents	Compulsory registered Labor contract workers for more than 3 months, civil servants, social insurance recipients as to retirement allowance and allowance for occupational accidents and unemployment, the poverty,minorities in a difficult situation, foreigners received a Viet Nam government scholarship, under 6-year-old childern, students, and persons engaged in the agriculture, forestry, and fisheries industries	·Consultaions, treatments, rehabilitation, regular check-ups for fetus, and childbirth ·Hospital transfer costs from country level hospital to upper level one, in case of emergency hospitalizaion, and under 6-year-old children, and the poverty	① Health insurance fund and personal payment: cost of consultaions and treatments The paid ratio from health insurance fund is divided into three types of insured category ② In case of treatments at the inappropriate level hospital, payment from health insurance fund will be reduced, according to the hospital levels	64.65 million Coverage rate: 70% (2014)	

dents, and children aged under 16 years in the city family register.

[Old] New Rural Co-operative Medical Care System (NRCMCS)

This is a healthcare system of optional coverage, intended to make more affordable for the rural farmers. The Urban and Rural Residents' Basic Medical Insurance Systems, integrated in 2016, has two-story structure system. On the first floor, benefits of basic medical expenses are paid from public medical insurance fund. On the second floor, benefits of high-cost hospitalization and visits for treatments of specific diseases are paid from medical insurance for serious illness, managed by public-private collaboration.

India

Three types of medical insurance systems exist in India: Central Government Health Scheme (CGHS) for public servants; Employees' State Insurance Scheme (ESIS) for employees of private formal sector; Rashtriya Swasthya Bima Yojana (RSBY) for the poor. The poor are households belonging to the Below Poverty Line (BPL), determined by the government. The institutional subscribers of ESIS and RSBY can use free medical care in the registered medical institutions. These medical security systems do not reach the Universal Health Coverage because of the limited targets.

Central Government Health Scheme (CGHS)

Financial resources are social insurance systems and public expenditures. The premiums are paid by the insured person's salary, 250～1000 Rupees per month. The public expenditures are subsidized from Central Government budget. Benefits cover the comprehensive medical care such as outpatient, hospitalization, and medicine.

Employee's State Insurance Scheme (ESIS)

Employee's State Insurance Corporation (ESIC) mainly manages operating body. Financial resources are premiums that employer burdens 4.75% of the wages and employees burden 1.75% of their wages. On the public expenditures, provincial government subsidizes 12.5% of medical benefit costs, within the maximum of 15,000 Rupees per person annually. Benefits cover the in-kind payments such as outpatient and hospitalization, and the cash payments as an invalidity allowance.

Rashtriya Swasthya Bima Yojana (RSBY)

Under the main management of provincial government, central government and provincial government subsidizes 75% and 25% of all medical insurance, respectively. There is no self-burden of insurance premiums. In the registered medical institutions, the insured can be hospitalized for free surgery, provided with transportation expenses for hospitalization.

The health care costs of public hospitals are free thanks to RSBY. Due to a shortage of medical supply, waiting for medical services becomes common problems[5-7, 20].

Indonesia

Sistem Jaminan Sosial Nasional Health (SJSN Health) was introduced, mainly managed by BPJS Health in 2014. Eligibility contains all Indonesian people and foreigners working in Indonesia over six months. Insured person can get medical treatments for free contact burden in general. Financial resources consist of premiums and government subsidization. Insurance premiums vary depending on the occupations and the type of services each individual offers. The government is responsible for the poverty. Over 30 % of all nations was uninsured in 2014, despite of aiming to achieve Universal Health Coverage[8, 9, 20, 25].

Korea

Social health insurance was introduced with the National Health Insurance Act in 1977, which was assured of industrial workers in large corporations. It was expanded to contain other workers such as public servants and private teachers in 1978, farmers and fisheries in 1988, and urban area in 1989. This program had finally achieved Universal Health Coverage in 1989, as a compulsory registered insurance for all residents in Korea.

It is operated by National Health Insurance Corporation (NHIC) and Health Insurance Review and Assessment Service (HIRA). Financial resources consist of premiums sharing in half with a capital and labors, and public revenues such as general and tobacco taxes[10, 11, 20].

Malaysia

Malaysia is aiming to succeed fair medical access, in spite of no public medical insurance system. Residents can receive medical services at public medical institutions with less self-burden, due to the help of federal budget. Medical treatment fees of public medical institutions have been set up, based on the Fee Act in 1951. Additional expenses such as examinations, surgery, hospitalization, and medicine are set up low burden. Private medical institutions provide medical treatments, not covered by health insurance, concentrating on urban areas[12, 20].

Philippines

In 1995, national healthcare insurance system in Philippines was introduced by the integration of parts of medical insurance (Medicaid), common to both systems: Social Security System (SSS) and Government Service Insurance System (GSIS). Philippines Health Insurance Corporation (PHIC: PhilHealth) manages nationwide healthcare insurance as an institution controlled by the government. PhilHealth, headquartered in Manila, has 15 nationwide branches and 72 service bases. The Philippine government is aiming to achieve the Universal Health Coverage System for all citizens to be insured by the PhilHealth.

Financial resources consist of social insurance premiums which capital and labors share 2.5% wages in half, asset management through investment activities, and public expenditure from Development of Health and local governments. Payment is in-kind benefits centered on inpatients. Public and private medical institutions designated by PhilHealth are public medical facilities provided by PhilHealth. A certain amount of medical expenses will be redeemed to physicians or hospitals, based on the severity of illness and the levels of medical facilities. Medical service fees of PhilHealth are not covered all costs of medical institutions charging a patient. Expenses beyond a certain amount will be a patient's self-burden[13, 20, 22].

Singapore

The government in Singapore has no idea to take care of people at the national level because of a small city state on the lack of economic basis. People need self-help in health care as much as possible. The government involvement stays at the minimum indirect assistance.

Medical health insurance systems in Singapore are based on the Fund system, managing the fund in the Central Provident Fund (CPF), which capital and labors compulsory build up money of a certain percentage from wages to a labor's personal account. There are three kinds of medical insurance systems: Medisave; MediShield; Medifund. In case of outpatient prescriptions and treatments of general outpatients such as colds, medical expenses will be self-burden[20, 23].

Medisave

It is a national medical savings scheme operated by CPF which can be used to pay for healthcare expenses such as personal or family's hospitalizations, day surgeries throughout the individual's lifetime, even after retirement. Account grows with interests.

MediShield

It is a health insurance scheme operated by CPF, which helps to pay for large and long-term hospital bills, without covering with Medisave. All insured members in Medisave have to join in MediShield as a rule. Health insurance system provided by the government is an insurance for medical services in public hospitals. The benefit is only for the insured person, and the upper limitation is for the insurance claims according to the hospitalization days and sorts of surgeries.

Medifund

It is an endowment fund set up by the government bearing by the National Treasury to help low-income people who cannot pay with Medisave and MediShield for all cost of medical expenses. The benefit is only for the registered members, supporting the cost of hospitalization, outpatient treatments, and nursing care.

As for public hospitals, Western Singapore is operated by National Health Hospitals (NHG), and Singapore Health (Singhealth) operates Eastern side. In case of the emergency, a patient will transport to the public hospitals determined by the region. The cost of medical treatments including general outpatient and prescriptions is set up that general people can consult. Treatment fee will be reduced for over 65-year-old people and children.

Thailand

In Thailand, three types of medical insurance systems are provided: Civil Servant Medical Benefit Scheme (CSMBS); Invalidity Benefits of Social Security Scheme (SSS); Universal Coverage (UC). In 2002, Universal Coverage was established and the public health insurance system institutionally covered all Thailand residents. Thailand has achieved Universal Health Coverage[14, 20, 24].

Civil Servant Medical Benefit Scheme (CSMBS)

Civil servants who have worked in government bodies are assured of their health care needs through the CSMBS. It is operated with tax resources as a public welfare. In general, insured person will be free to choose medical institutions to consult and for its payment. Benefits cover the comprehensive medical care with in-kind payment. Patients will receive no cash benefit.

Invalidity Benefits of Social Security Scheme (SSS)

Within Social Security Scheme, invalidity benefits are the public health insurance system for private employees. It is operated by the premiums of sharing in half with capital and labors, and additional subsidization of the government. In general, insured person can visit to the pre-registered medical institutions. Insured person has no personal payment at the time of consultations within the fixed limit. Benefits cover cash and in-kind payments such as consultations, nursing, medicine, and transportation. Payments from the system operators (insurers) to medical institutions are a capitation payment system.

Universal Coverage (UC)

Universal Coverage operated by tax resources is voluntary registered insurance for all residents such as farmers and self-employed, except for insured people of CSMBS and SSS. In general, insured person can use only pre-registered medical institutions (mostly public hospitals). Personal

payment for a consultation is 30 baht, and free for low-income people. Benefits mainly assure for treatments of acute symptoms with in-kind payment only. Payments from the system operators (insurers) to medical institutions are a capitation payment system.

Viet Nam

Medical insurance system in Viet Nam is managed by Ministry of Health (MOH) and Viet Nam Social Security (VSS), based on Health Insurance Act. Eligibility involves corporate employers, children, elderly, agriculture, forestry, and fisheries. The insurance coverage rate is about 70% in 2014, despite of aiming to achieve Universal Health Coverage. Financial resource is a system of social insurance premium, divided into five categories of insured persons[15, 20, 25].

Conclusion

The progress of medical health insurance systems vary in Asian countries. There are countries where benefit systems have relatively achieved for all or almost all nations such as Korea, Singapore, Philippine, and Indonesia. While, some countries have limited systems for farmers and self-employed people, occupied the majority of the population such as China, India, and Viet Nam. Universal Health Coverage is one of the solutions to the problems. Actually, achievement of UHC has been blocked by some reasons such as insufficient financial resources, shortage of doctors and medicine, waiting a long time medical examination, the tendency of the wealthy to enroll private insurance, and low rate to join UHC. Therefore, it is necessary to operate UHC to meet the historical circumstances and historical situation in each country, sharing information and incorporating the most useful aspects of mutual nation's system. This challenge would contribute to UHC achievement globally, not only in Asian countries.

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