Chapter 14
Creation of Universal Health Security in Thailand

1. Importance of Universal Health Security

Thailand began to have a health security or insurance for all or Universal Coverage of Healthcare (UC) Scheme when the Royal Thai Government issued a policy on such a matter in 2001 and the National Legislative Assembly passed the National Health Security Act, B.E. 2545(2002). The Act's intent is to set up a health-care system that provides essential health services for the people to have good health and live a decent life with good quality. According to the law, the National Health Security Office (NHSO), an organization governed by the Board comprising representatives of the public and popular sectors, has the duties to ensure that approximately all 47 million Thai citizens (or 75% of the Thai population) under the UC scheme, not under the Civil Servant Medical Benefit Scheme (CSMBS) and the Social Security scheme (SSS), are eligible to receive standard health services according to Sections 52 and 82 of the Constitution of Thailand, B.E. 2540 (1997).

The evaluation and situation of the health insurance system in Thailand before 2002, when the UC Scheme was launched, are as summarized below:

1.1 The Situation before 2002

If the 1972 Workmen's Compensation Fund, established by the Announcement of the Revolutionary Council No. 103 and the 1975 policy on free medical services for the poor are taken into consideration, Thailand has spent about 30 years on expanding the health security coverage from certain groups of people (such as workers' illness due to work-related cause and the poor) to the social security system in 1990, children and the elderly in 1994, and the universal healthcare scheme in 2002 (Table 14.1).

The strategy used by Thailand on this matter was the creation of health security coverage for various groups of people, beginning from the free medical services for the poor by the Kukrit Pramoj government in 1975. Later on, a royal decree on CSMBS was enacted in 1980 to provide medical-care privileges for civil servants and their dependants and in 1981, the Low-Income Health Card (LIHC) Scheme was launched to provide free medical services for low-income people followed by the Voluntary Health Card (VHC) Scheme in 1983–1984 for those who were not eligible under the LIHC scheme for the poor or underprivileged. A success was noted when the Social Security Act, B.E. 2533 (1990), was enacted to create health insurance for workers who are ill or disabled or die from non-work-related causes. In the initial stage, the law was applicable only to business enterprises, each with 20 employees more; later on, the scheme was

expanded in 1994 to cover all enterprises with 10 employees or more each and then to all enterprises each with 1 employee or more in 2002. And finally, the UC Scheme was launched in 2002 according to the National Health Security Act, B.E. 2005 (2002).

Table 14.1 Major events related to health insurance in Thailand, 1972–2002

Year	Event	Health insurance system			
		State welfare	Workplace's welfare	Compul-sory	Voluntary
1972	Workmen's Compensation Fund established as per Announcement of the Revolutionary Council No. 103, dated 16 March 1972			X	
1975	Policy on free medical services for the poor	X			
1978	Private health insurance companies began operations in Thailand				X
1980	Royal Decree on Civil Servant Medical Benefit Scheme, B.E. 2523 (1980)		X		
1981	Free medical service cards first issued under the LIHC scheme	X			
1983	Voluntary Health Card Project: Phase 1, Maternal & Child Health Fund				X
1984	Voluntary Health Card Project: Phase 2, for all family members				X
1990	Social Security Act, B.E. 2533 (1990) for business enterprises each with 20 employees or more			X	
1992	Extension of free medical services to elderly persons	X			
1993	Motor Vehicle Victims Protection Act, B.E. 2535 (1992)			X	
1994	Expansion of social security coverage to enterprises each with 10 employees or more			X	
1994	Workmen's Compensation Act, B.E. 2537 (1994), replaces the Announcement of the Revolutionary Council No. 103			X	
1994	Voluntary Health Card Project: Phase 4, with state subsidies for health insurance, reinsurance policy, and use of the cards outside designated areas				X

Year	Event	Health insurance system			
		State welfare	Workplace's welfare	Compul-sory	Voluntary
1994	Expansion of the Voluntary Health Card Scheme to cover community leaders and village health volunteers with government subsidies	X			
1994	The coverage of the free LIHC scheme was extended to children under 12 years of age	X			
1998	Revision of co-payment procedures for certain medical services under CSMBS after the 1997 economic crisis		X		
2000	The Social Security Scheme is expanded to cover old age pension and medical services for the employee's children			X	
2001	The Royal Thai Government declares the UC healthcare policy	X			
2002	The Social Security Scheme is extended to cover enterprises each with one or more employee			X	
2002	National Health Security Act, B.E. 2545 (2002), and establishment of the National Health Security Office (NHSO)	X			

Source: Modified from Thai Health Security System (2002).

Note: Compulsory means compulsory health insurance required by law; voluntary means voluntary health insurance.

The evolution of various health insurance schemes in Thailand before the 2002 UC Scheme was launched has resulted in the establishment of a segregated health insurance system consisting of several health insurance systems, each for a different target groups. As a result, Thailand has various health insurance schemes with different objectives, benefit packages, sources of financing, target groups and methods of payment to health facilities as shown in Table 14.2.

Table 14.2 Key features of various health insurance schemes prior to 2002

Scheme / Feature	LIHC	Voluntary Health Cards	CSMBS	Social Security Scheme	Motor vehicle victims protection law	Private health insurance*
Feature of health insurance	State welfare	Voluntary health insurance	State welfare	Compulsory insurance with state subsidies	Compulsory insurance for vehicle owners	Private insurance
Target groups	Low-income and underprivileged persons	People without LIHC or other kinds of insurance	Civil servants, state enterprise employees and dependants	Employees in private sector and temporary employees in public sector	Victims of vehicle accidents	General public
Population coverage (2001)	30%	23.4%	8.5%	7.8%	All victims	1.2%
Benefit packages Outpatient services	State	State (MoPH)	State/private	State/private	State/private	State/private
Inpatient services	State	State (MoPH)	State/private	State/private	State/private	State/private
Registration at health facilities	Required	Required	Not required	Required	Not required	Not required
Benefit packages exception	15 cases	15 cases	-	15 cases	Not exceeding 15,000 baht	Diseases exempt
Childbirth	Covered	Covered	Covered	Covered	None	Covered
Physical checkup	None	None	Covered	None	None	Dependent on insurance conditions
Special room	None	None	Covered	None	Covered	Covered
Health financing Source of financing	Govt. budget	Govt. budget and household	Govt. budget	Employee, employer and govt.	Vehicle owner	Household

Scheme / Feature	LIHC	Voluntary Health Cards	CSMBS	Social Security Scheme	Motor vehicle victims protection law	Private health insurance*
Method of payment to health facilities	Govt. budget, global	Capitation, performance-based	Performance-based	Capitation, performance-based	Performance-based	Performance-based
Co-payment	The amount exceeding entitlement					
Major problem	Not covering the really poor, inadequate budget	Lack of risk distribution	Rapidly and constantly rising costs	Covering while being employed only	Redundant eligibility and slow disbursement	Risk selection

Note: *Health insurance in addition to state-funded health insurance.

1.2 Lack of Health Security and Inequitable Access to Health Services

In 2000, 30% of the Thai population had no health security coverage. A study conducted by the Consumer Protection Foundation in 1999 revealed 15 instances of people being unable to get access to essential health care.

Even though specific group healthcare schemes, such as the LIHC Scheme, had been trying to modify their approach to reach the target groups, there was inefficiency in reaching the real ones. A study conducted by Sukanya Kongsawat and colleagues in 2000 among 2,093 low-income households in 6 provinces found that only 17% of them had received LIHCs while among the 1,003 LIHC-holders, only 35% were really poor, and the rest did not meet the eligibility requirements (Table 14.3).

Table 14.3 Proportions of low-income and non-low-income households that had received LIHCs, 2000

Card-holding	Low-income households		Non-Low-income households		Total	
	No.	Percent	No.	Percent	No.	Percent
- Having received LIHCs	353	17	650	12	1,003	13
- Not having received LIHCs	1,740	83	4,942	88	6,682	87
Total	**2,093**	**100**	**5,592**	**100**	**7,685**	**100**

Source: Sukanya Kongsawat et al. (2000).

1.3 Inequities and Catastrophic Household Health Expenses

The household socio-economic surveys conducted between 1992 and 2002 by the National Statistical Office (NSO) indicate inequities in health spending between the poor and rich households. In 1992, the poorest 10% of households (decile 1) spent 8.17% of their total income on health care, while the richest households (decile 10) spent only 1.27% on their health care, a 6.4-fold difference. The inequities in health had a positive trend as, in 2002, the health spending dropped to only 2.77% among the poorest households but rose to 1.71% among the richest households, the disparities dropping to only 1.6-fold. Such a positive trend was the result of the government's extension of the health insurance policy to various groups, especially the poor, the underprivileged, the disabled as well as labourers, between 1992 and 2002, including the UC policy in 2002.

The NSO surveys conducted between 1996 and 2000 revealed a decline in the number of households with catastrophic medical expenses from 4.9% in 1996 to 4.4% and 3.8% in 1998 and 2000, respectively (Table 14.4). In summary, before the launch of the UC Scheme, more than 600,000 Thai households (or 3.8% of 16.7 million households across the country) were faced with high health-care costs.

Table 14.4 Proportion of households with different levels of health to total (excluding food) expenditures, 1996–2000

Proportion of household's health to total (excluding food) expenditures	Households (%)		
	1996	1998	2000
0–0.5 %	31.9	33.2	34.5
0.5–10 %	51.3	51.5	50.8
10–25 %	11.9	10.9	11.0
25–50 %	3.5	3.6	3.1
>50 %	1.4	0.8	0.7
Total	100.0	100.0	100.0

Source: Analysis of data from Household Socio-Economic Surveys, 1996–2000.

1.4 Other Environmental Factors Related to Universal Health Security Policy

One of the important factors that was supportive of the creation of the universal healthcare policy in 2002 was the 1997 Constitution of Thailand, Section 52, which prescribed that Thai people shall enjoy an equal right to receive standard public health services and the indigent shall have the right to receive free medical treatment from state health facilities thoroughly and efficiently; and in addition, Section 82 provided that the State shall thoroughly provide and promote standard and efficient public health services. Based on such constitutional provisions, there were continued movements of the popular and academic sectors in creating and advocating such a policy prior to 2002.

Besides, Thailand's public health system development was based on the National Public Health Development Plans, which were part of the National Economic and Social Development Plans. The First 5-year National Public Health Development Plan focused on investment on infrastructure, especially the construction of provincial hospitals throughout the country. In the Second and Third Plans, the government gave more attention to rural health investment, producing more health personnel and beginning the provision of free medical services to the poor. As for the Fourth and Fifth Plans, the focus was placed on the primary health care policy aimed at achieving the goal of Health for All by the Year 2000, with the training of village health volunteers (VHVs) across the country and the construction of district hospitals (which were later changed to community hospitals) in all districts for the whole country as well as the accelerated production of doctors and nurses to be distributed to such rural health facilities. Later on, during the periods of the Sixth and Seventh Plans, all subdistrict (tambon) health centres across the country were developed in support of the primary health care programmes; and there were also other important events, i.e. the enactment of the Social Security Act, B.E. 2533 (1990), and the extension of the LIHC Scheme to cover elderly persons aged 60 years and over as well as children under 12 years of age.

According to the policy on development of all levels of health facilities, accelerated production and distribution of health personnel, and primary health care development over the past two decades, the country's public health service system has been strengthened and become the significant foundation for the success in the establishment of the UC Scheme in 2002.

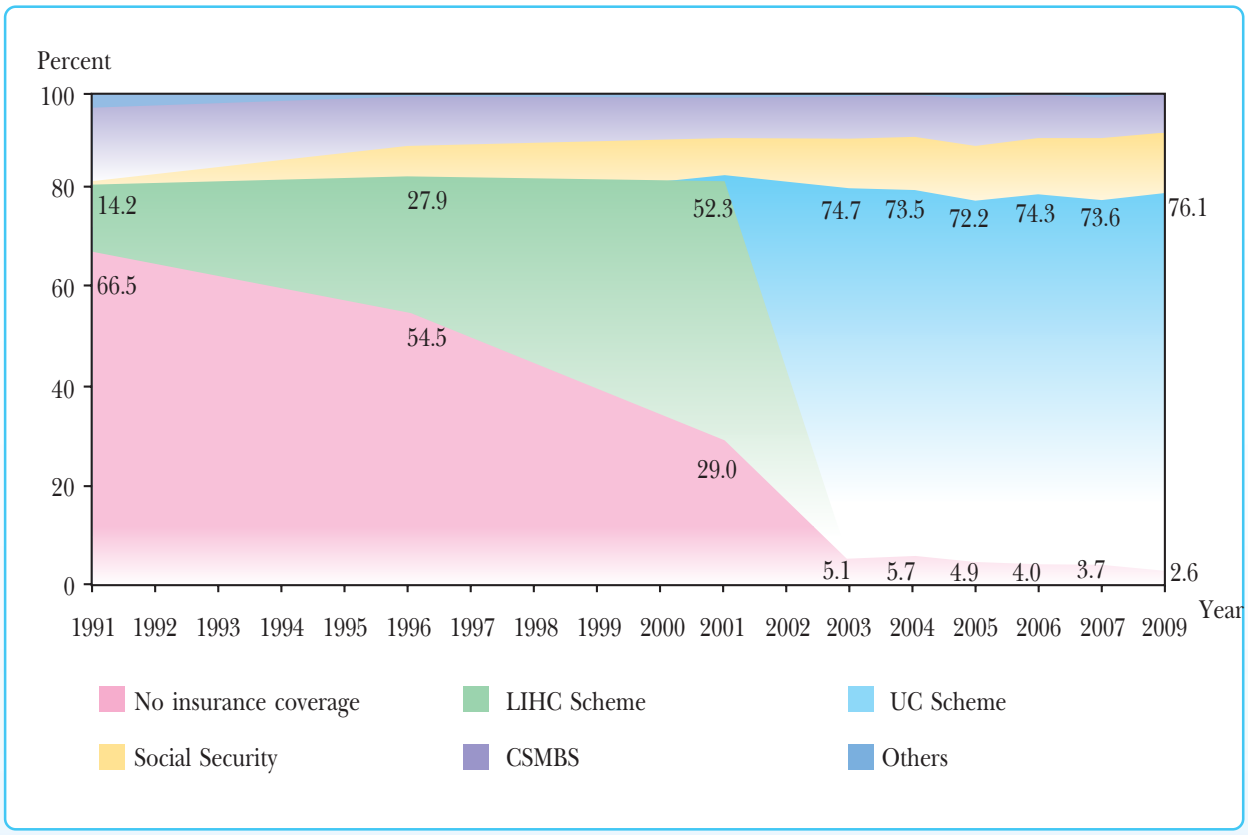
2. The Impacts of Universal Health Security

After the implementation of the UC Scheme, beginning in 2002, 95% of Thai people are covered by one of the three major health insurance schemes, namely UC or Gold Card, CSMBS, and Social Security. All the three schemes have different features related to the benefit packages, healthcare financing, matching fund payments, co-payments of beneficiaries, and methods of payment to health facilities. Empirical evidence and results of studies have reflected the impacts on the UC Scheme as follows:

2.1 Coverage of Health Security

Since the launch of the UC Scheme in 2002, the percentage of Thai people without any health insurance has dropped steadily from 29% in 2001 to 5.1% and 2.6% in 2003 and 2009, respectively (Figure 14.1); and 74% of the population were covered by the UC Scheme, 12% by the Social Security System, and 9% by CSMBS.

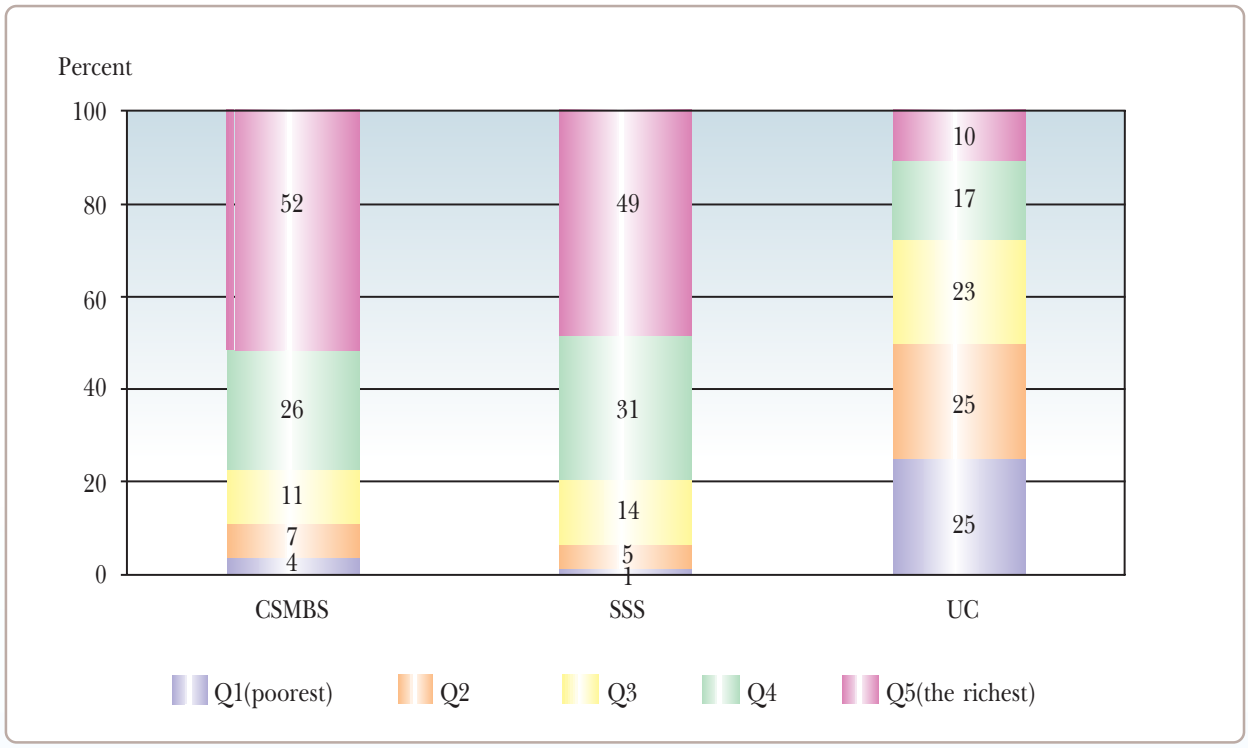
Figure 14.1 Coverage of various health security systems, 1991–2009



Source: Analysis of data from Household Health and Welfare Surveys, 1996–2007, National Statistical Office.

When classifying Thai people into five groups (quintile) based on their income ranging the first 20% poorest group to poor, moderate, rich and the last 20% richest groups, it was found that, in 2004, approximately 50% of the Gold Card holders (under the UC Scheme) were in the poorest and poor quintiles, while 49% of insured persons under the Social Security Scheme, and 52% of the eligible persons under CSMBS were in the richest quintile (Figure 14.2). The findings show that the UC Scheme is the important health security system for the poor. Besides, as analysis of the residences of the eligible persons under all the three health insurance schemes reveals that most of those under the UC Scheme are rural poor residents.

Figure 14.2 Proportion of eligible persons in the three health insurance schemes by their economic status

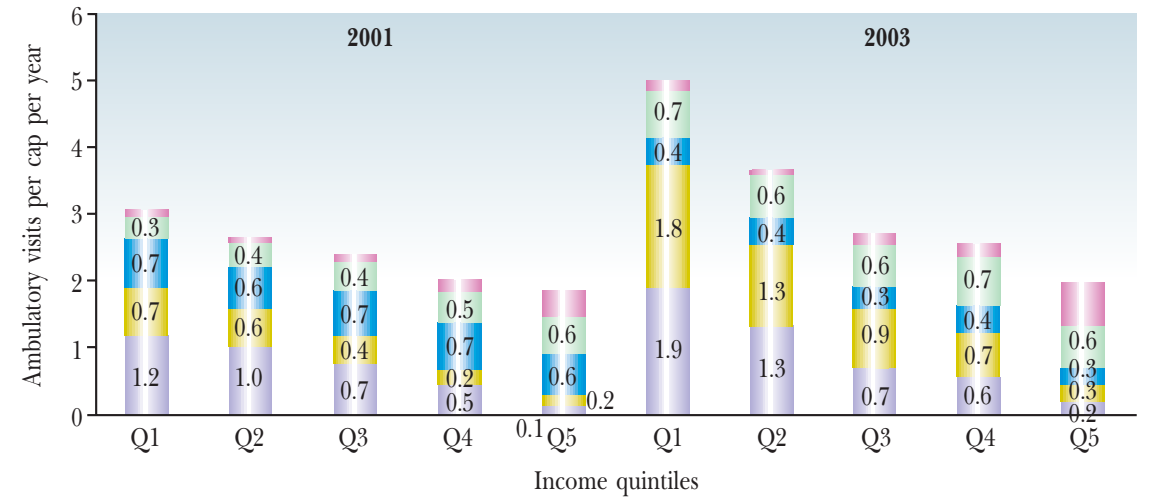


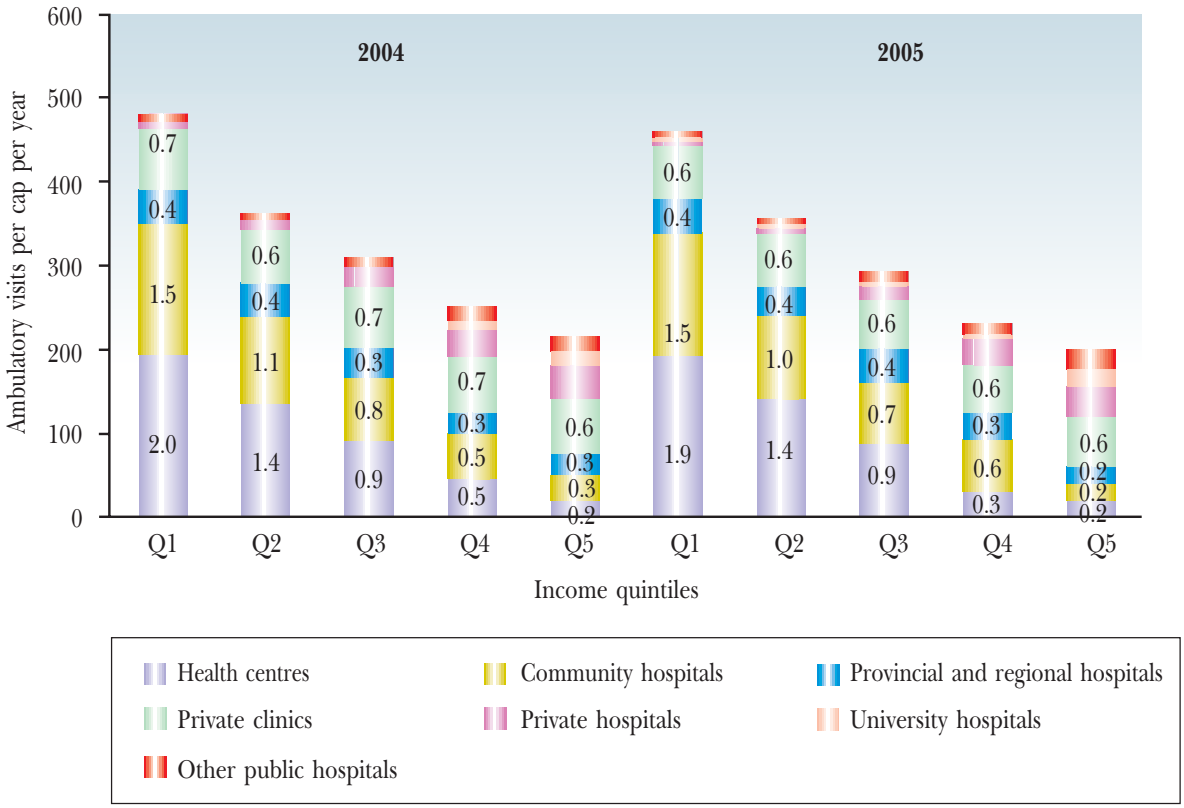
Source: Analysis of data from Household Health and Welfare Surveys, 2004, National Statistical Office.

2.2 Access to Health Services and Benefits from Government Health Resources

An analysis of data from the Household Health and Welfare Surveys, 2001–2003, on the utilization of outpatient (ambulatory) services revealed that the average number of outpatient visits of the poorest quintile increased from about 3 visits/person/year in 2001 to about 5 visits/person/year in 2003–2005 (Figure 14.3), especially for the services at subdistrict health centres and community hospitals which are primary and secondary care facilities where rural residents can access quite conveniently.

Figure 14.3 Utilization of outpatient (ambulatory) services of people by income quintile, 2001–2005

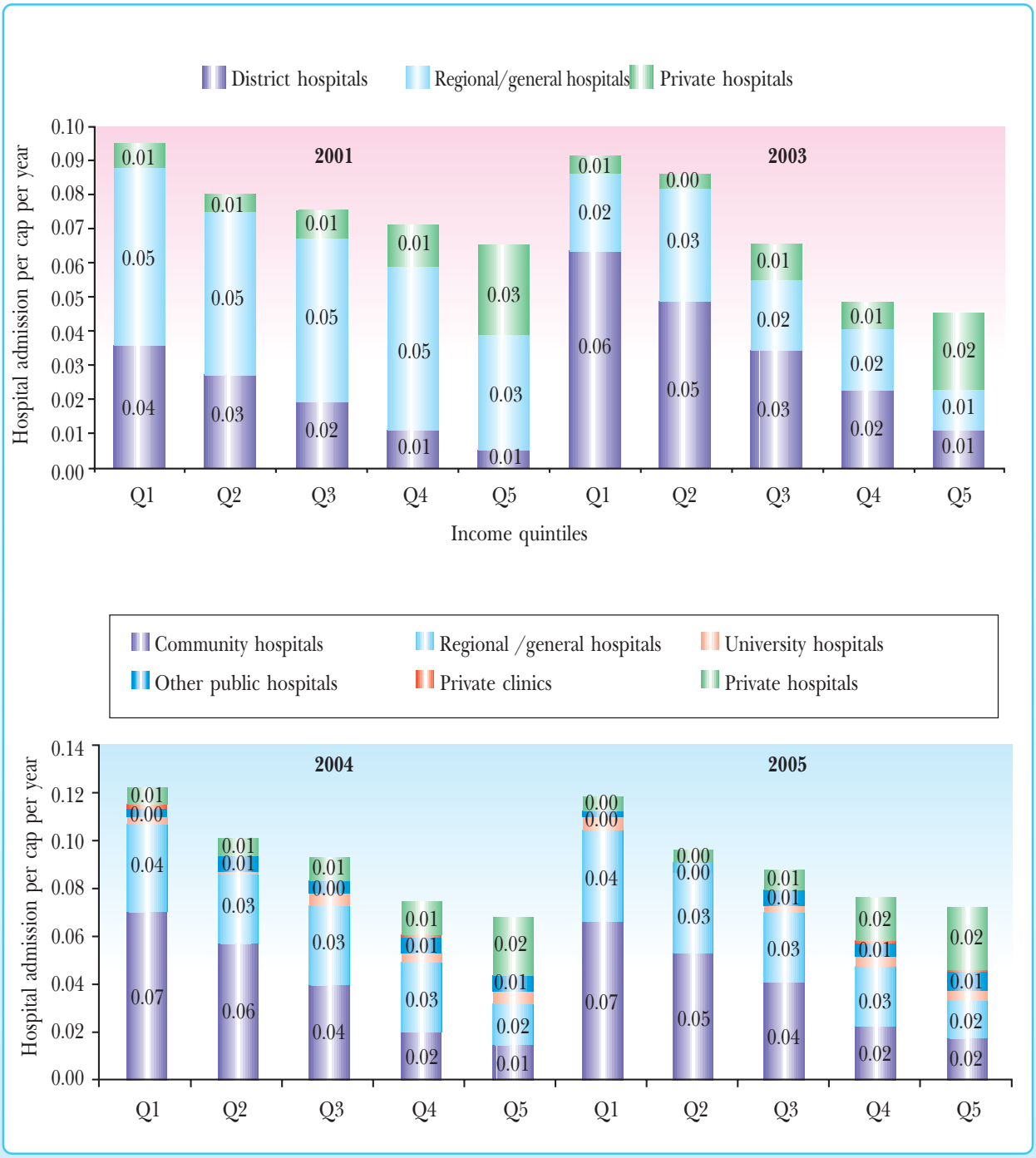




Source: Analysis of data from Household Health and Welfare Surveys, 2001–2005, National Statistical Office.

When analyzing data on inpatient services (hospitalization or hospital admissions) for 2001–2005, it was found that the average admission rate for each year for the poorest quintile was not much different, ranging from 0.09–0.10 admission/person/yr, but the type of health facilities that the poor and poorest quintiles used the most changed from regional/general hospitals in 2001 to community hospitals in 2003–2005 as such health facilities could be more easily accessed (Figure 14.4).

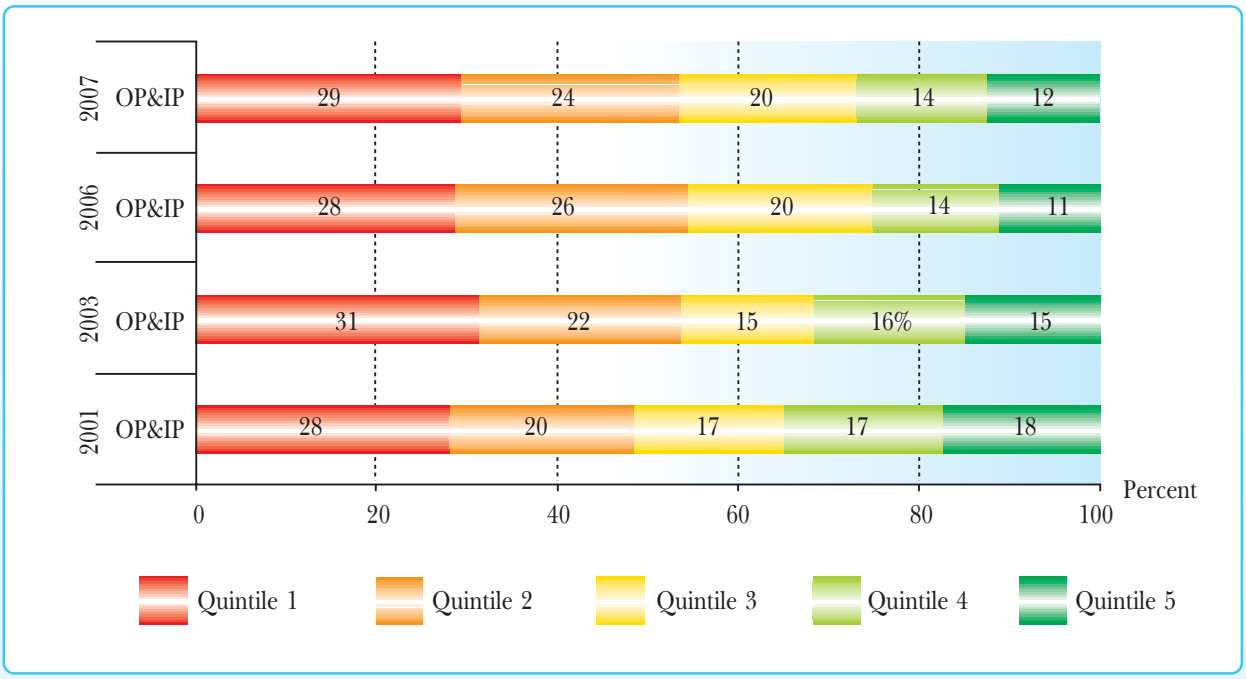
Figure 14.4 Utilization of inpatient services (hospital admissions) of people by income quintile, 2001–2005



Source: Analysis of data from Household Health and Welfare Surveys, 2001–2005, National Statistical Office.

Based on data on health service utilization of various population groups and the costs of services at various levels of health facilities, the analysis of benefits from government health resources obtained by the people with different economic status in 2001 before the launch of the UC policy and after the UC policy was implemented between 2003 and 2007 showed that the proportion of people in the poorest quintile (quintile 1) benefiting from the state health services rose from 28% in 2001 to 31%, 28%, and 29% in 2003, 2006 and 2007, respectively, and the proportion in poor quintile (quintile 2) rose from 20% to 22%, 26% and 24% respectively, over the same period, while those for the rich and richest quintiles (quintiles 4 and 5) dropped after the UC policy was implemented (Figure 14.5).

Figure 14.5 Comparison of benefits from state health resources received by population groups with different economic status, 2001–2010



Source: Prakongsai P. The Impact of the Universal Coverage Policy on Equity of the Thai Health Care System. PhD dissertation. London School of Hygiene and Tropical Medicine, 2008; and How Thailand achieved pro-poor health service utilization and government subsidies? IHPP, 2010.

2.3 Household Health Expenditure and Equity in Healthcare Financing

An analysis of household health expenditure or spending in relation to income of households with different economic status (decile) for 1992–2008 revealed that the proportion of health spending as a proportion of household income in the poorest decile (decile 1) dropped from 8.17% in 1992 to only 2.77% in 2002; and after the UC Scheme was launched, the proportion dropped to only 2.05 in 2008 (Figure 6.68), while that for the richest decile (decile 10) ranged from 1.1% to 1.7%.

With the UC Scheme, the household healthcare costs for catastrophic illnesses have been steadily declining. An analysis of data from the Household Socio-Economic Survey revealed that the proportion of households with catastrophic health spending dropped from 5.7% in 2000 to only 3.3% in 2009 (Figure 6.70). Such a drop that was significant for the households in the poorest quintile (quintile 1) ranged from 5.2% in 2000 to only 1.9% in 2007 and 1.4% in 2009 (Figure 6.27).

A comparative analysis of the household's overall consumption spending in relation to health spending after the UC Scheme had been implemented revealed a significant decline in the proportion of households' impoverishment due to catastrophic medical expenses, for both outpatient and inpatient services. In particular, for the proportion of impoverishment dropped from 3.8% in 2000 to only 1.5% in 2004 due to outpatient services and from 11.9% to 2.6% due to inpatient services for the same period.

The above data have show that, in addition to increasing the coverage of essential medical and health services, the UC Scheme has resulted in the decline of household health spending; and a large number of households have been relieved from catastrophic medical expenses.

2.4 Impacts on Health Facilities

Besides the positive impacts mentioned above, the UC Scheme has increased the medical care workload of state health facilities, especially primary care units (subdistrict health centres) and secondary care units (community hospitals) as shown in Table 14.5. It is noteworthy that the number of outpatient visits at health centres rose from 37.2 million in 2001 to 63.9 million in 2009. Similarly, the rise is noted for both outpatient and inpatient services at community hospitals while the number of state health personnel has not much increased, resulting in increased workloads at health centres and community hospitals.

Table 14.5 Utilization of outpatient and inpatient services at various levels of health facilities, 2003–2009

Type of services and facilities	No. of visits or admissions (in millions)						
	2003	2004	2005	2006	2007	2008	2009
Outpatient visits							
Health centres	37.21	38.14	38.44	50.84	52.88	56.09	63.92
Public health centres	-	-	-	0.45	0.71	1.03	1.96
Community hospitals	35.82	32.26	34.22	43.63	44.99	47.65	51.49
General/regional hospitals	9.88	11.32	11.18	16.55	16.96	17.69	17.78
University hospitals	0.73	1.30	0.76	0.05	0.14	0.32	0.38
Other state hospitals	4.35	2.38	1.81	1.60	1.70	2.36	2.55
Private clinics	19.66	22.92	21.90	0.27	0.28	1.15	0.17
Private hospitals	4.29	4.16	3.32	1.42	1.63	2,46	2.44
Total	**111.95**	**112.49**	**111.64**	**114.77**	**119.29**	**128.76**	**140.70**
Inpatient services							
Community hospitals	2.24	2.20	2.24	2.36	2.45	2.55	2.56
General/regional hospitals	1.16	1.30	1.44	1.94	1.98	2.10	2.13
University hospitals	0.06	1.09	0.13	0.14	0.14	0.16	0.17
Other state hospitals	0.39	1.87	0.18	0.18	0.19	0.21	0.22
Private hospitals	0.45	0.36	0.36	0.12	0.12	0.15	0.19
Total	**4.30**	**4.16**	**4.34**	**4.73**	**4.88**	**5.17**	**5.28**

Sources: 1. Utilization of outpatient services at various levels of health facilities, fiscal years 2003–2005, from Household Health and Welfare Surveys, 2001, 2004, and 2005, National Statistical Office.

2. Utilization of inpatient services at various levels of health facilities, fiscal years 2003–2005, from Household Health and Welfare Surveys, National Statistical Office, and for 2006–2008 from the Inpatients Database, National Health Security Office.

Regarding the financial situation of MoPH hospitals, the financing and accrual accounting data have shown that, after the implementation of the UC Scheme, the MoPH hospitals' financial situations were not so problematic, except for the hospitals located in less populous or remote localities, which had encountered a rather serious financial problem. That was evident in the fact that they had constantly rising cash balance and net working capital between 2003 and 2009 (Table 14.6). As for the financially troubled hospitals, NHSO and MoPH have helped resolve their problems by allocating additional budget for them on a special case basis.

Figure 14.6 Data on financial situations of health facilities that submitted complete data in fiscal years 2003–2009

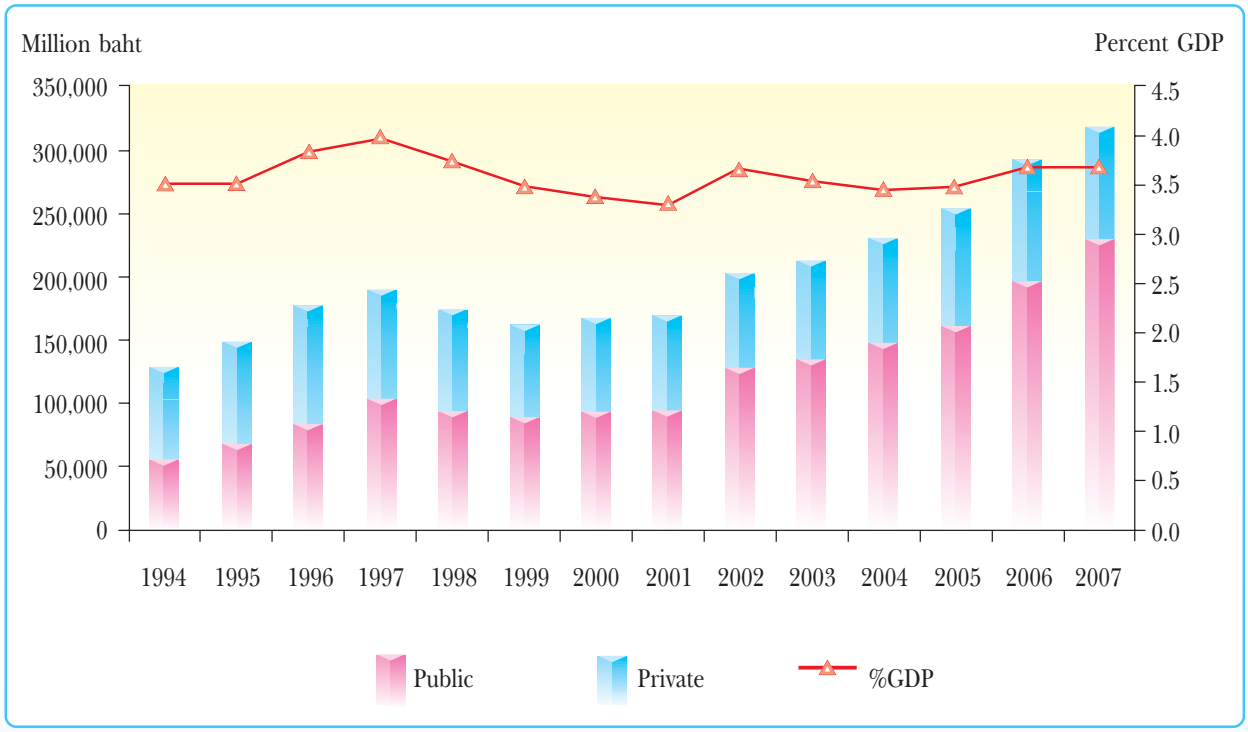
Description	No. of hospitals and financial status						
	2003	2004	2005	2006	2007	2008	2009
Hospitals submitting complete data each year (hospitals)	783	662	711	792	809	818	822
1) Cash balance (million baht)	15,635	15,734	21,158	18,468	28,141	43,276	42,963
2) Inventory (million baht)	2,990	2,972	3,590	3,783	4,294	4,818	5,241
3) Liabilities (million baht)	6,938	9,513	16,672	16,054	12,316	15,825	16,626
4) Net working capital (million baht)	11,687	9,193	8,076	6,197	20,119	32,270	31,579

Source: Bureau of Policy and Strategy, National Health Security Office.

2.5 Efficiency of Health-care System and state Investment in Health

According to Thailand's national health accounts for 1994–2007, after the implementation of the UC Scheme, the national health spending, as a proportion of GDP, did not increase much, ranging from 3.5% to 4%, while the proportion of state health spending rose considerably from 56% of the total health spending in 2001 to 73% in 2007 (Figure 14.6). That means the public sector's level of investment in health is larger after launching the UC Scheme.

Figure 14.6 Proportion of health spending in relation to GDP and amounts of health investment in the public and private sectors, 1994–2007



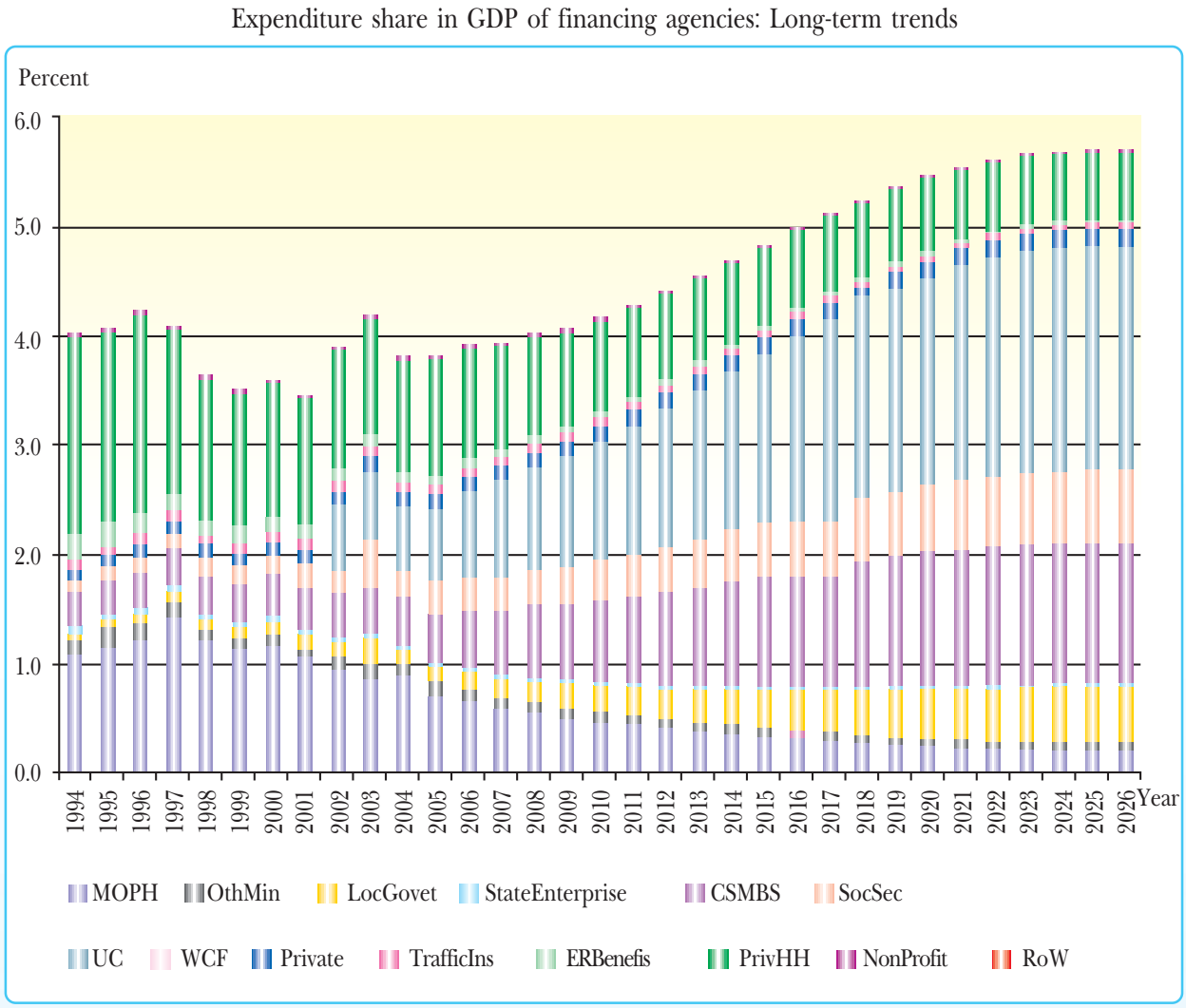
Source: National Health Accounts, Thailand, 1994–2007, International Health Policy Program – Thailand.

3. Current Problems and Future of UC Scheme

3.1 Sustainability and Adequacy of Healthcare Financing

In the medium and long terms, the sustainability and adequacy of the UC Scheme is the issue that health insurance policy-makers and academics in Thailand have given much importance too. However, the estimation of national health spending, compared with GDP, by experts of the International Labour Organization (ILO) and NHSO, has revealed that Thailand's national health spending ranges from 4% to 6% of GDP over the next 5 to 15 years, most of which will be under the UC Scheme, followed by CSMBS (Figure 14.7).

Figure 14.7 Estimated national health spending as a percentage of GDP, Thailand, 1994–2026



Source: Wolfgang Scholz et al (2008) Long term financial forecast

3.2 Increase in Health Spending

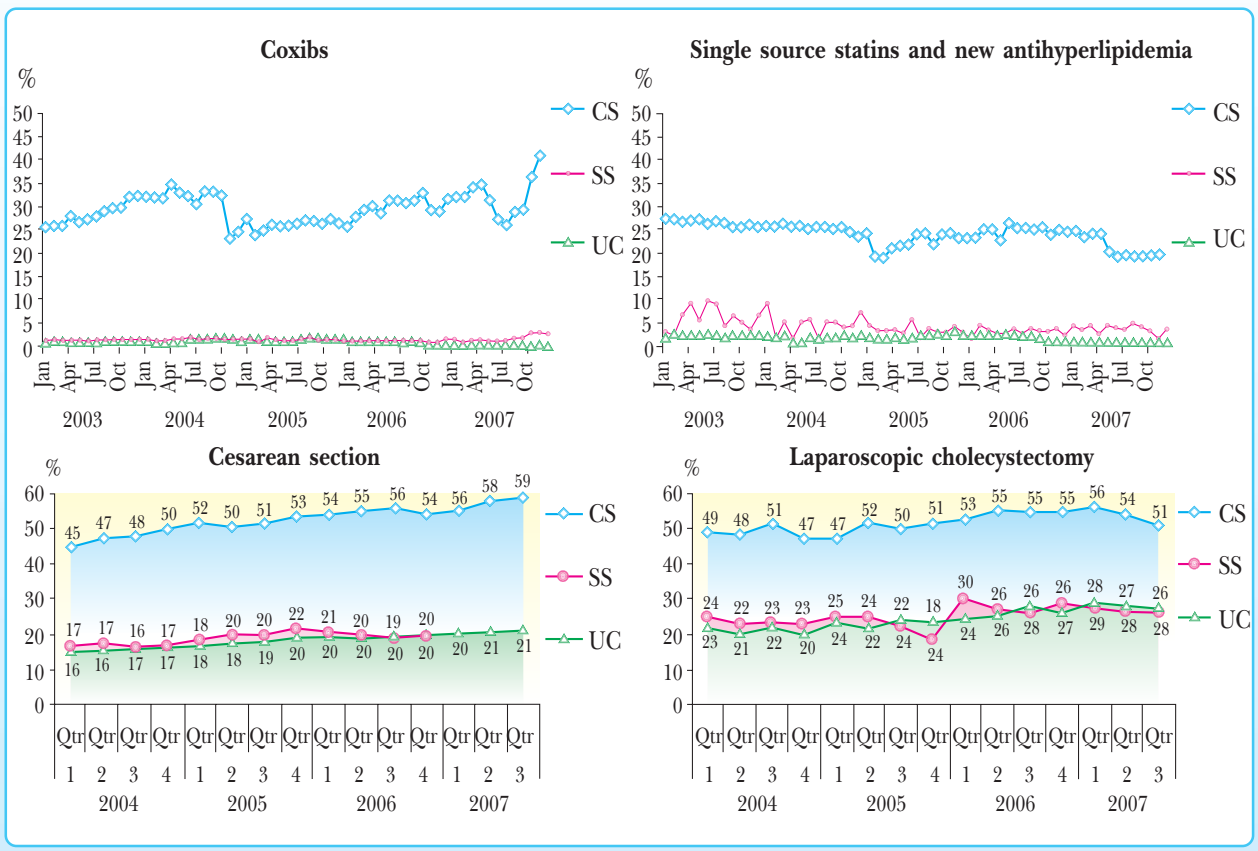
According to data on the burden of disease and health risk factors among Thai people between 1999 and 2004 and a study on direction of health investment under the 10th National Economic and Social Development Plan, more Thais suffer and die from chronic non-communicable diseases and risky health behaviours such as diabetes, cardiovascular disease, cerebrovascular disease, chronic obstructive pulmonary disease, depression, alcohol-related illnesses and cancer whose major risk factors are alcohol and tobacco use, accidents, consumption of food rich in carbohydrate and fat, inadequate intake of vegetables and fruit, and physical inactivity. The rising prevalence of such chronic non-communicable diseases tends to result in the rising health-care costs of the country. Meanwhile, changes in the population structure will result in a higher proportion of the elderly; and the inventions of new costly health technologies will lead to an increase in health expenditures in the future.

3.3 Disparities among Three Health Insurance Schemes (CSMBS, SSS, and UC)

One of the major problems in the creation of the UC Scheme in Thailand is the disparities among the three health insurance systems. A comparison of the service utilization of eligible persons under the three systems revealed that the number of SSS beneficiaries using outpatient services is 1.4 times those under the UC Scheme and CSMBS. As for inpatient services, the number of CSMBS beneficiaries using such services is 1.25 times those under the SSS and the UC Scheme, adjusted for sex, age, martial status, educational achievement, domicile and chronic illness.

Besides, empirical evidence has shown the disparities in medical services received under different health insurance systems. In particular, patients under CSMBS receive medicines outside the national essential drug list, imported original drugs, and high-priced drugs in markedly greater amounts than those under the UC Scheme and SSS, resulting in an increase in the overall national health spending. Moreover, the proportions of certain medical procedures are also higher such as caesarean section and laparoscopic surgery (Figure 14.8). Disparities were also noted the processes and outcomes of medical treatment for diabetic patients according to the standard practices such as lab tests for HbA1C and blood lipid and retinal examination.

Figure 14.8 Disparities in medical services among patients under the three health insurance systems



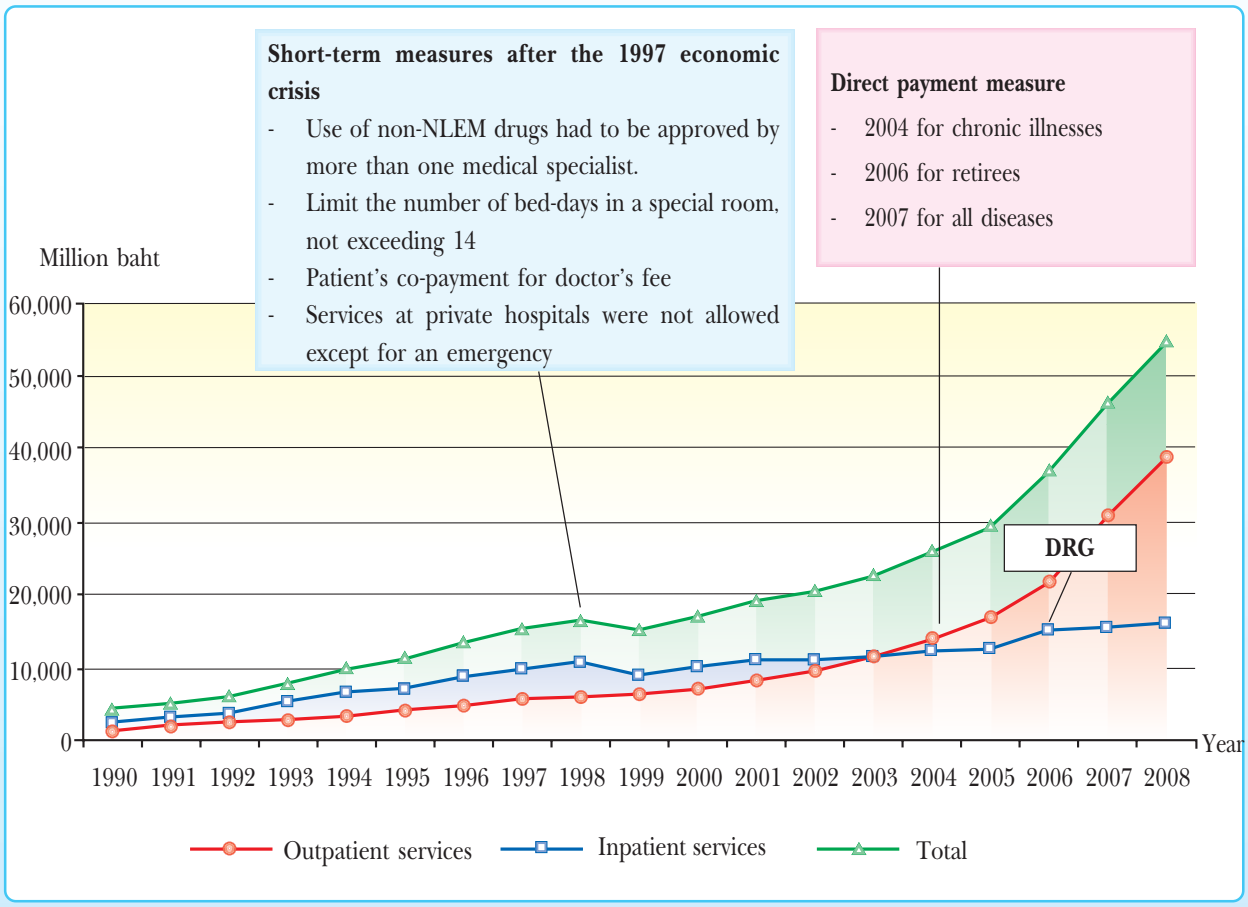
Source: Limwattananon, J.,S. Limwattanon,et al.(2009).

Besides, disparities were found in the hospitalization of CSMBS beneficiaries due to such illnesses as pneumonia, heart failure, ischemic heart disease, and cerebrovascular disease; their hospital lengths of stay were markedly larger than those for UC beneficiaries, even though adjusted for sex, age and illness severity. Regarding the number of bed-days for diabetic patients with acute and chronic complications under CSMBS was also significantly greater than those under the other two health insurance schemes. Meanwhile, the readmission rate within 30 days after discharge among UC eligible patients was found to be higher than that for CSBMS patients.

The major causes of the differences in medical services received by CSMBS eligible patients are the method of payment to health facilities, i.e. the fee-for-service, whereby the health facility tends to provide high-cost diagnostic and treatment procedures, some time more than necessary, resulting in the rapidly and steadily rising medical expenditure under CSMBS (Figure 14.9).

A matter of concern is the service quality because of the capitation payment to health facilities under the UC Scheme for outpatient services or the close-ended payment for other kinds of medical services, with a tendency for health facilities to limit the amount of services or use minimum resources if there is no efficient monitoring and control system.

Figure 14.9 CSMBS medical expenditures, 1990–2008



Source: Comptroller General's Department, Ministry of Finance.

4. Future Directions of the UC Scheme in Thailand

The data on the success of the UC Scheme and the equitable access to health services for the rural poor residents as well as the reduction of health-care spending for the poor households and the prevention of impoverishment due to catastrophic medical expenses are the indicators showing that the Thai government has succeeded to a certain extent in reducing health inequities after the UC Scheme is implemented. Thus, the government has to continue supporting such a policy, not just to reach the goal of implementing the populist policy. The UC Scheme has created health and social equity and enhanced the efficiency of the country's health system as it provides support for primary medical care, health promotion and disease prevention as well as health security for preventing risks from medical expenditure for all Thai citizens nationwide. However, the government has to allocate adequate resources for the UC Scheme, especially primary and secondary care to which the rural poor can have better access and use more frequently than tertiary care. Besides, the government needs to increase the efficiency of the health system with more investment on human resources for health, health promotion and major disease prevention. This is to cope with the rising proportion of elderly persons and chromic non-communicable diseases, which tend to result in a health-care financing burden in the long run.

Regarding the increase of efficiency of resource utilization for CSMBS and the reduction of disparities of the three health insurance schemes, the government has to give priority to such matters and resolve relevant problems in the next phase, as well as develop the health information system for the purpose of monitoring, evaluation and development of the UC healthcare policy on a continuous and sustainable basis.