

HEALTH SECURITY IN THAILAND – CAN THE UC SCHEME, INTRODUCED IN THE AFTERMATH OF THE 1997 ASIAN FINANCIAL CRISIS BE SUSTAINED IN THE CURRENT GLOBAL ECONOMIC CRISIS?

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1 OBJECTIVES

1. This paper will briefly describe the achievement of UC scheme which was built between the previous currency crisis in 1997 and current financial crisis in 2008 in Thailand as a safety net to protect lower income groups. This paper will argue the impact of UC scheme from three aspects, a) coverage to the poor, b) impact on beneficiaries, c) public financing and sustainability. The paper will further discuss whether the system will also be helpful in the context of the current global economic crisis.

2. Firstly the outline of health security system in Thailand will be described particularly from the viewpoint of coverage. Secondly, the impact of UC scheme on the vulnerable low income group will be discussed. Thirdly, the financial sustainability will be argued. In the end of paper, it will discuss the remaining issue and recommendation for other countries as a wrap up section.

2 DID THE UC SCHEME BROADEN THE COVERAGE OF HEALTH SECURITY FOR THE POOR?

2.1 Significance of Achieving universal coverage of healthcare

3. **The UC scheme has been working as a driving force for the safety net of healthcare for vulnerable people in Thailand:** Currently in Thailand, three health security schemes are in operation: (a) the CSMBS for government officer, (b) the SSS for employees working in the private company which employs more than 1 employee, and (c) UC scheme for the rest of the population. In April 2002, the Thai government introduced Universal Coverage Policy³. The scheme aimed to cover a major part of population who was not covered by any types of health scheme. Although this scheme seemed to be implemented with a political decision making by Prime Minister Thaksin with a short consideration, the underlining idea had been examined for nearly a decade by the administrators in the Ministry of Public Health (MOPH). In the history of MOPH by 2002, the government had attempted several different types of health schemes for uncovered people or informal sector such as Low Income Card scheme or Volunteer health card scheme (pre-paid type health vouchers) which all eventually resulted in

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² , For more information, see the conference website: <http://www.adb.org/Documents/Events/2009/Poverty-Social-Development/default.asp>

³ So called “30 baht health scheme” is the name given by Thai Rak Thai government at the earlier stage of development. However after the political turnover in 2006, the new government terminated this informal name by abolishing the copayment of 30 baht. Therefore the abolishment of copayment could be said not for the beneficiaries but for political tactics. This is also pointed out by Thai government officers.

unsatisfactory. While the SSS had been expanding its coverage to smaller companies, nearly 70% of total population was still considered uninsured. The implementation of the UC scheme was a kind of administrators' long cherished wish to achieve the universal coverage of healthcare.

4. **The quick achievement of the universal coverage raised the question on sustainability:** It should be noted that the Thai government clearly changed the strategy for achieving the universal coverage after the failure of health card scheme, from "gradual expansion of contribution based social insurance" to "speedy solution for enrollment of informal sector issue by introducing tax base system and avoiding contribution collection process. It might be possible to argue that the Thai government prioritized the political achievement rather than gradual progress of universal coverage by expanding SSS and substituting by other targeted scheme. In return for the rapid expansion of coverage by using general tax, financial sustainability issue became always questioned. Before discussing the details, in the following section, the characteristics of each scheme will be described first.

2.2 CSMBS (Civil Servant Medical Benefit Scheme)

5. **CSMBS is for the government officers and the most privileged scheme:** CSMBS (Civil Servant Medical Benefit Scheme) secured the healthcare financing for government officers, operated by Comptroller General Department of Ministry of Finance. CSMBS is not a social insurance scheme in serving as fringe benefit for government officer. CSMBS is a most privileged scheme in public health security scheme in all aspects including benefit, financing and accessibility. The member of CSMBS can access to any medical institutions. The benefit package includes eye glasses and special nurse, which are not available for UC scheme beneficiaries. Historically CSMBS has employed fee for service as a payment method. Therefore actual expenditure per capita is much higher than other two schemes which are operated based on closed end type capitation system. From the viewpoint of equity of health security, it is the issue how to make up the gap between CSMBS and other two schemes within the acceptable reform of CSMBS for the government officers.

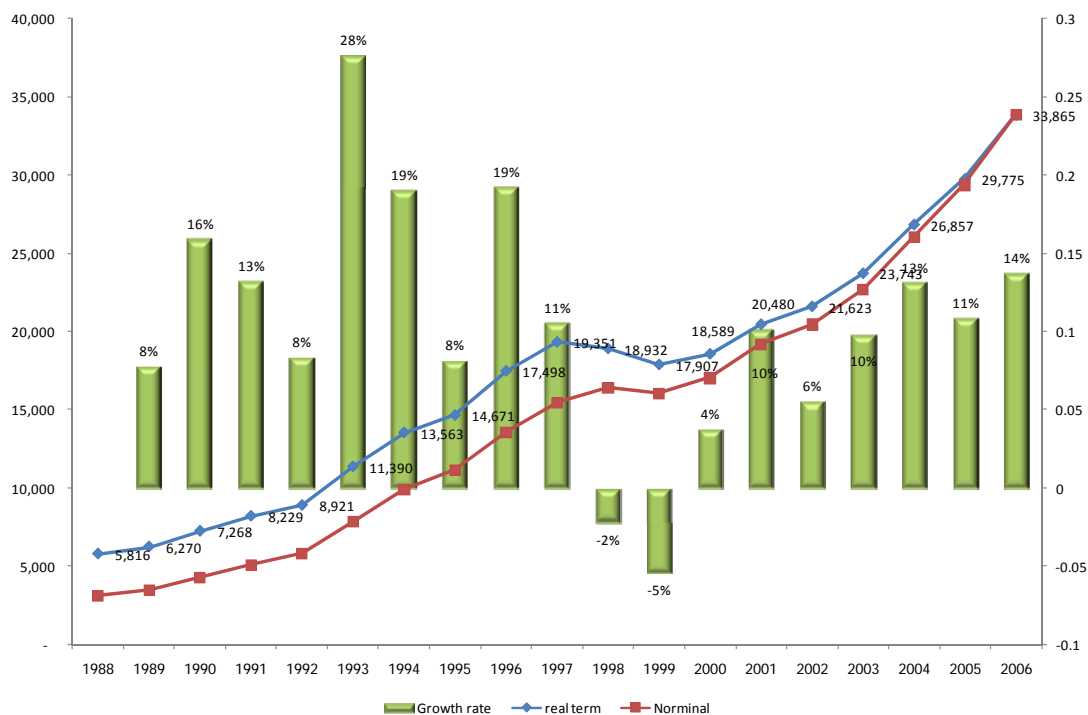
6. **The stakeholders are working for administrative integration of 3 schemes to make up the gap between the UC and CSMBS:** The stakeholders related to healthcare financing have been annoyed for a long time by the cost escalation characteristics of fee-for-service and different payment mechanism from the UC scheme. Even after the introduction of the UC scheme which is strongly oriented to cost-containment by capitation, the growth rate of expenditure of CSMBS shows more than 10% every year from 2003 to 2006. While CSMBS has been gradually compromising with other two schemes, it is still not easy to make up the gap in payment mechanism between the UC and CSMBS. In 2007, after the long discussion, CSMBS finally replace fee-for-service for IP with the DRG with relative weight (Diagnosis Related Group), which had been already installed in the UC, and also, the beneficiaries are allowed cashless service by registering preferred hospital in advance (CSMBS used reimbursement payment method in the past). The reforms carried out for CSMBS are heading to the integration of three public health schemes⁴.

7. **The cost containment of CSMBS is a critical issue on the sustainability of entire healthcare financing system in Thailand:** However these reforms are not enough to contain the cost escalation of CSMBS. The increase of expenditure for OP is more critical than that of IP. Annual increase rate for OP shows 22% in 2005, and 29%, 41% in 2006 and 2007 respectively.

⁴ On the other hand, it might be a great risk for the further cost escalation, in that the replacement of reimbursement system with cashless system could ease patient hesitation to utilize health services because of no payment in advance.

The background of this rapid expansion of OP cost should be carefully examined. Some government officers pointed out that there might be a moral hazard for hospital to split the medical payment claims of inpatient into IP and OP so that some part of IP cost, which are included in DRG payment, could be claimed as OP, which is based on fee-for-service without ceiling. If this assumption is right, this kind of loophole should be filled in. It should be noted that nearly 45% of public financing is spent for only 9% of population, the beneficiaries of CSMBS in Thailand⁵. For the sustainable development of the healthcare financing, the cost containment of the UC scheme is not enough, the cost containment of the CSMBS and integration of three schemes are inevitable⁶.

Figure 1: Cost escalation of CSMBS



Source: IHPP (2007)

2.3 SSS (Social Security Scheme)

8. **SSS has overcome the problem of cost escalation of CSMBS, but the expansion of the coverage cannot reach out enough to informal sector and vulnerable group:** The Social Security Act in 1990 stipulated to build Social security fund for healthcare financing, pension and other related benefit. The employee working in the private company employing more than 1 person can apply to be a member of SSS (dependents of employee are excluded). Benefit package is slightly limited compared to CSMBS, however this could be said a standard “social insurance” scheme for ordinary Thai workers. SSS is much closer to UC scheme in its

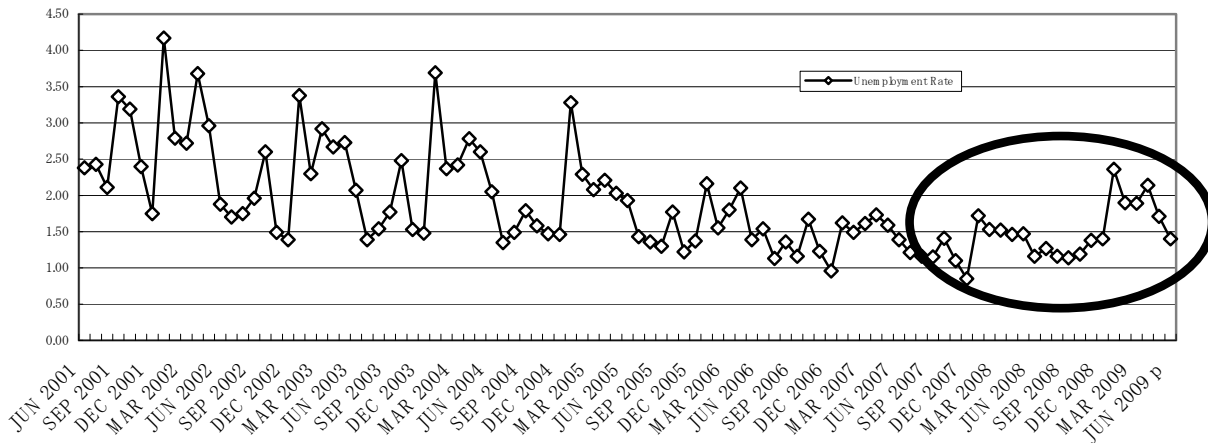
⁵ Author’s calculation based on IHPP (2007)

⁶ The privileged CSMBS is a kind of established interests not only for beneficiaries, but also for provider side. Since in the hospital financial management, the budget from the UC and reimbursement from the Comptroller General Department for CSMBS are practically treated in the same account in the hospital in the end, there is a moral hazard to push the debt or irrecoverable loss of the UC to CSMBS under the hospital manipulation.

budgeting system which employs the capitation system, and beneficiaries are required to register the local medical facility network in advance. SSS is financed through tripartite contribution from government, employer, and employee (1.5% of wage from each). The expenditure of SSS is tightly controlled by Social Security Board, which means SSS was designed to overcome the problem of CSMBs in escalation of expenditure, and less vulnerable for political manipulation than fully tax based UC scheme. However in enrollment of informal sector, SSS was not successful. Although SSS was designed to cover mainly formal sector employees, it is also aiming to cover small sized private company or self-employed as well. Based on the regulation, in theory, all workers in Thailand is entitled to join to the SSS, including self-employed small shop or family run restaurant. However, the number of beneficiaries of SSS is only 9.1 million people. The tripartite contribution would be a burden for both employer and employees.

9. SSS has safety net as built-in mechanism for unemployed people: In term of crisis management, SSS has a safety net as a built-in mechanism for unemployed people who could be excluded from SSS because of loss of entitlement. The article 39 of Social Security Act stipulates that the person who ceases to be employees (unemployed) shall be entitled to receive benefit for a further period of 6 month from the date the employment is terminated. It works as safety net for the unemployed people. Even after 6 month, if said person are working (having any kind of income and affordable to pay the contribution). The rate of unemployment shows that the impact of global financial crisis on Thailand is limited and temporary compared to lingering effect of Asian currency crisis in 1997 (figure 2). The peak of unemployment by this crisis was first quarter of 2009; therefore the unemployed people could be secured under the article 39 SSA until middle of 2009 as a desk study⁷. The people, who cannot afford to pay the contribution for SSS, still have an opportunity to be take care by the UC scheme, which will be explained in the following section.

Figure 2: Unemployment Rate



Source: National Statistics Office, Labour Force Survey.

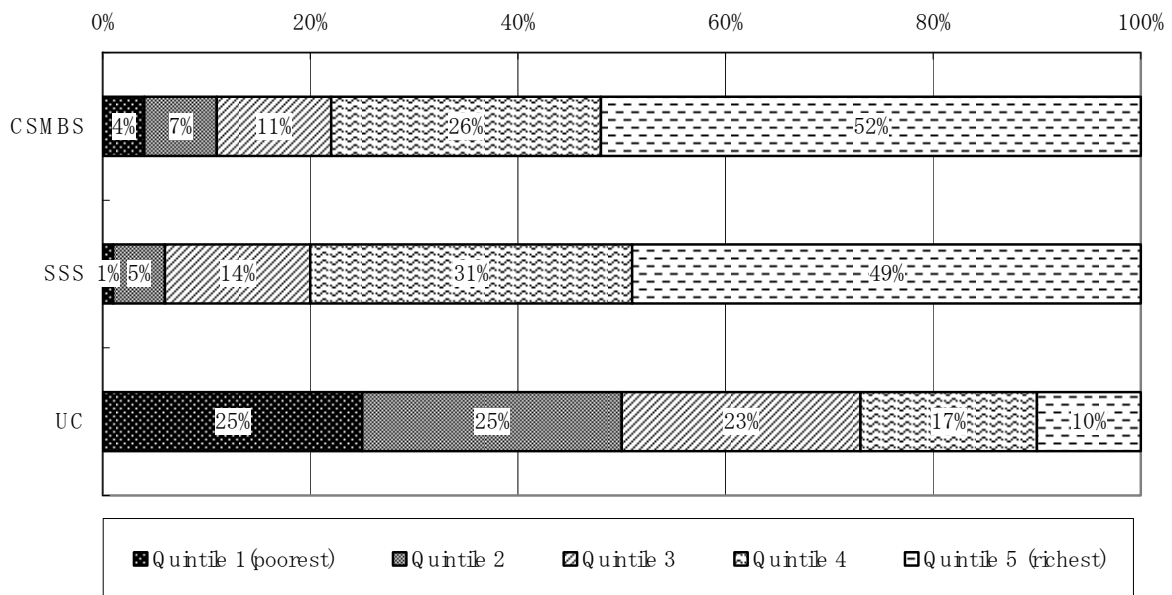
⁷ However the majority of employees in the private entities particularly small sized entities are not member of SSS. Hence it should be noted that article 39 could save only some part of unemployed people who had paid contribution before being his/her unemployment and rest of unemployed people stayed at the UC member or uninsured.

2.4 UC (Universal coverage policy)

10. **The UC scheme was implemented to cover the rest of all uninsured population with relatively generous benefit package:** In 2002, the government installed “Universal Coverage Scheme (30 baht health security scheme)”, which covered rest of population who are not entitled to be a member of any kind of existing health security schemes. The UC scheme was welcomed in its generous and ambitious characters. All necessary procedure for being membership was only submitting an application to the provincial health office or registered health facility network without any contribution, and then so-called “gold card” shall be issued. The member can access the healthcare service with only 30 baht per admission of inpatient or per visit of outpatient at any time within the network of registered facility. Benefit package is comprehensive model (inpatient, outpatient, and prevention and health promotion) except special nursing fee, eye glasses, and some really high cost treatment, but still including heart surgery, HIV/AIDS treatment, and prosthesis joint replacement.

11. **The UC functions as last safety net for the unemployed and informal sector:** From the viewpoint of crisis management, the UC scheme is expected to absorb all of vulnerable unemployed people. Although the unemployed people can maintain their entitlement 6 month after the unemployment, if they cannot afford to pay contribution after 6 month, they could be assumed to join to the UC scheme. In fact, the Thai government stressed the significance of “seamless and smooth social protection transfer from SHI (SSS), CSMBS dependents younger than 20 years old who will join UC scheme” as a short term strategy for response to the crisis.

Figure 3: Beneficiaries of Health scheme by income Quintiles 2004



Source: Health and Welfare Survey 2004, Thai National Statistics Office.

Table 1: Health Security schemes in Thailand

	CSMBS [Civil Servant Medical Benefit Scheme]	SSS [Social Security Scheme]	UC scheme [Universal Coverage Health Care Scheme]
Legal framework	1982: Decree of CSMBS	1990: Social Security Act	2002: National Health Security Act
Principle agency	Comptroller General Department (Ministry of Finance)	Social Security Office	National Health Security Office (independent agency)
Covering Population	Government Employees and those dependents (parents spouse, and up to 2 children under 20 years old)	Private Company Employees (excluding dependents)	Rest of population (uncovered by any type of public health schemes) Mainly former recipients of Medical Welfare Scheme, health card scheme and uninsured.
Number of Beneficiaries	4.2 million	9.1 million	47 million
Rate of Coverage (Approximation)	7-9%	15-16%	75%
Type of Scheme	Fringe benefit for government employees	Compulsory Social Insurance (tripartite contribution from gov., employer, and employee)	Tax based Welfare scheme (start with 30 bahts copayment, currently abolished)
Accessibility	Free Access	Accessible to contracted hospital and its network of referral system (both private and public). Registration of member in advance required.	Accessible to contracted hospital and its network of referral system (mainly public). Registration of member in advance required
	Fee for service and	Inclusive capitation	Capitation for outpatient and inpatient plus DRG
Prevention service	No service	No service	Included in capitation budget
Benefit package	Comprehensive package excluding special nurses	Comprehensive package (non work related) excluding special nurses and private bed	Comprehensive package excluding special nurses, private bed, and glasses.
Expenditure per capita (2006)	8,785 bahts	1,738 bahts	1659 bahts

Source: Author's Synthesis based on information from Health Policy in Thailand 2009, Bureau of policy and strategy, Ministry of Public Health 2009

12. **Compared to other schemes, the UC members tend to belong to lower income group:** However the UC scheme was sometimes regarded as the “health security for the poor” by its nature of membership. The government officers and employees, member of the CSMBS and SSS tend to belong to middle or high income group in the society. Since the UC scheme was designed actively to enroll the uncovered population, majority of members is lower class in income classification. In fact, as figure 3 shows, while in CSMBS and SSS, quintile 1 and 2 occupy only 11% and 6% respectively, approximately 50% of UC beneficiaries belong to quintile 1 and 2 of income quintiles which means poorest income group.

13. **The UC scheme has strong cost-containment mechanism and moral hazard for providers:** The UC scheme is distinguished from previous schemes for the poor such as Welfare Medical Service or Health Cared Scheme, in that it has a clear structure between entitlement (the number of registered beneficiaries) and financing. In the previous scheme, since the database of registration was uncompleted, the budget was allocated to the healthcare facilities based on the size of facility namely the number of doctors and nurses. In the UC scheme, total budget allocated to healthcare facility network, which is Contracting Unit for Primary Care: CUP (usually community hospital at the district level, including some health centers, as primary care unit) is calculated based on the number of registered beneficiaries in the catchments area of CUP, which is so-called global budget based on capitation. This budget is closed end budget, hence, the local providers have to deal with the patients within the capitation budget. This idea brought several outcomes. From the viewpoint of cost-containment, this works strong ceiling for hospital utilization of resources, since the providers cannot expect further budget allocation than initial calculation in principle. In addition, if the provider has no budget left in the account in the end of fiscal year, there could be a risk for patients with not sufficient treatments from healthcare facility.

14. **The UC solved coverage issue but still remains some issues on coverage:** Since the introduction of the UC scheme, it is possible to state the formally-defined “coverage problem” was solved. Although it might be ideal that all people can join SSS with contribution for the financial sustainability, it might be too early to enroll all of people with no constant cash income in the social insurance scheme, probably need more gradual expansion. Until then, the coverage of the UC could help majority of Thai people for the secured healthcare service. Some remaining issues have to be mentioned. First, since the registration of the UC scheme is operated based on the national ID number controlled by Ministry of Interior, the person who has no registration data in MOI database cannot access the medical services such as hill tribes. Second, some people who do not have enough information sometimes are not willing to register. Those people tend to go registration when they get sick and need to go to hospital. This scheme does not require the beneficiaries any type of payment, so they cannot understand why they need registration in advance. This will in turn reduce the budget allocation from NHSO (National Health Security Office)⁸ to CUP, since the capitation budget for CUP shall be calculated based on the current number of registration in the area.

3 HOUSEHOLD BURDEN AND UTILIZATION OF HEALTHCARE SERVICES

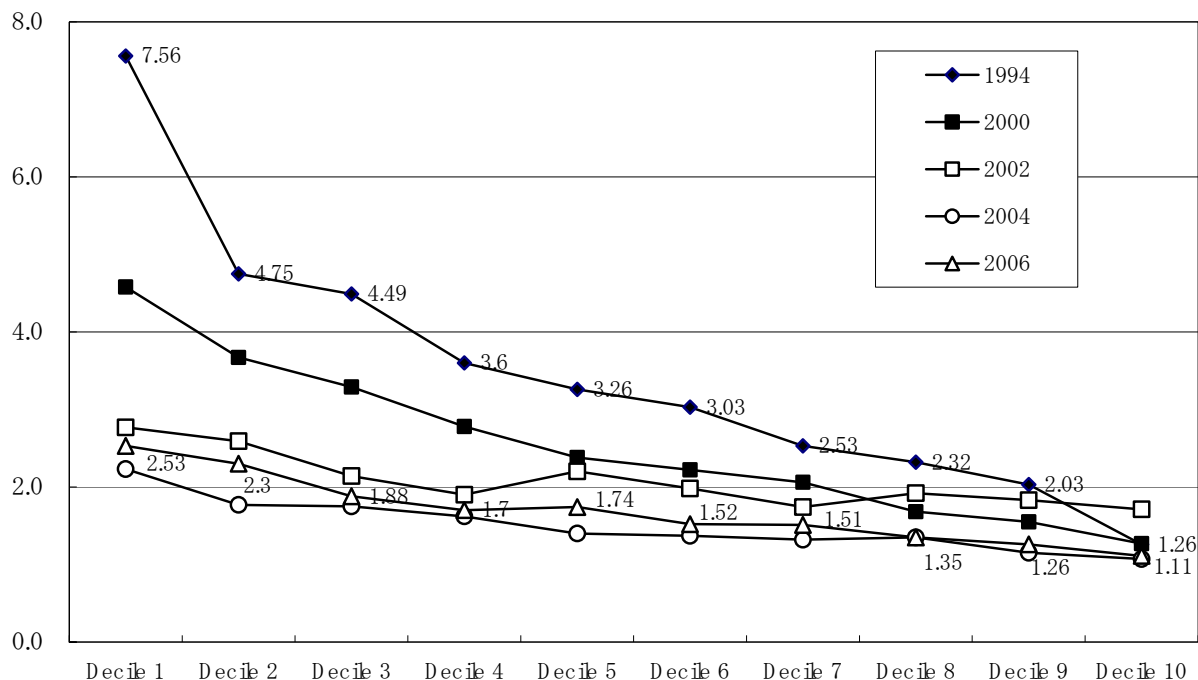
3.1 Household burden of healthcare expenditure (OOP)

15. Since the UC are designated to enroll the lower income groups, the mitigation of household burden of expenditure on healthcare services is critical indicator to assess the

⁸ National Health Security Office is an independent agency under the Ministry of Public Health, in charge of financing for healthcare.

achievement of the UC scheme. Before the introduction of the UC scheme, household in poverty spend a significant amount of income for the healthcare services. Figure 4 shows that the government reform on healthcare financing alleviated the burden of expenditure in the poorer households. In 1994, 7.56% of household income was spent for healthcare in the decile 1, and in 2006, decreased to 2.53%. Although the gap between rich group (decile 10) and poor (decile 1) in household health expenditure rate in the household income still exists, it was minimized in last decade.

Figure 4: Household health expenditure as % of household income by income deciles



Source: National Statistics Office, Socioeconomic Survey 1992-2006

3.2 Service Utilization and benefit package

16. **Under the well allocated health infrastructure and generous benefit package, the increase of utilization rate will in turn become a great pressure of expenditure:** One of the significant achievements in term of infrastructure of healthcare service in Thailand is health center and community hospital. Health center is usually located in each Tambon (sub-district level, per 10,000 populations) in all over the country at almost regular interval. Medical doctors are usually not allocated in health center though, the nurses or health officers are playing important role for primary health care at the tambon level. Patients who could not be dealt with in health center level could be referred to community hospital. The healthcare network (CUP) is a key infrastructure of primary health care service in Thailand. This means that Thailand has a high potential to provide healthcare services if sufficient financial and human resources would be provided. As described in the previous section, the household burden for health expenditure was significantly mitigated. When the UC scheme provided local people with low cost healthcare service without contribution, and reasonable accessibility of care, then it is quite natural that soon or later, the utilization rate of healthcare service will expand, and will be a great pressure on the financial sustainability.

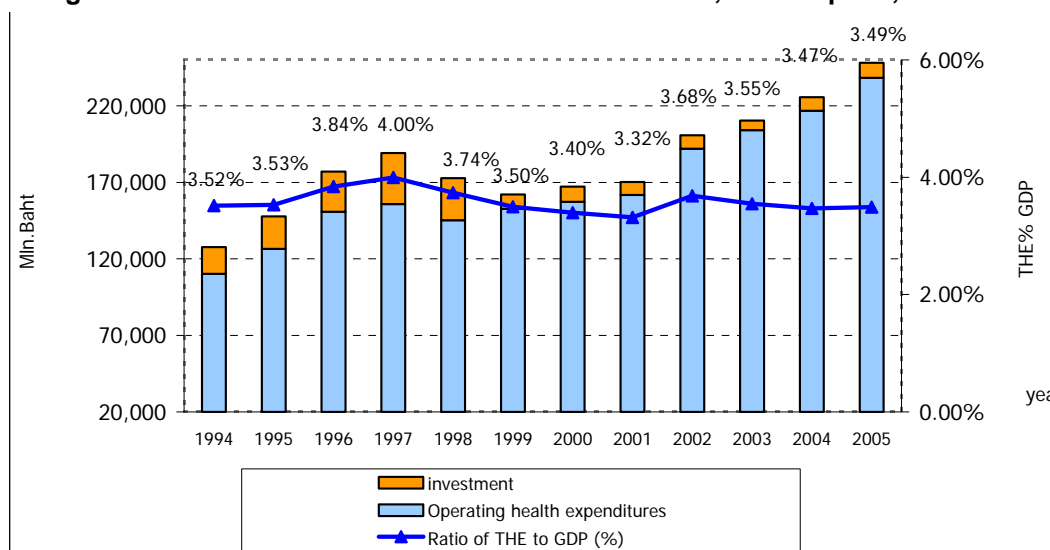
17. **The introduction of high cost therapy including RRT could be a driving force to increase the health expenditure:** The benefit package is also important elements to consider the perspective of sustainability. From the outset the government include almost of all therapies in the benefit package of the UC scheme. However the RRT (renal replacement therapy) was excluded because of really high cost⁹. CSMBS beneficiaries can utilize all types of renal replacement therapy, and since 1999, SSS beneficiaries were also allowed. In 2007, the UC scheme has allowed beneficiaries to access to renal replacement therapy with some conditions. Dr Thaworn, senior expert of NHSO, pointed out that the government’s decision making on the inclusion of RRT in the benefit package of the UC scheme was derived from “equity and ethical dimension and protecting households against financial catastrophe”. The Thai government has already started to study on the prospective of financial burden of renal replacement therapy. The study insisted that the unconditional introduction of RRT in the UC scheme will increase the budget for the UC by nearly 24% in next 10 years¹⁰.

4 INCREASING PUBLIC FINANCE FOR HEALTH SECURITY FOR THE UC SCHEME

4.1 Trend of Financing on healthcare

18. **Health expenditure increased significantly after the introduction of the UC, but not over invested:** Since 2002 of introduction of the UC scheme, the total health expenditure in Thailand has increased constantly. The total health expenditure at the current price in 2000 was 15.7billion baht, and became 23.8 billion baht in 2005. It is a reasonable trend by the expansion of health security coverage with the UC scheme, although, even before the UC, some part of uninsured people received benefit from Low Income Card or Voluntary health Card scheme. However the ratio of health expenditure to GDP has been stable for last decade ranging from 3.32 to 4.00% of GDP.

Figure 5: Amount of THE and ratio of the THE to GDP, current price, 1994-2001



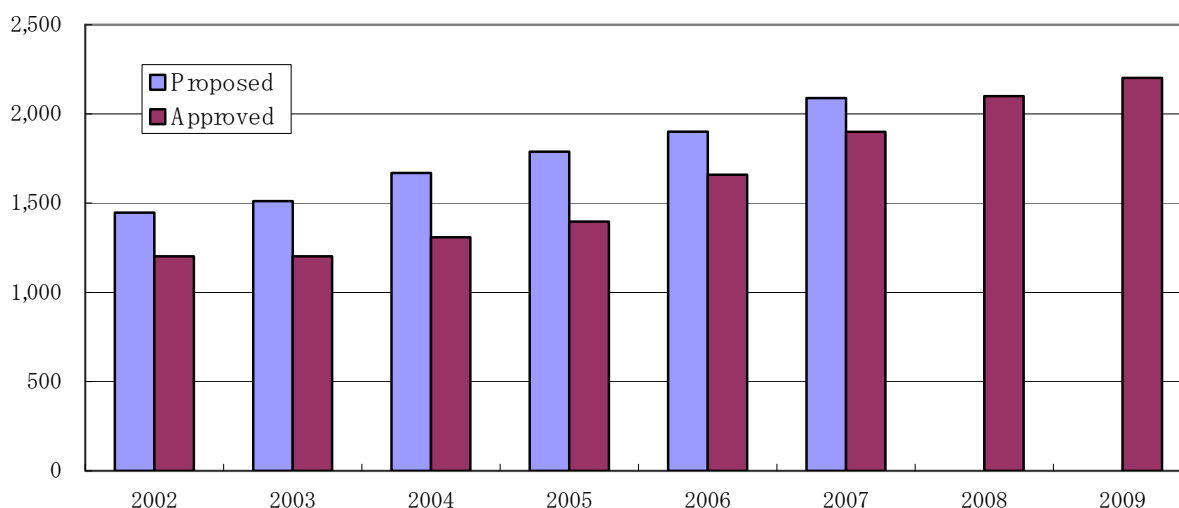
Source: IHPP, 2007

⁹ ARV (antiretroviral) for HIV/AIDS was also excluded at the earlier days. In 2006, included. And vaccine for influenza included in 2008.

¹⁰ IHPP (2007)

19. **The government nearly doubled UC budget last 6 years though, always below the requested amount:** The government nearly doubled its budget to the UC scheme per capita basis since 2002. Public contribution increased from 1,202 baht per capita in 2002 to 2,202 baht per capita in 2009, and it will increase approximately 2,300 baht per capita in the forthcoming fiscal 2010¹¹. However it should be considered that budget for the UC scheme is not provided as requested by local healthcare facilities. For the budget allocation, every year NHSO calculates the expenditure of previous year in the healthcare facilities, then proposed the budget required to manage in the forthcoming fiscal year. The budget shall be settled by the approval of government, which is usually lower than requested amount of budget as the figure 6 shows.

Figure 1: Proposed and Approved capitation rate



Source: IHPP, 2007

20. **Despite the increase of budget, it might be not enough for fiscal 2010 to maintain the same level of treatment in the local facility:** For fiscal 2010, NHSO initially proposed more than 2,800 baht for the capitation budget for the UC, which is more than 20% increase from previous approved budget. This steep increase of proposed capitation budget might include the extra cost for doctor's salary, which is the MOPH policy for this forthcoming fiscal year. This means that approved 2,300 baht for fiscal 2010 seems to increase, but it might be "not enough at all" and some budget for the medical treatment could convert to personnel cost for doctors¹². In that sense, it is skeptical that to say the capitation budget for fiscal 2010 has no influence from financial crisis¹³.

21. **Under the severe cut of budget, the UC capitation budget increased:** The Thai parliament passed national budget for fiscal 2010 (from October 1st 2009) with 1.7 trillion baht budget which is 13% lower than current year budget, excluding special budget for some stimulus spending to help the economic recovery¹⁴. It means the UC budget will increase in fiscal 2010 although majority of budget was cut. As seen in the previous paragraph, the budget

¹¹ It has not yet approved by Ministry of Public Health at the drafting stage.

¹² A government officer pointed out this issue in the interview.

¹³ This discussion needs further explanation and evidences after the workshop in Hanoi.

¹⁴ Reuter INDIA, Thai parliament passes 2009/2010 budget, last access; 20, Sep, 2009.

for the UC is not sufficient. However there might manifest the current government's attitude to the UC with no intention to turn over the policy direction.

4.2 Fiscal space for the sustainable UC scheme

22. **NHS Act defines the financial resources:** Under the National Health Security Act, the possible financial resources for the UC scheme is limited as defined from clause 1 to 8 of section 39 of NHS Act, for the UC scheme as 1) annual expenditure budget, 2) local government organization, 3) money earned by providing health service pursuant to this Act, 4) administrative fine pursuant to this Act, 5) money or property donated to the Fund, 6) interest or benefit earned by money or property of the Fund, and 7) other money or property earned by affairs of the Fund, 8) other contributions as described by law.

23. **Annual general budget is changeable by politica climate, and local government's contribution is difficult to expect:** The resources from 4) to 7) are negligible in its amount. "1) annual expenditure budget is currently a main source of financing. This main resource is not reliable in that the constant supply of budget is always manipulated and threatened by the changeable political will. Although, 2) local government organizations are allowed to contribute to the local health fund, generally speaking, the local organizations tend to regard healthcare service provision issue as MOPH issue, and difficult to expect them to persuade them to do so.

24. **Copayment cannot be a source, contribution collection is not feasible:** "3) Money earned by providing health service pursuant to this Act" implies "copayment", which defines as 30 bahts per visit for OP, or per admission for IP initially, later abolished in 2006. Approximately half of the beneficiaries of the UC scheme including dependents, elderly, poor, disabled, war veterans, monk and health volunteers have been exempted from copayment even before 2006 and the amount of income by copayment was less than 2% of total budget¹⁵. If the UC scheme would rely on the copayment as a substantial resource again, it would be political backwater. "8) other contributions as described by law" supposes the introduction of "collection of contribution" as ordinary social insurance, which will require the adoption of Royal Decree for the operation of collecting contribution. This method should face with the obstacle as to how the authority grip the income and collect contribution from even poorer informal sector.

25. **Setting earmark tax could be a one solution for the sustainable development of the UC:** It might be argued that the key issues on the sustainability of the financing of the UC scheme are, in mid-term, if the earmark tax could be secured enough to sustain the scheme regardless of political manipulation, and for the long-term strategy, if the NHSO can establish the operation of collection of contribution from the UC members or successfully encourage local authorities to raise contribution for the Fund. Because of the political friction between pro-Thaksin group and current government, it is unlikely to cut the budget for the UC substantially. The UC is crucial for the people living in the remote area, who are overlapping with

26. **In 2020, health expenditure to GDP will be 4.5%:** Thai government has already been studying financial sustainability closely with International Labour Organization. The financial forecast model based on status quo projection, which is first attempt in 2004, showed the total health expenditure in 2020 would be 3.88% of GDP. However the latest study using the 2006-2007 data to project the health expenditure from 2008-2020 showed that the Thailand will spend around 4.5% of GDP in 2020. This prediction could be too optimistic. Some researchers pointed out this result is a reflection of current situation. The utilization rate and benefit package should be critical to calculate the future expenditure.

¹⁵ Taweessri Greetong (2007)

5 DISCUSSION AND CONCLUSIVE REMARKS

27. **The universal coverage policy secured Thai people well:** Three health security schemes are well protecting the vulnerable people in Thailand compared to the last currency crisis in 1997. Whereas it is obvious that the situation of current crisis is totally different from previous one in its magnitude, range and depth. In the last crisis, there was no universal coverage of health security. The universal coverage scheme was successful in both SSS and UC have The remaining.

28. **How to control the expenditure of CSMBS could make a fiscal space for the UC scheme:** CSMBS is not expected to expand its coverage drastically in near future unless the government officers increase. The key issue of CAMBS is how to control the expenditure and to contain the cost of CSMBS for the sustainable operation of entire health system. Nevertheless to say, CSMBS is financed by tax through Ministry of Finance. In that sense, same questions to the UC should be raised, namely the sustainability issue. In fact, 45% of total health expenditure is used by CSMBS, hence sustainability of the UC partially depends on the success of the cost containment of CSMBS. A good control over CSMBS could make a fiscal space for the UC scheme. At the same time, the service level of CSMBS is somehow the UC scheme would like to catch up with. The discussion is not “which scheme shall be standard”, but both schemes have to compromise.

29. **In the long term the expansion of SSS should be reexamined from the viewpoint of sustainability:** It is ideal that if social insurance model can cover all of population in Thailand. However, because of the restriction of contribution collecting and affordability of beneficiaries, it is not realistic to expand SSS to informal sectors at this stage of development. Therefore this is a realistic option to promote the UC for maintaining universal coverage. It is also important to note that in the long term, SSS can be expected to expand its coverage along with gradual transformation of society from agricultural one to modern, or money economy or service industry society in which people could afford to pay contribution. From the viewpoint of sustainability, SSS has a similarity to the UC in financing mechanism; both scheme employ cost containing capitation system. Whereas SSS has difficulties in term of enrollment, financial stability is a good advantage of SSS in that it does not rely on tax heavily.

30. **The UC scheme should find the stable revenue source apart from political manipulations:** The UC could be a second best choice at the current situation in Thailand to achieve the universal coverage, because SSS have a certain limitation for expansion of coverage. The key issue on the sustainability of the UC scheme is how to establish the financing mechanism apart from changeable political will. For the budget competition, every year NHSO proposed the capitation budget based on the statistical calculation from actual expenditure in the healthcare facilities though, the decision making on the budget is rather a result of political compromise rather than academic debate. This means that the resources provided by NHSO are always below the required level, which in turn cannot secure the people in need.

31. **Service quality issue is remained:** The remaining issue which was not discussed in this paper is quality of services. The criteria of satisfaction of beneficiaries are changing with the passage of time. If standard of quality demanded by beneficiaries is higher than current one, then more resources would be required, hence the assumptions for sustainability should be reconsidered. For the discussion on fiscal space of Thailand for the sustainable development of health security issue, we probably need further data and assumptions, particularly perspectives considering on the impact of current economic crisis.

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