Thailand

Area	513,115 km²
Population[i]	67,312,624
Age structure	
• 0-14 years	22.0%
• 15-64 years	70.6%
• 65 years and over	7.4%
Infant mortality rate (per 1,000 live births) both sexes[ii]	13
Life expectancy at birth (years) female	72.1
Life expectancy at birth (years) male	65.8
Maternal mortality ratio (per 100,000 live births)[iii]	110
GDP per capita	
• Current USD[iv]	4,043
• PPP (current international $)[v]	8,086
• Constant local currency	64,722
Total expenditure on health (in millions of baht)	363,770.8
Private expenditure on health as percentage of total expenditure on health	25%
Unemployment rate[vi]	0.7%
Labour force[vii]	38.7 million
Percentage of workforce in informal economy[viii]	62.3%
Human development index (HDI) rank[ix]	87
HDI poverty indicators – Human poverty index rank	41
Adult literacy rate (ages 15 years and above)	94%

The Universal Coverage Scheme

Thaworn Sakunphanit
Worawet Suwanrada

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Thailand

Summary

Target group: Every Thai citizen not covered under other public schemes.

Target population: 47 million (80% of total population).

Benefits: Comprehensive package (in kind) that includes:

- prevention services covering immunizations, annual physical check-ups, premarital counselling, antenatal care and family planning services as well as other preventive and promotive care;
- ambulatory care and in-patient care (high-cost treatments such as cancer treatments, open heart surgery, antiretroviral drugs and renal replacement therapy are all included);
- only a few conditions are excluded, i.e., infertility, cosmetic surgery.

Delivery process:

- A national centralized, online registration database links providers to public health insurance schemes. Beneficiaries must register with a primary-care contracting unit near their home area (within 30 minutes' travel time from home). Primary care unit acts as a gate-keeper for access to care. Treatment outside this area is limited to accident and emergency care. For complicated cases, there is a referral system to hospitals or special institutes;
- Benefits are provided free of charge;
- Hospital submits electronic claims to the Universal Coverage Scheme for inpatient services.

Total expenditure (fiscal year 2008):

Expenditure	Nominal Price (in millions of constant 2005 PPP $)	% of GDP
Benefit expenditure	5,522.2	0.97
Administrative expenditure	50.6	0.01
Total	**5,572.8**	**0.98**

Source of funding: General tax revenue.

Impact:

- 88,000 households in 2008 were prevented from falling below the poverty line;
- Well-controlled diabetic patients increased from 12.2 per cent of total diabetic patients (2003-2004) to 30.6 per cent (2008-2009);
- Well-controlled hypertensive patients increased from 8.6 per cent of total hypertensive patients (2003-2004) to 20.9 per cent (2008-2009).

Information on the Authors

Thaworn Sakunphanit, Deputy Director, Health Insurance Research Office.

Worawet Suwanrada, Associate Professor, Faculty of Economics, Chulalongkorn University.

Socio-economic Context

Thailand is located in Southeast Asia. The official national language, spoken and written by almost 100 per cent of the population, is Thai. Buddhism is the professed faith of 94.6 per cent of the population and Islam is embraced by 4.6 per cent of the Thai people; the rest of the population practices Christianity, Hinduism and other religions.

Demographic Change

Thailand is rapidly becoming an ageing society. The "demographic dividend", the phenomenon of having a low dependency ratio, will end soon. The total fertility rate of Thailand is now far below the replacement level. The overall dependency ratio, which kept falling until 2010 (table 1), will rise owing to an increased proportion of the elderly. The population 60 years of age and over will increase to more than 7 per cent in 2010. Around 2005, Thailand became an "ageing society". By the year 2030, the proportion of the elderly in the Thai population is expected to increase to 15 per cent. A 2005 survey of population change and an analysis from the Bureau of Registration Administration of the Ministry of Interior showed the same pattern: a decrease in total fertility, belying previous estimates.

Table 1 | Population projection (in millions).

Age	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
0-14 years	16.2	15.2	13.4	12.3	11.7	11.4	10.8	10.0	9.3	8.7
15-59 years	43.8	46.0	47.8	48.4	47.7	46.1	44.3	42.4	40.3	38.2
60+ years	6.0	7.1	8.7	10.8	13.3	15.8	18.1	20.1	21.5	22.3
Total	**66.0**	**68.3**	**69.9**	**71.5**	**72.7**	**73.3**	**73.2**	**72.5**	**71.1**	**69.2**

Source: World Population Prospects, United Nations, Department of Economic and Social Affairs, Population Division, 2000.

The average family size will continue to decrease: from more than 5 persons per household to 3.9 in 2000 to 3.4 in 2010 and 3.1 in 2020. Also, data from the Urban Development Cooperation Division of the National Economic and Social Development Board (NESDB) show that there is increased migration from rural

areas to urban areas, which will decrease the rural population from 65.28 per cent in 2000 to 60.01 per cent in 2010.

Economic Performance

Since 1961, the base of the Thai economy has rapidly changed from agriculture to services and manufacturing. When Thailand started the first five-year National Economic and Social Development Plan (1961-1966), the Thai economy relied mainly on the agricultural sector. The share of agriculture decreased from 40 per cent of gross domestic product (GDP) in 1960 to 10 per cent in 2002, however, and manufacturing increased from 13 per cent to 37 per cent of GDP. Economic growth has been impressive over more than three decades although an economic crisis during 1996-1997 brought negative growth for a few years. Thailand had to adopt a structural reform for a loan of US$17.2 billion from the International Monetary Fund (IMF). In 1997, the Thai economy had generated a negative growth rate of 1.4 per cent and it experienced a greater decline to negative 10.5 per cent in 1998. Economic growth, which in Thailand is dependent on exports, resumed in 1999. Then in 2008, GDP growth dropped to 2.5 per cent, and, in 2009, the country faced another economic crisis, which manifested itself especially through problems in the sector of goods and services production.

The Status of Poverty and Social Protection

As early as the drafting period of the second National Economic and Social Development Plan (1967-1971), there were concerns about income distribution and poverty reduction, but Thailand used mainly economic policy in tackling poverty through economic growth. The country's economic growth has contributed to a sharp drop in poverty levels. Between 1999 and 2000, poverty rates fell by 2 per cent. However, poverty decreased between 2004 and 2006 at a relatively slow pace. The poverty headcount ratio fell from 11.2 in 2004 to 9.6 in 2006. There are 6.1 million people living below the national poverty line of 1,386 baht or 87.0 constant 2005 PPP $[1] per person per month.[x] However, it should be noted that the Thai poverty measurement uses the absolute poverty line, which is not sensitive enough for the measurement of social exclusion (income distribution).

Economic development in Thailand has led to greater income disparity instead of narrowing the gap between rich and poor. Since the first National Economic and Social Development Plan in 1962, the Gini coefficient for income distribution increased from 0.41 in 1962 to 0.54 in 1992 and then fell slightly when the country faced an economic crisis in 1997 (table 2). The share of income of the poorest 20 per cent (quintile) was

[1] PPP in this case study refers to the results of the 2005 International Comparison Program (ICP), which was led and coordinated by the World Bank (1 PPP $ = 15.93 baht).

Table 2 | GDP growth and the Gini coefficient.

Year	1962	1969	1975	1981	1986	1988	1990	1992	1994	1996	1998	2000	2002	2004	2006
GDP Growth (%)	7.8	7.8	4.9	5.9	5.5	13.3	11.2	8.1	9.0	5.9	-10.5	4.8	5.3	6.3	5.1
Gini Coefficient (person)	0.41	0.43	0.45	0.47	0.49	0.49	0.51	0.54	0.53	0.52	0.51	0.53	0.50	0.50	

Source: GDP Growth from National Economic and Social Development Board (NESDB); coefficient for 1962-1988 from Panarunothai, S. and Patamasiriwat, D., *Macronomic Indices for Measuring Equity in Health Finance and Delivery 1986-1998,* Center for Health Inequity Monitoring, Faculty of Medicine, Naresuan University, 2001; Gini coefficient for 2000-2004 from NESDB and National Statistical Office.

7.9 per cent in 1962 and 4.8 per cent in 2004 while the share of the richest quintile was 49.8 per cent and 51.0 per cent in those same years.

According to a national survey of older people in Thailand, there are elderly who do not have a secure living arrangement and/or a secure financial situation. The elderly still must depend on family support. According to the surveys of 1994 and 2002, the proportion of the elderly population living alone increased from 3.6 per cent to 6.3 per cent. The most recent survey in 2007 showed that it had increased further to 7.7 per cent. Some of those living alone faced problems or obstacles such as financial difficulties (15.7 per cent). Among all elderly, 31.3 per cent did not have savings or any financial assets, and 34.1 per cent had an annual income of less than B20,000 (1,255.50 constant 2005 PPP $). These situations led the current Government to introduce social protection measures aimed at the elderly.

NATIONAL RESPONSE

Thailand first recognized the imbalance of development with the fifth five-year National Economic and Social Development Plan (1982-1986).[2] The Government paid more attention to poverty reduction and developed and implemented various initiatives. Lessons learned led to redesigned programmes, which were implemented again. After decades of this learning-by-doing, the Government implemented basic social protection schemes, the Universal Coverage Scheme (UCS) and the 500 Baht Universal Pension Scheme, under the concept of universal coverage. The current government has a "pro-welfare-state" policy and has proposed implementing the plan, "Construction of Welfare Society within B.E. 2560 (2017)".[3] Social protection has been selected as a theme of the eleventh five-year National Economic and Social Development Plan (2012-2016). An ageing society has been perceived as one of Thai society's new concerns for the next 20 years.

[2] The National Economic Development Board, which became the National Economic and Social Development Board in 1972, is a national agency that is responsible for formulating the National Economic and Social Development Plan and translating it into action within a five-year time frame. As noted earlier, Thailand launched the first five-year National Economic and Social Development Plan in 1961.

[3] The official calendar in Thailand is based on the Eastern version of the Buddhist Era, which is 543 years ahead of the Gregorian (Western) calendar.

Process of Introducing the Universal Coverage Scheme

Current Health-care System

The health-care system in Thailand is an entrepreneurial market-driven system. It has a pluralistic public/private mix in both health-care providers and financing agencies. However, most health services are provided by public health-care providers. These public health-care facilities receive government monies mainly for salary and capital investment and are allowed to keep their revenue from services for running their business. In 2007, 65.9 per cent of hospitals and 63.3 per cent of beds belonged to the Ministry of Public Health (Wibulpolprasert, 2008). Currently, the Ministry owns 891 hospitals, which cover more than 90 per cent of the districts, and 9,758 health centres, which cover every subdistrict (tambon). Private hospitals have increased since the economic expansion during the period 1992-1997. Most of them are located in Bangkok and other urban areas. There were 318 private hospitals and 16,800 private clinics in 2007. Most of these clinics belong to doctors who are government civil servants. These doctors work in their own clinic after office hours.

These health services are financed mainly through third-party payers. Thailand reached universal health-care coverage in 2002. Government spending on health care gradually increased from 56 per cent in 2000 to 75 per cent in 2008, when it totalled B343 billion or 21.5 constant 2005 PPP $ (US$9.83 billion). Recurrent health-care expenditure as a percentage of GDP slightly increased from 3.2 per cent in 2001 to 3.8 per cent in 2008 (IHPP, 2010).

By law, Thai citizens belong to one of the country's social health protection schemes. The Civil Servant Medical Benefit Scheme (CSMBS) for central government employees and other small, public-employee benefit schemes cover 7 per cent of the population. The Social Security Scheme (SSS) for private employees covers 15 per cent of the population, and the rest (76 per cent) are covered by the Universal Coverage Scheme. The Universal Coverage Scheme covers everyone who is working in the informal sector, whether rich or poor. It should be noted that private health insurance companies play a very limited additional role in Thailand owing to their high premium rates and very strict underwriting policies.

The Process of Establishing the Universal Coverage Scheme

Raising Awareness at the National Level

The history of Thai health-care policy includes the ideology of using health care to strengthen State power in the nineteenth century and treating health care as an important part of long-term invest-

Table 3 | Cause and effect of health policy in Thailand.

	Health Policy	Implementation
Before 1961	Health care was used to strengthen State power.	Expansion of public health facilities and health protection scheme for employees, e.g., Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS).
Early National Socio-economic Plan	Health is an important part of long-term investment for economic growth.	
1973 Constitution	Health services for the poor should be provided free of charge.	Low-income scheme.
1977 Constitution	Health is considered as an entitlement of Thai citizens and equal access to basic health services should be guaranteed.	Universal coverage for health care.

Source: Sakunphanit (2008).

ment for economic growth. Health care is now considered to be an entitlement of Thai citizens. Every step pushed the Thai health system further into providing universal access to care and into the protection of people's rights (table 3).

Expansion of public health facilities to cover every administrative area started during the first five-year National Economic and Social Development Plan (1961-1966). Health care was considered not only as an important part of long-term investment for economic growth but also as a strategy for promoting the Government during the Cold War period. Though the majority of the population was active in the agricultural sector and lived in rural areas, it was difficult to encourage private health facilities to provide services in those areas. Therefore, the expansion of public health facilities to cover the entire population was crucial to overcoming physical barriers.

The Ministry of Public Health decided to establish a hierarchical health service system using administrative areas as the main approach for investment in the health-care infrastructure. In the third National Economic and Social Development Plan (1972-1976), the Government set targets to reach "one hospital for every district and one health centre[4] for every sub-district" (tambon). The period from 1992 to 2001 was

[4]Health centres are health-care facilities that provide mainly preventive and basic outpatient services. Health-care professionals in these facilities comprise public health personnel, nurses and other paramedical personnel. There were no medical doctors in these health centres.

the decade of the Health Centres Development Project. In 1993, with public health centres in closer proximity to more people, everyone could access services within one hour's walking distance from home.

The government policy of charging for services in public health-care facilities was established in 1945. Later, these facilities were allowed to keep their own revenue for running their business. An informal exemption for the poor was implemented along with the user charge.

It took nearly four decades for Thailand to gradually move from out-of-pocket payment to many prepayment schemes. Regarding the informal sector, there were two public prepayment schemes, the Medical Welfare Scheme and the Health Card Scheme, which were implemented before the era of the Universal Coverage Scheme.

The Medical Welfare Scheme was called the Low Income Scheme when it was introduced in 1975. Coverage of this Scheme was maintained by several successive governments, which financed the Scheme with government revenue. The name of the scheme was changed to the Medical Welfare Scheme when it expanded coverage to people 60 years of age or older, children 12 years or younger, the disabled, veterans and monks.

The Health Card Scheme was initiated in 1983 to support primary health care in the community. Designed as a community financing fund in the beginning, it then expanded nationwide, but many problems occurred owing to a lack of administrative skills and financial risks. Finally, the Health Card Scheme changed its financial model to voluntary health insurance and established the health insurance office at the Ministry of Public Health to manage the Scheme. The main target groups of the Health Card Scheme were households with an income level higher than the poverty line.

The policy of universal health-care coverage could be traced back to the idea behind the Health Card Scheme (Boonyuen and Singhkaew, 1986). After the successful implementation of the Social Security Scheme in 1992, Thai technocrats decided to expand coverage of the "occupational" schemes to both the formal and informal sectors. These pluralistic approaches had weaknesses in terms of efficiency, quality and equity. There was debate as to whether the Government should provide care to the poor or whether it should provide universal health care for the sake of upholding basic human rights. The Ministry of Public Health started to design policy options and estimated the cost of universal coverage.

There were three policy options: gradually reforming the existing schemes to cover all Thai citizens; undertaking a major reform to set up a central agency to manage health insurance; and coordinating every scheme. Advocacy efforts vis-à-vis politicians and related organizations included a series of discussions and a study visit to Australia and New Zealand (Office of Health Insurance, 1994).

International workshops were held among Thai experts and international experts between 1993 and 1996.

The Health Insurance and Standard Medical Service Bill was drafted during 1995-1996. The Bill proposed a compulsory health insurance model. However, the draft failed to receive full-hearted support from bureaucrats and politicians in the government (Sakunphanit 2004). Nevertheless, social movements pushed the universal coverage policy into the 1997 Constitution and the eighth National Health Plan (1997-2001).

Non-governmental organizations (NGOs) and civil societies played a significant role in providing legitimacy for universal health-care coverage. A group of NGOs also drafted their National Health Security Bill and campaigned for universal coverage in 2000. In addition, the press played an influential role in keeping the general public informed of the universal coverage policy. A public opinion survey confirmed that the universal care policy was popular. Political parties added this universal coverage for health care to their policies. After the general election in early 2001, the Government started the implementation of the Universal Coverage Scheme. Finally, the National Health Security Act was enacted on 19 November 2002.

Implementation

Scheme Design

The Universal Coverage Scheme provides health-care coverage to all Thai citizens who are not covered by any other public health protection scheme. It is a result of the reform of the Medical Welfare Scheme and the Health Card Scheme and is administered by the National Health Security Office.

The Scheme is designed for efficiency by using primary care as a gate-keeper and set-up referral system for complicated cases that need inpatient service. It also emphasizes managed care.

The Universal Coverage Scheme provides a comprehensive benefit package. Benefits include curative services, health-promotion and disease-prevention services, rehabilitation services, and services based on traditional Thai or other alternative medical school practices. The Scheme also provides personal preventive services and health-promotion services to all Thai citizens.

The co-payment of B30 (1.9 constant 2005 PPP $) per visit was abolished at the end of 2006. Data analyses indicated that abolition of the co-payment had no effect on the overall use.

For greater efficiency and effectiveness, fragmented medical services have been streamlined into a new integrated continuum-of-care design. The Universal Coverage Scheme introduced a new periodic health examination as a risk-stratification tool. The goal of the screening is to prevent the onset of disease or warn of an existing disease. Many chronic diseases are treated using an actively managed approach.

Health facilities must register for the Universal Coverage Scheme. The primary medical-care unit is the first contact point for beneficiaries, who are not allowed to go directly to secondary or tertiary care facilities without referral from the primary medical-care unit except in cases of bad accidents or other health emergencies.

Although health-information technology is fragmented, there are two applications that providers and social health-protection schemes now share at the nationwide level. The national beneficiary registration system is based on a national personal identification number. A centralized registration database has been developed since 2002. It covers the entire Thai population, including information from the Civil Service Medical Benefit Scheme, the Social Security Scheme and the Universal Coverage Scheme and is updated twice a month.

Costing for Universal Coverage

The Universal Coverage Scheme prepared an actuarial model to estimate the annual budget. This estimate is used for negotiations with the Bureau of Budget on a yearly basis.

Fiscal space is estimated from a long-term financial projection. The earliest model was developed in 2004 by experts from the International Labour Organization (ILO) and their Thai counterparts. Currently, models for the Civil Service Medical Benefit Scheme, the Social Security Scheme and the Universal Coverage Scheme have been developed by experts from ILO and the Thai counterparts using the ILO social-budgeting models. Preliminary projections show that Thailand will spend around 4.5 per cent of GDP on health in 2020.

The Universal Coverage Scheme uses different payment mechanisms to control the behaviour of hospitals.

The Social Security System, with supervision by the ILO and Thai experts, has introduced a payment methodology of capitation[5] since 1992. However, a small budget amount is kept to pay the high cost of prosthetics and fee-based medical devices.

Between 1998 and 2001, the Ministry of Public Health modified the methodology of capitation in six provinces under a social investment project. This model used capitation for outpatient care only and case-mixed payment (diagnosis-related group) for inpatient care. This initiative can solve the problem of the high cost of inpatient care. These six provinces were selected to be the first batch of provinces for the Universal Coverage Scheme in 2001, before it expanded nationwide.

Currently, the Universal Coverage Scheme uses different payment mechanisms for specific types of services in order to have health-care providers contain costs. Capitation is used for most

[5] Capitation: A payment methodology in which the physician is paid an amount determined by a per-member-per-month calculation to deliver medical services to a specified group of people.

preventive services and ambulatory care. In-patient services are reimbursed using the case-mixed system, the diagnosis-related group (DRG). However, the Universal Coverage Scheme approach is different from the "original" DRG payment system of calculating the inpatient budget, and the total relative weight of DRG is used to allocate the amount of money paid to hospitals. A small fraction of the budget is allocated to pay for specific services or equipment (i.e., prosthetic heart valves) under the fee-for-service method.

Contracted health-care facilities must send clinical and financial data to the National Health Security Office (NHSO), the organization responsible for managing the Universal Coverage Scheme. Every year, representatives of health facilities and the NHSO negotiate the capitation rate and other payment mechanisms.

The Voluntary Quality Improvement Programme is operated in parallel to the cost-containment mechanism. The Healthcare Accreditation Institute, a public organization, provides voluntary hospital accreditation for both public and private providers. This accreditation is popular with hospitals because it boosts their public reputation. The Universal Coverage Scheme also provides grants to this institute for its facility accreditation services.

Every year, an external evaluator analyses the performance of the Universal Coverage Scheme. As a financing agency, the Scheme is subjected to close financial monitoring by the Office of the Auditor General of Thailand. Finally, performance reports and audited financial statements are reported to the Cabinet and the Parliament and published in the *Royal Gazette*.

Impact Analysis[6]

Increased Access to Care

After implementation of the universal health-care scheme, the proportion of insured people accessing health facilities rose from 65 per cent in 1996 to 71 per cent and 71.6 per cent in 2003 and 2004, respectively. Further analyses showed that the outpatient utilization rate slightly increased (table 4). The utilization rate of both periods should be analysed separately owing to the different methodology of the survey in 2003-2005 and in 2006-2007.

At the inception of the Universal Coverage Scheme in 2001, its beneficiaries were not entitled to receive antiretroviral drugs for AIDS treatment and renal replacement therapy. However, the triple-drug antiretroviral therapy (ART) as a standard of care for people living with HIV and AIDS has been integrated

[6]Further discussion of the impact of the Universal Coverage Scheme on the establishment of a social protection floor is contained in case study 18 under "Joint Impact of the Universal Coverage Scheme and the 500 Baht Universal Pension on the Establishment of a Social Protection Floor".

Table 4 | Use of health services, by number of visits per member, 2003-2007.

	2003	2004	2005	2006	2007
Outpatient utilization (visit/members)					
Civil Service Medical Benefit Scheme	3.48	3.41	3.50	3.12	4.02
Social Security Scheme	1.92	1.96	1.53	1.29	1.87
Universal Coverage Scheme	3.48	3.66	3.50	2.34	3.40
Inpatient utilization (visit/members)					
Civil Service Medical Benefit Scheme	0.10	0.14	0.13	0.09	0.11
Social Security Scheme	0.06	0.07	0.05	0.07	0.07
Universal Coverage Scheme	0.09	0.09	0.08	0.09	0.09

Source: National Statistical Office, Health and welfare survey 2003-2007.

into the benefit package of the Scheme since 2006. In addition, since 2007, beneficiaries of the Universal Coverage Scheme have had access to chronic hemodialysis, continuous ambulatory peritoneal dialysis and renal transplantation.

Increased Quality of Care

The Universal Coverage Scheme supports the "real" concept of primary health care according to which people themselves become the key actors and become actively involved in improving their own health, with the close support of health personnel. Community committees have been established that are financed by the Scheme and local governments. These funds are used for disease prevention, health promotion and management of other social determinants of health according to health problems in each community. An annual health examination is included in the Universal Coverage Scheme benefit package to screen for health risks and to provide intervention. These activities are operated by health staff and health volunteers in the communities. Community and individual involvement is currently encouraged to supplement the previous top-down approach.

Analysis of the National Health Examination Survey (Aekplakorn, 2010) results revealed that after the introduction of the Universal Coverage Policy in 2002, the percentage of well-controlled hypertension and diabetic patients more than doubled from 2003 to 2008 (table 5). These two diseases are included in the annual screening programme, which follows up with chronic disease management.

Table 5 | Better performance of hypertension patients and diabetic control (as a percentage).

	2003-2004	2008-2009
Hypertension among those age 15 years and above		
Prevalence of hypertension (systolic blood pressure>=140 or diastolic blood pressure >=90 mm)	22.1	21.4
• Never been diagnosed	71.4	50.3
• Being diagnosed but not treated	4.9	8.7
• Getting treatment but uncontrolled	15.0	20.1
• Getting treatment and well controlled	8.6	20.9
Diabetes among those age 15 and above		
Prevalence of diabetes (fasting blood sugar>126 mg/dl)	6.9	6.9
• Never been diagnosed	56.6	31.2
• Being diagnosed but not treated	1.8	3.3
• Getting treatment but uncontrolled	29.4	34.9
• Getting treatment and well controlled	12.2	30.6

Source: National Health Examination Survey 2003-2004 and 2008-2009.

Challenges Ahead[7]

Expansion of Coverage to Other People Living in Thailand

Minorities who live in border areas of Thailand and are unidentified nationals were excluded from universal health-care coverage although the Cabinet has just approved a budget to provide medical care for this group. There are also other foreigners living in Thailand who are still not covered. This group is more complicated since some are illegal migrants.

Establishment of a System of Governance at the National Level and Alignment of the Pluralistic System

Thailand must establish a governance body to provide policy direction to the health-care system. Health-care financing also must be harmonized. A single-payer system is not possible. Many countries with universal health-care coverage have many insurance schemes, which are harmonized under the same revenue collection and their payment mechanism is overseen by the appropriate system of governance.

[7] Further discussion on challenges for the Universal Coverage Scheme and the 500 Baht Universal Pension Scheme as well as lessons learned applicable to other countries are available in case study 18 under "Common Challenges for the Universal Coverage Scheme and the 500 Baht Universal Pension Scheme" and "Key Factors for Replication (South-South Cooperation)".

Inequity from the Supply Side

Unequal distribution of health-care facilities among rural and urban areas or among regions still exists (table 6), and it affects people's access to care. Distribution of health personnel is also different between Bangkok and rural regions.

Table 6 | Health facilities, by region.

Region	Number of Health Centres	Public hospitals		Private Hospitals		Total		Population-to-bed Ratio
		Number	Beds	Number	Beds	Number	Beds	
Northern	2,228	216	20,314	50	3,944	266	24,258	1:498
Northeastern	3,464	318	26,752	42	2,801	360	29,553	1:740
Central, excluding Bangkok	2,556	266	47,050	105	9,066	371	39,735	1:388
Bangkok		43	47,051	89	12,711	132	29,092	1:223
Southern	1,510	177	15,327	32	2,042	209	17,369	1:498
Total	**9,758**	**1,020**	**156,494**	**318**	**30,564**	**1,338**	**140,007**	**1:468**

Source: Health Resources Survey Report, Bureau of Policy and Strategy, Ministry of Public Health, 2007.

Inadequate Medical Personnel

Owing to increasing work demands, lack of incentives and more opportunities in the private sector, health-care personnel, particularly physicians, have left rural care facilities. This situation has an adverse effect on social health-protection schemes, which depend mainly on public health-care facilities.

Bibliography

For information on the references, see the bibliography for case study 18, "The 500 Baht Universal Pension Scheme".

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