Thailand Case Studies

Thaworn Sakunphanit
Worawet Suwanrada

1. Country's Socioeconomic Context

Thailand locates in Southeast Asia. Its territory covers an area of approximately 514,000 square kilometres (Figure 1). The official national language, spoken and written by almost 100 percent of the population, is Thai. Buddhism is the professed faith of 94.6 percent of the population. Islam is embraced by 4.6 percent of the Thai people while the rest of the population practices Christianity, Hinduism and other religions.

Figure 1: Map of Thailand

1.1 Demographic change

Thailand is going rapidly to aging society. The "demographic dividend", phenomenon of lower dependency ratio, will end soon (Wongboonsin, 2003). The total fertility rate of Thailand is far below the replacement level now. The overall dependency ratio, which keeps falling until 2010 (Table 1: Population projection), will reverse to rise due to an increase proportion of the elderly. Population age 60+ will increase to more than 10% in 2010 and reach 20% within 25 years. In 2050 nearly one third of Thailand's population will be age 60 and over. Latest in around 2005, Thailand entered the period of an "ageing society". By the year 2030 the proportion of elderly in the Thai population is expected to increase to 15 percent. The survey of population change 2005 and analysis form administrative database of Bureau of Registration Administration, Ministry of Interior showed the same pattern that total fertility rate decreases rapidly than previous estimation.

Table 1: Population projection

	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
0-14	16.2	15.2	13.4	12.3	11.7	11.4	10.8	10	9.3	8.7
15-59	43.8	46	47.8	48.4	47.7	46.1	44.3	42.4	40.3	38.2
60+	6	7.1	8.7	10.8	13.3	15.8	18.1	20.1	21.5	22.3
TOTAL	**65.9**	**68.3**	**70**	**71.5**	**72.6**	**73.2**	**73.2**	**72.4**	**71.1**	**69.2**

Source UN pop 2000

Average family size will decrease continuously from more than 5 persons per household to 3.9 in 2000, 3.4 in 2010, and 3.1 in 2020. Also data from Urban Development Cooperation Division, National Economic and Social Development (NESDB) showed that there is increase migration from rural area to urban area which will decrease population in rural area from 65.28% in 2000 to 60.01% in 2010.

1.2 Economic Performance

The base of the Thai economy has rapidly changed from agriculture to services and manufacturing since 1961. Thai economy was mainly relied on the agriculture sector, when Thailand started the first five-year National Economic and Social Development Plans (1961-1966). The share of agriculture decreased from 40 per cent of gross domestic product (GDP) in 1960 to 10 per cent in 2002, and manufacturing increased from 13 per cent to 37 per cent of GDP. Economic growth has been impressive over more than three decades. An economic crisis during 1996-1997 brought negative growth for a few years. Thailand had to enter into a structural reform 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 percent, and a greater decline to minus 10.5 percent in 1998. Nonetheless, a resumption of the Thai economic growth revealed since 1999. Thailand depends on export for economic growth. Therefore, Thailand feels an economic crisis in 2009 from problem in real sector. GDP growth in 2008 dropped to 2.5 percent.

1.3 Situation of Poverty and Social Protection

Although there were concerns as early as the drafting of the second national plan (1967-71) for income distribution and poverty reduction, Thailand uses 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 percent. However, poverty fell 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/person/month (World Bank, 2008). However, it should be noted that Thai poverty measurement using absolute poverty line, which is not sensitive enough for measurement of social exclusion (income distribution).

Economic development in Thailand has been showed greater income disparity rather than narrowing the gap between the rich and the 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 a high point of 0 54 in 1992 and then fell slightly when the country faced economic crisis in 1997 (Table 2: GDP growth and GINI).

The share of income of the poorest 20 per cent (quintile) was 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 the same years.

Table 2: GDP growth and GINI

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 NESDB

Gini coeff of 1962-1988 from Panarunothai and Patamasiriwat (2001)

Gini coeff of 2000-2004 from NESDB and National Statistical Office (NSO)

According to the Survey of the Older Persons in Thailand, there are still some elderly who are not secured in terms of living arrangement and/or financial situation. Elderly still have to depend on family support in their old-age. According to the surveys 1994 and 2002, the proportion of the elderly population who lives alone increased from 3.6% to 6.3%. From the most recent survey in 2007, it increased to 7.7%. Some of those living along face problems or obstacles such as financial difficulties (15.7%). Among all elderly, 31.3% do not have savings or any financial assets, and 34.1% have an annual income of less than 20,000 baht. These situations led the current government to introduction social protection measures to secure the elderly.

1.4 National response

Actually, Thailand recognized the imbalance of development since the 5th five years National Economic and Social Development Plan. Government has paid attention more to poverty reduction. Different initiatives were developed and implemented. Lessons were learned and leaded to redesign, then implemented again. From this learning by doing for decades, finally, basic social protection schemes, the Universal Coverage Scheme (UCS) and the 500 Baht Pension Scheme, were implemented under concept of universal coverage. Current government has a policy toward "welfare state" and proposed the plan of Construction of Welfare Society within B.E.2560 (2017). Social protection is selected as a theme of the 11th five-year National Economic and Social Development Plans. Aged society has been perceived as one of new risks for Thai society in the next 20 years.

More detail of the Universal Coverage Scheme is discussed in Section 2. Section 3 provided insight of the 500 Baht pension scheme. Finally, overall impacts of the two schemes to other social protection schemes are evaluated. Lesson learnt for other countries will be drawn especially key factors for replication are in Part 4.

2. Universal Coverage Scheme (UCS)

2.1 Process of Introduction

2.1.1 Current Health Care System

Health care system in Thailand is the entrepreneurial market driven system. It has a pluralistic public/private mix in both health care providers and financing agencies.

However, Most of health services were provided by public health care providers. These public health care facilities receive government budget mainly for salary and capital investment and they are allowed to keep their revenue from their services for running their business. In 2007, 65.9 percent of hospitals and 63.3 percent of beds belonged to the MoPH (Wibulpolprasert, 2008). Currently, MoPH owns 891 hospitals which cover more than 90% of districts; and 9,758 health centres, which cover every sub-district, Tambon. Private hospitals have increased since economic expansion during 1992-1997. Most of them locate in Bangkok and urban area. There were 318 private hospital and 16,800 private clinics in 2007, which majority of them is in provincial areas. Most of these clinics belong to doctors who are government civil servants. They work in their own clinic after office hours.

These health services are finance mainly from third party payers. Thailand reaches the universal coverage for health care in 2002. Government spending gradually increase from 56 percent in 2000 to 75 percent of total 343 billion Baht in 2008. Recurrent health care expenditure as percent of GDP slightly increased from 3.2 percent of GDP in 2001 – 2002 to 3.8 percent of GDP in 2008 (IHPP, 2010).

Thai citizens by law are member of one of social health protection schemes. Civil Servant Medical Benefit Scheme (CSMBS) for central government employees and other small public employee benefit schemes cover 7% of population. The Social Security Scheme (SSS) for private employees covers 15% of population, and the rest (76%) are in the Universal Coverage Scheme (UCS). The UCS covers everyone who is in informal sector either rich or poor. It should be noted that private health insurance companies play very limited additional role in Thailand due to their high premium rate and very strict under-write policies.

2.2 The process of how the Universal Coverage Scheme was established

2.2.1 Raising awareness at National Level

Thai health care policy had history of evolution from the ideology of using health care to strengthen State power in 19 century toward considering health care as an important part of long-term investment for economic growth. Finally, health is considered as an entitlement of Thai citizens. Every step pushed the Thai health system forward to universal access to care and to protect the rights of the people (Table 3).

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 employee e.g. CSMBS, SSS
Early National Socioeconomic 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)

Expansion of public health facilities to cover every administrative area was begun from the 1st five-year National Economic and Social Development Plan (1961-1966). Health care was considered as an important part of long-term investment for economic growth, and one of strategic to promoting government during the "cold war" period. As majority of people were in agriculture sector and lived in rural area. It was difficult to encourage private health facilities to provide services in rural area. Therefore, expansion of the public health facilities to cover the entire population is crucial to overcome physical barriers. The MoPH decided to establish a "hierarchy" health service system using administrative areas as the main approach for investment in the health care infrastructure. In the third national socioeconomic plan (1972 – 1976), government set targets to reach "one hospital for every district and one health centre[1] for every sub-district (Tambon)". The decade of Health Centres Development project (1992-2001) was launched. In 1993 public health centres were close to people that they could access for services within one hour by walking.

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

It took nearly four decade for Thailand gradually moves from "out of pocket payment" to many "prepayment" schemes. Regarding the informal sector, there were 2 public prepayment schemes, Medical Welfare Scheme (MWS) and the Health Card Scheme (HCS), which were implemented before UC era

The MWS was called the Low Income Scheme (LIS) at the inception period. It was introduced in 1975. Coverage of this scheme was put up by several successive governments. This scheme is finance from government revenue. The name of scheme was change to Medical Welfare Scheme (MWS) when the expand to cover elderly people age more than 60 years old, children age 0-12 years old, disability people, veterans and monks.

The HCS was initiated in 1983 to support primary health care approach in the community, It was designed as a community financing fund at the beginning. It expanded nationwide, however a lot of problems occurred due to lack of administration skill and financial risk. Finally, the scheme changed its financial model to voluntary health insurance and established the health insurance office at the MoPH

[1] Health centres are health care facilities which provide mainly prevention and basic outpatient services. Health care professional in these facilities comprise public health personal, nurse and other paramedical personal. There were no medical doctors in these health centres.

to manage the scheme. Main target of this scheme was households which had income more than poverty line.

The policy for Universal coverage for health care could trace back to the idea behind the HCS (Boonyuen & Singhkaew, 1986). After success implementation of the SSS in 1992, Thai technocrats would like to expand coverage of the "occupational" schemes both formal sector and informal sector. These pluralistic approaches had weakness in terms of efficiency, quality and equity. There was debate whether government should provide care to the poor or government should provide universal health care for sake of basic human right. The MoPH started to design policy options and estimated cost of universal coverage. There were 3 policy options, gradually reform existing schemes to cover all Thai citizens or major reform to set up central agency to manage all the health insurance or coordinate every schemes. Politicians and related organizations were advocated through series of discussions and study visit to Australia and New Zealand (Office of Health Insurance, 1994). International workshops were held among Thai experts and international experts in 1993 and 1996.

"The Health Insurance and Standard Medical Service Bill" was drafted during 1995 – 1996. This bill proposed a compulsory health insurance model. However, the draft did not receive full-hearted support from the bureaucrats and politician in the government. Nevertheless, social movement pushed the UC policy into the 1997 Constitution and the 8th National Health Plan (1997-2001).

NGO and civil societies play significant role to make legitimacy to the Universal Coverage for Health Care. Group of NGOs also drafted their National Health Security Bill and campaigned for universal coverage in 2000. The press also played an influential role in keeping the general public informed in the UC policy. A public opinion survey confirmed that the UC policy was popular. Political parties added this Universal Coverage for Health Care into their policy. Then after General Election in early 2001, government started implementation of the UCS in 2001. Finally, The National Health Security Act was enacted on November 19th, 2002

2.3 Implementation

2.3.1 Scheme design

The Universal Coverage Scheme (UCS) is only one public health protection scheme, which provides health care coverage to all Thai citizens who are not covered by any other public health protection scheme. This scheme was a result of the reform of the MWS and HCS. This scheme is administered by the National Health Security Office (NHSO).

This scheme designs for efficiency by using primary care as a gate keeper and set up referral system for complicated cases who need inpatient service. Managed care concept is applied in the UCS.

The UCS provides comprehensive benefit package. Benefits include curative services, health promotion and disease prevention services, rehabilitation services, and services provided according to Thai traditional or other alternative medical schools. The UCS

also provides personal prevention services and health promotion services for all Thai population.

The co-payment of 30 baht per visits was abolished at the end of 2006. Data analysis indicated that abolition of the 30 Baht copayment had no effect on overall utilization,

Provision of medical services under the universal coverage has been changed from fragmented service to the new integrated "Continuum of Care" design for more efficient and effectiveness. The UCS introduced the new periodic health examination as a risk stratification tools. Goal of this screening is to prevent the onset of disease or the warning of an existing disease. Many chronic diseases are under active manage approach.

Health facilities have to register to the scheme. But it is policy of this scheme to contract the primary medical care unit to provide ambulatory services for the beneficiaries, and is the first contact point for the beneficiaries. They are not allowed to go directly to secondary or tertiary care facilities without referral from the primary medical care unit except accidental or emergency situations.

Although health information technology is fragmented, there are 2 applications which providers and social health protection schemes now accept to share in nationwide level. The national beneficiary registration system bases on uniqueness of national personal identification number. A centralized registration database has been developed since 2002. It covers entire Thai population include information of the CSMBS, the SSS and the UCS is updated regularly twice a month.

2.3.2 Costing for the Universal Coverage

The UCS prepare actuarial model to estimate annual budget. This estimation is used for negotiation with the Bureau of Budget on 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 Organisation (ILO) and the Thai counterparts. Currently, models for the CSMBS, the SSS, the UCS have been developing by experts from the ILO and Thai counterparts using the ILO's social budgeting models. The preliminary results of projection show that Thailand will spend around 4.5% of GDP on health in 2020.

Different payment mechanisms are used in the UCS to manipulate behavior of hospitals.

The SSS with supervision from experts from the ILO and Thai experts has been introduced capitation to Thailand since 1992. However, small amount of budget are kept to pay high cost prosthesis and equipment by fee schedule.

The MoPH had modified methodology of capitation of the SSS in 6 provinces under Social Investment Project (SIP) during 1998-2001. This model used capitation for only out-patient and case-mixed payment (DRG) for inpatient. This initiative can

solve the problem of high cost in-patient care. These 6 provinces were selected to be the first batch of province for the UCS in 2001, before expanded to nationwide.

Currently, the UCS uses different payment mechanisms are used for specific type of services for providing different degree of inceptive and cost containment pressure to health care providers. Capitation is used for most of prevention services and ambulatory care. In-patient services are reimbursed using case-mixed system, DRG. However, the UCS approach is different from "original" DRG payment system that the global budget for in-patient is calculated, and total Relative Weight of DRG is used to allocate the amount of money paid to hospitals. Small fraction of budget is allocated to pay by fee-for-service method for specific services or equipments i.e. prosthetic heart value.

The UCS requires that contracted health care facilities have to send clinical data and financial data for reimbursement and adjust payment rate. The NHSO which manages the UCS schemes and representative of health facilities negotiate for capitation rate and payment rate for other payment mechanism every year.

Voluntary Quality Improvement Programe is encouraged in parallel with cost containment mechanism. Healthcare Accreditation Institute (Public Organization) provides voluntary hospital accreditation for both public and private providers. This accreditation is popular for hospitals to show their reputation to public. The UCS provided grants to this institute for improvement of quality process in hospitals.

Performance of the UCS is evaluated annually from external evaluator. As a financing agency, the UCS is subjected to closely financial monitor by the Office of The Auditor General of Thailand. Finally, performance reports and audited financial statements to the Cabinet and the Parliament and reports in the Royal Gazette.

2.3 Impact analysis

Increase Access to Care

After implementation of the universal healthcare scheme, proportion of insured people having access to health facilities when ill has risen from 65% in 1996 to 71 and71.6% in 2003 and 2004 respectively (Table 4). Further analysis showed that trend of OP utilization rate is slightly increased. The utilization rate of both periods should be analysed separately due to different methodology of the survey in 2003-2005 and 2006 – 2007.

Table 4: Health Services Utilisation

	2003	2004	2005	2006	2007
OP utilization (visit/members)					
CSMBS	3.48	3.41	3.50	3.12	4.02
SSS	1.92	1.96	1.53	1.29	1.87
UCS	3.48	3.66	3.50	2.34	3.40
IP utilization (visit/members)					
CSMBS	0.10	0.14	0.13	0.09	0.11
SSS	0.06	0.07	0.05	0.07	0.07
UCS	0.09	0.09	0.08	0.09	0.09

Source: NSO: Health and welfare survey 2003 – 2007

Beneficiaries of the UCS did not entitle to get antiretroviral drug for AIDS treatment and renal replacement therapy at the inception of the scheme in 2001. However, the triple-drug ART as a standard of care to people living with HIV/AIDS is integrated into the benefit package of the UCS in 2006. And in 2007, beneficiaries of the UCS beneficiaries can access to chronic hemodialysis, CAPD and renal transplantation.

Increase Quality of Care

The UCS supports "real" concept of primary health care which people themselves must become the key actors and active involvement in improving their health, which is closed support by health personnel. Community committees are established which is finance by the UCS and local governments. These funds are used for prevention and promotion for health and other social determinants of health according to health problems in each community. Annual health examination is included in benefit package of the UCS to screen health risk and to provide intervention. These activities are operated by heath personals and health volunteers in communities. Community and individual involvement are currently encourage to balance the previous top down approach.

Analysis of the National Health Examination Survey revealed that after Universal Coverage Policy in 2002, percentage of well controlled hypertension and Diabetic patients increased more than double from 2003 to 2008 (Table 5). These two diseases are included in annual screening program, which follow by chronic disease management.

Table 5: Better performance of hypertension and diabetic control

Diseases	2003-2004	2008-2009
Hypertension among those aged 15 and above		
Prevalence of hypertension (% with sBP>=140 or dBP>=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 (sBP >=140 or dBP >=90)	**15**	**20.1**
Getting treatment and well controlled (sBP <140 and dBP<90)	**8.6**	**20.9**
Diabetes among those aged 15 and above		
Prevalence of Diabetes (%; FBG>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 (FBG<130 mg/dl)	**12.2**	**30.6**

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

2.4 Challenges ahead

Expand coverage to people who live in Thailand

Minorities who live in boarder of Thailand are unidentified nationality, and are excluded from universal coverage for health care. The Cabinet has just approved to provide budget to provide medical care for this group. There are also other foreigners who live in Thailand which are still not covered. This group is more complicate. Since some are illegal migrants.

Establish system governance in national level and alignment of Pluralistic system

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

Inequity from supply side

Distribution of health care facilities among rural and urban areas or among regions still exists (Table 6), and it affected equity in people's access to care. Distribution of health personnel is also different among Bangkok and regions.

Table 6: Health Facilities by Regions

	Health Centres	Public hospitals		Private Hospitals		Total		Population to bed ratio
		Number	Beds	Number	Beds	Number	Beds	
Northern region	2,228	216	20,314	50	3,944	266	24,258	1:498
Northeastern region	3,464	318	26,752	42	2,801	360	29,553	1:740
Central region exclude 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 region	1,510	177	15,327	32	2,042	209	17,369	1:498
Total	**9,758**	**1,020**	**109,443**	**318**	**30,564**	**1,338**	**140,007**	**1:468**

Source: Report on Health resource survey 2007

Brain drain: inadequate medical personals

Working harder without enough incentive together with increasing demand and more financial incentives in the private sector have resulted in the outflow of human resources, particularly physicians, from the rural public facilities. This situation has adverse effect to social health protection schemes. Because they use mainly public health care facilities to service their beneficiaries.

.

3. 500 Baht Universal Pension Scheme

3.1 Necessity of the Introduction of New Public Pension System

It is not exaggerated to say that, various factors are forcing Thai government to consider the design for new public pension scheme. As mentioned in the first section,

Thailand is currently under the process of demographic change towards aged society. The National Economic and Social Development Board (hereafter, NESDB) projected that the percentage of the elderly population (in case of Thailand, which means older than 60 years old population) will increase gradually and exceed 20% in 2023, and in 2030 the potential support ratio is going to drop to 2.52 (NESDB, 2007). The 2007 Survey of the Older Persons in Thailand by National Statistical Office (hereafter, NSO) found that, the main source of income for the elderly in Thailand is still the financial support from their children. Nevertheless, the fertility decline may more or less change this trend in the near future. Among Thai people, such continuation of aging process starts to raise public awareness of financial preparation for their old-age livelihood. According the opinion poll "Knowledge and Attitude toward the Elderly"among 18-59 years old population nationwide conducted under the cooperation of NSO, Ministry of Social Development and Human Security and College of Population, Chulalongkorn University in 2007, approximately 95% of the observations vote most to the importance of financial preparation. Unfortunately, this poll has confirmed the fact that, 42.4 % of them have not started to prepare financially or have not ever thought about their old-age yet.

Theoretically, lack of private financial preparation for old-age may be substituted by public pension, if well equipped. Thailand had various types of formal income maintenance systems for providing financial support to the elderly, regrettably, such system was not universal to all elderly population before the introduction of 500 Baht pension scheme. There are compulsory and contributory public pension systems for only private and public employees. Those systems are the Social Security Fund (private employees; contributory system), Government Pension Scheme (for central and regional government officers; be comprised of two parts of pension, namely national budget financed part and contributory part), Local Government Officers Pension Scheme (local authorities ; non-contributory system), Private School Teachers and Headmasters Mutual Fund (private school teachers and headmasters; contributory system) and Public Enterprise Employees Pension Scheme (public enterprise employees; mostly contributory system in form of provident fund, which the employees are forced to save a certain rate of monthly wages and the employers contribute equally or less on top of that.) (Chandoevit, 2006 and Suwanrada, 2009). For the rest of the working population mentioned above, there existed no pension scheme. They could access to the mean-tested old-age allowance system, which was the former shape of 500 Baht universal pension scheme, if necessary to them.

Such unfair public pension system in terms of coverage and accessibility caused widespread requests for the reform of current public pension system or the introduction of new system. In addition, in the Part 9 Rights to Pubic Health Services and Welfare from the State and Directive Principles of Fundamental State Policies parts of the Constitution of the Kingdom of Thailand B.E. 2550 (2007), two sections concerning with the grand design of public pension system in the future has been clearly written respectively.

Section 53. A Person who is over sixty years of age and has insufficient income for the living shall have the right to receive such welfare and public facilities as suitable for his or her dignity as well as appropriate aids to be provided by the State.

Section 84(4). The State shall pursue directive principles of State policies in relation to economy to provide savings for the people and State officials for their living at the old age;

The rest of this section will be composed of four parts. Firstly, the so-called social debate on the introduction of pension system in Thailand before the introduction of 500 Baht universal pension scheme has been introduced. Secondly, the process of introduction will be discussed. Thirdly, the implementation of 500 Baht universal pension scheme will be explained. Finally, we will clarify the challenges ahead of 500 Baht universal pension scheme under the design of public pension system in Thailand.

3.2 Social Debate before the Introduction of 500 Baht Pension Scheme

In order to extend the coverage of old-age income maintenance to the rest of population, which the majority are in informal sector, there are three policy options. The first policy option is to change the existing mean-tested old-age allowance scheme to universal pension. This option is of course tax-financed. The second policy option is to establish new contributory public pension scheme. The third policy option is the promotion of the so-called Community-based Social Welfare Fund (hereafter abbreviated as CBSWF). This option can be theoretically regarded as privately provided (or initiative) pension system. This section will cover all the main points of the first and the second options.

3.2.1 The Establishment of New Contributory Public Pension System

Previously, the establishment of new contributory public pension system has been proposed in many forms. Until the proposal of the so-called "National Pension Fund", Ministry of Finance used to promote the plan of defined contribution scheme "National Provident Fund", which afforded to force the employees to save more. This scheme also expected high-income classes in informal sector to voluntarily participate. Nevertheless, this proposal has been criticized and is still pending because it did not focus on the medium or low income classes, which are the majority of the population without formal old-age income maintenance tool.

Recently, there are many academic researches, which were financially granted by Thailand Research Fund, Thai Health Promotion Fund or Foundation of Thailand Gerontology Research and Development Institute (TGRI), conducted by Thai academicians. Those researches are Pananiramai (2003) Khamnuansilpa and the others (2006), Patamasiriwat (2007), Suwanrada(2008b) Chandoevit and the others (2008) and Suwanrada and Chandoevit(2009). The direction of policy proposal of those researches is to maintain the mean-tested old age allowance system for the initial old, especially for the truly unprivileged elderly, in the transition period and to establish the contributory pension scheme for the rest of the working population. Moreover, the central government and/or local authorities may support financially for the contribution of the poor. In addition, local authorities are proposed to be the node of contribution collection. There are many reasons why many academic researchers preferred contributory pension to universal pension, i.e. the favour of self-reliance with dignity rather than begging from the government, the resources should be allocated to the truly unprivileged elderly rather than equally allocated, the concerns

on increase of financial burden of future generation affecting by the fertility decline, as well as the capacity of government budget.

From 2006 to 2008, these researches have been presented many times not only at the academic forums among academicians but also in broadly public forums, in which many stakeholders, i.e. academicians, central and local government officers, practitioners, NGOs, politicians, community representatives and general participants participated. In addition, in the Elderly Council Congress 2008 in April 2008, the participants agreed to the policy option of the establishment of the contributory pension scheme for the rest. The National Elderly Committee also approved in principle the introduction of this policy option. Fiscal Policy Office, Ministry of Finance gave up the idea of National Provident Fund and afforded to proposal the National Saving Fund option, which focuses on the establishment of the contributory pension scheme for the rest. The National Saving Scheme for Old-Age Promotion Sub-committee, which was assigned by the National Elderly Committee, became the platform for brainstorming and revising the Ministry of Finance option.

Finally, after the introduction of 500 baht universal pension scheme explained in the following chapter, in December 2009, Abhisit Vejajiva Cabinet has approved the "National Pension Fund Act B.E. 25XX". At present, this act is waiting at the Council of the State for the pass through the decision making of the parliament. This option proposes the voluntary, contributory and defined contribution type pension scheme. The target group of this scheme is the 20-59 years old working population who have not affiliated to any compulsory public pension schemes. Basic contribution is 100 baht per month at Government Saving Bank and Bank for Agriculture and Agricultural Co-operatives. Government co-contributes on top at three rates 50-80-100 baht per month depending on age of contributor. The benefits will be allocated to the contributors when he or she becomes 60 years old in form of life annuities. The persons with low economic capacity who cannot completely contribute, such as the disability, the government will contribute 50% of normal rate into his or her individual account instead.

3.2.2 The Promotion of Community-based Social Welfare Fund

In many areas of Thailand, for example Songkhla, Lamphang, Trat or Khonkaen provinces or Bangkok Metropolitan, a large number of communities have initated the so-called Community-based Social Welfare Fund. The objective of such establishment is to solve the problem of the inadequacy or the lack of publicly provided social welfare services, particularly pension coverage. These schemes provide various types of welfare through the lifecycle of the community members. The benefits often include family support (maternity fee), educational loan, community business loan, subsidy for medical expenses, subsidy for funeral expenses, etc. In some groups, pension is also one of the special-feature benefits (Suwanrada, 2009). Some Thai practitioners and academic researchers afforded to propose this scheme as the core for old-age benefits expansion.

Table 7 shows the benefits package of a type of the Community-based Social Welfare Fund in Songkhla (a province in the south of Thailand), which is widespread known as Contractual One-Baht Expenses Reduction Group. In principle, the members of the scheme will strictly decrease their unnecessary expenditure 1 baht for

his or her contribution 1 baht per day. After paying continuously contribution for 180 days, the member will be eligible for all types of benefits except pension, which requires long-term contribution for 15 years. The level of pension depends on the duration of contribution as shown in Table 7. *Chob Yodkaew*, who is the founder of this scheme, thinks that, to contribute 1 baht per day by cutting unnecessary expenses is self-training and applicable to everyone. Thus, such scheme is friendly even to the poor because of its low contribution rates and its accessibility.

However, Suwanrada (2009) has pointed out the limitations to the community-based social welfare fund, particularly related to pension benefits. There exists no interregional insurance function because each group is administrated under a unified rule but is financially independent without any cross-subsidization across communities. In addition, the financial sustainability of the scheme depends on the internal situation of the communities such as, the number of members, the balance between contribution and benefits, the returns of the fund and the age structure of the members. There are a large proportion of elderly as members in some places due to the attractiveness of the subsidy for funeral expenses and pension. There is no guarantee that young generations will participate voluntarily in such areas, potentially harming the financial sustainability of the fund in the long run (Suwanrada, 2007). At this stage, Abhisit Vejajiva Cabinet made decision to allocate subsidy for the well-organized groups in order to empower the community-based welfare fund. Nevertheless, the utilization of CBSWF for pension coverage purpose has not been emphasized clearly by this government.

Table 7: Benefit Package of CBSWF in Songkhla Province

Types	**Details**	
Maternity Pay	- For Newborn Baby: 500 baht per birth (limited to 1,000 baht / year) - For Mother: Medical Expenses Subsidy 100 baht /nights (limited 5 nights/birth)	
Medical Expenses Subsidy	100 baht / night (limited to 10 nights per year)	
Education Loan	30% of Educational Expenses	
Funeral Expenses Subsidy	2,500 baht – 30,000 baht (according to contribution periods)	
	180 days - 2,500 baht	1,460 days - 15,000 baht
	365 days - 5,000 baht	2,920 days - 20,000 baht
	730 days - 10,000 baht	5,840 days - 30,000 baht
Debt Clearing for the Death	Maximum 30,000 baht (limited only to debt of local/community saving organization and continuously and punctually repaid debt)	
Saving Reward for the Death	Reward 50% of saving of the death (limited to 15,000 baht and local/community saving organization account / 100 baht monthly paid to the surviving family)	
The Needy	Fund will pay contribution as his/her representative	
Contribution Collector Compensation	130 baht / time (30 baht will used as daily contributions)	
Pension	**300 baht – 1,200 baht/month (according to contribution periods)**	

	15 years - 300 baht/month	**40 years - 800 baht/month**
	20 years - 400 baht/mont	**45 years - 900 baht/month**
	25 years - 500 baht/month	**50 years - 1,000 baht/month**
	30 years - 600 baht/month	**55 years - 1,100 baht/month**
	35 years - 700 baht/month	**60 years - 1,200 baht/month**

Source: Table 3 in p.57 of Suwanrada (2009).

3.3 The Process of the Introduction of 500 Baht Universal Pension Scheme

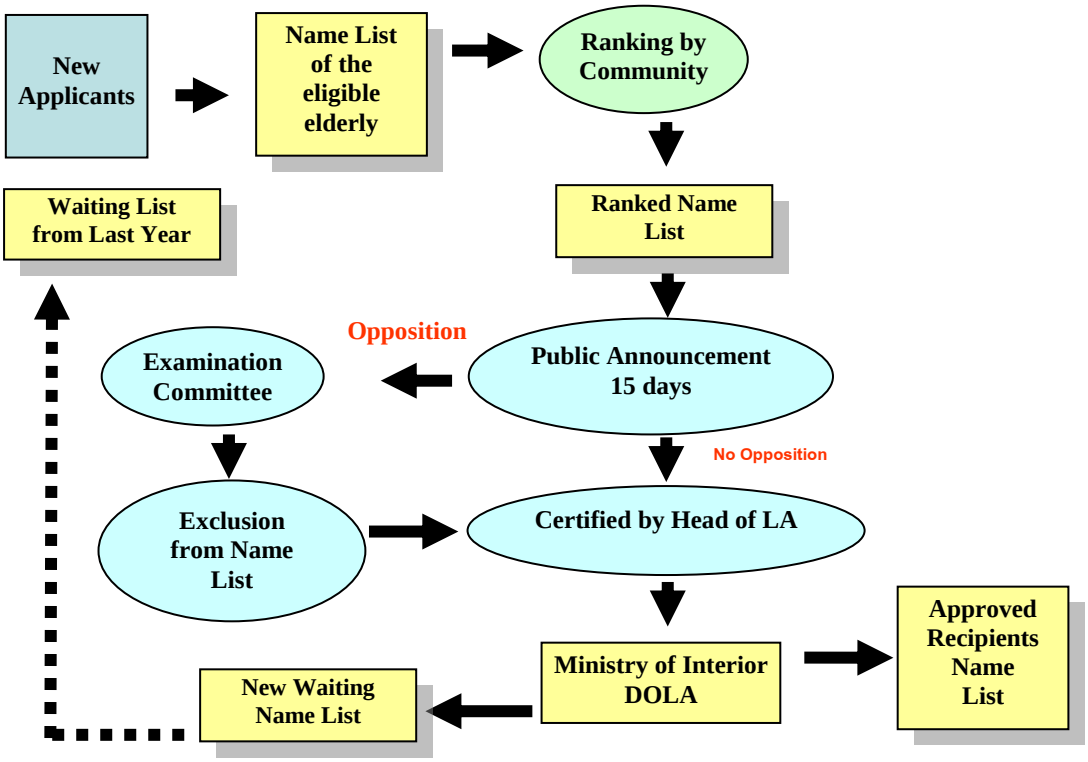
3.3.1 Historical Background: *before universal pension scheme*

The old-age allowance system was established in 1993 in form of mean-tested system under the responsibilities of the Department of Public Welfare to provide financial assistance to the unprivileged elderly, defined as a person at least 60 years of age with inadequate income to meet expenses, with no supporters, be abandoned or unable to work. The allowance per head per month was 200 baht. In the beginning, the process of selection is as follows. Firstly, the villages' public welfare assistance committee had to identify eligible elderly. After that, the provincial unprivileged elderly selection committee would recheck the eligibility of the targeted elderly and passed their name lists to the provincial governor for official approval. In the first year after the introduction of this scheme, the numbers of recipients was merely 20,000.

In 2000, the amount of allowance increased to 300 baht per head per month. In 2002, the rule for targeting the appropriate recipients has been revised, namely, the elderly who were in several unprivileged situations or inhabiting remote area with minimal public services should be prioritized. In addition, the scope of members of selection committee has been diversified; to representative from local authorities or elderly related local organization or community.

In 2005, there were big reforms on mean-tested old-age allowance system. Towards the decentralization process in Thailand, the tasks of identifying clients and defining allowance payments were delegated to local authorities through grants from the central government, namely, the Department of Local Administration (DOLA), Ministry of Interior. The definition of unprivileged elderly was maintained as before. The targeting process occurs cooperatively between local authorities and the "*prachakom*" (community council). See Figure 2. The elderly in the new applicants list and the waiting list (from previous fiscal year) will be ranked by the community. The community councils uses a range of method for ranking, i.e., ranking by age of the elderly, using the majority voting mechanism, adopting the community committee system, ranking by regarding various characteristics of the elderly, allocating allowance to all elderly (Suwanrada, 2009). In addition, local authorities with an adequately strong fiscal resources can use their own funding to increase allowances (totally must not exceed 1,000 baht per month) or increase the number of qualified recipients. In 2006, benefits have been increased to 500 baht per head per month.

Figure 2: Old-Age Allowance System Targeting Process



Source: Figure 1 in Suwanrada (2009)

3.3.2 Limitations of mean-tested old age allowance system

In practise, there were many limitations on the implementation of mean-tested old age allowance system. Basically, all local authorities had to follow the process clarified in Ministry of Interior Order on Old-Age Allowance Payment of Local Authorities B.E.2548 (2005). According to Suwanrada (2009), local authorities had extremely diversified understandings in the process among local authorities. Some allocated allowance to all elderly without mean-tested procedure, while some followed the process strictly. The definition of *prachakom* was also treated differently. Some local authorities were strict such that, they created two-tiers committee system or cross-check or recheck system in order to maintain the transparency and good governance on unprivileged elderly selection process. Nevertheless, targeting inefficiency problems occurred. According to the Monitoring and Evaluation Project of National Elderly Plan by College of Population Studies, Chulalongkorn University, more than 50% of unprivileged elderly still have not received the old-age allowance.

The implementation failure mentioned above more or less forced the government to concern the change 500 baht pension scheme from mean-tested to universal. ILO (2004a and 2004b) and Mujahid G., Pannirselvam J. and B. Doge (2008) also recommended the introduction of such scheme. The change of the philosophical view of the government is also critical factor for the change. It reflects from the policy speech of Prime Minister Abhisit Vejajiva delivered to the parliament at the start of his cabinet in the end of December 2008 or the opening speech at the Elderly Council Congress 2009 in April 2009, which showed his concern on the old-age allowance as the right of the elderly and the grateful rewards from the society.

3.4 Implementation of 500 Baht Universal Pension Scheme

Following the decision making of the National Elderly Committee (Chairperson, Prime Minister), 500 Baht universal pension scheme has been officially kicked off in April 2009. At the stage of April-September 2009 which was the midst of fiscal year 2009, Thai government used additional budget to implement this scheme as one item of economic stimulus package using the authority from the Order of National Elderly Committee on Old-Age Allowance Payment B.E. 2550 (2009). From fiscal year 2010 (October 2009-September 2010), the Order of Ministry of Interior on Old-Age Allowance Payment B.E. 2550 (2009) has been launched in October 2009. The source of fund of the scheme has been switched to annual government budget.

All elderly (over 60 years old), who are not in elderly public facilities or do not currently receive income permanently (i.e. government pension recipients, government employed persons), are eligible to the scheme. In principle, the elderly or the authorized representative must register at the local authorities, where he or she has inhabitancy registration. The qualified recipients can choose among four methods; (1) to receive cash directly at local authority office by himself, (2) to delegate authorized representative to receive cash directly at local authorities office, (3) to have pension be transferred to bank account of the elderly and (4) to have pension be transferred to bank account of the authorized representative. However, the elderly must bear the fee for bank account transfer if they do not have Krungthai Bank aacount. To disseminate the information of the universal pension, not only the announcements of local authorities, the commercial film on free television or advertising board are used to persuade the elderly to join the registration. At the same time, the booklet on the basic rights of the elderly produced by the Ministry of Social Development and Human Development are also distributed.

As of fiscal year 2010, the number of 500 baht pension recipients are approximately 77.5% of elderly population. There are still 1.22 million elderly who have not registered to this scheme yet. See Table 8.

Table 8: Number of 500 Baht Universal Pension Scheme

	Number of the Elderly
No. of the Elderly (as of September 30, 2009)	**7,239,755**
No. of the Recipients (Mean-tested System) A	**1,872,182**
After Introduction of Universal Pension	
- 1st Round Registration (April-Sept 2009) B	**3,576,661**
- 2nd Round Registration (Oct 09 – Sept 2010) C	**204,050**
No. of the Registered Elderly (A+B+C)	**5,652,893**
Government Officers	**360,679**
Non-registered Elderly	**1,226,183**

3.4 Challenges ahead

As mentioned above, three competing schemes are in the concern of Abhisit Vejajiva cabinet. He is still holding all cards in his hand. Challenge ahead for Thailand is to make clear the picture of grand design for public pension system. Following the

speech of Prime Minister Abhisit Vejajiva on many occasions, we can sketch the blueprint of his grand design for public pension system in the future. The government officers have separately their own pension system. While, universal 500 baht pension scheme is going to become basic pension or social protection floor. Old-age benefits under the Social Security Fund or life annuities from National Pension Fund becomes the first tier of private employees and the rest of population (excluding government officers) respectively.

4. Conclusion: For the build-up of SPF in Thailand

4.1 Joint impacts of UCS and 500 Baht pension on the entire Social Protection Floor building

- Poverty reduction
  Not only income security scheme like 500 Baht Universal Pension, but also the UCS decreases poverty. There was a study showed poverty reduction from the UCS during 2001-2004 (Siamwala & Jitsuchon, 2007). Recent analysis (Table 9) revealed that around 88,000 household in 2008 were prevent from poverty. Out of pocket payment for health care increased the numbers of poor Thai households by 9.9 percent (=1.4/14.4) in 1996. This figure dropped to 5.4 percent (=0.5/8.6) in 2008.

Table 9: Poverty impact of out-of-pocket payments

	1996	2000	2004	2008
Pre-payment poverty headcount	14.4%	18.6%	10.9%	8.6%
Post-payment headcount	15.8%	20.3%	11.5%	9.0%
Poverty impact	1.4%	1.7%	0.6%	0.5%

Source: Limwattananon (2010): analysis of Health Welfare Survey (various years)

- Universalism rather than targeting

  Thailand gradually moves from targeting approach to universalism. Thailand used to use targeting approach for sake of fiscal constraints in both health and elderly income allowance. However, there were many concrete evidents both type I error (benefit leakage) and type II error. The poor did not protect properly.

  Egalitarian approach to providing equal access to necessary health and social services was debated in the 1970s. Two decades later after economic crisis, Social movements successfully extended the egalitarian concept into the 1997 Constitution, which leaded to a universal health coverage policy 2002. Further social movement and advocacy of elderly society push the universal elderly income security into the 2007 Constitution. Finally, current government announced for the universal 500 Baht pension scheme and amended the Elderly act. Although this income security is not enough for living condition, it provide more secured in old-age lifespan.

Although main stream of social protection in Thailand is move toward the egalitarian policy, balance of the social risk management between individual and institutions still a hot debate especially the pension system. Many affluent groups are still libertarian or laisser-faire.

4.2 Common obstacles in UCS and 500 Baht Universal Pension

- Infrastructure
  Health care infrastructure should be the first step before arrangement of health care financing for universal coverage. Well function of local governments are needed for universal pension for informal sector.

- Administrative capacity

  Capacity of to design, implementation and monitor the system under specific context of country has to be establish and maintain. This is a long term investment.

- Aging society

  Strategies to ensure healthy and productivity elders are needed. Social health protection schemes have to not only guarantees access for everyone, but also actively improve health service benefits in such a way to encourage people to change their behaviour to healthy life style.

  Long term care for elderly who finally loss their physical capability and need both health care and long term care is another issue. Home-care should come before institutional care. And the traditional pattern of care within the family has to encourage as far as possible

- How to Financial and Sustainability

  The UCS and 500 Baht Pension Scheme now depend on general revenue financing through annual budgeting process, and remains vulnerable to receive budgets below actual cost of services from budgetary competition among Ministries. Current taxes are not enough, new taxes are needed.

4.3 Key factors for replication (South-South cooperation)

Political and system ideology

Experiences in Thailand have shown that system ideology with an appropriate social justice is a prerequisite of social policy formulation. Economic development, which emphasizs on growth and ignore redistribution, lead to inequities and social unrest.

Stake holder participations

The interrelationship among of civil society, academic and politician in policy is the key of success. Prof. Dr. Prawase Wasi proposed the concept of “Triangle that moves

the mountain". The Triangle consists of: Creation of relevant knowledge through research, Social movement or social learning and Political involvement (Wasi, 2000). This concept was applied successfully during the agenda setting, policy formulation and policy implementation of the UCS and 500 Baht Universal pension scheme.

Bibliography