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Joint Learning Workshop:
Moving Toward Universal Health Coverage

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Participant Preparatory Materials

Moving Toward Universal Health Coverage
THAILAND[14]

Basic Demographic and Health Statistics

The following table presents a brief overview of some key health and demographic statistics in Thailand[xviii]:

Table I: Selected Demographic and Health Statistics, Thailand, 2006:

	Thailand (2006)
Gross national income per capita (PPP international $)	7,440
Population (in thousands) total	63,444
Per capita total expenditure on health (PPP int. $)	346
Private expenditure on health as percentage of total expenditure on health	35.6
Infant mortality rate (per 1 000 live births) both sexes	7
Life expectancy at birth (years) female	75
Life expectancy at birth (years) male	69
Maternal mortality ratio (per 100 000 live births)	110

Evolution of Health Financing Reform in Thailand

While the health system in Thailand has strong public and private sectors, nearly 65 percent of resources spent on health and utilization of services are in the public sector.[xix]

Since the 1970s, Thailand has made a concerted effort to move towards universal health coverage. Significant progress was achieved in the past three decades, with 75 percent of the population covered through some type of health insurance by 1998. However, it was not until 2001 when a new government came into power that universal health insurance was introduced to achieve truly universal health coverage.

[14] This case study was compiled by the Results for Development Institute with inputs from Dr. Thaworn Sakunphanit, Deputy Director, Health Insurance System Research Office (HISRO), Thailand. The following sources have also been consulted:
Good Practices in Health Financing: Lessons from Reforms in Low- and Middle-Income Countries. 2008. Eds Pablo Gottret; George J. Schieber, and Hugh R. Waters. The World Bank.
Universal coverage in Land of Smiles: lesson from Thailand's 30 Baht Health reforms. D.Hughes, S.leethongdee. *Health affairs*, July/Aug 2007 Vol.26, no.4

A summary timeline of the evolution of the health financing system in Thailand until 2001 is summarized in the table below:

Table II: Summary Timeline of Health Financing in Thailand, 1962-2001:

Date of Implementation	Scheme	Coverage in 2001 (Approximated)
1962-86	Gap in the progress on coverage, focus on infrastructure development	
1963	Civil servants medical benefits scheme	9%
1975	Free medical care for low income	20%
1983	Community financing (Health Card Phase I – II)	
1990	Voluntary public health insurance (Health Card Phase III - V)	13%
1992	Compulsory Social Security	11%
1993	Free medical care for children	16%
1995	Free medical care for the elderly	6%
2000	**TOTAL HEALH INSURANCE COVERAGE**	**75%**

Expansion of rural healthcare infrastructure and specifically a rapid expansion of public provincial hospitals, rural district hospitals, and health centers was initiated beginning in 1962. A strong political movement against the military government in 1973 resulted in temporary democracy in Thailand. This, combined with a global focus on "Health for All", resulted in many policy changes, particularly a big push for a focus on primary health care, universal health coverage, and recruitment of village health volunteers and the establishment of many community-financing schemes in health (e.g., village drug funds, sanitary funds, nutrition funds). The push for expanding rural infrastructure continued into well into 1980. This push resulted in expanded access to essential health services.

This era also allowed progressive student leaders an opportunity to gain rural public health experience and management skills. This group formed the "Rural Doctor Society" in 1978. During this era, trained village health volunteers and village health communicators were used as the main tool in the nation's primary health care strategy. Their roles were to assist health personnel in delivering basic integrated health care. The village health volunteers have played a significant role in improving access to rural primary health care services.

Between 1975 and 1992, four main insurance schemes were founded:

- **The Medical Welfare Scheme (MWS):** Established in 1975 under the name "Free medical care for low income" and funded through general taxation. Beneficiaries were the poor with monthly incomes of less than Baht 1,000. Beneficiaries were entitled to free medical services from public health facilities. The scheme was later expanded to cover the elderly, children, veterans, disabled, monks, and priests. The scheme was later renamed the "Medical Welfare Scheme".
- **Health Card Scheme:** This was a publicly subsidized voluntary health insurance scheme, which evolved from a community financing project in its early phases. It covered the near-poor population. The voluntary nature of the scheme resulted in problems of selection bias.
- **Compulsory Social Security Scheme (SSS):** Covered all private employees. This scheme is financed through a tri-party arrangement, namely employees, employers, and central government contributions. Establishments that had 20 employees or more were the first group targeted. The scheme gradually

expanded to cover all formally employed employees, even those working in small businesses (as small as 1 employee).

- **Civil Servant Medical Benefit Scheme (CSMBS)**: Civil servants and public employees and their family members were covered by CSMBS. The CSBMS was fully funded from general tax revenue through the Department of the Comptroller's General, Ministry of Finance.

Beneficiaries of the CSMBS enjoy free choice of providers and the CSMBS pays providers based on a fee for service. However, other schemes have required their beneficiaries to register and seek care at certain first-contact health facilities, either a health center or a hospital. Anyone who bypasses this system must pay out of pocket. The schemes pay providers based on global budget (for MWS and the Health Card Scheme) and capitation payment system (for the Social Security Scheme).

Until 2000, these four public health insurance schemes combined (with a small fraction of private health insurance) covered approximately 75 percent of the population.

Several options and movements originating through "technocrat" and civil societies to move the system towards comprehensive universal coverage were not successful. However these movements created critical mass and legitimacy for the universal coverage movement. Many political parties now tout universal coverage in their election campaigns. And in late 2000, one such political party won the national election with a commitment to provide universal coverage for health care through a "30 Baht to treat all diseases" scheme.

Summary of Reforms

A new government that aimed to expand (public) health insurance coverage to the entire population came into power in 2001. The new party proposed the National Health Security Act which was enacted in 2002, with very strong support and influence from civil society. The National Health Security Act has since then been one of the most important social tools for health systems reform in Thailand. Private health insurance organizations play no role in this reform, and remain only as a supplemental option for high income groups.

Since October 2001, the Universal Coverage Scheme (or UCS or "30 Baht Scheme") has combined the previous Medical Welfare Scheme and the Voluntary Health Card Scheme to further expand coverage to an additional 18 million people. The UHC scheme aims to provide "*universal access to essential health care and reducing catastrophic illnesses from out-of pocket payments by establishing a tax-based financing system and paying providers on a capitation basis*." This scheme covers 74.6 percent of the population as of 2007 estimates. The benefits package is a comprehensive package of care, including both curative and preventive care. The scheme is financed solely from general tax revenue. Public hospitals are the main providers, covering more than 95 percent of the insured. About 60 private hospitals joined the system and register around 4 percent of the beneficiaries.

The Baht 30 copayment was abolished by the next government in November 2006, and the system is now totally free of charge.

Since October 2003, the government has also embarked on universal access to antiretroviral drugs (ARVs). Through May 2007, more than 90,000 patients had been registered in the system.

Funding

Currently, different methods of financing are applied for the various public health insurance schemes in Thailand. The Compulsory Social Security Scheme (SSS) is financed by contribution from employees, employers, and central government contributions. However, the Civil Servant Medical Benefit Scheme (CSMBS) and the Universal Coverage Scheme (UCS) are financed from general tax revenues.

The UCS is financed through general tax revenues paid to local contracting units on the basis of population size. General tax revenue was decided as the source of funding for the scheme because of the political urgency and focus on nationwide scale-up. The target population for the scheme is largely in the informal, agricultural sector and does do not
have access to consistent cash income for any kind of regular premium payment, therefore making premium collection difficult.

A copayment of Baht 30 was also implemented. This copayment was exempted for low income people, children below 12 years old and the elderly (i.e., those above 60 years old). While this copayment did not reflect the marginal cost of interventions, it did prevent overuse.

The 30 Baht copayment was abolished in November 2006 for political reasons. However, abolition of the 30 Baht copayment had no effect on overall utilization of out-patient services. This is likely because the majority of beneficiaries have been already exempted from the copayment.

The UCS reform raised public health spending from about 66.25 billion Baht in 2000-01 to 72.78 billion Baht in 2001-02. Thus, the reform cost US$ 175 million. The government has responded to problems of the scheme being underfinanced in the first few years by increasing the overall budget for UCS up to 82.02 billion (18%) and 91.36 billion (10%) in the years 2006 and 2007 respectively.

Co-financing arrangements for the scheme are currently being considered—for example, one proposal suggests partial or non-subsidization of medical care costs for beneficiaries who decide to stay in a private room.

The table below summarizes the funding mechanisms for each of the insurance schemes in Thailand today.

Table III: Funding Mechanisms for Insurance Schemes, Thailand, 2008:

Scheme	Source of Funding	Copayment	Per Capita Expense (as of 2008) x 1,000 Baht
Universal Coverage Scheme (UCS)	General tax revenue	Previously Baht 30, now abolished Copayment only required if using nonemergency services from unregistered facilities	2.2 (USD0.07)
Civil Servant Medical Benefit Scheme (CSMBS)	General tax revenue	Yes, for some inpatient care and for private hospitals	12.1 (USD0.37)
Compulsory Social Security Scheme (SSS)	Tripartite—employers, employees, and central government contributions.	Maternity and emergency services beyond budget ceiling	1.8 (USD0.05)

	For employees: 1% of payroll each up to Baht 15,000		
Private health insurance	Out of pocket	Varies by insurance plan	Varies

Population Coverage, Enrollment, and Communication

The table below summarizes the various population groups covered by each of the insurance schemes in Thailand:

Table IV: Population Coverage through Insurance in Thailand, 2007:

Scheme	Target Population	Population Coverage (as of 2007)
Universal Coverage Scheme (UCS)	Every Thai citizen not covered under the CSMBS or SSS	74.6%
Civil Servant Medical Benefit Scheme (CSMBS)	Government employees or pensioners and their dependents	8.01%
Compulsory Social Security Scheme (SSS)	Private employees or temporary public employees	12.9%
Private health insurance	Individuals and private firms	2.16%
TOTAL		**98%**

For the UCS, in order to be enrolled in the program, all members must register with a contracting unit (CUP) and receive a card for care in their home area (i.e., within 30 minutes travel time from home). Treatment outside this area is limited to accident and emergency care.

At the outset of the scheme, health volunteers and medical personnel were utilized to directly approach potential beneficiaries to enroll them. These volunteers and medical personnel would regularly visit families within their catchment areas to encourage enrollment. Mass communication (e.g. television, radio and newspaper) were also used to disseminate information about the scheme.

A centralized registration database, which is updated regularly, is also a useful tool in identifying and enrolling beneficiaries in the USC scheme. The central registration database consolidates information on the entire Thai population, and includes registration information of the CSMBS, the SSS and the UCS. So, when patients seek care at, their entitlements are checked with the centralized online database to ensure that they are enrolled in an insurance scheme. If the database shows that that are not members of the CSMBS or the SSS, they are asked to register for the UCS at that time.

Benefits package

The table below provides a summary of the benefits provided to beneficiaries under each existing scheme.

Table V: Summary of Benefit Package of Insurance Schemes, Thailand, 2009:

Scheme	Benefits Package	Exclusions	Maternity	Annual Physical	Prevention/Promotion

Universal Coverage Scheme (UCS)	Comprehensive	15 conditions	Yes	Yes	Yes
Civil Servant Medical Benefit Scheme (CSMBS)	Comprehensive	None	Yes	Yes[1]	No[1]
Compulsory Social Security Scheme (SSS)	Comprehensive	15 conditions	Yes	No[1]	No[1]
Private health insurance	Varied	Varies	Varies	Varies	Usually no

Note: 1. The CSMBS and the SSS do not have prevention and promotion benefits. However, their beneficiaries can enjoy prevention and promotion benefits which are provided by the UCS for all Thai citizen i.e. national immunization program.

The curative package covers ambulatory and hospitalization services with some exclusions, such as cosmetic surgery, infertility treatments, organ transplants, and the provision of private room and board. For high-cost care, the UCS has adopted a similar package to the one provided by the SSS in order to standardize the packages across the scheme to minimize inequities in health care services. Thus, substantial high-cost interventions are offered. The UCS provides preventive package for all Thai citizens, focused on health promotion and disease prevention, covers immunizations, annual physical checkups, premarital counseling, antenatal care and family planning services, as well as other preventive and promotive care. All contracted public and private providers are bound to provide registered beneficiaries with these services.

Initially ARV treatment for HIV/AIDs and renal replacement therapy were excluded from the UCS but were included beginning in October 2003 and January 2008 respectively, because of strong social movements pushing for these inclusions. In January 2008, based on a cost-benefit analysis, the NHS Board decided to provide the seasonal flu vaccination to high-risk groups. There was no increase to the budget because it was determined that it costs less to vaccinate for the flu than to treat it. Evidence from a cost-benefit analysis showing that the cost of treatment and care for flu patients in high-risk groups is higher than the cost of vaccination has resulted in the decision to provide seasonal flu vaccination to high-risk groups.

The decision to expand benefits to include renal replacement therapy from January 2008 is forecasted to put more burdens on the health care system.

The table below illustrates some high cost inclusions and exclusions in the UCS.

Table VI: Universal Coverage Scheme High-Cost Benefits and Exclusions, Thailand, 2009:

Included services	Excluded services
Chemo for cancer Radiation therapy for cancers Open heart surgery including prosthetic cardiac valve replacement Percutaneous transluminal coronary angioplasty Coronary artery bypass grafting Stent for treatment of atherosclerotic vessels Prosthetic hip replacement therapy	Other organ transplants Cosmetic surgery Infertility treatment

Prosthetic shoulder replacement therapy
Neurosurgery
Antiretroviral treatment
Renal replacement therapy including kidney transplants for patients with end stage disease

Service Delivery System

The table below summarizes the service delivery systems for each of the insurance schemes in existence in Thailand today.

Table VII: Service Delivery Systems for Insurance Schemes, Thailand, 2009:

Scheme	Choice of Provider	Ambulatory Services	Inpatient Services
Universal Coverage Scheme (UCS)	Limited and must register with primary care units in vicinity of residence or workplace	Mainly public with some private	Mainly public with some private
Civil Servant Medical Benefit Scheme (CSMBS)	Almost unlimited – can go to any public facility	Mainly public	Public and private
Compulsory Social Security Scheme (SSS)	Limitation and must register with contracted hospital in vicinity of residence or workplace as point of entry to seeking care	Public and private	Public and private
Private health insurance	High with free choice	Public and private	Public and private

The Thai insurance system is based on the health system that is founded on the principles of primary care. For UCS in particular, primary care provider units (PCUs) have been designated as gatekeepers to provide care for UCS beneficiaries. As gatekeepers, PCUs are expected to provide people in their catchment areas with continuous and comprehensive care with a holistic approach. According to the services provided, health facilities under the UCS can be classified into three groups:

- *Contracting unit for primary care*: These CUPs are primary health facilities offering curative, promotive, preventive, and rehabilitative services such as ambulatory care, home care, and community care. They can be facilities ranging from community hospitals to tertiary care public or private hospitals. Each CUP has its own catchment area and population.
- *Contracting unit for secondary care:* The CUSs are health facilities that offer secondary care, mainly in patient health services. They can be facilities ranging from community hospitals to tertiary care public or private hospitals.
- *Contracting unit for tertiary care*: The CUTs provide expensive care and specialized care with high technologies. They can be regional hospitals, university hospitals, or specialized health institutes.

The UCS uses both public and private health care facilities. Private health care facilities that would like to provide services to UCS beneficiaries must to submit all requested documents to the UCS. Private health

facilities are investigated according to standard criteria of the UCS before contracts are signed. There is no such investigation for public health care facilities as they are automatically registered in the delivery network.

In principle, UCS beneficiaries are free to choose their primary providers. However, because of limited number of primary providers in rural areas, beneficiaries are assigned mainly to public primary providers close to their communities or their workplaces.

Provider Payment Mechanisms

The table below summarizes the provider payment mechanisms for each of the insurance programs in Thailand today.

Table VIII: Provider Payment Mechanisms, Thailand, 2009:

Scheme	Payment Mechanism
Universal Coverage Scheme (UCS)	Mainly capitation: risk-adjusted capitation for ambulatory services, DRG under global budget for in-patient
Civil Servant Medical Benefit Scheme (CSMBS)	Fee for service for out-patient services, DRG for in-patient services
Compulsory Social Security Scheme (SSS)	Mainly risk-adjusted capitation using utilization, chronic diseases and relative weight of DRG
Private health insurance	Fee for service

Before reform in 2007, a fee-for-service system was employed in the CSMBS to pay for both outpatient and inpatient services. In 2007, the scheme reformed its payment for inpatient services to a Diagnosis Related Group (DRG) system with several base rates of payment according to previous charges by individual hospitals.

The SSS and UCS use capitation as the main payment mechanism. The capitation budgeting system was expected to increase equity because it depends on the population size in each locality. It was also expected to increase efficiency because it includes all costs, and the hospitals must act like an insurer of registered beneficiaries, in essence, and for financial survival, hospitals must continue to improve efficiency. This is similar to health maintenance organizations (HMOs) in the United States.

The main payment mechanism of the SSS is capitation. Capitation comprises a basic capitation component, risk adjustment component, separated increments reflecting service utilization, and specific services that are paid on fee-for-service basis using a standard price list.

Initially, the UCS allowed providers the option of getting either total capitation or capitation for out-patient services and DRG for inpatient services at the provincial level. Due to the disincentive to pay providers for high-cost care and delays in case referrals, the UCS decided on a single payment system since 2003. However, some private providers were paid using total capitation until October 2007.

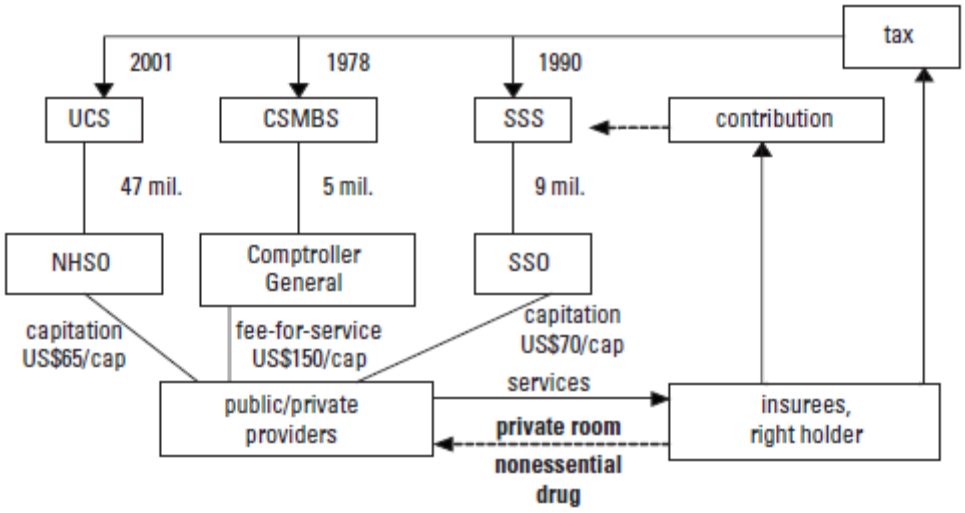
The current payment mechanism for UCS is a mixed system of risk-adjusted capitation for primary care, a DRG-based capped global budget, and fixed rate fees for some services.

It should be noted that health promotion and prevention for all Thai citizen are paid by the UCS,

Institutional structures

Governance in the Thai public health insurance system is fragmented. The Comptroller's General Department of Ministry of Finance oversees the CSMBS. Private health insurance companies are overseen by another institute in the Ministry of Finance. The Social Security Office of the Ministry of Labor oversees the SSS. And the National Health Security Office manages and oversees the UCS. The figure below presents a snapshot of the governance structure of Thai public insurance.

Figure I: Thailand: The Health Insurance Model, 2007



Note that while there are no standardized coding and reporting systems among Thai health care facilities and among insurers, the CSBS, SSS, and UCS have joined an initiative to integrate utilization databases among the schemes to develop statistical analysis of utilization activity, planning and monitoring processes.

The Civil Servant Medical Benefit Scheme:

Oversight and management: The CSMBS is managed by the Comptroller's General Department (CGD), which is a department of the Ministry of Finance. Director General of the CGD is responsible for the overall management of the scheme. There is no steering board for the scheme. Amendments of benefits package, standard guidelines, quality standards, and payment mechanisms are decided upon by the CGD. However some amendments need approval from the Cabinet.

Information systems: The CSMBS has its own information infrastructure. The clinical information system for CSMBS was developed a few years ago. A registration database of beneficiaries allows tracking of inpatient and outpatient visits. Hospitals transmit this data online to initiate the reimbursement process. The CSMBS has also developed an authorization process for some cancer therapies.

The Social Security Schemes:

Oversight and management: The SSS is managed by the Social Security Office (SSO), which is an office within the Ministry of Labour. The Secretary General of the SSO oversees the scheme. The SSS has a Social Security Board comprised of representative from employers, employees, and government. This board is chaired by a

permanent secretary of the Ministry of Labour, and Secretary General of the SSO is Secretary of this board. Board of the SSS has autonomy by law to steer overall management of the scheme. Contribution rates, benefits package, standard guidelines, quality standards, contract process, and payment mechanisms are decided upon by the Board.

The SSO has branch offices in every province in Thailand and even in some large districts. These branch offices are responsible for monitoring and ensuring compliance employer and employee contributions, and the offices pay benefits in cash to beneficiaries as necessary.

Information systems: The clinical information system for SSS was developed and implemented in 1990 and provided an aggregate report of outpatient and in-patient services utilized by beneficiaries. This information system has since been updated.

Customer service: The SSO has a dedicated call centre. Branch offices and the call centre are available to beneficiaries to answer questions and request. Complaints and grievances are reviewed at branch offices and at the central office. Finally, outstanding grievances are decided in a subcommittee of the Medical Board.

The Universal Coverage Scheme:
Oversight and management: The UCS is managed by the National Health Security Office (NHSO), which is an autonomous agency that was established by the National Health Security Act 2002. The Secretary General is responsible for oversight of the scheme. The UCS has a National Health Security Board, which is chaired by the Minister of Public Health. The Board is comprised of representative of ministries, local governments, health care professional organizations, NGOs, private providers, and health experts.

The National Health Security Board has autonomy by law to steer overall management of the scheme. Co-payments, benefits package, standard guidelines, quality standards, contract processes, and payment mechanisms are decided by Board. There is a Standard Board which is responsible to prepare quality standards and oversee beneficiary complaints and grievances.

Information systems: The UCS has its own IT infrastructure. While the clinical information system of the UCS is similar to other two schemes, it is not identical. The UCS has also developed specific applications for health facilities to collect data for reimbursement in specific disease management programs (e.g. leukemia, diabetic mellitus, HIV/AIDS, etc.).

Customer service: The UCS also has a dedicated call centre. Branch offices and the call centre are available to beneficiaries to answer questions and request. Complaints and grievances are reviewed at branch offices and at the central office. Finally, outstanding grievances are decided in a subcommittee of the Standard Board.

The NHSO has regional branches offices and province branch offices to handle beneficiary questions and requests.

The table below outlines some of the roles and responsibilities of each of the schemes' governing bodies:

Table IX: Roles and Responsibilities of the NHSO, CGD and SSO in Operationalizing Insurance in Thailand, 2009:

	Universal Coverage Scheme (UCS)	Civil Servant Medical Benefit Scheme (CSMBS)	Compulsory Social Security Scheme (SSS)
Oversight of scheme	**NHSO**	**CGD**	**SSO**
Setting parameters (benefits package, definitions of poor, etc.)	**NHSO Board**	**Director General**	**SSO Board**
Contract management	**Yes**	**No**	**Yes**
Accreditation/Empanelment of providers	**Yes**	**No**	**Yes**
Collecting premiums, if any	**No**	**No**	**Yes**
Enrollment	**Yes**	**Yes**	**Yes**
Financial management/planning	**Yes**	**Yes**	**Yes**
Actuarial analysis	**Yes**	**Yes**	**Yes**
Setting rate schedules for services/reimbursement rates	**Yes**	**Yes**	**Yes**
Processing and provider payment	**Yes**	**Yes**	**Yes**
Outreach, Marketing to beneficiaries	**Yes**	**Yes**	**Yes**
Service delivery	**Yes**	**Yes**	**Yes**
Developing clinical information system for M&E	**Yes**	**Yes**	**Yes**
Monitoring local-level utilization and other patient information	**Yes**	**Yes**	**Yes**
Monitoring national aggregate information	**No**	**No**	**No**
Customer service	**Yes**	**Yes**	**Yes**

Monitoring and Evaluation

Evidence that the UCS has succeeded is abundant:

- **Thailand has been able to achieve nearly universal coverage**. The number of uninsured has dramatically decreased from 20 percent of the total population in 1998 to 2 percent in 2007. Anyone still uninsured can register at any time. An individual who gets sick or needs health services can appear at a health facility near home, register, and receive free care at the same time. The capitation payment system gives health care providers an incentive to reach out to enroll people in their catchment areas. The more people registered, the higher will be their income.
- **The number of people facing catastrophic health expenses has decreased.** Household health expenditures decreased after the implementation of UCS. In 2002, household savings on health care services among the previously uninsured and currently insured by the UCS was approximately B 9,650 million (US$253.95 million). A year later, savings gradually increased to B 12,726 million (US$334.89 million). In addition, the proportion of people facing catastrophic health expenditures was also reduced significantly from 5.4 percent in 2000 to 2.0 percent in 2006. The Thailand Development Research Institute reported that the UCS has also brought at least one million Thais out of poverty.
- **Beneficiaries are satisfied with the level of service received.** One public concern about the UCS was quality of services. Successive survey of UCS beneficiaries about their perceptions of the UCS were conducted in 34 provinces in 2003 to 2007. More than 85 percent of the respondents expressed satisfaction with service quality.

The Way Forward

Thailand provides an example of a country reaching universal coverage using a pluralistic approach. While the Thai system has been able to achieve great strides towards achieving universal coverage, the country aims to continually improve the efficiency and effectiveness of its health care system. Some areas of focus in the coming years include:

Aligning the pluralistic public health system: There are many collaborative efforts ongoing among the three main implementing offices of social health insurance in Thailand, the CGD, NHSO and SSO. However, to date there have been only a few success stories from their collaborations. The most successful example is the synchronization of member registration databases, which is a database of the three schemes enrollees that is linked with the Ministry of Interior's database. Similar types of collaboration among the three agencies are encouraged.

Reforming payment mechanisms: Thailand is working on methods of moving the three schemes towards similar payment mechanisms. For example, the CSMBS plans to reform its payment mechanism to control for cost escalation. A standard fee schedule, systematic adjudication processes, utilization review, and medical auditing systems are being considered for implementation across schemes. In addition, case-mixed payment for some out-patient services and closed-end budgets are also targeted in the long run. The SSS also plans to reform payment mechanisms by using DRGs for inpatient and risked-adjusted capitation for outpatient care.

Linking preventive services to curative services: The NHSO together with the SSO and the CGD have already implemented a new periodic health examination as a risk stratification tool. The goal of this screening and evaluation program is to prevent the onset of disease and/or provide warning of existing disease. A further goal of the periodic health examination is to educate patients about behavioral patterns or environmental exposures that pose risks for future diseases. Once identified, risky groups will be informed of their predisposition and encouraged to join risk modification programs and undertake appropriate treatment under standard care maps.

Preparing for an aging society: Survey data from 2005 found that decreasing total fertility rates and longer life expectancies are contributing to an aging society in Thailand. Therefore, Thailand is studying strategies to ensure a healthy and productive elder society. Social health protection schemes should guarantee access for everyone, including the elderly, and actively improve health service benefits in such a way as to encourage healthier lifestyles.

Long term care for the elderly is another important issue for Thailand.

Improving equity, quality and efficiency through primary care: One of Thailand's main strategies is to strengthen primary care services and increase the availability of care. The current government has already launched medium term projects to increase the capacity of the public sector to deliver primary care centers and hospitals. However, it still too early to say that primary care is well established in Thailand.