CHAPTER 3

ANALYSIS OF THE EXISTING HEALTH INSURANCE SCHEMES

In this chapter, the researcher firstly review literature and statistics to examine the socio-economic characteristics of Thailand, including demographic profile, economic performance, income distribution, education level, morbidity and mortality pattern. Then the existing health insurance scheme will be examined and occupational characteristics of the uninsured will be discussed. Finally, some schemes will be selected based on the examination for further evaluation by the Delphi Technique.

1. Country Background: Socio-Economic Characteristics of Thailand

In the economic development, industrialization brings more urbanization, more employment opportunities, fewer traditional family units, more exposure to convenient life styles, more effective control over disease vectors, and so on. On the other hand, there are such negative effects on people as crowding, exposure to accidents, high level of tension, pollution, new occupational hazards and need for psychological and physical adaptation.

Thailand has experienced the above-mentioned situation through a rapid economic development in the 1970s and 1980s with an average growth rate of 7% [7]. This economic development has enabled Thailand to double its per capita income and a sizable number of people have got out of absolute poverty [8].

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[7] Royal Thai Government. 1989. Health and Social Development in Thailand, p.11

[8] In 1970, GDP was 7,087 million dollars and increased to 93,310 million dollars in 1991. World Development Report 1993, World Bank.

Better nutrition, safe water supply, sanitation and higher educational attainment have reduced infant mortality rates and maternal mortality rates, and needless to say, raised the health status of people (Table 5, 6). Successful family planning programs have resulted in reduction of population growth rate. The proportion of children of the total population has declined compared to the increase in adult and old age population growth (Table 7).

The economic development and the demographic change have brought an epidemiological transition and created serious problems with respect to equity in health. While diseases of poverty such as infectious disease and malnutrition have declined, diseases of affluence such as heart disease, hypertension, cancer, and mental health problems have become causes of major morbidity and mortality. In recent years, accidents, drug addiction and AIDS have also become serious problems.

The huge gap between the rich and the poor, and the urban and rural has been observed in terms of accessibility and utilization of health service. The widening of income inequality is measured by Gini coefficients. Ikemoto presented the table of "Income distribution by Household Decile: per capita Household Income" in 1994 (Table 8). The mean income increased from 1,544 Baht in 1990 to 2,174 Baht in 1992. The mean income of the bottom 10% of the population increased as well from 154 Baht to 200 Baht. As for the income share, the top 20 percent of the population receives more than half of the total income. The share of the top 20% in the total income increased from 57.1% in 1990 to 60.5% in 1992, while the Gini coefficient increased from 0.508 in 1990 to 0.540 in 1992.

> Today, per capita income of the Northeast, the poorest region of the country, is about one-sixth that of Bangkok and almost one third of the country's population still remain in absolute poverty. Low income and poverty, moreover, is found to be closely related to heath, education and other social problems[9].

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[9] Health and Social Development in Thailand, p. 12.

The urban poor and the rural population still have a relatively low living standard, while infectious disease are a major cause of morbidity, and the infant mortality rate and the maternal mortality rate are high.

Table 4. Selected Social, Economic and Health Indicators

ECONOMIC INDICATORS		
GNP per capita (1990)	$1,570	
GNP average annual growth rate (1980-91)	5.9	
GDP per capita (1991)	$1,637	
Government budget to Health (percent; 1993)	5.7	
SOCIAL & HEALTH INDICATORS	1970	1991
life expectancy at birth	59.0	69
crude birth rate per 1,000	39	21
crude death rate per 1,000	9	6
total fertility rate per 1,000	5.5	2.3
infant mortality rate per 1,000	73	27
PUBLIC HEALTH & EDUCATION		
population per physician (1991)	4,425	
population per nurse (1990)	550	
population per bed (1991)	738	
adult illiteracy rate (%; 1990)	7	
primary school enrollment (percent; 1990)	85	

Source:

- World Bank. World Development Report 1993. pp. 288-292.
- Robinson, Byeon, Teja, and Tseng,. 1991. Thailand: Adjusting to Success Current Policy Issues. p. 2. Social Indicators.
- Hsiao, 1993. Health Care Financing in Thailand: Challenges for the Future. p. 27.

Table 5. MOPH Expenditure as a Share of the Government Expenditure (in million Baht)

	Total Govn't Expenditure (1)	Govn't exp by MOPH (2)	(2) as % of (1)
1987	227,500.0	9,525.1	4.1
1988	243,500.0	10,372.5	4.25
1989	285,500.0	11,733.1	4.1
1990	335,000.0	16,225.1	4.8
1991	387,500.0	20,568.6	5.3
1992	460,400.0	24,640.4	5.35
1993	560,000.0	32,898.1	5.87

Source: Thailand Budget in Brief. 1988 - 1993. Bureau of the Budget, Ministry of Finance

Table 6. Population Growth and Projections

Average annual growth of population (%)			Population (million)*		
1970-80	1980-91	1991-2000	1991	2000	2025
2.7	1.9	0.4	57	65	82

Source: World Bank. World Development Report 1993. p. 288

* Population in 1993 was 58.5 million, data presented by Labor Studies and Planning Division, Department of Labor Protection and Welfare, 1993.

Table 7. Income Distribution by Household Decile:
--- per capita Household Income ---

	1988	1990	1992	1988	1990	1992
H.H. Decile				Share		
Bottom	137	154	200	1.1	1.0	0.9
2nd	327	377	482	2.7	2.4	2.2
3rd	432	513	647	3.6	3.3	3.0
4th	537	654	815	4.4	4.2	3.7
5th	654	814	1014	5.4	5.3	4.7
6th	825	1018	1303	6.8	6.6	6.0
7th	1076	1317	1732	8.9	8.5	8.0
8th	1438	1780	2390	11.9	11.5	11.0
9th	2209	2680	3738	18.2	17.4	17.2
Top	4480	6136	9414	37.0	39.7	43.3
ALL	1212	1544	2174			
Gini Coefficient				0.488	0.508	0.540

Source: Ikemoto, Y. 1994. Income Distribution and Malnutrition in Thailand. p. 7.

2. Examination of the Existing Health Insurance Schemes

The main part of this chapter is an examination of the existing health insurance schemes in Thailand. There are many projects currently providing health insurance or health insurance related schemes. The eight major schemes are examined in terms of:

1) objectives,
2) target populations and its coverage,
3) source of finance,
4) total and per capita expenditures,
5) form of payment to providers,
6) benefits,
7) providers,
8) management.

This examination is mainly based on the summary tables of health benefit schemes and health insurance schemes in Thailand made by Tangcharoensathien (1991, updated in 1993) and related surveys and studies. A summary table (Table 8) is attached at the end of the section 2.

2.1 Civil Servant Medical Benefit Scheme (CSMBS)

1) Objectives

The scheme was established by the First Royal Decree in 1980 and amended several times in the following years. The scheme is aimed at providing fringe benefits part of which is medical care. Fringe benefits are provided in addition to the monthly salary.

2) Target Populations and its Coverage

Target population of the scheme is a) current civil servant and employees, b) retired pensioners and c) dependents of current employees and pensioners. Dependents includes parents, spouse and up to three children under 20 years old. The total population coverage including government employees

and dependents, and state enterprise employees and dependents are estimated to be approximately 6 million which is 10.3% [10].

3) Source of Finance

Source of finance is the government budget from general tax revenue. The insured do not have to pay any premium or fee except some co-payment.

4) Total and Per Capita Expenditure

As for the government employees and dependents, the total expenditure in 1991 was 4,315.5 million baht and per capita expenditure was 770 baht. As for the state enterprise employees, the total expenditure in 1991 was 564.1 million baht and per capita expenditure was 732.6 baht [11]. As for 1993, the only available figure is 7906.5 million baht total expenditure [12].

The funds spent on CSMBS has grown considerably, even though there was only a slight increase in the number of beneficiaries. That is because public hospitals rely more on payments from CSMBS to make-up their deficits resulted from rendering services to reduced price or free care patients.

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[10] The number of persons under coverage consists of 1.8 million current civil servants and employees, 0.2 million pensioners and a number of their dependents... The number of dependents has never been recorded ... but each of civil servants and pensioners may have 2 to 3 dependents...The total number of persons under coverage is thus estimated to be 6 to 8 million.
Rojavanit, A. 1993. The social Welfare for Health Care: The Civil Servant Medical Benefit Scheme. p.2.

[11] Rojavanit (1993) presented that the expenditure of the scheme was 5,127.3 million Baht in the fiscal year 1991, which was a 1.5% share in the total budget of the country.

[12] The General Comptroller Department and Provincial Treasurers, Ministry of Finance.

5) Form of Payment to Providers

Ministry of Finance refunds outpatient bills to the patients and inpatient itemized bills to public hospitals. Inpatients at public hospitals have very little co-payment. The insured have incentives to consume more of the treatment than they actually need (moral hazard). Outpatients of private hospitals can not make any claims. Inpatients of private hospitals have to share a co-payment according to the law [13].

6) Benefits

Medical benefits includes: a) medical consultation; b) drug supply; c) medical treatment, operation and other therapeutic care; d) inpatient hospital accommodation; e) general nursing; f) delivery expense.

7) Providers

Outpatients can only be accepted at public facilities. Either public or private hospitals provide inpatient service. There is no referral line imposed.

8) Management

The general comptroller department and the provincial treasurers of Ministry of Finance are the center bodies for payments and reimbursements for the scheme's medical bills.

5.2 Free Medical Care for the Low Income Household (LIC)

1) Objectives

The scheme was initiated in 1975 with the aim of creating more equitable opportunity in receiving government health service among the poor as well as increasing

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[13] The provision stated that inpatients at private hospitals can claim: 1) 600 Baht per day for room and food, but not more than 30 days; 2) Medical appliance according to the rate determined by the Ministry of Finance; and 3) 50% of other expenses including drugs, investigation and others, but not beyond 3,000 Baht ceiling.

accessibility to health services and improving the health status of the poor.

2) Target Populations and its Coverage

Target population of the scheme is the income level below 1,500 baht per month for single person and 2,000 baht per month for households. Income in cash and in kind, profits from sale or service, and returns from assets are all included in the concept of income. Income is assessed by local village committee, that is, means testing. The eligible are given the low income card to be able to receive free service. Population coverage is 11.90 million which is 20.3% to the total population in 1993 [14]. The criteria were adjusted upward to the income 2,000 Baht per month for singles and 2,800 Baht per month for households in 1993.

However, there is a difficulty in correctly determining the eligibility of those who are issued low income cards. Misclassification happens, that is, there are the poor who do not receive the card and the non-poor actually receive the card.

3) Source of Finance

The scheme is financed through the general tax revenue. Since the scheme is under-funded [15], public hospitals try to balance the account through cross subsidization of the allocated budget with other hospital fee revenue generated mainly from CSMBS.

4) Total and Per Eligible Expenditure

Total expenditure in 1992 was 4,468.3 million baht and per eligible expenditure was 375 baht [16].

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[14] Tangcharoensathien, 1994. Exempting the Poor: The Thai Experience, p. 2.

[15] "in 1992, the expenditure was 4,468.3 million baht while budget was 2,767.5 million. Budget could only cover 62% of expenses."
Tangcharoensathien, 1994. p. 3.

[16] Ibid, p. 3.

5) Form of Payment to Providers

The government allocates an annual budget (block grant) to provincial health offices, then it is allocated to public health facilities in provinces, districts and subdistricts.

6) Benefits

Ambulatory care and impatient care are provided at public outlets.

7) Providers

Public outlets provide the service. Health centers are the designated outlet for first contacts. Then patients can be referred to secondary care with a referral letter. However, a significant increase in the use of district hospitals recently indicates that the referral system are not working effectively.

8) Management

Ministry of Public Health is in charge of overall administration of the scheme.

5.3 Free Medical Care for the Elderly (EC)

1) Objectives

The scheme was established in 1992 with the aim of increasing accessibility to health services and improve the health status of the elderly.

2) Target Populations and its Coverage

Target population is people 60 years old and above who are not covered by other schemes. Population coverage is 2.63 million which is 4.5% to the total population. The number of the elderly is estimated to increase to 5 million by the year 2000. However, a large proportion benefits by other schemes such as the Civil Servant Medical Benefit which covers retired government officials and their dependents, the Health Card Program and the Low Income Card.

3) Source of Finance

The government allocates an annual budget (general tax revenue) for the free medical care for the elderly scheme. Since the scheme runs into a deficit, the public hospitals have to use the revenue from other schemes such as CSMBS.

4) Total and Per Capita Expenditure

Total expenditure in 1991 was 267.5 million baht and per capita expenditure was 81 baht.

5) Form of Payment to Providers

The government allocates an annual budget (block grant) to provincial health offices, then it is allocated to public health facilities in provinces, districts and subdistricts.

6) Benefits

Ambulatory care and impatient care are provided at public outlets.

7) Providers

Any public outlets can provide service, however, there is no referral line imposed.

8) Management

Ministry of Public Health is in charge of overall administration of the scheme.

5.4 School Health insurance (SHI)

1) Objectives

The scheme is aimed at promoting accessibility to health services among primary school students.

2) Target Populations and Its Coverage

Target population is all primary school children grades one to six (6 to 11 years old) and secondary school children grades seven to nine (12-14 years old). Population coverage is 6.7 million which is 11.5% to the total population.

3) Source of Finance

The government allocates an annual budget (general tax revenue) for the school health insurance.

4) Total and Per Capita Expenditure

Total expenditure in 1991 was 180.9 million baht and per capita expenditure was 27 baht.

5) Form of Payment to Providers

The government allocates an annual budget (block grant) to provincial health offices, which is then allocated to public health facilities in provinces, districts and subdistricts.

6) Benefits

Ambulatory care and impatient care are provided at public outlets. In addition, the dental service (mobile dental clinic) is provided in some areas.

7) Providers

MOPH outlets provide services, however, there is no referral line imposed.

8) Management

Ministry of Public Health is in charge of overall administration of the scheme.

5.5 Workmen Compensation Scheme (WCS)

1) Objectives

The scheme, introduced in 1974, is an employer liability scheme. The scheme is aimed at protecting workers from illnesses, injuries, death and disability caused by work or work-related conditions.

2) Target Populations and Its Coverage

Target population is workers in firms with more than 10 workers. Population coverage in 1993 was 3.3 million which was 5.6% of the total population [17].

3) Source of Finance

The employer solely contributes 0.2 to 3% of payroll, depending on the risk of each industry. High risk industries such as manufacturers of metal, iron work, industrial chemicals, gas, rubber and plastic have high contribution rates. On the other hand, service industries such as hotels, restaurants, business and trading tend to be charged reduced contribution rates.

4) Total and Per Capita Expenditure

Total expenditure in 1991 was 396.9 million baht and the per capita expenditure was 233 baht.

5) Form of Payment to Providers

Patients can sought care anywhere, hospitals reimbursed directly from WCS office on a fee-for-service basis. The maximum claim is 30,000 Baht per episode of illness.

6) Benefits

Medical compensation benefit for work-related illness and injuries, temporary and permanent disability benefit, survivors' pension, funeral grant and rehabilitation expenses are provided to the insured. There is also income-related cash benefit for sick leave.

7) Providers

Any private and public hospitals provide services. There is no referral line imposed.

8) Management

The Workmen Compensation Office is set up in the Social Security Office under the Ministry of Labor and Social Welfare.

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[17] Social Security Office. 1993. Report on Population Coverage of WCS and SSS.

The Workmen Compensation Office is in charge of the management of the scheme [18].

5.6 Social Security Scheme (SSS)

1) Objectives

The scheme was enacted in 1990 and put into force February 1, 1991. The scheme is aimed at protecting workers (employees) from non-work related illnesses and injuries, and compensating maternity cases, the disabled and for death.

2) Target Populations and Its Coverage

Target population is workers in firms with more than 10 workers. Population coverage in 1993 was 4.6 million which was 7.8% [19].

3) Source of Finance

Source of finance is made by the tripartite contributions. The employers, employees and the government equally contribute to the SSA fund at the rate of 1.5% of the wages. The SSA fund subscribed by the three parties was 2,373 million Baht in 1991. The fund is estimated to increase to 13,876 Baht by 1996 [20].

4) Total and Per Capita Expenditure

Total expenditure in 1991 was 1,540 million baht and the per capita expenditure was 700 baht excluding extra-contractual service.

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[18] Before the social security office was set up, WCS was managed by the Department of Labor of the Ministry of Interior.

[19] Social Security Office. 1993. Report on Population Coverage of WCS and SSS.

[20] The recently issued Traffic Victim Protect Act contributes to raising the SS fund's financial status. If the SSS beneficiaries meet traffic accidents, their medical care fees are paid by the respective insurance company with which the vehicle is registered. In case of traffic accidents, medical care fees are quite expensive.

5) Form of Payment to Providers

Medical treatment and drugs are provided without charges (No co-payment at registered hospitals). The SSS adopted the capitation system. The SSO contracts to health care facilities on an individual basis and asks facilities for giving services to a certain number of workers. Each health care facility is given an amount of money proportional to the number of people whom the facility is willing to give coverage of health service. A flat capitation charge is given per person under care per unit time (700 Baht per person per year) regardless of the number of services sought by the workers. Emergency cases can seek care anywhere and injured workers claim directly from SSO according to rates set by the office (extra-contractual service).

6) Benefits

The SSS gives compensation covering non-occupational injuries or illness, maternity, invalidity (permanent loss of employment due to disability), and death. There is also a cash benefit for sick leave, maternity leave and disability. Family allowance (assistance for children), unemployment and old-age pension are planned to be future benefits.

7) Providers

Contracted private and public hospitals provide services. There are now more than 156 public, university, military and private contractors. There is no referral line imposed.

8) Management

The Social Security Office, a part of Ministry of Labor and Social Welfare, is in charge of administration and management. There are 3 committees outside of the SSO: tripartite Social Security Committee; Medical Committee; and Appeal Committee. The tripartite social security committee consists of 15 persons: 5 persons from the government, 5 from the employers and 5 from the employees. They give advice on policy and administration. The medical committee consists of 15 medical doctors from public and private hospitals. They give advice on medical care. The appeal committee consists of 9 persons, 3 from the government, 3 from the employers and 3

from the employees. These committees meet regularly every two weeks.

5.7 Health Card Program (HCP)

1) Objectives

The scheme was introduced in 1983 as a pilot project with the aim of promoting community development in primary health care, improving rational use of services via a referral line and raising more health resources.

2) Target Populations and Its Coverage

Target population is premium affordable households (500 baht). MCPH's focus of target population was on the borderline poor in rural areas who are not covered by Free Medical Care for the Low Income Household. Since HCP shifted its objectives to put more emphasis on cost recovery than on service provision, it tried to target the middle income class in rural population [21]. Population coverage is 2.7 million which is 4.6% of the total population.

3) Source of Finance

Source of finance is household income. A health card costs 1,000 Baht per year to cover medical costs for all family members [22] throughout the year. A half of the cost, 500 Baht, is contributed by the household. The other 500 Baht per household per year is subsidized by the general tax revenue through the MOPH budget.

4) Total and Per Capita Expenditure

Total expenditure in 1991 is 183 million Baht and the per capita expenditure is 68 baht.

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[21] Kiranandana, T. 1993. Voluntary Health Insurance in Thailand. p. 44.

[22] The average number of family members is 4.2. Tangcharoensathien, 1993. Thailand: Lessons Learned from the Social Security Scheme and Health Card scheme. p.7

5) Form of Payment to Providers

Form of payment is the block grant from the Health Card Fund at a fixed rate of 40 to 70% of the fund by the end of the year. There is no co-payment imposed.

6) Benefits

The services covered include ambulatory care for sickness and injuries, inpatient care and mother and child health services. There is no limitation of benefit coverage.

7) Providers

Beneficiaries can attend MOPH outlets either at health centers or district hospitals. Previously, the first contact was health centers, then patients had to follow referral lines for higher level of care. However, since beneficiaries prefer to go to district or provincial hospitals which are considered to provide high quality care, the referral system has become relaxed. Beneficiaries can visit either health centers or district hospitals.

8) Management

The health Insurance Office was established in the Ministry of Public Health in 1991. The Health Card Center was incorporated in the Health Insurance office. The Center is in charge of administration and management of the Health Card Program.

5.8 Private Health Insurance (PI)

1) Objectives

The private insurance started operation in 1978 when the Thai Medical and Health Company Limited was established. The objective of private insurance is to improve security and provide better health care for private employees and employers

who can afford the premium while sometimes combining with life insurance [13].

2) Target Populations and Its Coverage

Target population is private employees and employers who can afford the premium: those are the upper-middle and high income groups of the population. Population coverage is 0.2 million which is 0.3% to the total population.

3) Source of Finance

Source of finance is based on premiums which varies according to the policy of each insurance firm.

4) Total and Per Capita Expenditure

Total expenditure in 1991 was 445.2 million Baht and the per capita expenditure was 1,855 baht.

5) Form of Payment to Providers

Form of payment is mainly fee-for-services and reimbursement for actual expenses later.

6) Benefits

Medical examination, ambulatory care and inpatient care are provided, but vary with the policy of each insurance firm. Benefit are usually very generous with high premiums.

7) Providers

Both public and private outlet provide services. Some insurance firms contract with particular hospitals.

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[13] There are two categories of private insurance, Life and Non-life. Among 17 Life Insurance Companies, 6 companies write health insurance policies as supplementary agreements attached to the main individual or group life insurance policies. Among 67 Non-Life Insurance companies, 12 companies write health insurance policies. Six companies are registered with the Insurance Commissioner to perform only health insurance business, and the other six are registered with the Commissioner to perform miscellaneous insurance business which includes both individual and group health insurance.

Kiranandana, 1993. pp. 1-6.

8) Management

Each private insurance company does its own management. In general, management of private insurance is inefficient [14]:

a) the commission rate of brokers and agents is very high, at over 30% of total expenses;
b) the expenses for operation and management have been increasing continuously at high rates;
c) the growth of operational expenses has been at a higher rate than the growth rate of policies and premiums.

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[14] Ibid. p. 25.

Table 8: Summary of Health Benefit & Health Insurance Schemes in Thailand

	CSMBS	LIC	EC	SHI	WCS	SSS	HCP	PI
OBJECTIVE	fringe benefit to civil servants	guarantee medical service to the poor	guarantee medical service to the elderly	guarantee medical service to school children	protecting workers from work-related illness	protecting workers from non-work related illness	community development	providing medical benefit to premium affordable individuals
POPULATION COVERAGE	current civil servants & employees, pensioners, dependents 6 mil (10.3%)	low income individuals (B2000/month) & households (B2800/month) 11.9 mil (20.3%)	elderly aged 60 and above who are not covered by other scheme 2.63 mil (4.5%)	school children grade 1 to 9 6.7 mil (11.5%)	employeess in firms with more than 10 workers 3.3 mil (5.6%)	employees in firms with more than 10 workers 4.6 mil (7.8%)	premium affordable households, more in rural areas 2.7 mil (4.6%)	upper-middle or high income groups 0.2 mil (0.3%)
SOURCE OF FINANCE	general tax revenue	general tax revenue	general tax revenue	general tax revenue	employer liability scheme	tripartite contribution: 1.5% of payrolls of employer, employee, government	household income	household income
TOTAL EXPENDITURE	B5127.3 mil	B2500 mil	B267.5 mil	B180.9 mil	B396.9 mil	B2373 mil	B183 mil	B445.2 mil
PER CAPITA EXPENDITURE (1991)	B855	B233	B81	B27	B233	B700	B68	B1855
FORM OF PAYMENT	refunds by Ministry of Finance	block grant to provincial health office	block grant to provincial health office	block grant to provincial health office	fee for service, reimbursed from WCS office	capitation fee of B700 per insured per year	block grant from health card fund	fee for service, refunded from insurer
BENEFITS	medical exam' ambulatory & impatient care	ambulatory & impatient care	ambulatory & impatient care	ambulatory & impatient care	ambulatory & impatient care for illness, injury, disability, death.	ambulatory & inpatient care for illness, injury, maternity, disability, death.	ambulatory & impatient care	ambulatory & inpatient care
PROVIDERS	OP at public, IP at public or private.	public outlets, secondary care with referral line	public outlets. no referral line imposed	MOPH outlets. no referral line imposed	contracted public & private outlets	contracted public & private outlets	MOPH outlets, follow referral lines for higher level of care	public or private outlets, mainly private
MANAGEMENT	MOF	MOPH	MOPH	MOPH	WCS office in SSO	SSO	Health Insurance Office in MOPH	private insurance company

Source:
- Tangcharoensathien, V. (1991) Summary Table of Health Benefit Schemes and Health Insurance Schemes in Thailand.
- _____. (1993) Summary Table of Health Insurance and Medical Welfare Scheme Characteristics in Thailand, Updated.

Note: For the majority of schemes, the latest figures for total expenditure and per capita expenditure available are for 1991. Therefore, in order to standerdize results, the researcher has used 1991 figures for all schemes. No doubt figures have risen since 1991.
(See section 2 of the chapter 3 for the latest available figures.)

3. Occupational Characteristics of the Uninsured

There are approximately 24 million (43% to the total population) people who are not covered by any insurance scheme in 1994. The uninsured have to make out-of-pocket payments for health care at both public and private health service outlets. Public hospitals apply the two price system. They charge the full amount of health service fee to those who are covered by any medical benefit scheme, but lower rate of fee to those who have to pay out of pocket [25]. However, the uninsured tend to use self-prescribed drugs or other traditional remedies for minor illnesses.

Who are the uninsured? How is the uninsured classified in terms of occupation? What is the socio-economic characteristics of each classified group? Tangcharoensathien explored that

> they are poor workers in informal industrial sectors not covered by the WCF, poor rural peasants and urban slum dwellers without FCs (LIC) although income is just above the borderline of the poverty level and there are the self-employed with their own businesses ranging from poor vendors to shop keepers [26].

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[25] "there is an incentive for public hospitals to overcharge, for example, the reimbursable government employees, private insurance-covered patients, etc. to improve the hospital's financial status and thus improve services under budget deficits"
Tangcharoensathien. 1990. Community Financing: The Urban Health Card in Chiangmai, Thailand. p. 73.
"The price differentials reflect in part cost difference but are more influenced by the public service concept of MOPH and the relative political strength of the parties involved."
Rojavanit. 1993. p. 10.

[26] Tangcharoensathien. 1990. p. 74.

In addition, high school students (15 to 18 years old) are also included in the uninsured group unless their parents are covered by a scheme.

The uninsured are:

a. poor workers in informal industrial sectors not covered by the WCF or SSS;
b. poor rural peasants without LIC;
c. urban slum dwellers without LIC;
d. the self-employed; and
f. high school students whose parents are not covered by any scheme.

It is difficult to identify socio-economic characteristics of each classified uninsured people since any secondary data is not available. However, it is possible to go into depth in occupational classification. Table 9 presents the occupational characteristics of the total population [17]. The researcher identify the scheme which actually or possibly cover a classified group. Among eight schemes, private insurance (PI) is joined by any people who have ability to pay a premium. Free Medical Care for the Elderly (EC) is joined by anyone older than 60 years of age. Every occupation group in the table has possibility to be covered to a certain extent by those two schemes. Thus, PI and EC are excluded from the table.

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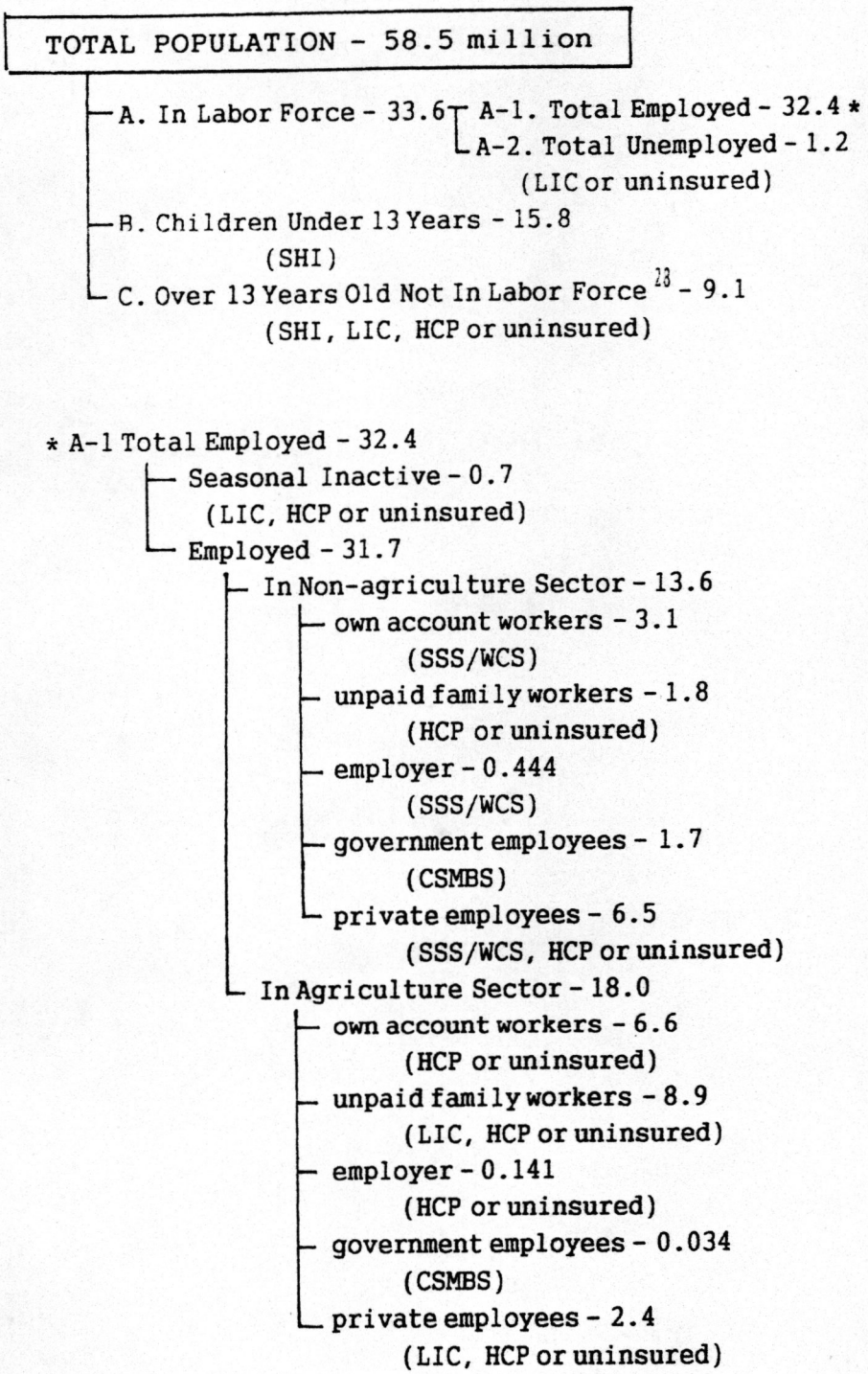
[17] Source: Labor Studies and Planning Division, Department of Labor Protection and Welfare. 1993.

Table 9. Population and Labor Force
- with identifications of possible insurance scheme coverage -



[28] In case of university student, universities usually provide their own health benefit scheme for the students.

Thus, the 23.67 million uninsured people would be some segment of:

- seasonal inactive
- unpaid family workers in non-agriculture sector
- the private employees in non-agriculture sector [19],
- own account workers, unpaid family workers, employer and private employees in agriculture sector,
- the unemployed,
- children over 13 years old not in labor force.

The agriculture sector has more uninsured population than non-agriculture sector.

Which insurance scheme will be potential one to cover these uninsured group? Table 9 indicates that these group of people which contain the uninsured group would be actually or possibly covered by either one of LIC, HCP, WCS, SSS, or SHI. The researcher will focus on the three schemes, namely, Free Medical Care for the Low Income Household (LIC), Social Security Scheme (SSS) and Health Card Program (HCP). The reason of selecting these three schemes is explained in the following section.

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[19] There are total of 8.9 million private employees, of which 2.4 million engaged in agriculture and 6.5 million in non-agriculture sector. This number includes employees in state enterprises and private employees at companies which have less than 10 employees.
Nittayaramphong, Tangcharoensathien, Walee-itthikul, Pannarunothai, 1993. Payroll Tax Financed Health Insurance in Thailand: A Policy Analysis. p.1

4. Selection of LIC, SSS and HCP as Possible Potential Schemes

The selection of LIC, SSS and HCP are mainly based upon scheme's target population and premium:

1) Free Medical Care for the Low Income Household (LIC)

The current population coverage by LIC is the biggest (20.8%) among existing schemes. Since LIC covers the population whose income level is below the poverty line, it would be able to expand the uninsured who are borderline poor but not covered by any scheme. Since LIC is a government welfare program financed by general tax revenue, beneficiaries do not have to pay any premium.

In the category of tax-financed health benefit scheme, the target population of other schemes has occupational or demographic regulation which can not always be applicable to the uninsured group. CSMBS is for civil servants and dependents. The scheme is not applicable to the current uninsured population. The target population of EC, people over 60 years old, has often been covered by other schemes already. SHI is only for primary and secondary school children. Thus, SHI is not appropriate when considering the coverage of the uninsured in general.

2) Social Security Scheme (SSS)

Since economic development and industrialization in Thailand lead to regular employment for more people, both Workmen Compensation Scheme and Social Security scheme will be expected to expand the coverage. However, WCS is the employer liability scheme. More employers might prefer to join SSS which has tripartite contribution. Premium which is 1.5% of the employee's payroll has been adequate so far. In addition, SSS will be implementing new voluntary scheme by the end of 1994 and increasing the number of benefits from 1996. Such development of SSS would be deserving of some expansion in population coverage reaching to currently uninsured population.

3) Health Card Program (HCP)

HCP is the voluntary health insurance and people who can afford the premium can join the scheme. HCP's target is the rural population, a majority group of Thai population. The premium of health card for a household is 500 Baht per year. This price is relatively affordable for most of households. Thus, HCP will be likely to reach to the uninsured.

Private insurance targets upper-middle income group. Average premium is about 1,200 baht per person per year [30]. There are a segment of uninsured people in the upper-middle income group. However, the number should be small. Thus, private insurance will not be appropriate to expand to cover the uninsured in general.

-- Summary of the Three Schemes --

1) Free Medical Care for the Low Income Household (LIC)

LIC, a tax-financed health benefit program, was started in 1975 and later expanded in full scale to cover the whole country. The scheme is managed by MOPH. Those who are covered are household under the estimated poverty line which is set at 2,800 per year, and 2,000 baht per year for a single person. Population coverage in 1993 is 11.9 million (20.3%). Ambulatory care and inpatient care are provided at public health facilities.

2) Social Security Scheme (SSS)

SSS, a compulsory health insurance scheme, was started in 1991 to insure employees in firms with 10 workers or more.

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[30] The average health insurance premium in individual life insurance business is about 1,200 baht per person in 1990 and 1991.
Mallikamas, S. 1992. Private Health Insurance in Thailand: An Investigation of Flows of Funds. p. 39.

The scheme is financed by tripartite contribution by employer, employee and the government at the rate of 1.5% of the wage. The Social Security Office is in charge of the management. Population coverage in 1993 is 4.6 million (7.8%). Benefits are provided for non-occupational illness or injuries, maternity, invalidity and death at contracted public and private hospitals.

3) Health Card Program (HCP)

HCP, a voluntary health insurance, was started in 1983. The scheme is managed by MOPH. Those who are eligible for the service are premium (500 baht) affordable household. Population coverage is 2.7 million (4.6%). The Health Card Fund is contribution from the household (500 baht per household per year) and subsidy from the government (500 baht per household per year). Ambulatory care and inpatient care are provided at public health facilities.

The three schemes will be evaluated by the Delphi Method according to equity and efficiency criteria in the following chapter to identify the potential scheme.