CHAPTER 1

INTRODUCTION

1. Background and Problems

Good health is one of the most important human concerns. And health care is a basic necessity to maintain one's productive life. Thus, it is the right of citizens to receive health care regardless of ability to pay in order to relieve suffering. In other words, it is indispensable to provide all the population equal access to health care. However, health care has unusual economic characteristics which is different from ordinary commodities. There are distinct market failures and it is difficult to establish a competitive market in the field of health care. (Table 1) The market failures of health care provide grounds for government intervention, and affect not only access to care but also the behavior of both consumers and providers.

One of the noteworthy characteristics of health care is the uncertainty. As for an ordinary commodity, people purchase it when they need it and can pay for it. However, because of unpredictability of illness, people can schedule neither when they need health care (except regular physical check-ups or immunizations), nor how much they have to pay for it. More often than not, sudden illnesses cause large financial losses for people. Medical treatment can be lengthy and expensive, and can have a high cost in terms of loss of productive capacity. Such special characteristics of health care may suggest a potential role for health insurance in order to protect the individual and family against such uncertainty.

Health insurance is regarded as a better option than other health financing schemes. Firstly, health insurance, by pooling risks and resources, converts unpredictable future expenses into payments that can be budgeted for in advance, thus, reducing financial crises. Secondly, since financing for

Table 1. Market Failures of Health care

Perfect Competitive Market	Health Care Market
1. Perfect Information - consumers' perfect knowledge	1. Asymmetry of Information between physician and patient - consumer ignorance - supplier-induced demand (Moral Hazard)
2. Certainty	2. Uncertainty - emergency (heart attack, accident, etc) - future sickness
3. Homogeneous Products	3. Heterogeneous Products - health services vary with providers.
4. Many Buyers and Sellers - consumer sovereignty	4. Limited Sellers - physician's authority - weak consumer sovereignty - hospital--local monopoly
5. No Government's Control	5. Government Intervention - subsidies or regulation
6. Free Entry Into Market	6. Regulated Entry - licensing to providers
7. Private Good - private consumption without externality	7. Public Good with Externality - communicable disease - immunization

Source:

- Hsiao, W. C. 1992. Cooperative Health Care: A Comprehensive Strategy to Finance Health Care for Developing Nations.
- Lectures on Health Financing by Dr. Wattana S. Janjaroen and Dr. Sara Bennett in the MSc in Health Economics Program of Faculty of Economics, Chulalongkorn University, August, 1993.

health care through government tax revenue is often limited, some form of health insurance, requiring contributions by individuals and/or employers, can be very attractive to a health sector which is starved of funds. Through increasing resource availability and promoting access to care for the population, equity and efficiency goals can be effectively promoted by health insurance.

Risk pooling among many people is the principle of insurance. Premiums are paid to an insurance institution which compensates any insured victim of an event for any financial loss resulting from the events by guaranteeing free or low cost (co-payment or deductibles) of health service. Collected premiums form the pooled fund which increases resource availability as well as mobilizing resources. An insurance institution involves 3 parties, namely the insurer who collect premiums, insured persons who pay premiums, and providers who give health services. The larger the group of people who share risks by paying premiums, the higher the chances that the pooled fund will be sufficient to pay for the care that each member is likely to require.

Although health insurance is considered to be a good option for financing health care, there are some criticisms. Since patients are ignorant about medical treatment, they depend on physicians for the quantity of care to consume (the agency relationship). The third party payment mechanism of insurance lessens economic constraints on both patients and physicians. Thus, over-consumption and over-treatment (moral hazard) frequently occurs. Moreover, some segments of people in society such as the poor, unemployed, elderly, etc., often have difficulty in being covered by any insurance scheme.

In Thailand, there are a number of programs currently providing health insurance or health insurance related schemes for particular subgroups of the population. Some people can be under the coverage of more than one scheme while a large proportion of them are not covered by any scheme. The total coverage of the currently running health insurance scheme is approximately 59.4% of the total population of 34.73 million.

The health insurance scheme in Thailand is classified into three categories. (Table 2)

1) Tax-financed Health Benefit Schemes including:
   Civil Servant Medical Benefit (CSMBS),
   Free Medical Care for the Low Income Household (LIC),
   School Health Insurance (SHI),
   Free Medical care for the elderly (EC: Elderly Card).

2) Compulsory Health Insurance Schemes including:
   Workmen Compensation Scheme (WCS),
   Social Security Scheme (SSS).

3) Voluntary Health Insurance Schemes including:
   Health Card Program (HCP),
   Private Health Insurance (PI).

These schemes have developed and expanded the coverage in recent years. However, there are problems of inequity and inefficiency such as with coverage, financing and management.

Currently, about 40.6% (23.67 million people) of the total population have not yet been covered by any insurance scheme for the health service. The uninsured includes poor workers in informal sectors, poor farmers, urban slum dwellers, and the self-employed with their own businesses. In addition, high school children (15-18 years old) can be included in the uninsured group unless their parents are covered by a scheme. They have to pay user fees out of household budgets when they consume health care at both public and private outlets. However, most of the uninsured are poor and usually have financial constraint in paying for health care services. Although public hospitals apply the sliding scale pricing system, the poor pay for health care at a higher proportion of household income than the better off. Thus, the uninsured tend to depend on self-prescribed drugs or other primitive remedies. For alleviating the burden of out-of-pocket payment and attaining equal access for equal need for all citizens, it is vital to reexamine the current insurance system.

In the past two decades, Thailand has experienced rapid economic development, demographic change and epidemiological transition. People expect higher health status and prefer modern professional care. Medical technology has been improved and hospitals require expensive medical equipment. Many factors have contributed to raising health expenditure. Health expenditure has steadily been rising at a higher rate than the growth of GNP. In the year 2,000, the health expenditure is estimated to be 8.1% of the GNP. And the per capita health expenditure is estimated to be 3,718 Baht. (Tangcharoensathien, V. 1990, pp.49-50) How to control health expenditure inflation and develop more efficient use of resources are also urgent questions.

The government is seeking further development of health insurance in achieving health care for all the population as well as government cost reduction. It is important to explore equity and efficiency outcomes provided by health insurance. Can the health insurance system in Thailand achieve these goals for all the population? Which scheme will be able to meet both equity and efficiency requirement and to expand the insurance coverage to the uninsured? A systematic and critical analysis on the current health insurance schemes could be meaningful.

The thesis will firstly focus on examining the existing insurance schemes in Thailand. Secondly, selecting Free Medical Care for the Low Income Household, Social Security Scheme and Health Card Program which would have the potential to expand to the uninsured [1], the attempt will be made on evaluating them according to the equity and efficiency criteria and identifying the most equitable and efficient scheme. The researcher, then, explores the potential in expanding population coverage of the identified schemes. In the field of Welfare Economics, the trade-offs between equity and efficiency is considered and the concept of equity and efficiency is defined depending on the context. However, in the macro approach of the thesis, the trade-offs will not be considered,

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[1] The reason of selecting LIC, SSS and HCP is explained in section 4 of the chapter 3.

and definitions of equity and efficiency will not be adhered to strictly. Thirdly, the thesis will explore strengths and weaknesses of the potential scheme. Finally, some recommendations will be made for further study regarding the future development of health insurance.

Table 2. Population Coverage by Insurance Schemes in Thailand

Health Insurance Schemes in Thailand	population coverage	percentage
1. Tax-financed Health Benefit Scheme		
1) Civil Servant Medical Benefit Scheme	6.0 mil	10.3%
2) Free Medical Care for the Low Income Household	11.9 mil	20.3%
3) Free Medical Care for the Elderly	2.63 mil	4.5%
4) School Health Insurance	6.7 mil	11.5%
2. Compulsory Health Insurance Schemes		
1) Workmen Compensation Scheme	3.3 mil	5.6%
2) Social Security Scheme	4.6 mil	7.8%
3. Voluntary Health Insurance Scheme		
1) Health Card Program	2.7 mil	4.6%
2) Private Health Insurance	0.2 mil	0.3%
Insured Population	34.73 mil	59.4%
Uninsured Population	23.67 mil	40.6%
Total Population	58.5 mil	

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.
- Labor Studies and Planning Division, Department of Labor Protection and Welfare, 1993

NOTE: 1. The target population of Workmen Compensation Scheme and Social Security Scheme are identical, namely employees in establishments of more than 10 workers. It should not be double counted.

2. Since there is a possibility that an individual is covered by more than one scheme, the figure of total insured population (34.73 million) is slightly over-estimated.

2. Objectives

2.1 General Objective

The general objective of the thesis is to contribute to evaluation of the experiences of insurance schemes in Thailand under the equity and efficiency consideration with the aim of suggesting potential schemes to reach the uninsured group of 23.67 million people.

2.2 Specific Objective

There are six specific objectives:

1) To examine the existing insurance schemes in order to assess major determinants of their function.

2) To evaluate some of the existing schemes according to the equity and efficiency criteria.

3) To identify the most equitable and efficient scheme.

4) To identify the scheme which would have the highest possibility in expanding population coverage.

5) If the schemes in 2) and 3) are found to be identical, assume the scheme would be the most potential one to expand to the uninsured, and explore major advantages and disadvantages of potential scheme.

6) If the schemes in 2) and 3) are not found to be identical, assume the both scheme would have the potential to expand to the uninsured, and explore major advantages and disadvantages of those schemes.

3. Literature Review

There is considerable literature which describes principle, organization, practices of health insurance. Much of the literature which describe health insurance in Thailand are also available in English. The literature of significance is concerned with the following issues:

3.1 principle and practice of health insurance,
3.2 concept of efficiency and equity,
3.3 compulsory health insurance,
3.4 voluntary health insurance,
3.5 tax-financed health benefit schemes.

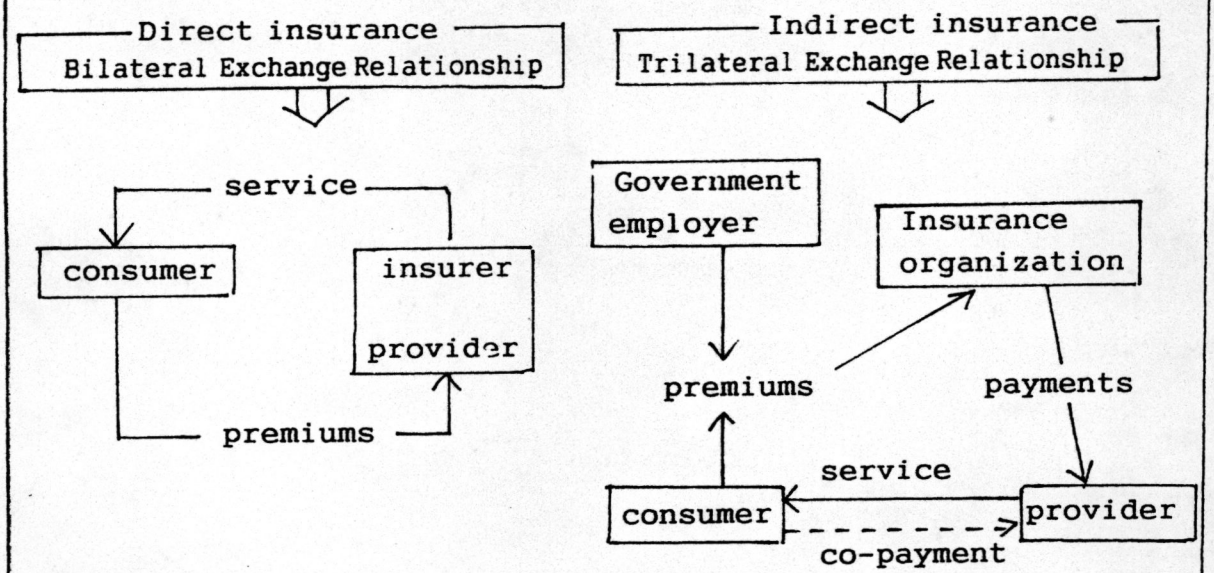
3.1 Principle and Practice of Health Insurance

Many countries have made an effort to adopt appropriate insurance schemes. Each scheme varies with objectives, target populations, source of finance, paying mechanism and health service delivery. Health insurance was developed because major illness is uneven and seldom predictable for individuals. When serious illness strikes, the patient often incurs large medical expenses and also faces the risk of impairment or loss of earning ability. When risks are pooled across populations, unpredictable losses can be transformed to predictable losses. And with cross-subsidization of resources from the healthy to the sick, from the rich to the poor, from small family to large family with a number of dependents is achieved, individual security is enhanced.

In providing health care benefits under insurance schemes, there are two kinds of methods, direct method and indirect method. In the direct method, an insurance agency provides health services in its own institutions, usually employing salaried medical personnel. In the indirect method, insurer and medical provider are separated. Patients receive health services free of charge or for a small co-payment to the

provider and the insurance agency pays the provider the service rendered, namely "Third party payment system" (Mills, 1983). (Figure 1)

Figure 1. Direct and Indirect Insurance

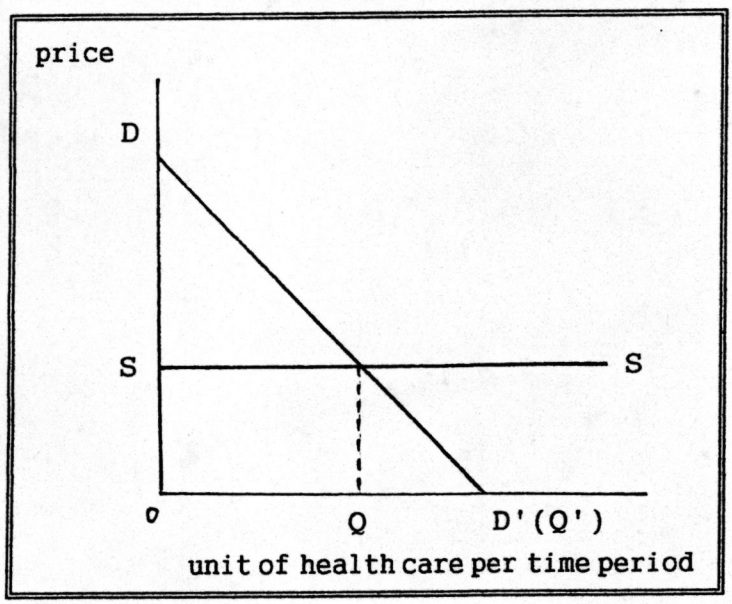


The third party payment system causes problems of inefficiency. Economic constraint on patients and providers are significantly weakened by the fracture of the direct bilateral exchange relationship. Both patients and providers are less concerned about the price and quantity of services utilized since it is the insurance agency that bears the immediate costs. Consequently, unnecessary services and drugs are often given, and patients visit doctors frequently (moral hazard). Moreover, in the health care market, since consumers do not have sufficient knowledge, doctors as suppliers of health care have considerable direct influence on consumption. Consumer sovereignty, means that each individual is the best judge of one's needs and wants, is weak. Thus, doctors act as patient's agents for deciding the quantity of consumption (agency relationship or supplier-induced demand). Moral hazard and agency relationship lead to consumption of large quantity

of health care, thus resulting in the rapid escalation of health expenditure.

In Figure 2, the curve DD' shows individual's demand for health care at different prices and the curve SS is the supply of health care. If a consumer faces a price for health care of P, the equilibrium price, one would consume up to Q quantity demanded. However, if one faces no price due to being covered by insurance, one will increase his consumption up to Point D' which is equal to Q'. The cost of this extra units of consumption is less than the cost of producing them. The consumption is inefficiently high, leading to higher costs which would require higher premium. This is the situation of, so-called, over-consumption. (Mills, 1983)

Figure 2. Individual's Demand for Health Care



Moreover, health insurance may cause inequity among people. Although the health insurance scheme is undoubtedly feasible to be developed for the workers in the organized sector, the scheme is difficult to implement for the workers in the non-organized sector and farmers. The scheme also tends to exclude the high-risk groups such as the disabled, elderly, and unemployed. (Abel-Smith, Ron and Tamburi, 1990, and Hsiao, 1990)

Mills (1983) clarified the nature of health insurance and the various forms it can take, concentrating on their economic efficiency and equity implications. Studying the operation of health insurance systems in developing countries, she identified important issues and problems and suggested possible solutions regarding the health insurance scheme as a potential source of funds for health care in developing countries. Kutzin and Barnum (1992) reviewed a number of critical institutional characteristics of insurance programs in four developing countries - Brazil, China, Korea and Zaire, and assessed their impact on the efficiency and equity of the health sector. Then they pointed out that efficiency and equity goals can be more effectively promoted by an insurance institution which actively organizes the entry of consumers into the health system and removes the financial incentives that encourage providers to increase the volume and cost of services.

As for health insurance in Thailand, Hsiao (1993) studied health insurance system in his comprehensive examination of the health care financing system in Thailand. His overview of the system included the national health expenditure accounts, health status of people, the organization and financing of health services, and the payment mechanism. He tried to reveal the achievements and problems of the Thai system, and suggested policy options for policy-makers to consider. Tangcharoensathien (1991, updated in 1993) made the significant summary table of health benefit schemes and health insurance schemes in Thailand.

3.2 Concept of Efficiency and Equity

Welfare economics which is concerned with criteria for evaluating alternative economic policies takes both efficiency and equity considerably into account. Since efficiency and equity are in principle not compatible each other, there must be trade-offs between them. The nature of trade-offs is that how much efficiency one needs to give up to get some increase in equity, or how much equity one needs to give up to get some gain

in efficiency. The degree of gain or sacrifice either in efficiency or equity depends on attitudes and value judgements of individuals, society, the government, etc. (Stiglitz, 1986) Concept of efficiency and equity is as follows.

Efficiency

The basic notion of efficiency in economic term is "Pareto efficiency". Pareto efficiency allocation means an allocation of resources where there is no other way to reallocate the resources, which makes someone better off without at the same time making someone else worse off. The notion can be interpreted in several way depending on the context:

i) maximizing outcome with the least possible cost,
ii) the greatest possible utilization of resources with the least possible cost,
iii) the ratio of outcome to input to be more than 1.

The first one, i) maximizing outcome with the least possible cost, is often a common interpretation.

Abel-Smith and Dua (1987) assessed community financing according to criteria including resource efficiency considerations. Resource efficiency means net yield (the gross yield minus the cost of raising the resources), reliability of the means of finance, stability in the revenues and the flexibility in the use of funds. Hoare and Mills (1986) explained efficiency of financing mechanisms in terms of raising finance. Efficient financing means a mechanism which can produce the difference between the gross and the net yield of a source of finance. Hsiao (1990) assessed health financing system by criteria including efficiency in terms of resource allocation, technology diffusion and administrative efficiency.

Equity

Mooney (1986) defined equity as:

i) equal expenditure per capita; equal amount of money is spent on each individual in the population,
ii) equal inputs per capita; each individual in the population has equal ability to purchase inputs,
iii) equal inputs for equal need; allocating resources to a particular group or geographical area in proportion to its health needs,
iv) equal access for equal need; ensuring that for all individuals with the same need, they will have the same opportunity to use health services,
v) equal utilization for equal need; each individual equally uses health service in proportion to individual's health need,
vi) equality of marginal met need; each individual has equality to meet the same marginal need,
vii) equal health status; individuals in the population have equal health status.

The definition which seems most often to be adopted as a policy objective in health care systems is that related to equality of access (iv. equal access for equal need).

Hoare and Mills (1986) explained vertical equity which implies progressiveness and horizontal equity which implies some equalization of risks or burdens. Hsiao (1990) presented three criteria to evaluate equity in health care financing such as equal access, progressiveness and risk pooling.

3.3 Compulsory Health Insurance

Health insurance is divided into two types in terms of membership characteristics, namely, compulsory health insurance and voluntary health insurance.

Compulsory health insurance is also called social insurance. It is financed by imposing mandatory insurance

payments on employed workers as a percentage of their wages, and by imposing on their employers a similar or somewhat higher payroll tax. [2] The payments are referred to as insurance contributions and qualify those covered for a range of benefits. Government may in some instance also contribute to the schemes. When legislation makes membership compulsory for a large section of population, low and high risks are shared and resource are pooled. Then, the financial viability of the joint undertaking becomes much higher than voluntary membership. Compulsory insurance is based on "social solidarity". (Ron, Abel-Smith and Tamburi, 1990) There are pre-conditions to implement compulsory health insurance:

a) there should be a large enough number of regularly employed workers to yield a population base adequate to spread health care risks on an actuarially stable basis;

b) the average earnings of these workers should be high enough to pay regular premiums. And the ultimate feasibility of introducing a compulsory health insurance depends on "the availability and stability of relevant health care infrastructures [3]."

The source of finance is stable because it is kept separately from the Ministry of Finance and not affected by political priority. However, the population coverage is limited to workers in the formal sector and providers are not

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[2] Social Insurance is more often than not only contributed by employer without contributions from employees and the government. (i,e., Workmen Compensation Fund in Thailand)

[3] "These are the medical resources, both manpower and facilities, the ability to contribute on the part of all three sources (employer, employee and government), and the administrative capacity to implement and operate the scheme with increasing efficiency."
Ron, Abel-Smith, and Tamburi,. 1990. Health Insurance in Developing Countries: the Social Security Approach. p. 6.

necessarily mindful of the quality and cost of services. (Hoare and Mills, 1986, and Tangcharoensathien, 1990)

Abel-Smith, Ron and Tamburi (1990) made a comprehensive examination on health insurance schemes in developing countries as a social security undertaking, with respect to the source of fund, delivery systems and payment mechanisms. They identified strengths and weaknesses of the social health insurance by reviewing actual experiences of several developing countries in Asia.

In Thailand, There are two schemes in the category of compulsory health insurance namely Workmen Compensation Program and Social Security Scheme. Nittayaramphong, Tangcharoensathien, Walee-itthikul, and Pannarunothai (1993) reviewed the Workmen Compensation Scheme and the Social Security Scheme in terms of efficiency, equity and quality of care, and identified strengths and weakness of each scheme. Kubo (1993) conducted the research on the Social Security Act in Thailand. He reviewed the historical background of the Social Security Act up to its initiation on September 1, 1990 and identified its significance. He made a brief comparison of Social Security Act between Thailand and Japan and drew a future prospect.

3.4 Voluntary Health Insurance

Membership of voluntary health insurance is not mandatory and people who are willing and able to pay premiums join the scheme. Private health insurance is the major form of voluntary health insurance. The differences of mechanism between private health insurance and social insurance are:

a) private health insurance does not include pensions for invalidity or old age;

b) premium is not based on pooled risks, but on personal risk characteristics and actuarially determined likelihood of illness in the individual or group

covered. (Hoare and Mills, 1986) Thus, people with higher risks and fewer resources tend to join, while others will abstain. Voluntary membership leads to "adverse selection" (Ron, Abel-Smith and Tamburi, 1990)

In Thailand, there are two schemes in the category of voluntary health insurance such as the health card program and private insurance. Thai health card program was precisely and academically studied by Tangcharoensathien in 1990. He first made a comprehensive and precise review on the health care financing system in Thailand. Then he surveyed the potential strength and development of the Thai health card project, focusing on two urban slums in Chiangmai as the case study. He used three methods: the household interview survey, the document analysis, and the qualitative approach, in order to complement the inherent weaknesses in each approach. He concluded that Health Card Program would be an effective option until Social Security Scheme will be able to cover the urban poor. Supachutikul and Sirinirund made a report on the health card project in 1993. They comprehensively reviewed the project in terms of principle, coverage, utilization pattern, referral system, cost recovery and overall impact on society.

As for private health insurance in Thailand, Mallikamas (1992) shed light on the potential role of Thai private health insurance in financing health care. He investigated flows of funds for medical care through private health insurance contracts since the mid 1980s, and made policy suggestions both for solving current problems and for developing private health insurance. Kiranandana and Limsakul (1993) reviewed the evolution and past performance of private health insurance, and explored its roles and contribution to the national health insurance system. They analyzed problems and obstacles which have prevented the development and growth of private health insurance in Thailand, then forecast the future prospects and expansion.

3.5 Tax-financed Health Benefit Schemes

Social welfare programs are literally tax-financed health benefit schemes. The schemes are financed out of the general tax revenues which is usually regarded as a common method of financing health care. However, tax-financed health services are often limited to the urban area or for economic and political elites of the country. Although there are some welfare programs for the low income earners as well as the elderly, the programs often fail to work effectively due to the lack of adequate management and sufficient funds. Hoare and Mills (1986) pointed out that the general tax revenues are not the most reliable source of finance for the health sector because:

a) low political priority frequently given to the health sector in national budget decisions and public;

b) economies of many developing countries are not stable;

c) the frequent use of public expenditure as a tool of macro-economic policy;

d) coverage is often limited to particular population groups.

In Thailand, there are four main schemes in the category of tax-financed health benefit schemes such as the Civil Servant Medical Benefit Scheme, the Free Medical Care for the Low Income Household (Low Income Card), the Free Medical Care for the Elderly and the School Health Insurance.

Rojvanit (1993) identified strengths and weakness of the Civil Servant Medical Benefit Scheme, in terms of its coverage, benefits, sources of finance and the reimbursement system of the scheme in order to assess its efficiency and equity. Mongkolsmai (1993) reviewed the Free Medical Care Programs for the low income earners and veteran, the elderly,

the handicapped and children under the age of 12, in terms of its coverage, health care delivery system, financing mechanism and expenditures incurred. Then he evaluated those schemes in terms of efficiency in use of resources, effectiveness in reaching the target groups, equity in access and financing. He concluded that although Free Medical Care for the Low Income could promote equity in access to health care, the scheme still needs to be cross-subsidized by other financing schemes such as voluntary health insurance and Social Security Scheme.

The above issues will be discussed and considered in more detail in the main body of the thesis.

4. Conceptual Framework

Conceptual framework of the thesis consists of 4 sections:

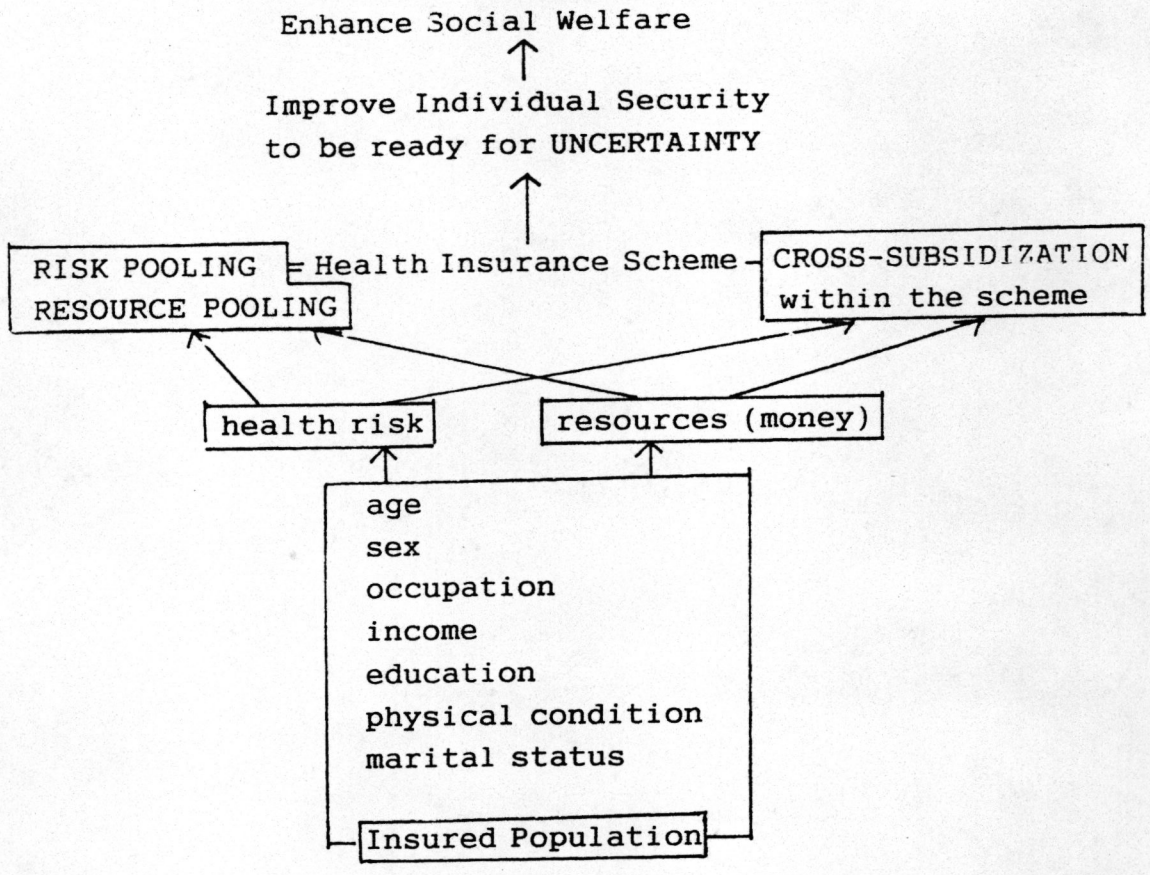
4.1 Theory of Insurance
4.2 Health Insurance Dynamics
4.3 Evaluation of Schemes under Equity and Efficiency Consideration
4.4 Research Framework

The theory and practice of insurance (4.1) is the foundation of the thesis. Health insurance dynamics (4.2) shows mechanism of insurance involving the 3 parties, namely insurer, insured persons and provider. Evaluation of schemes under equity and efficiency consideration (4.3) is the critical part of the thesis showing inter-relationship between scheme and equity and efficiency variables. Research framework (4.4) gives an overview of the structure of the thesis.

4.1 Theory of Insurance

Diagram 1 shows theory and practice of insurance. Risk and Resource Pooling and Cross Subsidization are the two important principles of health insurance. Health risks and resources are pooled among a large group of people with different probabilities of requiring care. Cross Subsidization (a subsidy from a beneficiary to another beneficiary) is made from individuals with higher resources to those who can contribute less and from those with a lower incidence of illness to those who require care more frequently. Health risks vary according to age, sex, occupation, income level, education, physical condition and marital status. The same is true to resources (the amount of contribution each individual can make). Health insurance helps to lessen and spread risks, and avoid unpredictable financial losses. It improves individual security and works to enhance social welfare.

Diagram 1. Theory of Insurance



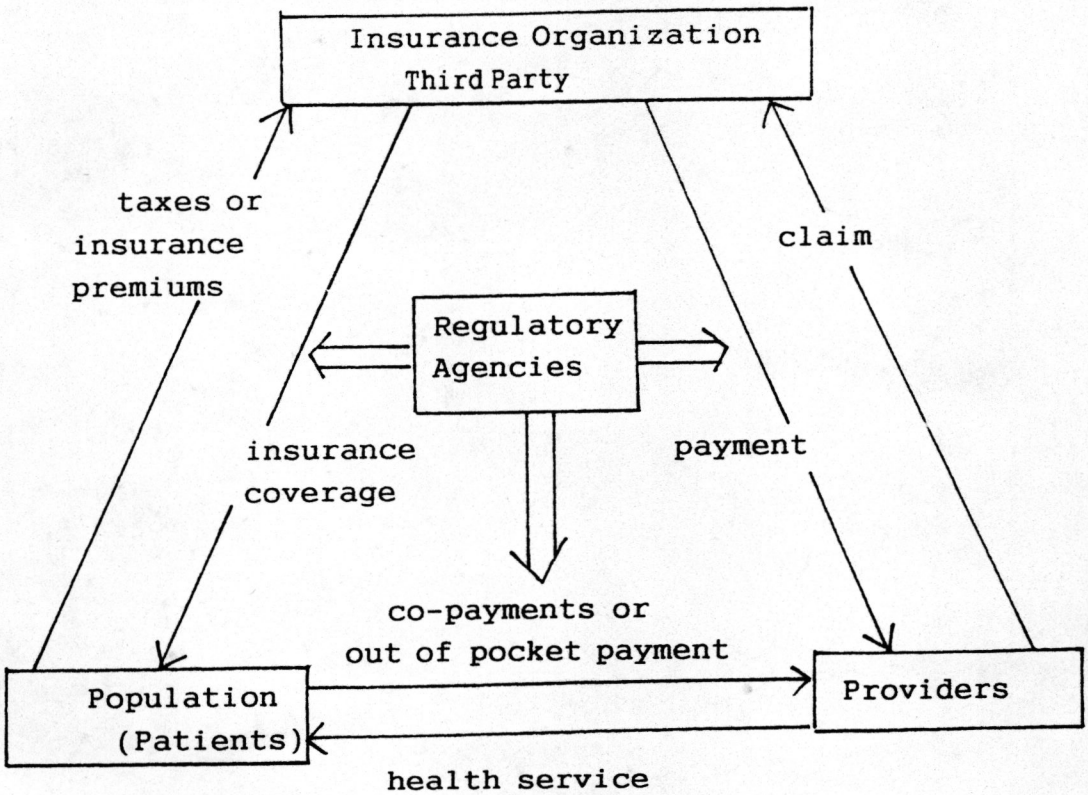
4.2 Health Insurance Dynamics

Diagram 2 simplifies the operation mechanism of health insurance and shows the directions of payments and services. There are three parties, besides regulatory agencies,: Patients, Providers and Insurance Organization. And there are six actions interrelated with the three parties. Patients have demand for health care and they pay co-payment to providers (form of payment varies, among co-payment, deductible, user fee, free of charge, etc., with schemes) and premiums to insurance organization. Providers give health service to patients and claims to insurance organization. The insurance organization

entitles patients benefit from an insurance scheme and pays providers according to their claims or capitation system.

Each action should be monitored and assessed under equity and efficiency consideration. It is clear that increasing insurance coverage and reaching to the uninsured include complicated dynamics involving all the parties.

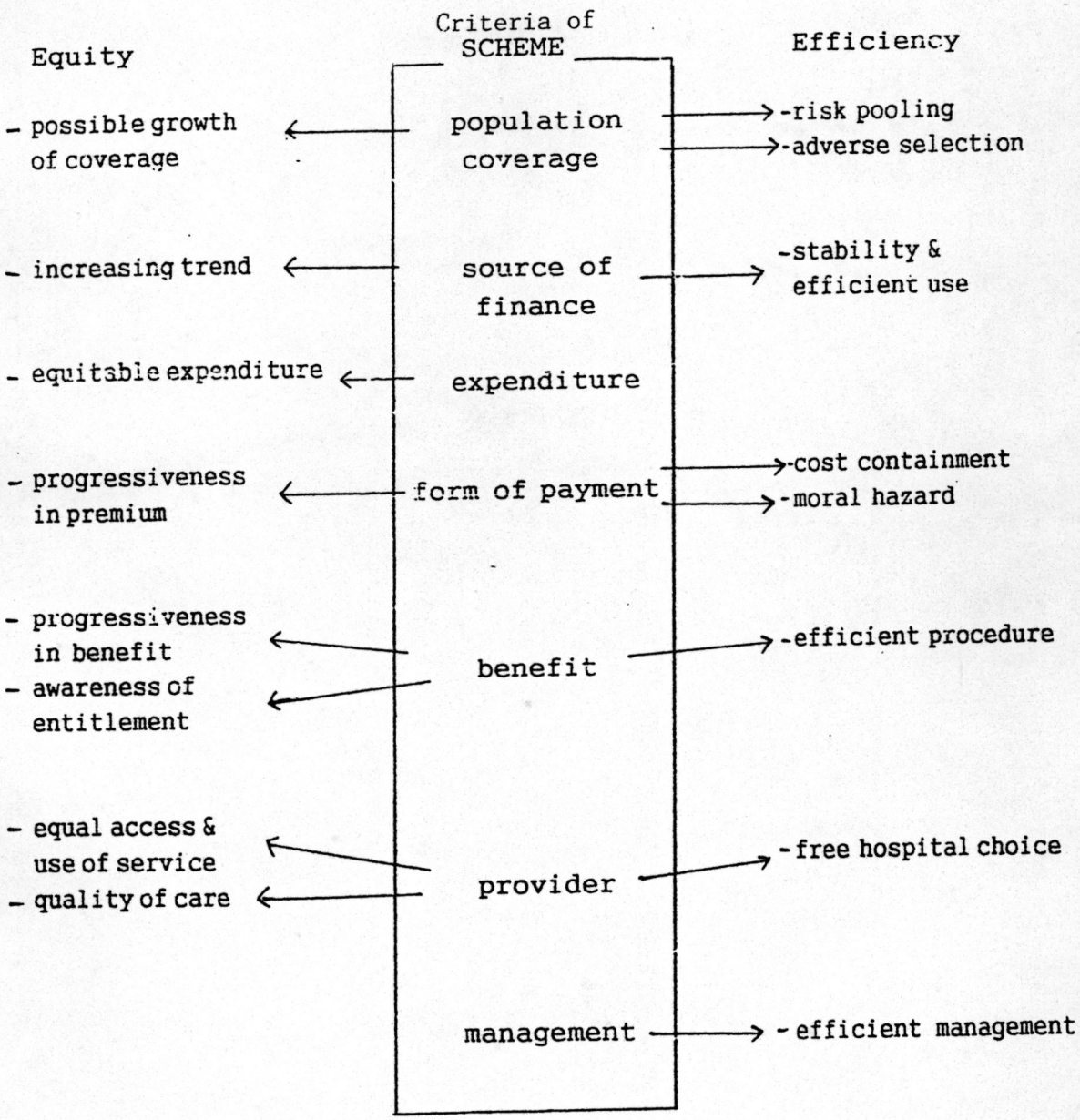
Diagram 2. Operation of Health Insurance



4.3 Evaluation of the Schemes Under Equity and Efficiency Consideration

Issues for discussion arise out of all the criteria of the scheme, under the headlines of equity and efficiency. Diagram 3 shows how the examined items (section 2 of chapter 3) of the scheme is related to both the equity and efficiency variables. These variables are drawn into questionnaire and evaluated by a group of experts in the Delphi survey.

Diagram 3. Relations between Examination Criteria and Equity & Efficiency Criteria



4.4 Research Framework

Diagram 4 shows the sequence of the thesis. After the explanation of the theory and mechanism of insurance, examination of the current health insurance schemes in Thailand is made. Then three schemes will be evaluated under the equity and efficiency consideration by using Delphi Method in order to contribute to a consideration of the most potential scheme to reach the uninsured group of 23.67 million people. Finally, major advantages and disadvantages of the potential scheme will be discussed.

Diagram 4. Sequence of the Thesis