The Study Programme
for the Improvement of Social Insurance System
- Health Security and Vulnerable people-

Country Reports

Japan International Corporation of Welfare Services (JICWELS)

Contents

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Bangladesh

Country Report

Country: Bangladesh

Course: Improvement of Social Insurance System

1. Geographical and Political features of Bangladesh

Bangladesh is a country in **South Asia.** It is located in the Bengal region of the eastern Indian subcontinent and the name *Bangladesh* means "Country of Bengal" in the official Bengali Language. It shares borders with India and Myanmar, and faces the Bay of Bengal to its south. It lies between latitude 20° and 27°N, and longitudes 88° and 93°E.

Straddling the Tropic of Cancer Bangladeshi climate is tropical with a mild winter from October to March, a hot, humid summer from March to June. Interestingly, the country has never frozen at any point on the ground. A warm and humid monsoon season lasts from June to October and supplies most of the country's rainfall. Natural calamities, such as floods, tropical cyclones, tornadoes, and tidal bores occur almost every year combined with the effects of deforestation, soil degradation and erosion.

Bangladesh is now widely recognized to be one of the country's most vulnerable to climate change. Natural hazards that come from increased rainfall, rising sea levels, and tropical cyclones are expected to increase as climate changes, each seriously affecting agriculture, water and food security, human health and shelter. Also, there is evidence that earthquakes pose a threat to the country. Evidence shows that tectonics have caused rivers to shift course suddenly and dramatically.

Bangladesh is a unitary state and parliamentary democracy Direct elections in which all citizens, aged 18 or over, can vote are held every five years for the unicameral parliament known as Jatiya Sangsad. The parliamentary building is known as the *Jatiyo Sangshad Bhaban* and was designed by architect Louis Kahn. Currently the parliament has 350 members including 50 reserved seats for women, elected from single-member constituencies. The Prime Minister, as the head of government, forms the cabinet and runs the day-to-day affairs of state. While the Prime Minister

is formally appointed by the President, he or she must be an Member of Parliament who commands the confidence of the majority of parliament. The President is the head of state but mainly a ceremonial post elected by the parliament.

2. Statistical data

Form 1-4 filled up with the data available

3. Outline of the Social Security System

In Bangladesh though typical SHI doesn't exist, some types of NGO based and private insurance exist. Actually National health system financed by tax revenue and donor assistance is complementary to SHI.Essential Service Delivery (ESD) Package *provided at free of cost to all citizens* in rural areas complementary to SHI**.**Services at secondary and tertiary level are also free with some exception at specialized hospitals. Demand Side Financing (DSF)/maternal health voucher scheme entitling pregnant women's access to free antenatal, delivery, emergency referral and postpartum care services.

4. Outline of the Object Tax for Social Security System

Not applicable

5.

5.1 Historical development of MIS

The NGOs/MFIs came in the Micro-insurance scene in late 1990s and early 2000s. They are mostly insurer as well as service provider.The informal sector can be regarded as the main target group for community insurance. Important players are Grameen Kallyan (GK), BRAC, Gonoshashtho Kendra (GSK), Dhaka Community Hospital (DCH), Dusthya Shasthya Kendra (DSK), Integrated Development Foundation (IDF), Nari Uddug Kendra (NUK), Sajida Foundation, Society for Social Service (SSS) etc. Gonoshashtho Kendra (GSK) pioneer to introduce HMI.GSK operates a health microinsurance scheme based on the insured's ability to pay .GSK Health Insurance Scheme classifies four different groups according to their socioeconomic status:

- Group A: distressed women and poor people
- Group B: marginal farmers who face insufficiency and/or even starvation
- Group C: can afford to eat twice a day and have some surplus

- Group D: represents those who do not have enough surplus but are sufficient.

Grameen Kalyan (GK-'Village Well-being') was established in 1996 as a sister NGO of the Grameen Bank.

Bangladesh Rural Advancement Committee established a pilot health microinsurance (HMI) in July 2001.

BRAC's Micro Health Insurance for the Poor Rural Women in Bangladesh (MHIB) launched in November 2001.

GK and MHIB differ in that GK is both a insurer and provider while MHIB is insurer only. MHIB reimburses BRAC's health centers for the services provided to the MHIB members.

5.2 : Laws and regulations for MIS: In fact there is no specific rules or act for health insurance in Bangladesh but Health Policy and other policy documents urge for health insurance

5.3 Administration and management of MIS (Central Level) : Not applicable

5.4 Administration and management of MIS (Local Level) : Not applicable

5.5 MIS Structure in Bangladesh : Insurer, Number of Insured, of selected NGOs

Organisation	Health Facility	Beneficiary	Member	Non-Member	Population (approx)
BRAC	-	70,000	12,000	-	350,000
GK	38	290,000	51,000	7,000	500,000
DSK	01	10,000	9,500	10,000	500,000
IDF	02	36,000	28,000	8,000	180,000
NUK	01 Hosp.	100,000	7,000	3,500	600,000
Sajida Foundation	04	36,840	7,861	24,193	600,000
SSS	16	42,000	42,000	n/a	250,000
GSK	01 Hosp. 04 Sub-center	37,183	n/a	n/a	165,364
DCH	01 Hosp.;19 Rural HC 12 School HC; 24 Industrial HC		On average 3000 – 4000 visitors per month		

Service Package and Price : Selected NGOs:

Organisation	Service	Package and Price
BRAC	ANC, PNC, Consultation Delivery, Medicine Pathology	BDTk. 100 for VO; BDTk. 200 for non-VO (< 06 member family) 50% off pathology; ultra poor 80% off 10% off medication; ultra poor 80% off BDTk. 500-1000 referral support Free annual check up for head of HH 25% off for non-use on renewal
GK	General Consultation Medicine (ED) Other medicine Pathology/Check-up Referral/Hospitalisation	BDTk. 05 for GB; BDTk. 10 for non-GB 40% off for GB; 25% off for non-GB 10% of MRP for both GB and non-GB 30-50% off for both GB and non-GB 50% (10% of total cost)
IDF	Consultation Medicine Pathology	BDTk. 10 for member; BDTk. 50 for non-member RMP for member; MP for non-member 50% off for member
NUK	Pathology Medicine	30% off for all pathological and diagnostic tests Provision as cost recovery basis
Sajida Foundation	Consultation Antenatal care Normal delivery Annual check-up Pathology Treatment Loan	Free for member; BDTk. 30 for non-member Free for member; BDTk. 10 for non-member BDTk. 225 for member; BDTk. 1000 for non-member Free for member BDTk.15-40 for member; BDTk.20-50 for non-member

		Without interest for member
SSS	Consultation Investigation Operation	BDTk. 20 for member; BDTk. 40 for non-member 30% of MP for member; 50% of MP for non-member BDTk. 3000 for member; BDTk. 6000 for non-member
GSK	Consultation Pathology Medicine Delivery Referral/Hosp.	BDTk. 03-10 50% off 00-75% based on SES BDTk. 50-3000 based on SES GSK sliding reimburse ratio
DCH	Consultation Pathology Referral/Hosp.	BDTk.05 for some card holders Free for 03 simple tests DCH price

Financial Situation of MIS -Premium structure: Selected NGOs

Organisation	**Premium Structure**		
BRAC	Category	Family member	Premium
	VO	up to 05	BDTk.100
	NVO	up to 05	BDTk.250
	VO	up to 08	BDTk.150
	NVO	up to 08	BDTk.300
	VO	more than 08	BDTk.200
	NVO	more than 08	BDTk.350
GK	BDTk. 140 per anum per 08 member family for GB BDTk. 180 per anum per 08 member family for non-GB		
IDF	BDTk. 150 per annum per family member		
NUK	Family Health Card: BDTk. 200 per card for 01 year BDTk. 300 per card for 02 year BDTk. 25 per lost card for replacement		
Sajida Foundation	Family Health Cards: BDTk. 200 per card for 01 year BDTk. 300 per card for 02 year BDTk. 350 per card for 03 year.		
SSS	Family Health Cards: BDTk. 60 per annum for member, BDTk. 80 per anum for staff BDTk. 100 per anum for non-member		
GSK	Sliding scale of premium & itemised co-payments as per SES		

	80%, 46%, 20% and 10% off for Group A,B,C & D respectively (distance to GSK hospital also considered for lowest two groups) e.g. C-section BDTk. 50, 500, 1500, 3000 for Group A, B, C & D BDTk. 3500 for non-member
DCH	Family Health Card: BDTk. 40 per month (up to 12 members) BDTk. 20 for renewal School Children Card: Free to school children Worker Health Card: BDTk. 02 per month per worker Sport Card: Free to sport players (publicity) Destitute Card: Free for poor households (BDTk. 05 per visit)

Private Health Insurance in Bangladesh:

Insurance Industry	**Number of Operators**
Public Sector Life Insurers	01
Private Sector Life Insurers	16
Total Life Insurers	17
Public Sector General Insurers	01
Private Sector General Insurers	42
Total General Insurers	43

5.7: MIS related policy within the National Development Plan : Our health policy has the indication about health care financing issues where it focuses on health insurance specially for the poor segment of the society as a health protection scheme.

5.8: List of aid projects of MIS with other donors: KfW will provide fund for the implementation of a pilot project on Social Health Insurance . It has also funded for the development of Concept Paper on health Insurance. However, there might be some other organization will extend financial or technical assistance for the implementation of the project.

6

6.1 . Problems are to be solved in current MIS

Our public health expenditure is about 1% of our GDP. It is suggested that we need to increase public health expenditure through introducing social health protection scheme specially for the poor segment of the country. We need to enact the law and other legal instruments to support the social health insurance. Moreover, there are still some open ended questions which are to be

solved before starting the pilot. There is no specific implementing organization of health insurance as the concept is very new in our context.

6.2. Contents of the reform to solve the problems: Public health expenditure might be increased and initially supports from development partners would be explored. During the pilot period a cell would be created for the implementation of the pilot activities through engaging Health Insurance Company

6.3. Problems for carrying out this reform: It might be difficult but not impossible to convince different stakeholders before finding the successful implementation of the Pilot.

ANNEX1-FORM 1

The State of the Nation
Area size (Area size K m^2): 147570 sq-kilometer
Population by aged group

(in thousands)

Year		1991	1996	2001	2006	2010
0-4	Male	9482	7921	8327		
	Female	9213	7581	7675		
5-9	Male	9505	9733	8749		
	Female	8886	8947	7947		
10-14	Male	7175	7839	8389		
	Female	6467	7616	7483		
15-24	Male	9175	10781	11250		
	Female	9690	10516	11962		
25-34	Male	8032	8629	9300		
	Female	8236	8745	10323		
35-44	Male	5886	6924	7678		
	Female	4997	6458	6474		
45-59	Male	4762	5625	6130		
	Female	4104	5062	4939		
60+	Male	3298	5262	4268		
	Female	2748	4486	3461		
65-	Male					
	Female					
Total	**Male**	**57314**	**62714**	**64091**		
	Female	**54141**	**59411**	**60264**		

ANNEX1-FORM 2

Year	1991	1996	2001	2006	2011
Population growth rate (% per annum)	2.17		1.48		1.37
Birth rate (per 1,000 population)	31.6	25.6	18.9	20.6	19.2
Mortality rate (per 1,000 population)	11.2	8.2	4.8	5.6	5.6

Infant mortality rate (per 1,000 population)		87	82	66	52	43
The rate of the population of 65 years and over to the total population (%)		5.42	7.98	6.38		
Life expectancy at birth	M	60.5	59.1	64.0	64.5	66.80
	F	59.8	58.6	64.5	66.6	
Life expectancy at 60 and 65	60					
	65					
Unemployment rate (per 1,000 population) *Average rate				4.3	4.3	

ANNEX1-FORM 3

Year		1991	1996	2001	2006	2011
National Income (US$)			Tk. 1655448 mill.	Tk. 2176503 mill.	$ 43735.40 mill.	
Average Wage (US$)						
Average Wage of Male and Female (US$)	M					
	F					
Average Income (US$)			Tk. 13318 mill.	Tk. 16534 mill.	$ 311.08 mill.	
Total GNP (US$)			Tk. 809554 mill.	Tk. 2356025 mill.	$ 73587 mill.	$ 121019 mill.
GNP per capita (US$)			Tk. 14558 mill.	Tk. 17898 mill.	523	818
Total GDP (US$)			Tk. 1752847 mill.	Tk. 2252609 mill.	$ 68475 mill.	$ 111750 mill.
GDP growth rate		3.34	4.62	5.27	6.43	6.6
GDP per capita (US$)			Tk. 14102 mill.	Tk. 17112 mill.	487	755
The rate of social insurance of						

contribution as a percentage of National Income						
	Premium contribution of employee					
	Premium contribution of employer					
	Premium contribution of self-employer etc					

ANNEX1-FORM 4

Number and percentage of workers engaged in industrial classification

(in Million)

Year	**1991**	**1996**	**2001**	**2006**	**2011**
Primary industry					34.1
Secondary industry					13.5
Tertiary industry					6.7

Five leading causes of death

Year	**1st**	**2nd**	**3rd**	**4th**	**5th**
1991					
1996					
2001					
2006	Unspecified	Cardiovascular	Injuries	Perinatal causes	Respiratory diseases
2011					

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Indonesia

INDONESIA

COUNTRY REPORT

SOCIAL SECURITY IN INDONESIA

2012

I. Introduction

The Republic of Indonesia (RI), or familiarly known as Indonesia, is the world's fourth most populous country, a continent-sized archipelago of 17,000 islands across three time zones. It is the third largest democracy in the world, with more Muslim citizens than any other state. It is the biggest economy in South East Asia and predicted to be the tenth largest in the world by 2030.

The Indonesian economy survived the recent global economic crisis well. Indonesia continues to post significant economic growth. As of April 2012, the country's economy is expected to grow by 6,1 percent in 2012 and increase to 6,4 percent in 2013. The country's gross national income per capita has steadily risen from $2.200 in the year 2000 to $3.720 in 2009. The economy was helped by its robust domestic consumption base and a limited exposure to exports. In terms of macroeconomic stability, Indonesia has managed to fulfill many of its fiscal targets, including a significant drop in Debt-to-GDP ratio from 61 percent in 2003 to 27.5 percent in 2009. Meanwhile, the budget deficit is projected to be as little as 0.4 percent of GDP in 2011.

Indonesia has formulated a long-term development plan which spans from 2005 to 2025. It is segmented into 5-year medium-term plans, each with different development priorities. The current medium-term development plan covering 2009-2014 is the second phase and focuses on: (*a*) promoting quality of human resources; (*b*) development of science and technology; and (*c*) strengthening economic competitiveness.

II. Contents (Social Security in Indonesia)

In order to increase the quality of life society, the past several years government ensure and committed to continue to improve the implementation of social security for all people of indonesia especially in terms of principle, which is education and health. In the field of education, the government continues to carry out the program and assistance poor students to improve public education. Meanwhile, in the field of health, the Government has been implementing healthcare for the poor programs (**Jamkesmas**)and a maternity benefit for the uninsured persons (**Jampersal**) to improve the quality of health services to the society.

1. System and Organization

Currently, the Indonesian system of social protection is not organized according to one universal criterion. For each program and group of population, there is one regulation and one special administration which are responsible for the collection of contribution and provision of benefits. The implementation of legislation and supervisory activities are assumed by different Ministries.

The form of social protection includes public intervention and privates initiatives. The current form of publicly provided social protection is based on two kinds of public intervention, namely (*a*) contributory social insurance and mandatory saving (social security), and (*b*) non-contributory provision of social support to targeted poor and vulnerable group of society (social assistance). Private insurance plays for private old age provisions and private health insurance.

2. Social Assistance

Indonesian social assistance involves two programs namely income support and social service. The current program does not involve family benefits, the third type of social assistance. In 2005, the new elected government extensively widened the scope of social assistance through 'Oil Subsidy Reduction Program' (**Program Kompensasi Pengurangan Subsidi Bahan Bakar Minyak-PKPS BBM**).

Many local governments jointly subsidize social assistance programs in addition to the national social assistance program for local residents. Most of them extend the coverage of healthcare for the poor program (**Askeskin/Jamkesmas**) and school program to the near poor. In some provinces or districts, the local governments extend healthcare program to the entire local residents including the non-poor household.

The following programs of income supports in Indonesia:

a. Social Welfare Program (**Bantuan Kesejahteraan Sosial Permanen**), the oldest program among social assistance programs in Indonesia, provides income support to neglected elderly, neglected children and poor disabled persons. A temporaryscheme is targeted at the victim of natural disasters/social disasters and troubled migrant workers. The schemeis implemented by the Ministry of Social Affairs and Local Governments.

b. Cash Transfer (**Bantuan Langsung Tunai**) has been introduced in 2005. The unconditional cash transfer (bantuan langsung tunai tidak bersyarat) was implemented from October 2005 to December 2006 providing 19.2 million poor with income support. The unconditional cash transfer has been replaced by conditional cash transfer (bantuan langsung tunai bersyarat) since January 2007. In contrast to unconditional cash transfer,

the conditional cash transfer provides income support to very poor family conditionally upon investment in human capital – school attendance, healthcare, nutrition). The target groups of conditional cash transfer program are very poor households with children between 0 and 15 years and/or a pregnant mother at the time of registration. Each family will receive funds for up to six years. During three years of implementation, in 2010 the conditional cash transfer namely Program Keluarga Harapan, was implemented in 20 provinces, 86 districts and 739 sub districts for 816.000 very poor households. The program is targeted to reach 2.4 million poor households in 2014.

The following programs of social services in Indonesia:

a. Healthcare for the Poor (**Jaminan Kesehatan Masyarakat Miskin / Askeskin - Jaminan Kesehatan Masyarakat / Jamkesmas**) has been implemented since January 2005 for 74,6 million the poor and the near poor to cover free-of-charge primary healthcare services including maternity at public health center (**PUSKESMAS**) and inpatient treatment in third-class hospital wards. The Ministry of Health assigned **PT ASKES** to run this scheme until 2007. The Ministry of Health has been taking over the implementation since 2008 to directly distribute the funds to Puskesmas and hospitals.

b. A maternity Benefit for the Uninsured Persons (**Jaminan Persalinan/Jampersal**) has been implemented since 2011 for pregnant women who are not covered by any maternity scheme.

c. School Aid Programs provide operational aid to primary and secondary schools (**Bantuan Operasional Sekolah-BOS**) and scholarships for senior secondary school students (**Bantuan Khusus Murid-BKM**). The programs have been implemented since 2005.

d. Social Welfare Insurance Program (**Asuransi Kesejahteran Sosial - ASKES**) has been implemented since 2003 by the Ministry of Social Affairs for the poor and near poor working in informal sector of economy. The Program covers limited healthcare benefits and death benefits for maximum 3 years of membership.

3. Private Insurance

Private Insurance comprises of pension funds and health insurance program. By the end of 2009, the number of operating pension funds were 279 plans, consisting of 251 employer's pension funds-FIPFs (**Dana Pensiun Pemberi Kerja-DPPK**) and 25 Financial Institution Pension Funds-EPFs (**Dana Pensiun Lembaga Keuangan-DPLK**). Of the total plans, there were 2.67 million registered as participants in the plans, both as active participants and passive participants (retirees, widows/widowers, children, deferred pensioners).

FIPFs is a pension fund established by any individual or entity having employees, as it founder, to implement a defined benefit pension program or a defined contribution pension program, for the interests of all or part of such founder's employees, as participants, and creating obligations on the employer's part. EPFs is a pension fund established by a bank or a life insurance company to implement a defined contribution pension program for individuals, either employees or self employed.

III. Closure

1. Problems

Out of a population of 230 million, more than 30 million Indonesians currently live below the poverty line and approximately half of all households remain clustered around the national poverty line. Their income on average only 200.000 rupiahs per month ($24US). In addition, employment growth has been slower than population growth. Such conditions would result in public service for social security will be distorted.

2. Future plan

The government continues to strive to resolve the problems of poverty and unemployment, because both of these can interfere with the stability of social security in indonesia. The policies pursued must be able to reduce poverty and unemployment figures, one of them with programs aid to the poor.

In order to increase community access to basic medical services, particularly for the poor population, the provision of health care to the society guarantee which is already implemented in previous years through the **Jamkesmas and Jampersal** program will be continued and expanded in scope. In 2013, the **Jamkesmas** program is intended approximately 86,4 million in the form of increased access of poor population and the **Jampersal** program to about 2,7 million pregnant mothers.

Starting in 2014, the Government will implement the national programme of social security systems (**SJSN**) which aimed to provide the assurance of protection and social welfare for the whole people of Indonesia, especially the implementation of social security in the health field in 2014.

Regards,

Agung Kurniawan P.P. (Fiscal Policy Office – Indonesia)

The National Social Health Insurance Programe In Indonesia

(Country Report)

National Development Planning Agency/BAPPENAS

TOKYO, Japan

September 17 to Oktober 6, 2012

I. Introduction

Maps of Indonesia

Indonesia is comprised of more than 17,500 islands and is home to more than 237 million people contained in more than 350 ethno-linguistic groups. It is not only the world's largest tropical archipelago nation but also the globe's most varied tourist destination, with distinctive beaches, mountains, lakes, forests, flora and fauna, rich and diverse in history, traditions, culture and cuisine.

Indonesia extends from 6 degree of north latitude until 11 degree of south latitude, and from 97 degree until 144 degree of longitude. It is situated between two continents-Asia and Australia/Oceania. This strategic location has a significant influence towards its culture, social, politics and economy.

Indonesia's territory extends along 3,977 mile between the Indian Ocean and the Pacific Ocean. If the coastal area between the islands be connected, Indonesia's area would become 1.9 million square miles.

There are five large islands in Indonesia, they are: Sumatra with an area of 473,606 square km, Java with an area of 132,107 square km, Borneo/Kalimantan (the third biggest island in the world) with an area of 539,460 square km, Sulawesi with an area of 189,216 square km, and Papua with an area of 421,981 square km.

Indonesia is a unitary state composed of 33 autonomous provinces. These provinces are divided into 370 districts, 95 municipalities, 6,093 sub-districts and 73,067 villages.

II. The National Social Health Insurance Program: Work in Progress

The Current Status of the System

The Indonesian healthcare delivery system consists of both public and private providers. Its funding also draws from avariety of sources, both public and private.

The backbone of the system is a government line item budget aiming to fulfill the constitutional mandate to provide statutory health services to all citizens. The state budget is allocated for both public and personal healthcare. After the introduction of administrative and government decentralization in 1999, local government is obliged to contribute financially to development, including health.

The Indonesian Government installs and finances primary healthcare centers (Puskesmas) and sub-centers (Puskesmas Pembantu and midwife/village clinics) at the sub-district and village level as points of healthcare delivery. The government also installs and finances hospitals for referral to secondary care in all districts in Indonesia.

Currently, the government allows public providers to impose tariffs based on their costs, as mandated by Law No. 9/1968 jo Law No. 20/1997 on non-tax state revenues, Law No. 5/1974 jo Law No. 18/1997 on local taxes and retribution, and Law No. 32/2004 on regional government. This policy also applies for members of existing health insurance schemes. The difference between service charges levied by public providers and payment rates set up by health insurance agencies must be born by the insurance members, so that cost sharing occurs in the financing of health services. There are two reasons for the mismatch: on the one hand, the insurers have fixed their rates based on what is taken for an acceptable rate for the members, not strictly on cost-recovery mechanisms. Furthermore, there are no

functional standards for service quality and matching costs under conditions of efficiency. As this de facto cost sharing is regressive to members' income, tariffs create an access barrier particularly for people with a low income. On the other hand, user fees account for an essential source of revenue for public healthcare providers.

Private health insurance only plays a role in a small segment of the market for affluent individuals, and as a substitute for the health insurance scheme for formal sector employees provided by state-owned JAMSOSTEK. By statute, formal employees must be insured either by JAMSOSTEK or by any scheme that matches or exceeds the coverage provided by this company. Many enterprises chose either private insurers, or they offer coverage from their own resources.

The Indonesian government allows the private sector to install and provide healthcare services for a wide spectrum of services. The private entities serve all levels of care, primary, secondary and tertiary. The major source of finance for private healthcare providers is user fees. Private providers are mostly located in areas where people can afford their services.

In conclusion, the Indonesian personal healthcare system combines a government line item budget, out-of-pocket fees for service, and health insurance. Out-of-pocket payments are a major source of revenue for Indonesian healthcare providers. User fees have brought inequity to the healthcare system both in terms of financial and geographical access.

The National Social Security System (NSSS) Law opens an avenue to restructure the personal healthcare system. The way forward requires careful design to assure that the future system can significantly diminish inequity, and improve its performance and outcomes. The design also needs to carefully integrate personal healthcare with overall health policy with its important elements of public health, and with other programs within the national social security system.

The reform process has started with the ratification of Law No. 40/2004 on the National Social Security System (NSSS Law). This law sets the basic principles for universal social security, as well as a timeframe for the preparatory works necessary for the new system to be implemented throughout Indonesia.

NSSS - the Law on the National Social Security System

Article 19 of Law No. 40/2004 on the National Social Security System, called the NSSS Law below, dictates that personal healthcare is to be carried out through a national health insurance scheme that is based on the principles of social insurance and equity.

Health insurance as a national program is built within national structures and functions to ensure social justice for all Indonesian citizens. The program's structure and functions are to be regulated by a new Presidential Regulation on the National Health Insurance Program (PresReg NHIP). Furthermore, there is a need for a comprehensive and integrated regulatory framework spanning from the NSSS Law to implementation level regulations. The comprehensiveness, alignment and concord of regulations on the health insurance program will greatly influence the effectiveness of the PresReg NHIP as a regulatory instrument in ensuring the attainment of benefits from health maintenance and protection for all the population in meeting basic healthcare needs.

The fulfillment of the principles of social insurance depends on the financing system, and on the implementation system framework that connects members, executing agencies of social security and social (health) service facilities. This framework therefore includes both the flow of funding and that of benefits. In this context the following aspects need to be carefully
designed in order to ensure a functioning social health insurance scheme:

Allocation and flow of funding include the following functions: 1) determination of contributions and entitlements; 2) collection of contributions; 3) pooling of funds collected; 4) purchasing of services; 5) provision of services.

The attainment of social insurance principles will also be influenced by the way the benefit flow is ensured. These are the
important elements of such a flow: 1) services received and fulfillment of basic healthcare needs; 2) availability of quality healthcare and freedom for members to choose healthcare facilities; 3) the level of direct co-payments from members for healthcare services covered by insurance.

The equity principle stated in the NSSS Law postulates that members receive services according to their medical needs, not according to their contributions. This includes equity of financial and physical access to healthcare. It also means equal protection from financial risks when in need of healthcare, standardized quality of healthcare, and relief of financial burdens that may constrain members from benefiting from healthcare or even impoverish them. The respective wording of Article 19 of the NSSS Law is as follows:

(1) Health insurance shall be administered on a national scale based on the principles of social insurance and equity.
(2) Health insurance shall be administered with the aim of ensuring that members receive the benefits of healthcare and protection so as to fulfill basic health needs.

The NSSS Law dictates that four points are to be further regulated in the new PresReg NHIP: 1) membership, 2) amount of contribution, 3) benefit package, and 4) provision of services by service facilities.

III. Closure

1. Problems

However, a continuous finetuning and further development of the Road Map for Universal Health Coverage Reform in Indonesia are, naturally, very important issues.

2. Future plan

Last but not least, it needs to be emphasized that achieving universal coverage, as intended by the Government of Indonesia, is a lengthy and incremental process, especially in a vast and heterogeneous population like that of Indonesia. With its longterm political commitment to achieving social security for all, the Government of Indonesia has met an essential pre-condition for success.

The Study Programme
for the Improvement of Social Insurance System
- Health Security and Vulnerable people-

Kosova

Improvement of Social Insurance System-Modernization of Health Security Administration

(September 17, – October 6, 2012, Japan)

Country Report

Republic Of Kosova

Geographical and Political features of Republic of Kosovo

•**Government**

Type: Republic

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Constitution: The Kosovo Assembly approved the constitution on April 9, 2008. It came into force on June 15, 2008.

•

Branches: ***Executive***--president (head of state); prime minister (head of government).

•***Legislative*--**unicameral Assembly (120 seats, 4-year terms; 100 seats generally elected, 10 seats reserved for ethnic Serbs, 10 seats reserved for other ethnic minorities).

•***Judicial***--Supreme Court.

Subdivisions: 38 municipalities.

KOSOVO

- Population: 1,733,872
- Geography: Southeast Europe
- Area: 10,887
- Climate: Influenced by continental air masses resulting in relatively cold winters with heavy snowfall and hot, dry summers and autumns

Main Data of Health Statistics 2010

Total Population	**1,733,872 million persons**
Live Births	**33751 - 27.645 in Health Institution (2010)**
Total Fertility Rate	**2.0**
Infant Mortality Rate	**19.1 per 1,000 Live Births**
Maternal Mortality Ratio	**7.2 per 100,000 Live Births**
Life Expectancy at Birth	**[67] years old (Female)** **[71] years old (Male)**

Main Health Problems (National Level)

- Lack of adequate health financing
- Lack of Health Information System
- Lack of sufficient financial resources
- High mortality rate among mother and child
- Lack of Health insurance found

Main Health Problems (Local Level)

- Insufficient financial resources
- Lack of trained human resources
- Inadequate access in health care facilities
- Inadequate referral system
- Lack of data for direct funding for services, medicines and medical products

Social Security System

•Health sector is struggling with insufficient funds for provision of accessible, quality health care services for entire population

• Ensuring of the sufficient and sustainable financing of the developing health sector is one of the main challenges of the Ministry of Health

•Reforms have been initiated by drafting two very important draft-laws, general Health Law and Health Insurance Law (HIL), which are expected to be adopted by Parliament until December 2012

•Purchaser–provider split, commissioning of the health care services through contracting, development of transparent payment mechanisms and performance payments, requires sufficient number of human resources with developed knowledge, skills and technical capacities to initiate, develop and carry out these complex tasks, along with the process of establishing future Health Insurance Fund

Payment system of medical care expenditures

- The public health system in Kosovo is currently funded through the state budget and co-payments
- Revenues of health institutions are not keept in the health sector but paid to the treasury in accordance with the Law on Public Financial Management and responsibilities
- According to the WB, out-of–pocket payment to the private sector amounts approximately to the same amount than the public health expenditure. There is no mandatory public health insurance
- PHC is directly funded by the Government through the Municipal Health Grants allocated by the Ministry of Finance after a consultative process with the MoH and relevant municipalities. The PHC budget for 2012 is 41 million Euros (MF 2012).

Government calculation for health budget in 2013

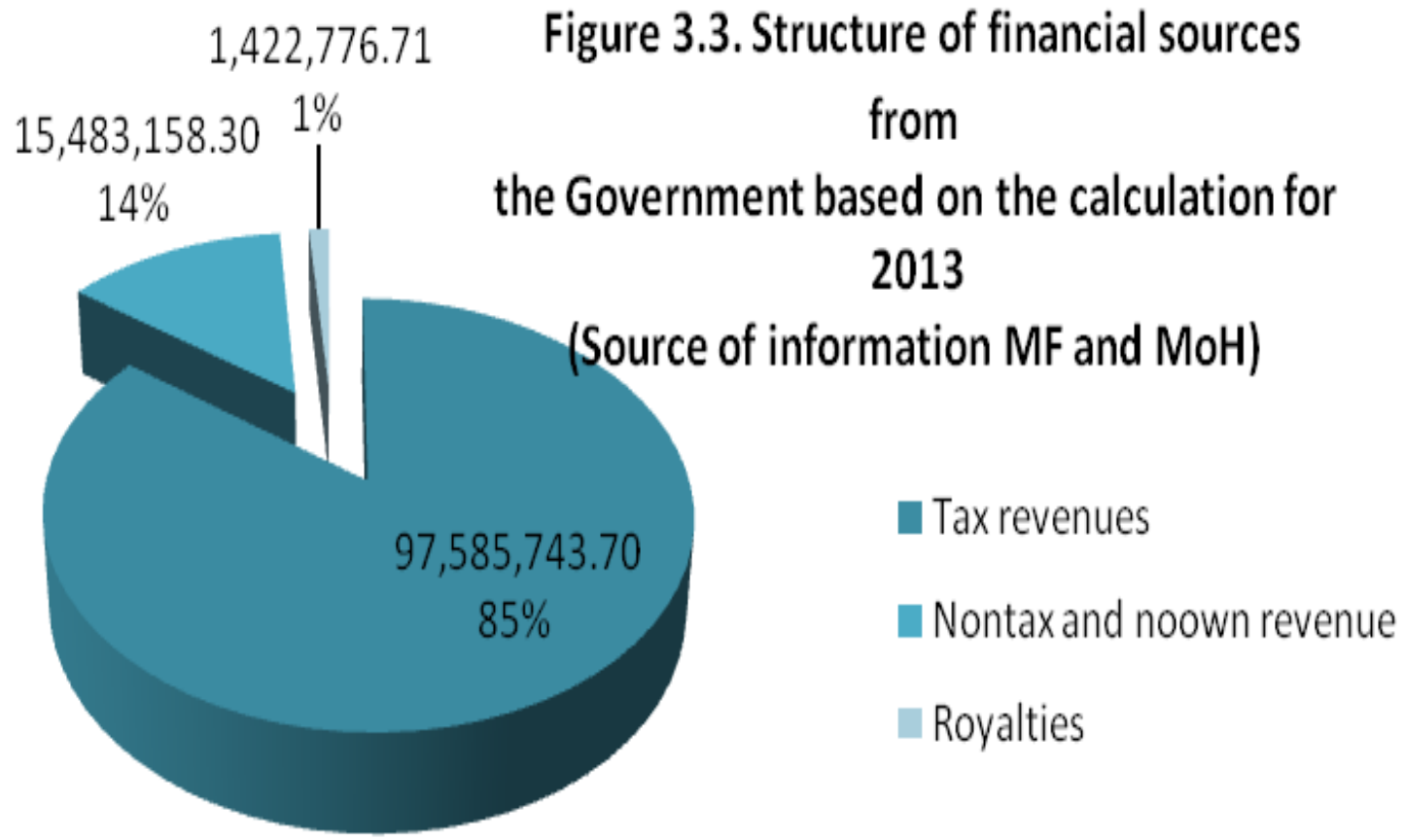
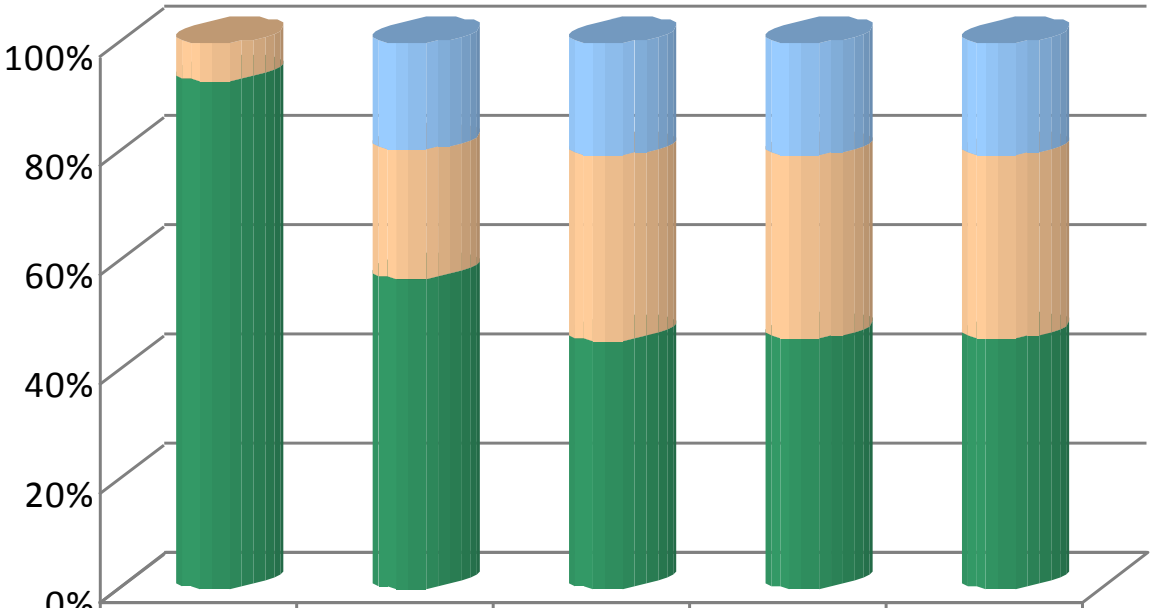


Figure 3.3. Structure of financial sources from the Government based on the calculation for 2013 (Source of information MF and MoH)

Projection of financial resources based on new law

Figure 3.1 Projection of financial sorces based on the new law of MoH

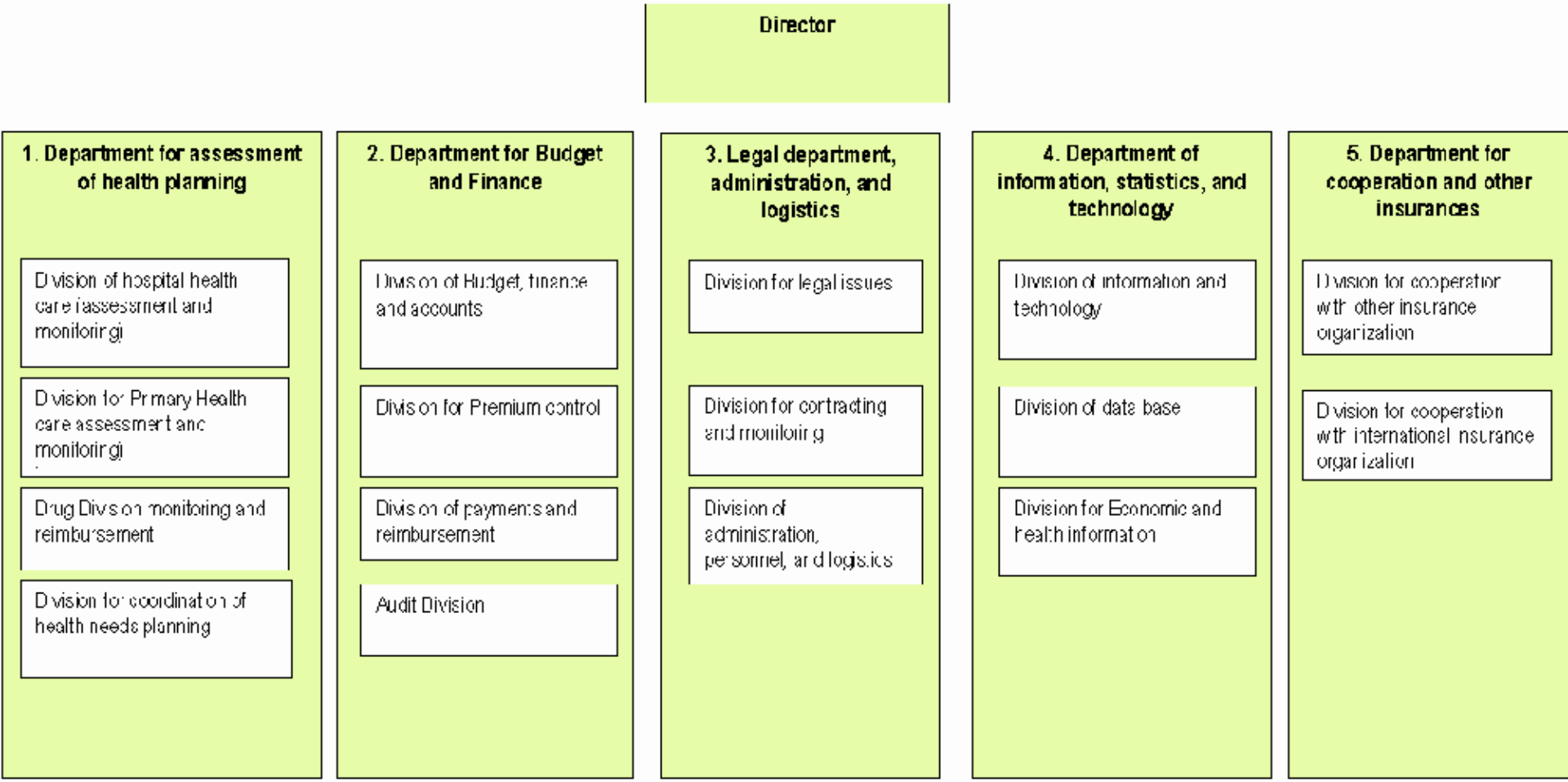


	2012	2013	2014	2015	2016
Premium Payment		28,945,519	37,105,810	38,362,214	38,362,214
Citizens Primiums	8,646,872	34,795,012	60,067,194	61,622,022	61,622,022
Budget transfer	115,970,98	84,123,383	80,888,231	84,765,955	84,765,955

IMF Country Report

	2009	2010	2011	2012
Budget for Ministry of Health (second and third level) (in million euro)	66	71	79	89
Budget for municipalities (in million euro)	26	27	38	41
Total (in million euro)	92	98	117	130
GDP (in million euro)*	3,912	4,216	4,637	4,911
Total health costs as a % of GDP	2.35	2.33	2.53	2.64
* Source: IMF Country Report, April 2012; MF;				

Organization Chart of Future Health Insurance Fund



- Thank you

The Study Programme
for the Improvement of Social Insurance System
- Health Security and Vulnerable people-

Laos

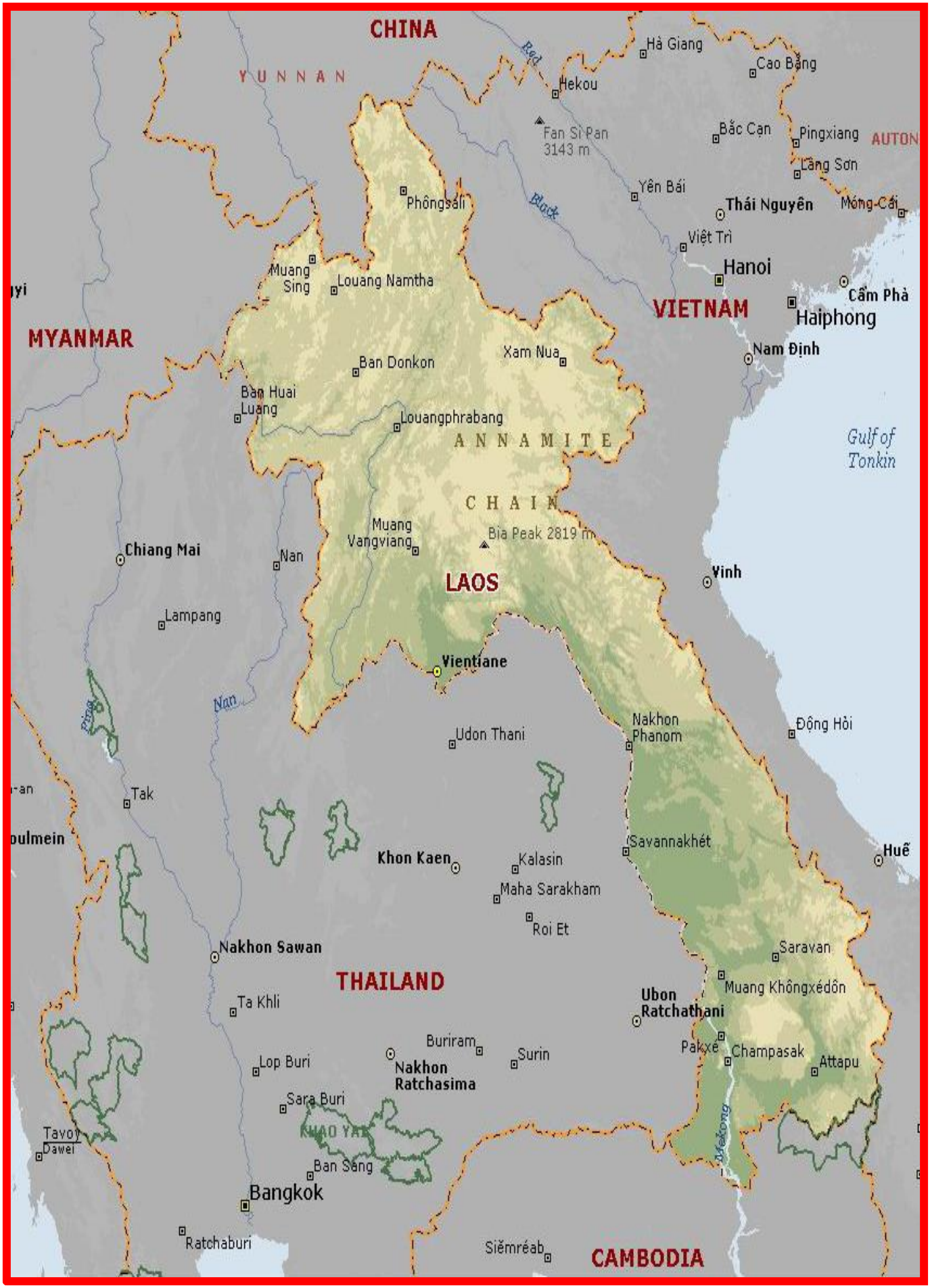
LaoPeople's Democratic Republic
Peace Independence Democracy Unity Prosperity

Country Report

For the training and dialogue program course on
"Improvement of Social Insurance System" (J1200718)
Japan, 17 September to 6 October, 2012

Prepared by:

Director of Social Security Management Scheme Division
Social Security Department
Ministry of Labour and Social Welfare
Tel: 856 20 55615569, Fax: 856 21 213287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Hanoi
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Haiphong
Nam Định
Phôngsali
Muang Sing
Louang Namtha
MYANMAR
VIETNAM
Ban Donkon
Xam Nua
Ban Huai Luang
Louangphrabang
ANNAMITE
CHAIN
Gulf of Tonkin
Muang Vangviang
Bia Peak 2819 m
Chiang Mai
Nan
LAOS
Vinh
Lampang
Vientiane
Udon Thani
Nakhon Phanom
Đồng Hới
Tak
Khon Kaen
Kalasin
Savannakhét
Huế
Maha Sarakham
Roi Et
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Saravan
THAILAND
Muang Khôngxédôn
Ubon Ratchathani
Ta Khli
Buriram
Surin
Pakxé
Champasak
Attapu
Lop Buri
Nakhon Ratchasima
Sara Buri
KHAO YAI
Tavoy
Dawei
Ban Sang
Bangkok
Ratchaburi
Siĕmréab
CAMBODIA

I. General information on Lao PDR.

Lao People's Democratic Republic is a landlocked country located in South East Asia sharing borders with Thailand, Cambodia, Vietnam, China and Myanmar.

The population is estimated at 5. 874 million in 2007 with an average life expectancy at birth of 62,5 years, an infant mortality rate of 64.4 per 1000 live births and a fertility rate of 4,2% children per woman in 2002 (Population 2012 estimated at 6 million).

The Land area is 236.800 square km. The majority of the population is living in rural area (83%), and only 17% of population is living in the major cities.

The population is composed of 48 different ethnic groups of which the Laolum located in the lowland areas close to the Mekong River is predominant (67%).

The official religion is Buddhist.

The GDP per capita is 701 US$ in 2007.

The Lao P D R's terrain is mostly rugged mountain with some plain and plateaus. The rainy season runs from May to November whereas the dry season is from December to April.

74.37% of the Lao PDR population (10-year old and above) is active, from which 49.66% of male and 50.34% of female.

Lao PDR has rich water resource; the Mekong is the main water resource for navigation as well as agriculture and hydropower development.

The official language in the Lao PDR is the Lao language as is spoken and written.

II. Social security system in Lao PDR

1. Social Security Scheme for the Public Sector.

The current decree for the social security scheme for the public sector employees was approved in 2006. Its title is social security decree for government employees No.70/PM. The pension benefit is one of social security benefits. This scheme is managed by the State Authority of Social Security (SASS).

SASS is an autonomous organization that is under control of its board of Directors. The board functions under the supervision of the Minister of Labor and Social Welfare. The board is composed of 7 members.

This scheme is reform from the social security decree No. 178/PM. The decree No. 178/PM is managed differently from the decree No. 70/PM. There are four main departments performing under two ministries involved with the fund management such as Social Security department, war veteran department and treasury department. The first three are under ministry of labour and social welfare. The last one is under ministry of finance. Most of operation or management rules are lied with the social security department. The policy-age pension department has duties to approve for awarding pension. The war veteran department has duties to approve invalidity pension applications. The treasury depatment has the responsibility to control the social security fund. The system is operational at three levels such as central level, provincial level and district level.

To be eligeble for old pension, insured men must attain the age of 60 years, and 55 years for insured women. And both men and women have to fufil 25 years of service. For persons who used to participate in the revolution process before

the year 1975 and those who have performed duties close to poisonous substance, their retirement age and duration of service can be reduced to 5 years.

A person who qualifies the above-mentioned conditions will receive pension equal to 75% of his basic salary plus 1% for each additional year of service.

The social security fund for the pubblic sector comes from the monthly contributions made by public employees 6% of their basic salary. This reflects a small part of total expenditure. The government has to cover all the rest in order to meet all requirements in the field of social security benefits. Nevertheless, the improvement of the existing public sector social security system is being in the process. improvement of the existing public sector social security system

Currently, the number of old age pensioners are approximately 22,500 persons. As the Lao population is considered as young population the number is expected to increase quite fast. The number of civil servants now is about 100,000 persons who are officially registered with the system. There is no figuere on military and police who are also the member of the social security fund. It is obvious that the fund is mainly finaced by the government.

Now aday the government of Lao PDR has received assistance from the government of Luxembourg to develop social security system with a total period of 4 year from the year 2002 to 2005. The Luxembourg assistance project has been implemented through the International Labour Organization (ILO). The project has tree main objectives as following:

1. To reform the public sector social security scheme.
2. To strenngthen the private social security scheme.
3. To find out the possibility to create the social security system for people working in the informal sector.

Since Laos has independence in the year 1975 up to now, the government has established two separate social security systems. One is the system for the public sector employees and the other is for the private sector employees.
The social security scheme for employees of the public sector was established in 1993. This scheme is administered by the Ministry of Labour and Social Welfare (MOLSW). The fund is kept under the Treasury Department of MOF. The scheme coverage includes civil servants, military and police. The scheme is funded by contributions of employee and government. Employees pay 6% of their wages, the government subsidises to expenditure for benefits.

Until 2006 reform for degree 178/PM to decree 70/PM was has accepted. The contribution for this fund: insured person is contribution 8% their salaries and government contributes 8.5% person salaries, but 0.5% for worked injury and occupational deceases. Since the introduction of social security system for the public sector the scheme now covers approximately 360,539 insured persons (583,457 beneficiaries).

2. Social Security System for the private sector.

The benefit for the private sector employee scheme is one of social security benefits as stimulated in the decree 207/PM. The decree has been implemented by Social Security Organization since June 01, 2001.

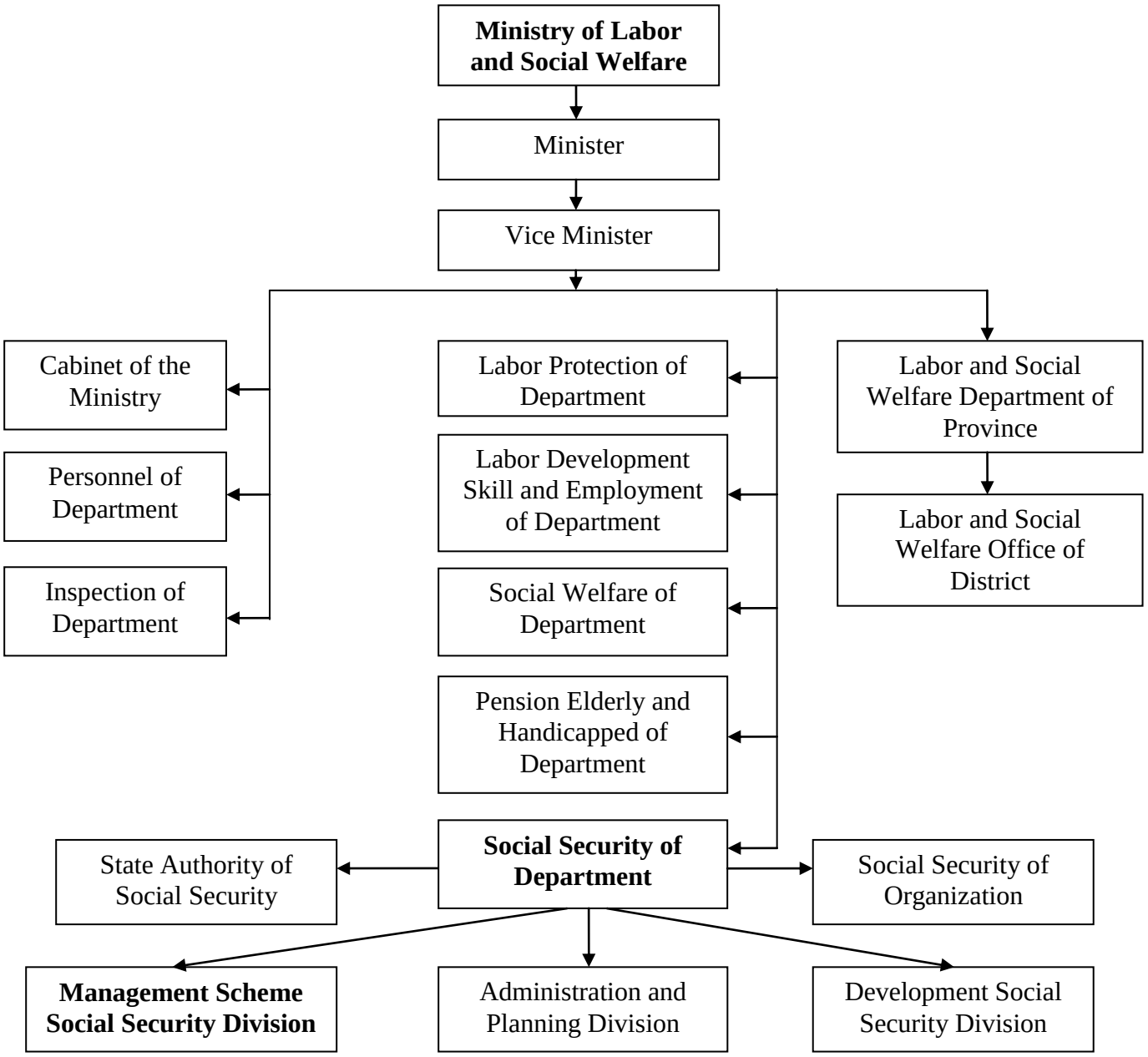
The decree regarding social security system for the private sector employees was approved in 1999 and it was officially implemented in early 2001. It's a contributory and compulsory scheme. The scheme applies to all employers who have 10 or more employees. The total contribution rate is 9.5% of employee's earnings in which 5% comes from employers and 4.5% from employees.

Social Security Organization is an autonomous organization that is under control of its board of Directors. The board functions under the supervision of the Minister of Labour and Social Welfare. The board is composed of 11 members of whom there are three representatives from the government organization, four from employees and four from employers. The management unit of SSO comprises a director general and two deputes responsible for daily operation of SSO.

Qualifying condition: an insured person has to complete at least five years of contribution to the social security fund and has to attain the age of 60 years. In case of necessity 55 years of age will be allowed to retire, but the amount of his retirement benefit (pension) will be reduced for 0.5% per month until he reaches 60 years old. In contrast, a person having 60 years of age but continuing to work his pension will be increased 0.5% per month according to the period he works after 60 years. For this case, the insured is allowed to work only up to 65 years old.

Since the introduction of social security system for the private sector the scheme now covers approximately 59,905 insured persons (124,538 beneficiaries).

The Structure and Organization of Ministry of Labor and Social Welfare



ANNEX1-Form 1
The State of National
Area size (236,800 square Km)
Population by aged group. Unit: thousands

Year		1991(1990)	1996	2001	2006	2011
0-4	Male	373	368.9	426.91	370.8	476.00
	Female	388	375.4	419.5	366.2	457.56
5-9	Male	279	353.6	417.39	373.4	363.29
	Female	292	367	402.10	365.9	358.74
10-19	Male	481	544.2	627.99	731.6	753.11
	Female	464	552.2	618.80	711.7	729.87
20-29	Male	332	387.3	389.28	479.0	571.90
	Female	284	342.3	440.50	493.2	576.25
30-39	Male	238	285.7	318.81	345.1	371.84
	Female	227	280.3	324.80	354.4	386.86
40-49	Male	154	177.4	196.46	254.1	291.61
	Female	142	172.8	201.80	255.1	296.64
50-59	Male	121	133.5	133.51	156.4	193.83
	Female	113	117.4	151.80	163.9	200.51
60-64	Male	45	48.3	50.79	50.7	57.60
	Female	45	44.7	55.00	55.7	62.50
65	Male	83	92.4	96.33	103.4	109.51
	Female	79	84.7	105.00	117.1	127.50
Total	Male	2,106	2,391.3	2,657.49	2,864.40	3,188.67
	Female	2,034	2,336.8	2,719.60	2,883.20	3,196.39

Source: National Statistic Center (NSC)

ANNEX1-Form 2

Year	1991	1996	2001	2006	2011
Population growth rate (%per annum)	2.40	2.84	2.74	2.40	2.22
Birth rate (per1,000population		40.30	38.10	33.70	28.00
Mortarity rate (per 1,000population)	5.5	14.70	13.90	9.40	7.70
Infant mortarity rate (per1,000population)		162.20	96.80	67.20	54.1
The rate of the population of 65 years and over to the total population(%)				3.9	
Life expectancy M at birth F		53.70 55.90	56.40 59.70	61.70 63.00	62.30 66.40
Life expectancy 60 at age 60 and 65 65	-	-	-	-	-
Unemployment rate (per1,000population) average rate	-	-	5	3	3

Source: National Statistic Center (NSC)

ANNEX1-Form3

Year		1991	1996	2001	2006	2011
National income (US$)						
Average Wage (US$)						
Average Wage of Male and Female (US$)	M					
	F					
Average income (US$)						
Total GNP (US$)						
GNP growth rate						
GNP per carpita (US$)						
Total GDP(US$) (Million US$)				13,495,315	3,334	8,181.21
GDP growth rate		4.50	5.90	6.20	7.90	8.50
GDP per carpita(US$)		211	344.9	450	580	1,281
The rate of social insurance of contribution as % of salary for em-ee		Covernmemt subsidied	Covernmemt subsidied	Covernmemt Subsidied	8.5%	8.5%
	Premium contribution Of employee (Thaursand $)	6	6	6	7,484	8
	Premium contribution Of employer (Thaursand $)	-	-	5	11,553	5
	Premium contribution Of self-employer etc.	-	-	9.5	9.5	9.5

Source: Ministry of LSW

ANNEX1-Form4
Number and percentage of workers engaged in industrial classification

Year	1991	1996	2001	2006	2011
Primary industry			116		
Secondary industry			542		
Tertiary industry			22,916		
Total			89,405		

Source: Ministry of industry and commerce

Five leading causes of death

(Year)	1st	2nd	3rd	4th	5th
1991	Malaria	-	-	-	-
1996	Malaria	-	-	-	-
2001	Malaria	Pneumonia	Cardiopadia	Accident	Meningitis
2006	Pneumonia	Accident	Brovacculaire	Traumatisme	Crânien
2011	Diarrfiouea	Acute Respica	Dengue fever	Malaria	

Source: Ministry of Public Health.

Lao People's Democratic Republic
Peace Independence Democracy Unity Prosperity

Country Report

The Training and Dialogue Program on
" Improvement of Social Insurance System" J12-00718/ID. 1280912
Japan, September 17, 2012 to October 6, 2012

I. Geographical and Political Features

Lao people' s Democratic Republic is a landlocked country in South East Asia sharing borders with Thailand, Vietnam, Cambodia, China and Myanmar. The country occupies an area of 236,800 Sq. Km, of which circa 75% is mountainous with forests. Lao PDR comprises 17 provinces including Vientiane capital.

The Mekong River has Traditionally served as Lao PDR's lifeline, and forms the country borders with Thailand as well as with Myanmar. The Mekong flows over 1800 km along these borders. The Mekong River valley and its fertile flood plains form the country's main agricultural zones.

The population is estimated to 6,385,000 in 2011 with an average life expectancy at birth of 64.7 years, an infant mortality rate of 54.1 per 1000 live births. The majority of the population live in the fertile low lands near the Mekong River and its tributaries. Roughly 83% of the population lives in rural areas and 17% of population lives in the major cities.

The population is composed of 49 different ethnic groups of which the Lao-lum located in the lowland areas close to the Mekong River is predominant(67%).Buddhism was apparently in the late 13th or early 14th centuries. Today about 62% of the population are Theravada Buddhists. Long after the introduction of Buddhism, the people were reluctant to accept the new faith and continued to worship different "phii" (earth spirit). It was not until the mid 17th century, that Lao PDR maintained a continuous Theravadin tradition. However still today in everyday life, different "phii" are feared and recognised, even if the "phii" worship has been officially banned. The Lao PDR's terrain is mostly rugged mountain with some plain and plateaus, The Lao PDR is in tropical climate, the rainy season runs from May to November whereas the dry season is from December to April. The official language in the Lao PDR is the Lao language as is spoken and written.The Lao PDR is divided into 17 provinces, which are divided into 139 districts and 9,113 villages, the village is smallest administrative unit.

II. Social Security System in Lao PDR.

Since Laos has independence in the year 1975 up to now, the government has established two separate social security systems. One is the system for the

public sector employees and the other system is for the private sector employees.

The social security scheme for employees of the public sector was established in 1993. This scheme is jointly administered by the Ministry of Labour and Social Welfare (MOLSW) and Ministry of finance (MOF). The fund is kept under the Treasury Department of MOF. The scheme coverage includes civil servants, military and police. The scheme is funded by contributions of employee and government. Employees pay 6% of their salaries, the government pays all the rest of expenditure. Benefits covered by this scheme comprise old-age pension, disability benefit, survivor benefit, sickness benefit, maternity benefit, work injury and medical care. Until the year 2006 the Lao government decreed the new decree on Social Security for employees of the public sector to replace the old decree which the contribution is 8% of employee's salaries and government pays 8.5% and the qualifying period for old-age pension benefit is reduced from 25 years to be 15 years. The scheme is administered by the State Authority of Social Security (SASS) which is an autonomous body, under the supervision of the Minister of MOLSW.

The decree regarding social security system for the private sector employees was approved in 1999 and it was officially implemented in early 2001. It a contributory and compulsory scheme. The scheme applies to all employers who have 10 or more employees. The total contribution rate is 9.5% of employee's earnings in which 5% comes from employers and 4.5% from employees. The insurable target groups are all employees who work for State, private and partnership enterprises in the areas of industry, agriculture, services, However, the system provides exception for those who are working for:embassies, international organizations, companies that have a multinational network located in Laos for the period not exceeding 12 months, companies that have affiliates in other countries and who are sent to work abroad for 12 months or more, who work for the government such as civil servants, military, police and student. Benefits provided under this system from the beginning of its introduction are composed of old age pension, invalidity benefit , survivor benefit, sickness benefit, maternity benefit, medical care and work injury benefits. The scheme is administered by the social security organisation(SSO) which is an autonomous body, under the supervision of the minister of MOLSW.

III. Outline of Medical Insurance System (MIS).

The Medical Insurance System (MIS), which was implemented in 2001, consists of two significant systems. The first is the Medical Insurance System for Enterprises Employees and for Community Based Health Insurance (CBHI). The medical insurance system for enterprise employees is administered and supervised by the Social Security Organization. Social Security Organizationdivides the supported capital that employers and employees contribute to the SSO's fund. 4 % of the 9.5% contribution will be deducted for Medical Insurance.

The Community Based Health Insurance (CBHI) is supported by the government of Japan through the UNHSF. Technical assistance is also provided by the WHO. The CBHI is the system concerning the provision of healthcare to people working as farmers, gardeners, retailers and other similar vocations. There is a large percentage of the population engaged in such professions and it is hard for them to spend for medical treatment in the case of illness. The rate of payment is calculated based on the number of family members and there are two alternative options to get access to the service or treatment as follows:

1. **First option**: the first option is the insurance for people who can access provincial hospitals or central hospitals directly:
   - Families with 1 member: 37.25 US$ /insured person/year
   - Families with 2-4 members: 62.08 US$ /insured person/year
   - Families with 5-7 members: 80.71 US$ /insured person/year
   - Families that have more than 8 members: 86.92 US$ /insured person/year
   - Monks, religious practitioners and students who stay in dormitories: 14.9 US$ /insured person/year
2. **Second option**: the insured person has to be treated at the nearest district hospital first. If the closestdistrict hospital cannot treat the insured person, them he/she must be sent to contracted hospitals. The rate of cover depends on the contract. It might be 50%/ 50% , 60%/40% or 70%/30%

   The rate of supported capital is indicated below
   - Families with 1 member: 26 US$ /insured person/year
   - Families with 2-4 members: 44.7 US$/ insured person/year
   - Families with 5-7 members: 55.88 US$/ insured person/year
   - Families that have more than 8 members: 62.08 US$/ insured person/year
   - Monks, religious practitioners and students who stay in dormitories: 14.90 US$ /insured person/year

The CBHI is administered and supervised by the Ministry of Health and is under the inspection and supervision of minister of the Ministry of Health.

The Civil Servant Scheme was initially implemented in 2006. The system is under the control and supervision of the State Authority Social Security (SASS). It is also monitored by the Minister of the Ministry of Labor and Social Welfare. The SASS divides the supported capital that civil servants and the government contribute to the SASS's fund. 4 % of the 16.5% contribution will be deducted for Medical Insurance.

In the actual implementation of Medical Insurance System, the three organizations mentioned (SSO, SASS, CBHI) will be in the form of capitation methods with state hospitals which covers 10.55 US$/insured person/year. Insured person can receive treatment at a specified hospital regardless of medical care costs or the number of treatments.

To make sure that the insurance is appropriate, the contract made with the three organizations (SSO, SASS, and CBHI) has indicated the types of treatment that are not covered as follows:

1. Cardiac Surgery, Sexual changing surgery, Organ transplantation surgery.
2. Thalassemia
3. Hemodialysis
4. Tubal ligation (accept that it is medically required), In Vitro Fertilization.
5. Traffic accidents
6. Patients who have been in hospital more than 3 months due to the same disease.
7. Esthetic dentistry, Operative dentistry.
8. Chemotherapy, Radiotherapy
9. Glass cost, Prothetic lens cost.
10. Yearly check ups

The expansion of the Medical Insurance System, specifically the Civil servant Medical Insurance System and Enterprise employees Medical Insurance System are now being set up in every province in the country. Interestingly, the CBHI is now being operated in 25 districts throughout the country. There are a significant number of insured persons as follows:

1. The Social Security Organization has 126,039 insured persons.
2. State Authority Social Security has 355,090 insured persons.
3. The CBHI has 140,000 insured persons.

In order to allow the Medical Insurance System to cover the whole country, to make the program sustainable, and to quarantine the benefits of insured persons, the government of Lao PDR has issued decrees and regulations as follows:

1. Decree No 207/PM, dated 23 December 1999 on the Social Security System for enterprise employees.
2. Rule No 723/MOH, dated 13 April 2005 on the Community Based Health Insurance.
3. Decree No 70/PM, dated 20 April 2006 on State Authority Social Security.

The Law on the Social Security System is now being drafted

The problems of the Medical Insurance System

- The Medical Insurance System was implemented in four central hospitals in Vientiane capital in 2001. The program is now being operated in 17 provincial hospitals throughout the country. However, it is not implemented at the district hospital level.
- All of three organizations (SSO, SASS, CBHI) implementing the contract of medical care are doing so in the capitation method with the state hospitals.
- The percentage of insured persons is only 9.72% of the total population
- The rate of insurance does not balance with the rate of treatment.
- Regulations and laws about MIS are not fully managed, so it is difficult to control.

To solve the problem mentioned, the Lao government has a policy to integrate the three organizations into one as the SASS to average the capital and to make sure that the capital fund available is sustainable.

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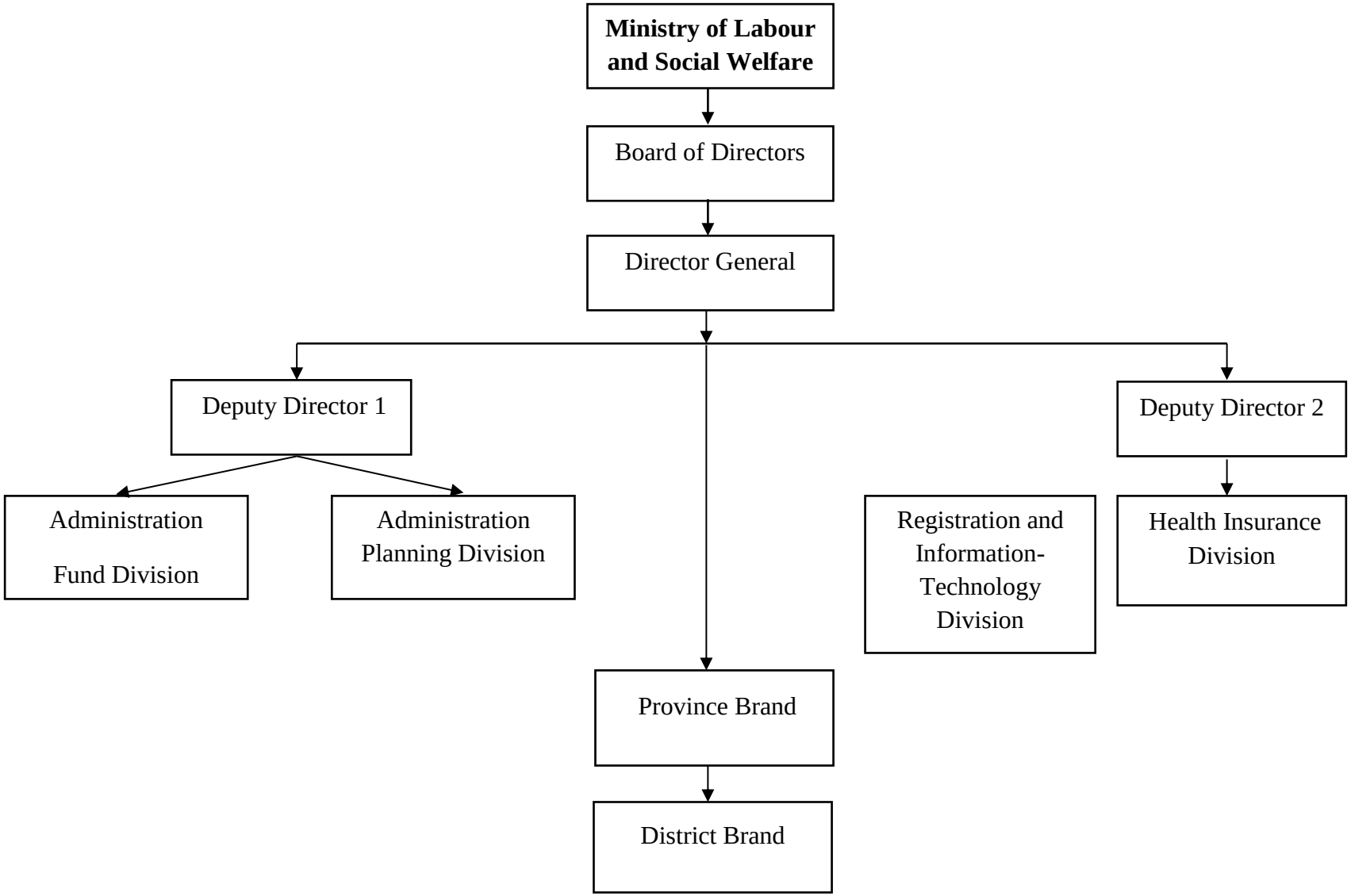
State Authority of Social Security



ANNEX1-Form 1

The State of the Nation

Area size (Area size Km^2) Unit: thousands

Population by aged group

Year		1990	1996	2001	2006	2011
0 - 4	Male	373	368.90	426.91	370.80	476.00
	Female	388	375.40	419.50	366.20	457.56
5 - 9	Male	279	353.60	417.39	373.40	363.29
	Female	292	367.00	402.10	365.90	358.74
10 - 19	Male	481	544.20	627.99	731.60	753.11
Female		464	552.20	618.80	711.70	729.87
20 - 29	Male	332	387.30	389.28	479.00	571.29
Female		284	342.30	440.50	493.20	576.25
30 - 39	Male	238	285.70	318.81	345.10	371.84
Female		227	280.30	324.80	354.40	386.86
40 - 49	Male	154	177.40	196.46	254.10	291.61
Female		142	172.80	201.80	255.10	296.64
50 - 59	Male	121	133.50	133.51	156.40	193.83
Female		113	117.40	151.80	163.90	200.51
60 - 64	Male	45	48.30	50.79	50.70	57.60
Female		45	44.70	55.00	55.70	62.50
65 -	Male	83	92.40	96.33	103.40	109.51
Female		79	84.70	105.00	117.10	127.50
Total	Male	2,106	2,391.30	2,657.49	2,864.40	3,188.67
Female		2,034	2,336.80	2,719.60	2883.20	3,196.39

Data resource: Lao National Statistic Centre

ANNEX1-Form 2

Year		1991	1996	2001	2006	2011
Population growth rate (% per annum)		2.40	2.84	2.74	2.40	2.22
Birth rate (per 1,000 population)			40.30	38.10	33.70	28.00
Mortality rate (per 1,000 population)		5.50	14.70	13.90	9.40	7.70
Infant mortality rate (per 1,000 population)			162.20	96.80	67.20	54.10
The rate of the population of 65 years and Over to the total population (%)					3.9	
Life expectancy at birth	M		53.70	56.40	61.70	62.30
	F		55.90	59.70	63	66.40
Life expectancy at 60 and 65	60					
	65					
Unemployment rate (per 1,000 population) *average rate						

Data resource: Lao National Statistic Centre

ANNEX1-Form 3

Year		1991	1996	2001	2006	2011
National Income (US$)						
Average Wage (US$)						
Average Wage of Male and Female (US$)	M					
	F					
Average Income (US$)						
Total GNP (US$)						
GNP growth rate						
GNP per capita (US$)						
Total GDP (US$) (MillionUS$)					3,334.00	8,181.21
GDP growth rate		4.50	5.90	6.20	7.90	8.50
GDP per capita (US$)		211	344.90	450	580	1,281
The rate of social insurance of Contribution as a percentage of Salary for employer		Government subsidized	Government subsidized	Government subsidized	8.5%	8.5%
The rate of social insurance of Contribution as a percentage of Salary for employee		6%	6%	6%	6%	8%
	Premium contribution of employee					
	Premium contribution of employer					
	Premium Contribution of self-employee etc.					

Data resource: Lao National Statistic Centre

ANNEX1-Form 4

Number and percentage of workers engaged in industrial classification

Year	1991	1996	2001	2006	2011
Primary industry			441		
Secondary industry			2,055		
Tertiary industry			86,909		
Total			89,405	92,561	

Data resource: Ministry of Industry and Commerce

Five leading causes of death

Year	1st	2nd	3rd	4th	5th
1991	Malaria	Diarrhea	Pneumonia	Meningitis	Accident
1996	Malaria	Pneumonia	Diarrhea	Accident	Meningitis
2001	Malaria	Pneumonia	Cardiopathia	Accident	Meningitis
2006	Pneumonia	Accident	Cerebrovascular	Traumatism	Crani-Traumatism
2011	Diarrhea	Acute Respiratory infection	Dengue	Malaria	Pneumonia

Data resource: Ministry of Health

Social Security Systems and Health Insurance in Lao PDR

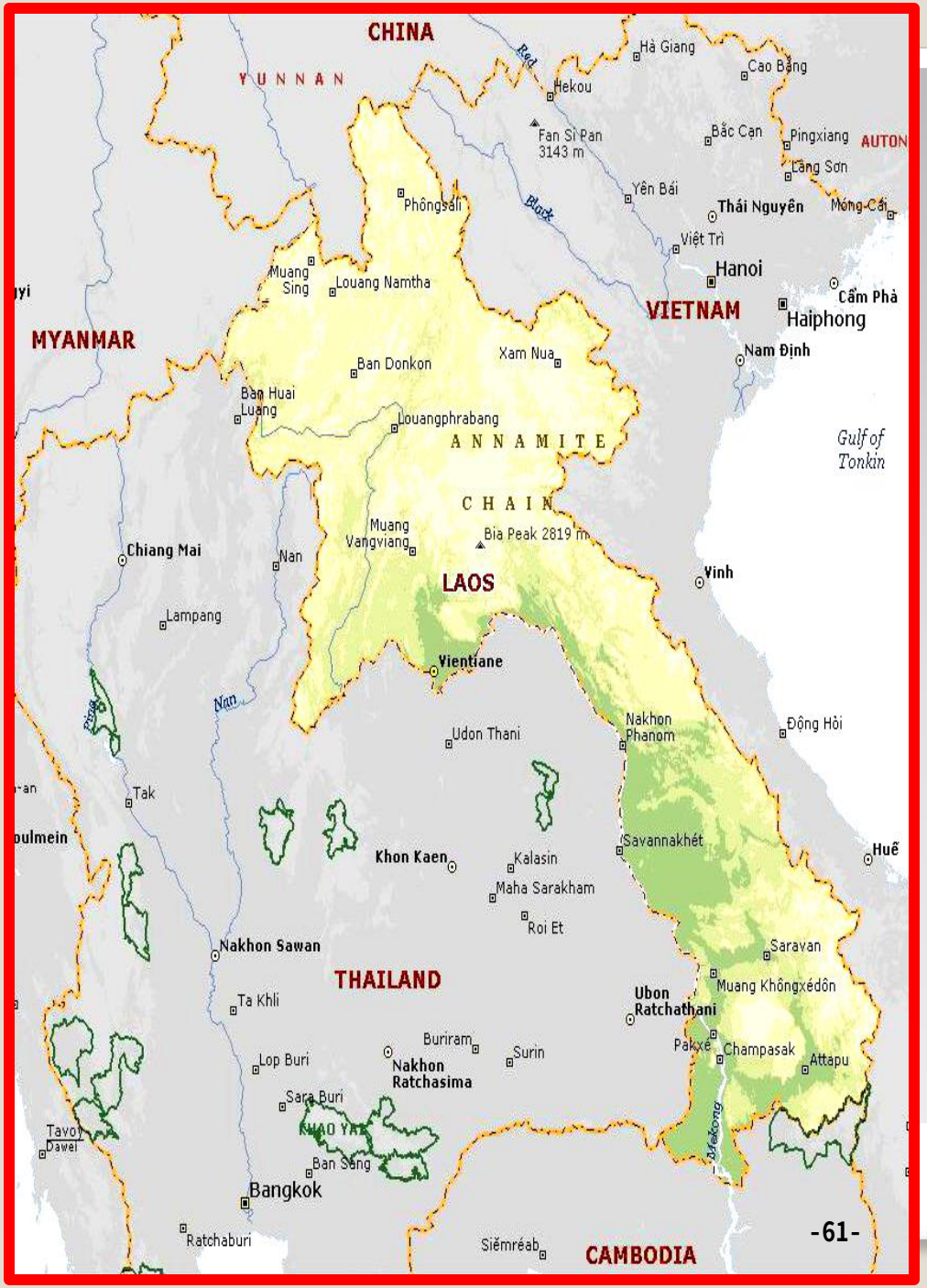
For the training and dialogue program course on "Improvement of Social Insurance System" (J1200718)
Japan, 17 September to 6 October, 2012

Ministry of Labor and Social Welfare
Department of Social Security

Presentation By :

Head of Social Security Management Schemes Division

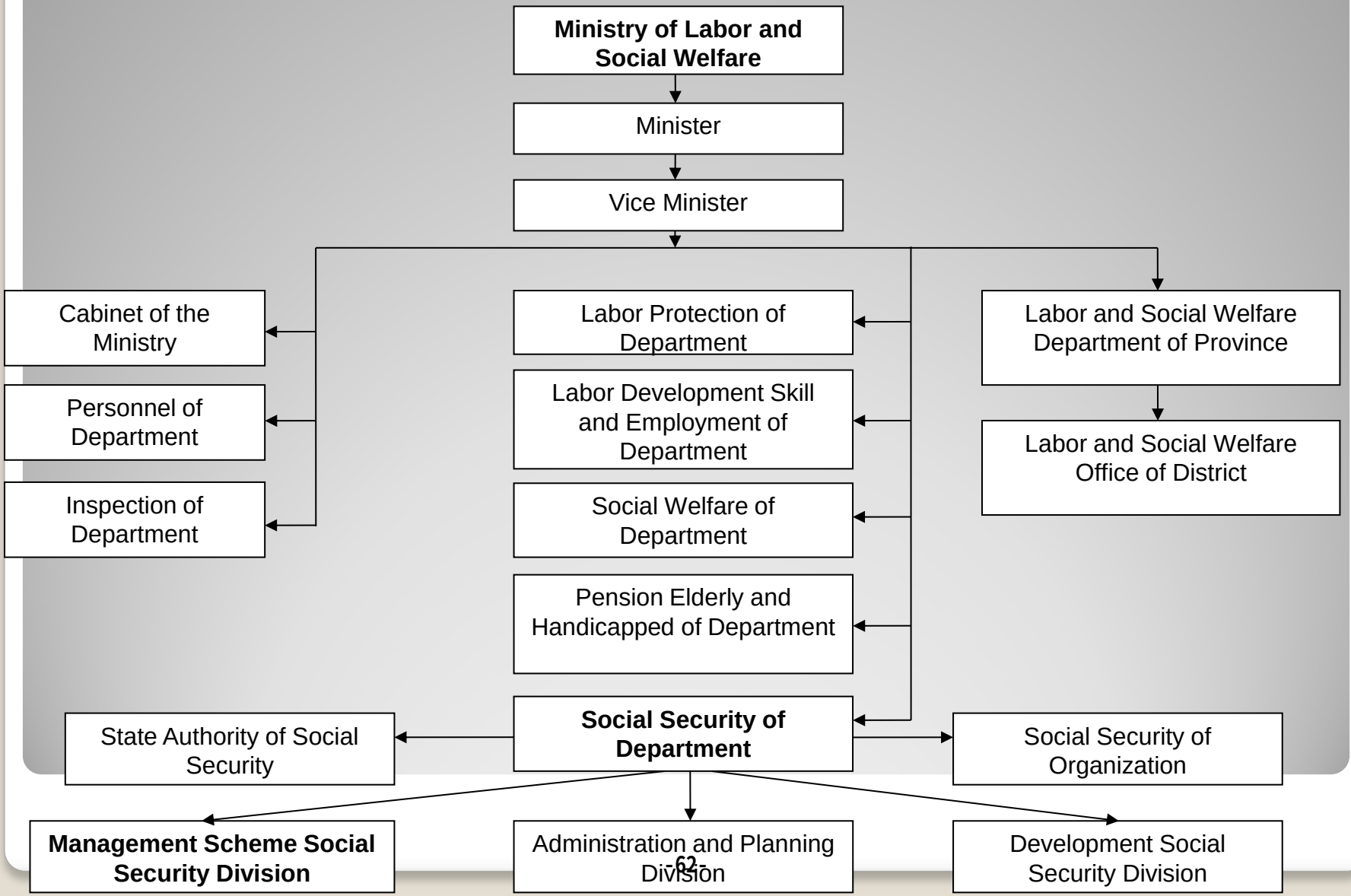
Email: nikonevongsavath@yahoo.com
Tel: 020 55615569, 021 213013



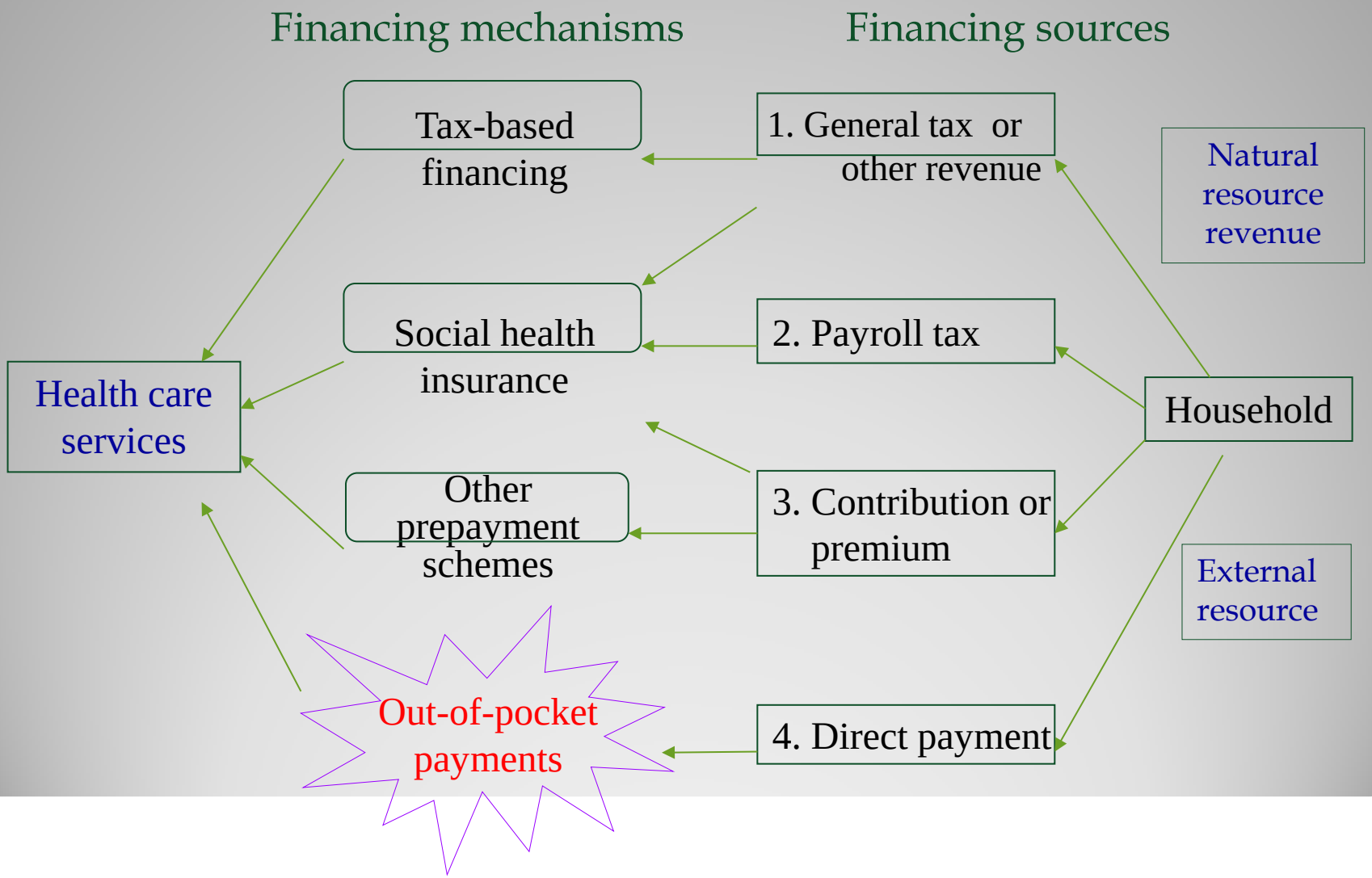
Lao PDR

-Small country, middle of Indochina in South East Asia.
-Area : 236,800 Square Kilometers.
-Share border with : China, Cambodia, Vietnam,Thailand and Myanmar.
-Population : 6.385.060 million(2011).
-Capital city : Vientiane.
-Consist of 16 provinces.
-GDP per capita : 1,281 US$. (2011).

Structure and Organization of Ministry of Labor and Social Welfare



Health Financing Schemes

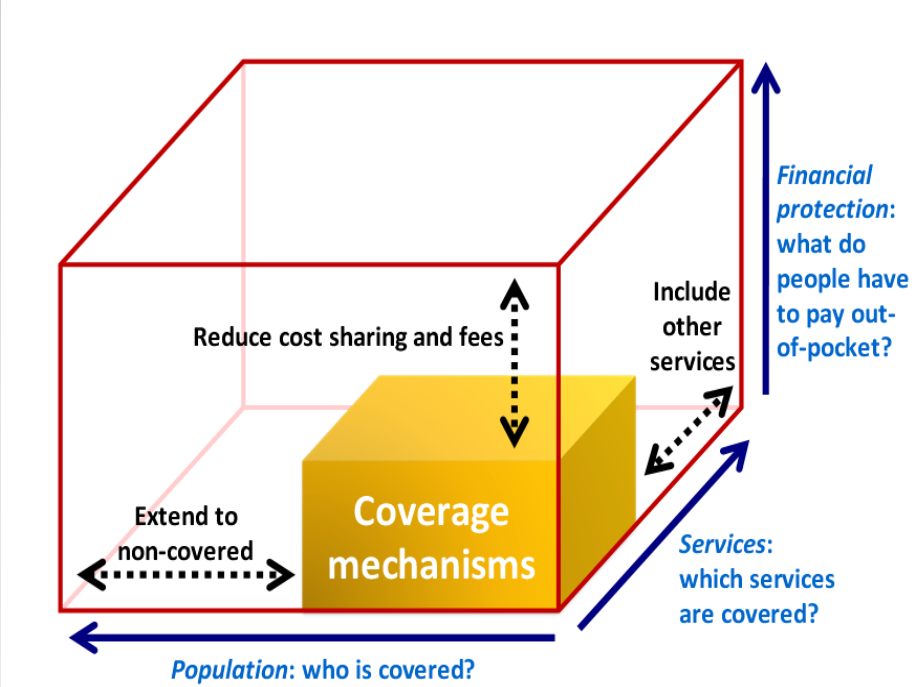


The Vision of Universal Coverage

Three Dimensions

Universal Coverage

- Everyone has access to needed services without the risk of financial hardship linked to paying for care.
- Universal Coverage is about equal access to quality services and financial protection



Overview

- ❖Policy on Social Security and Health Insurance
- ❖ Social Security Implementation-(Social Health Insurance)
  - State Authority Social Security (SASS)
  - Social Security Organization (SSO)
  - Community Based Health Insurance (CBHI)
  - Health Equity Funds (HEF)
- ❖ Development Plan on Social Security
- ❖Challenges

1. Policy on Social Security in Laos

- The government of Lao PDR has issued the social security policy in order to provide services and to support people and community in every economic sector and profession with intention to allow them having opportunity to join the scheme and receive the social security benefits or services which are created based on the principle of solidarity, helping each other and sharing risks.

1. Policy on Social Security (Contd.)

- The development of social security system in Lao PDR is necessary to extend its coverage to all employees working at the city and rural area including high aged group, low income community in order for them having appropriate assistance and efficient benefits due to the development and their participation to the social security system.

2. Social Security Implementation

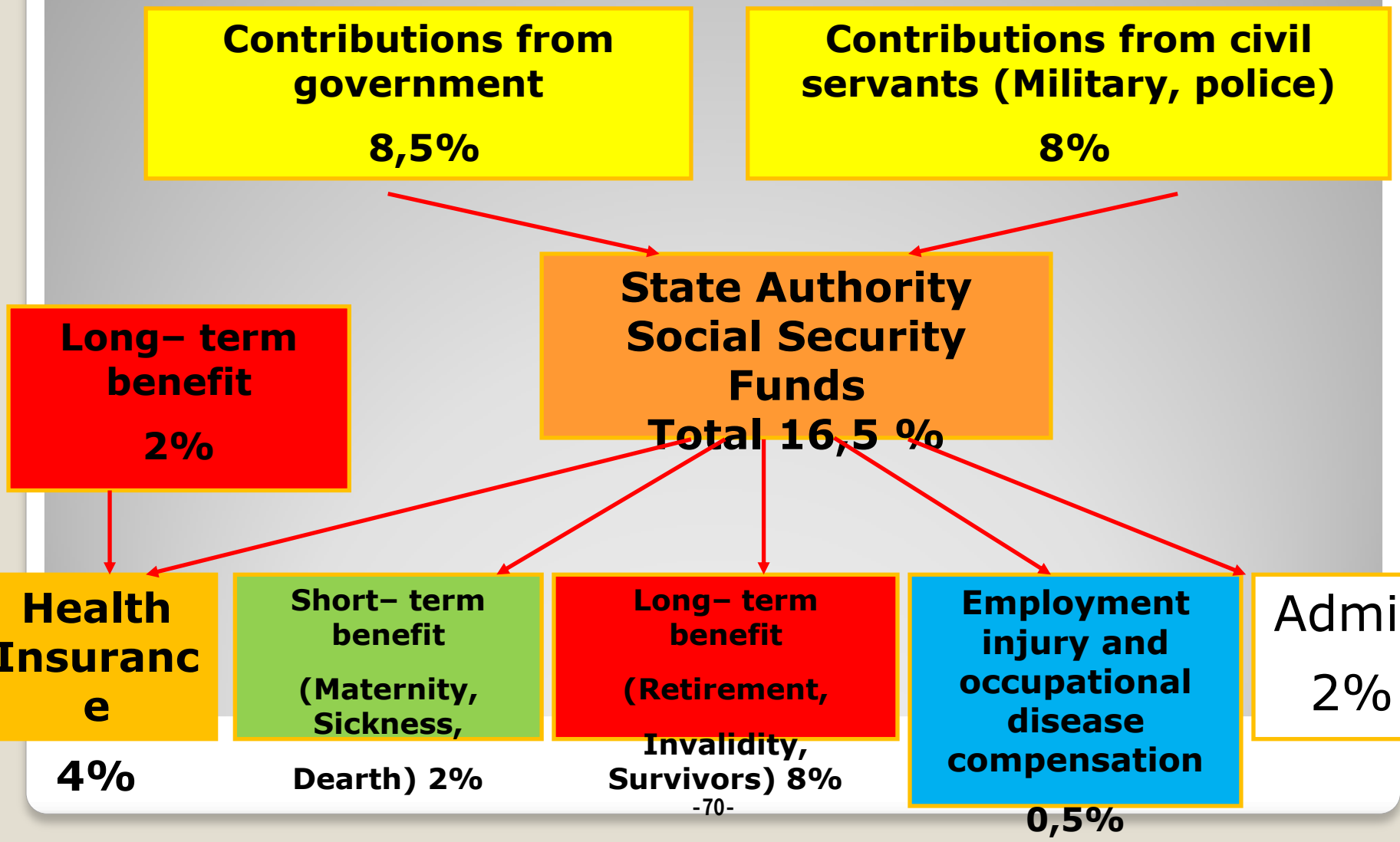
- Almost 20 years, since 1993 the government has established and developed the public sector social security scheme which include also military and police, the social security system for private sector employees, community based health insurance fund (CBHI) and health equity funds (HEFs).
- The schemes for the public and private sectors cover seven social security benefits. The other two funds focus only on health care.

State Social Security System

Formal Sector (compulsory shemes)

- In the 2006, The State Authority for Social Security (SASS) has been established. The social security scheme has been reformed. The total contribution rate has increased to 16.5% of which employees pay 8% and the rest is *made by the government.*
- ***The Social* Security Fund is divided in to 5 sub--funds such as: 1) Long term benefit fund 2) Short term benefit fund 3) Employment injury and occupational disease compensation fund 4) Health insurance fund 5) Administration fund.**
- **Beneficiary Members 583.457 people.**

State Authority Social Security Funds



Social Security for Interprise

Formal Sector (compulsory shemes)

- In the 2001 The Social Security Organization (SSO) has been established. This social security scheme is compulsory for enterprises employing 10 or more employees. SSO has Seven branches in provinces now.

- The sources of revenues of SSO is from contributions of employers 5% and employees 4.5% and is divided to 5 sub fund same as the SASS.
- Beneficiary Members 124.538 people.

Social Security Organization Funds

Contributions from Employers 5%

Contributions from Employees 4,5%

Social Security Organization Funds

Total 9,5 %

Long– term benefit

2%

Health Insurance

2,2%

Short– term benefit

(Maternity, Sickness, Dearth) 1,3%

Long– term benefit

(Retirement, Invalidity, Survivors) 5,5%

Employment injury and occupational disease compensation

0,5%

Admin

Community-Based Health Insurance (CBHI)

For the Non Poor in Informal sector

CBHI Initiative in Laos

- 1997 -to-2000 :
  - Situation analysis
  - Lessons gathering
- 2000- to 2002 : Legal framework
- 2002- to 2004 : CBHI pilot stage
- Since 2005: CBHI extension stage
- Since 2009: Develop NHI

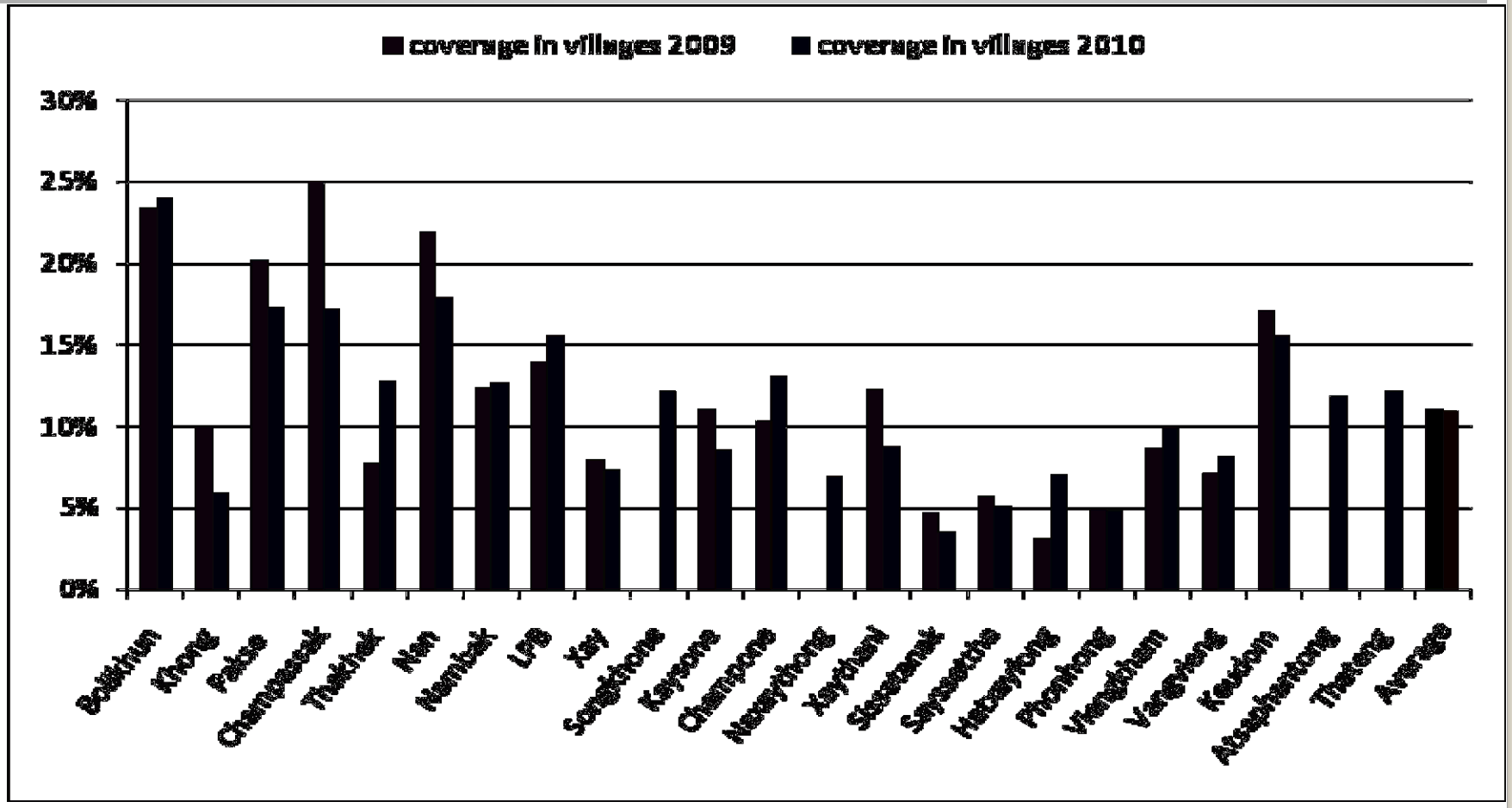
Design of CBHI
(National regulations for CBHI in Laos)

- Voluntary membership
- Family coverage (extended family according to family book)
- Monthly family premium payment (about 7 USD / year / p)
- Benefit package: free access to OPD and IPD + preventive services
- Health care providers: district and provincial/central public hospitals with mandatory referral (HC when functioning)
- Health provider payment: capitation
- Management framework: community based management under MOH/DPB supervision at Provincial, Regional and National levels (10% of contribution allocated to district management)

Result of CBHI

- Sep 2012, CBHI schemes cover 1451 villages in 25 districts of 10 provinces with 2471--9 families 140,000 people.
- Hospitals received the amount of 6 billions kips as capitation payment in 2010
- Utilization of services: OPD 145,000 cases or 1.2 visit/p/year and IPD 12,000 cases or 0.1 time/p/y

CBHI Coverage by district



Health Equity Funds (HEF)
For the Poor in Lao PDR

HEF "History"

Piloted from 2004 by SRC/LRC
Extension with fund from bilateral cooperation
Major increase in 2009 with WB/ADB funds
MOH Guidelines on HEF in 2011

(First initiated by projects, then in large-scale MOH programs funded by grants)

Management

Policy – Guidance - Oversight

- HEF committees Central, Province, District, Village

Coordination-Consolidation-Evaluation:

- MOH Central HEF Unit

HEF Implementation

- HEF Management / Implementation Agency or
- PHO/DHO HEF Unit

Service delivery

- Public & Community Health facilities

Payment mechanisms

Several mechanisms in place

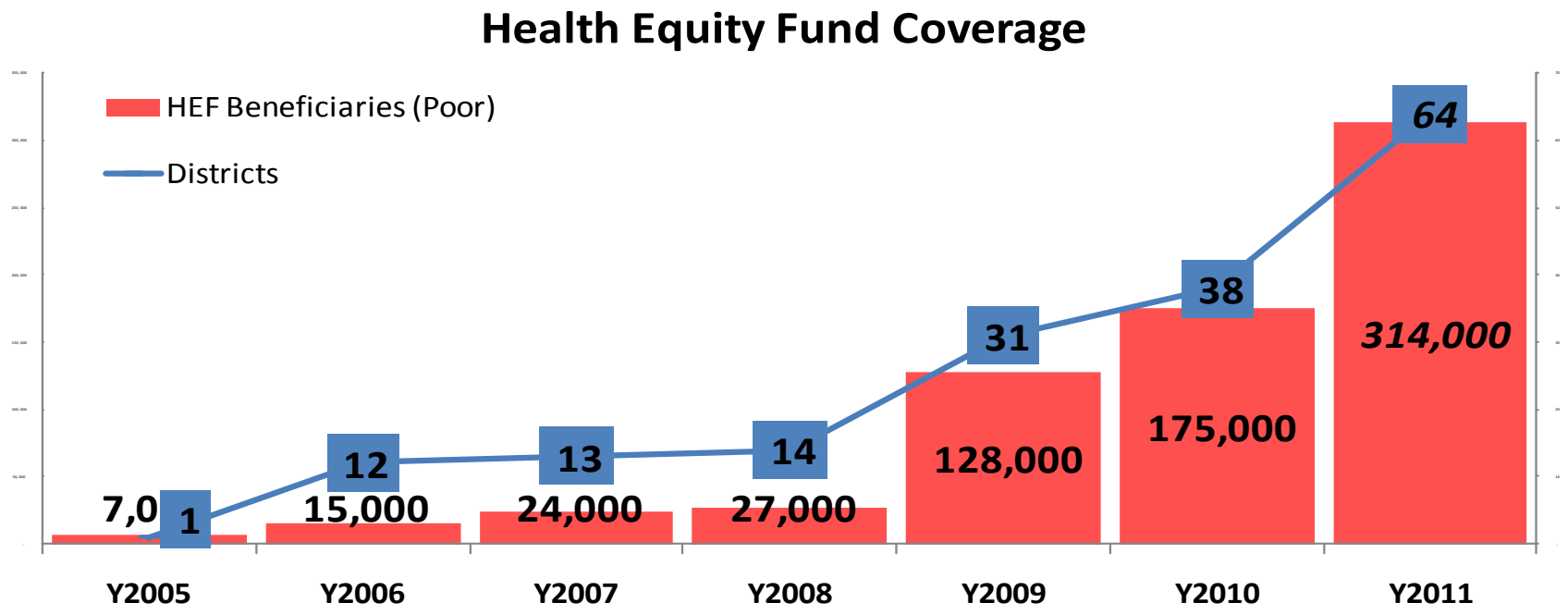
For curative & preventive services (user fees)

- Payment of bills
- Fixed fees by category of service
- Capitation & purchase of CBHI premium

For indirect costs

- Fixed fees for food allowance, transport, others
- Included in the capitation

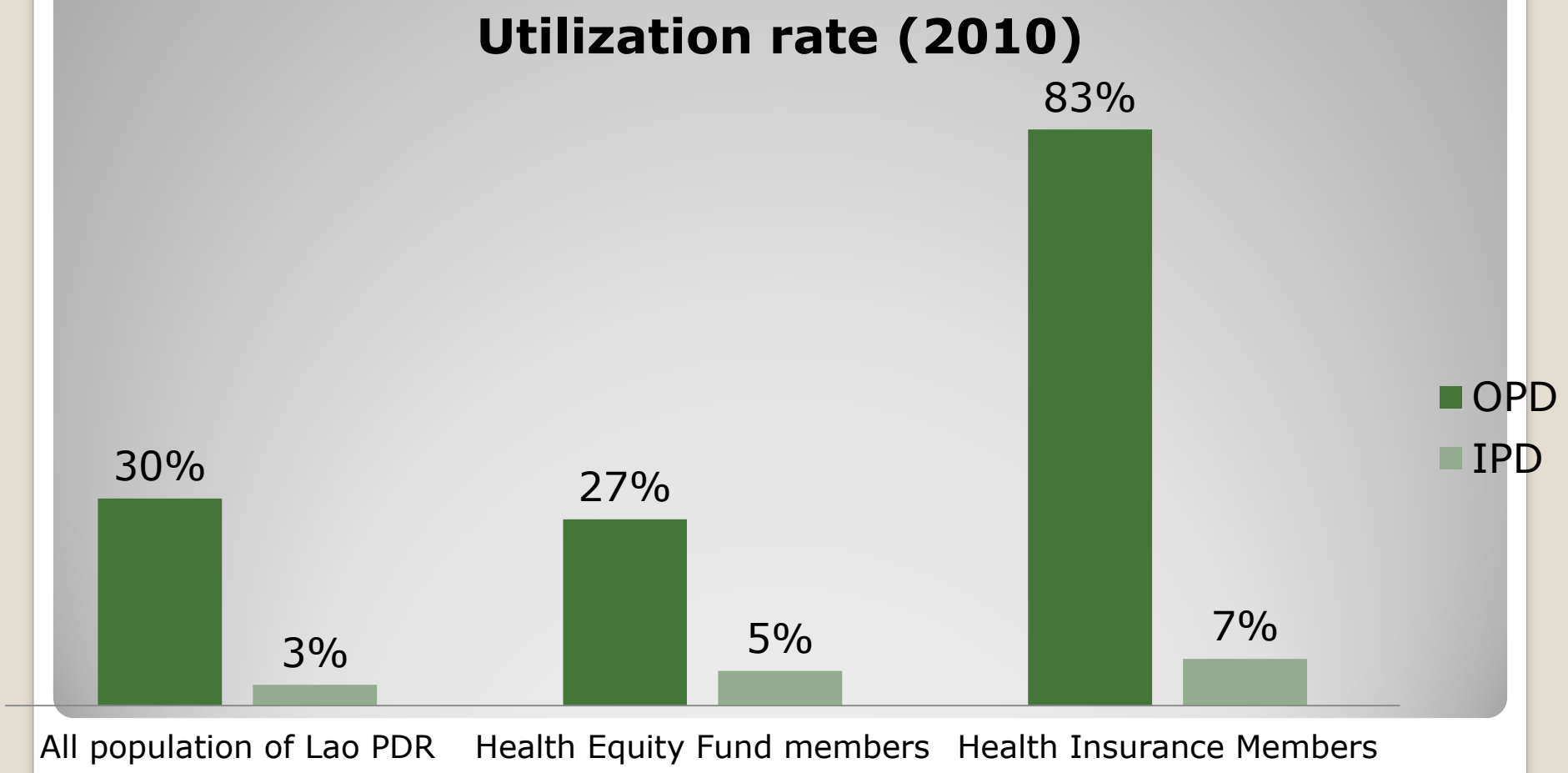
HEF Coverage



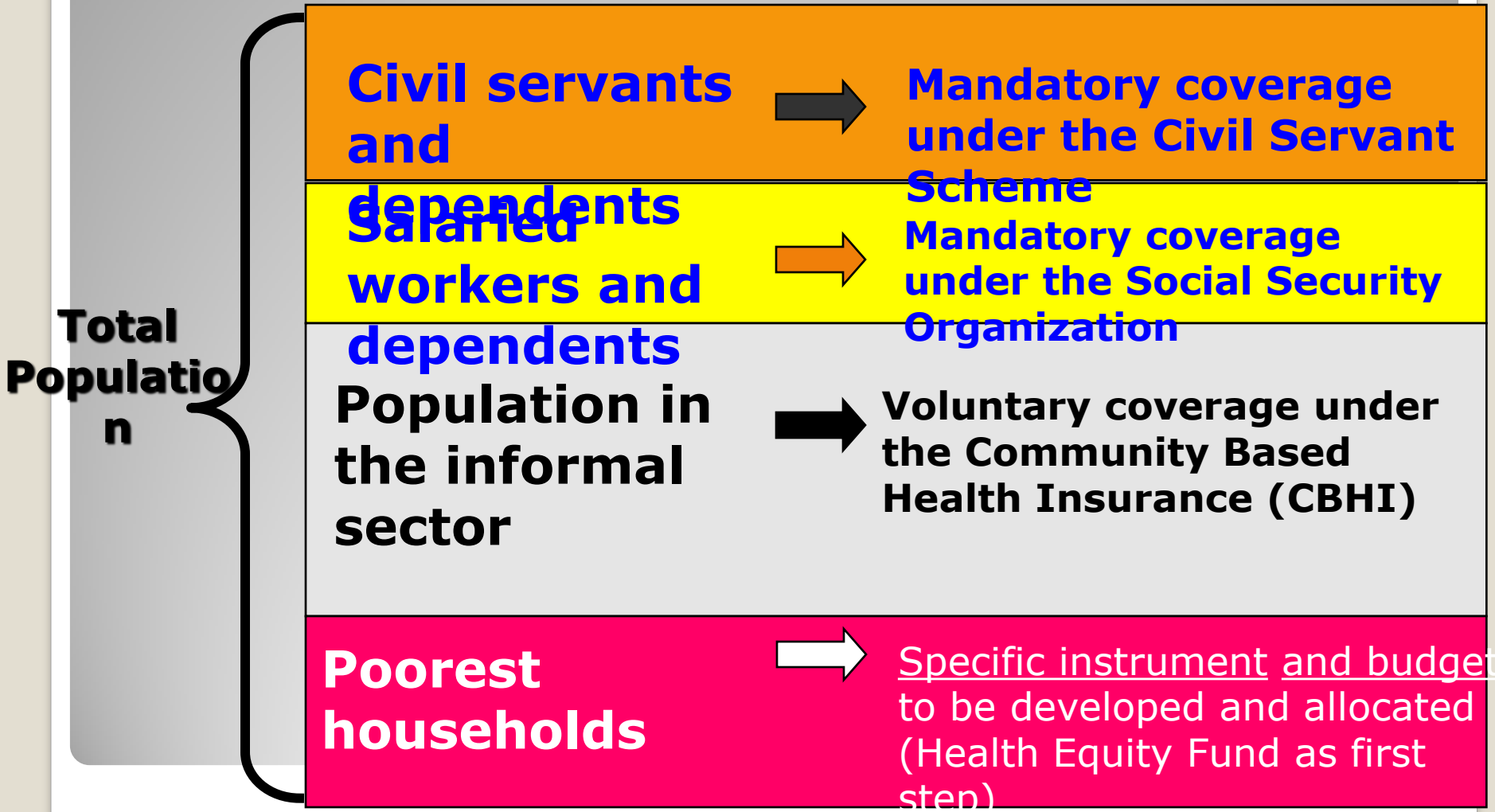
HEF Coverage in Lao PDR	Y2005	Y2006	Y2007	Y2008	Y2009	Y2010	Y2011 (P)
Districts	1	12	13	14	31	38	64
HEF Beneficiaries (Poor)	7,000	15,000	24,000	27,000	128,000	175,000	314,000
% of poor of covered districts	11%	4%	5%	5%	11%	12%	13%
% of total poor population (est.)	0%	1%	1%	2%	8%	11%	21%
% of total population	0.1%	0.3%	0.4%	0.4%	2.1%	2.8%	4.9%
% of total districts covered	1%	8%	9%	10%	22%	27%	45%

Source: MOH September 2012 poor covered 713,944 people

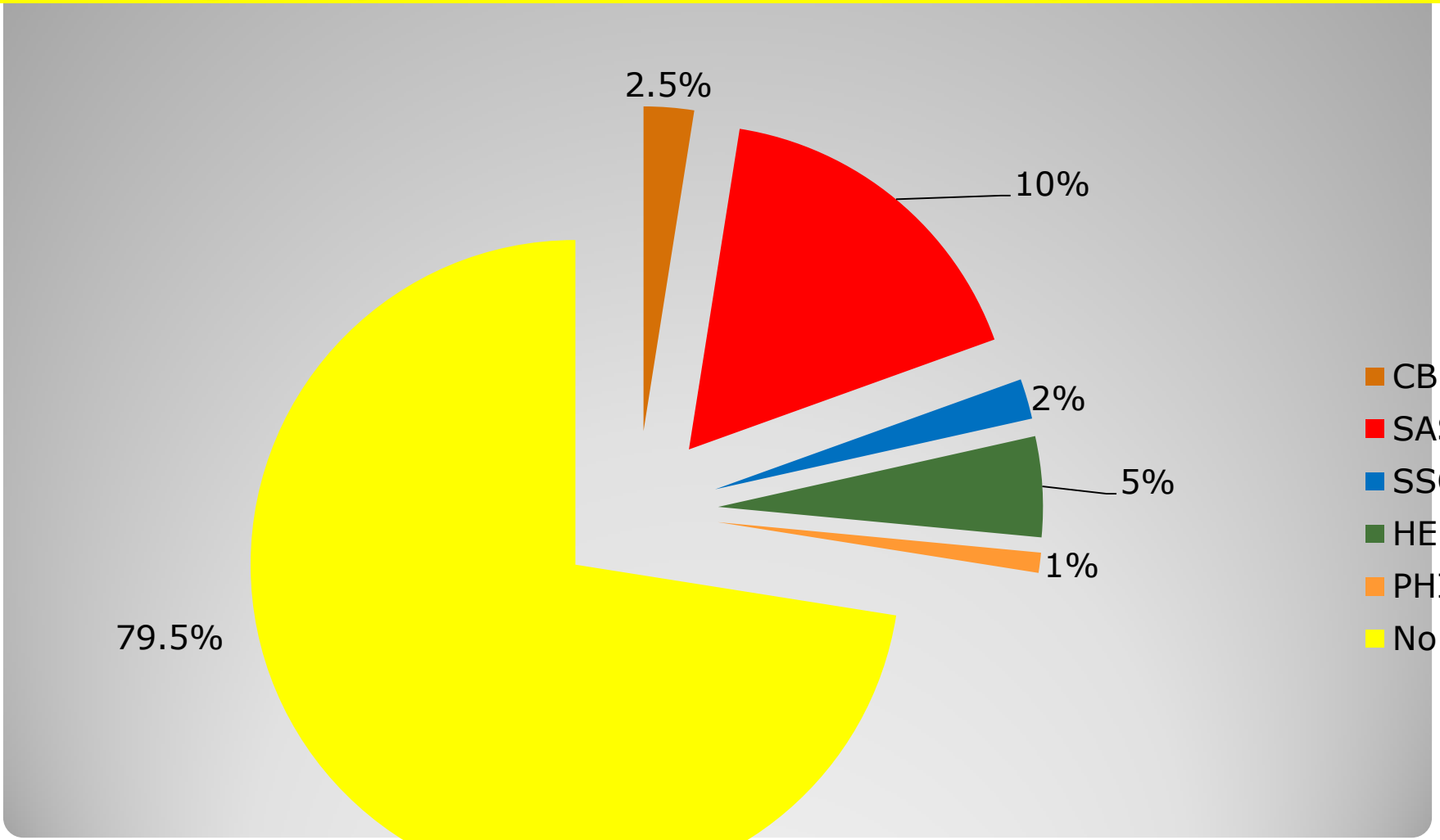
Utilization of services



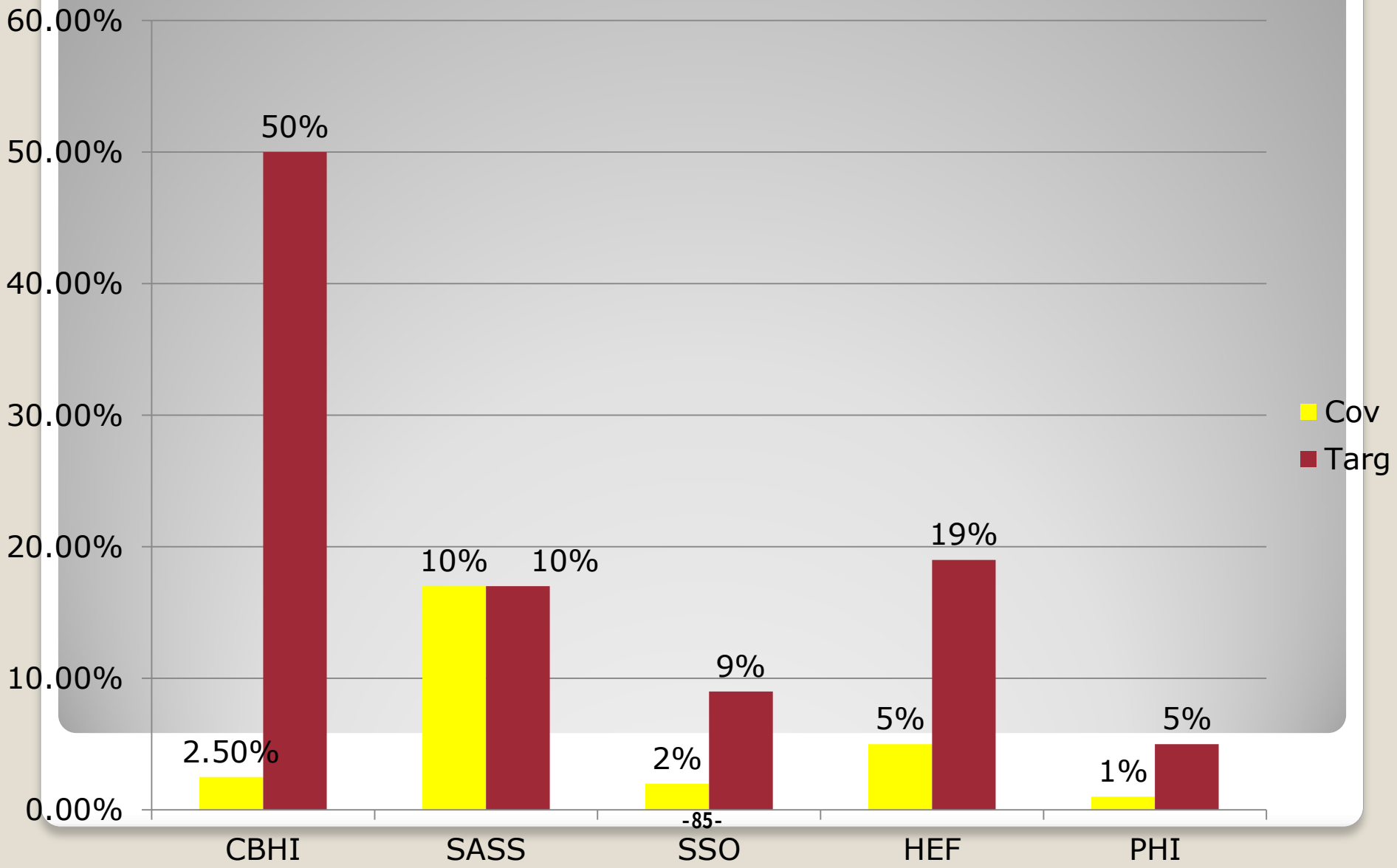
Towards universal coverage in Laos



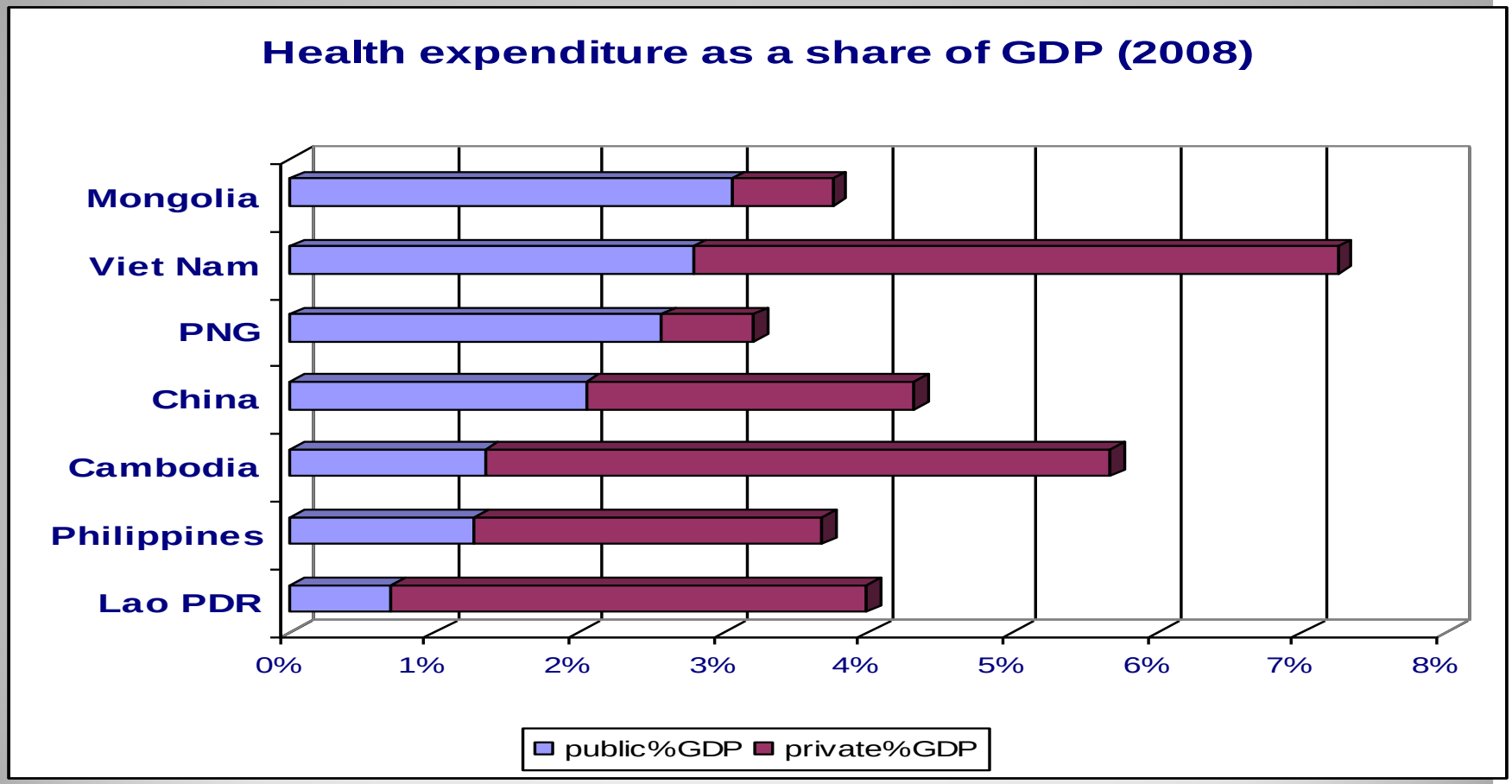
Coverage by different scheme (2011-12)



Coverage per target people

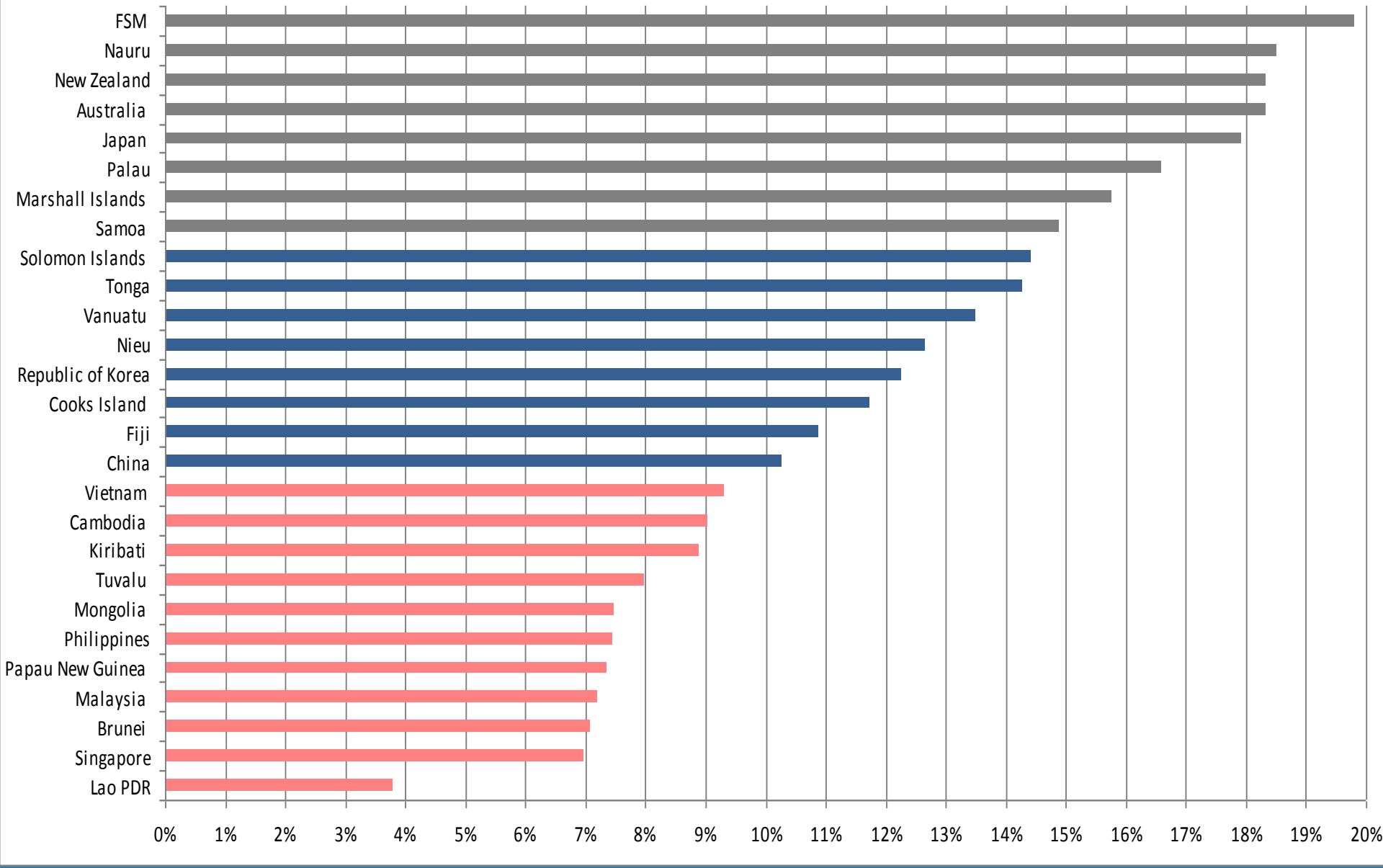


Compare Health Expenditure with Country's



Source: World Health Organization

GOVERNMENT PRIORITY TO HEALTH (general government health expenditure as % of total government expenditure)



Source: World Health Organization

3. Development Plan on Social Security

1) General Direction

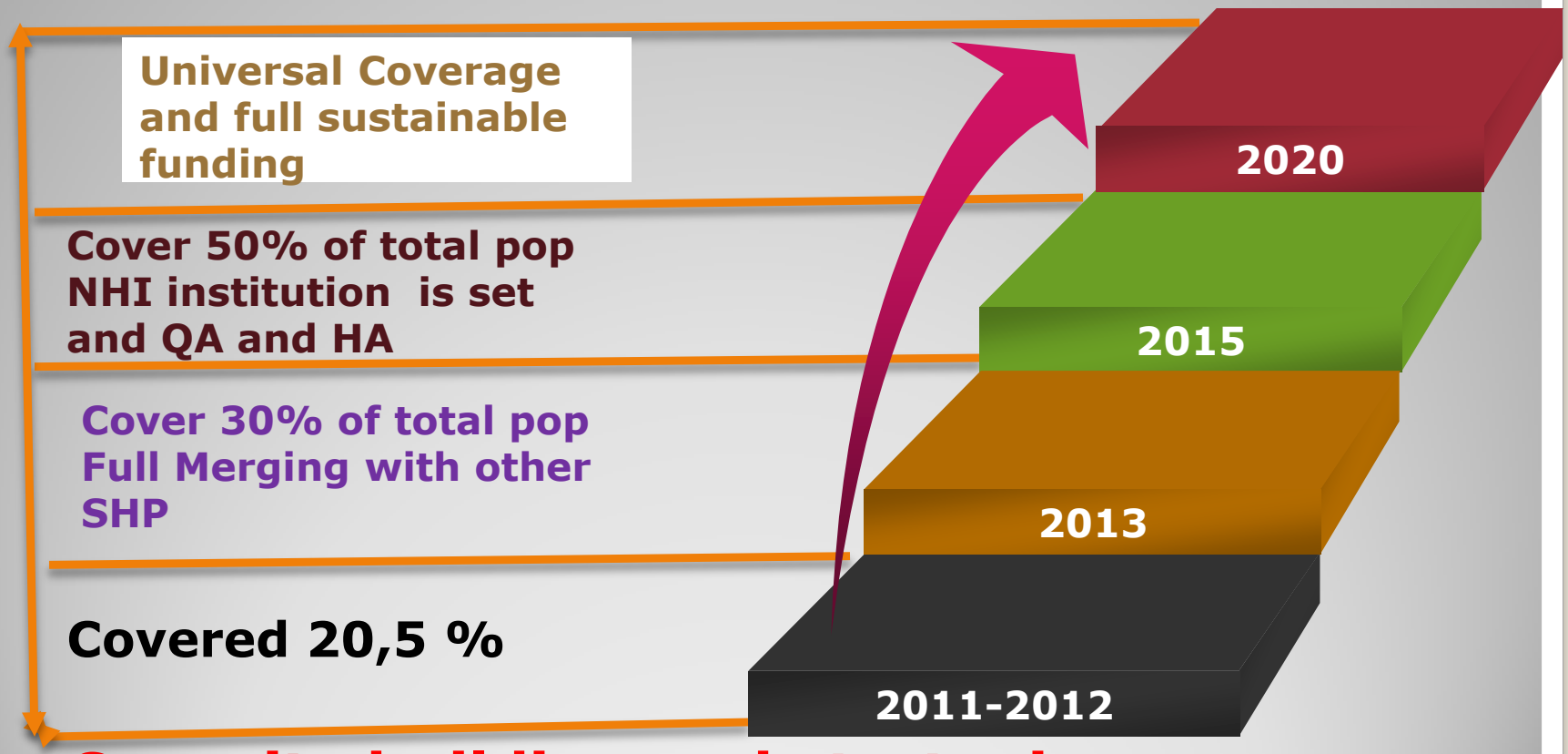
- Sound development of social security and social health insurance schemes for highly effectiveness of service provision.
- Improve the awareness of people for their contribution to the social security as well as health insurance system development.
- Expand coverage of social security and Health Insurance to all target groups of people.

3. Development Plan on Social Security (Contd.)

2) Target

- Establish the National Social Security to provide services or protect public servants and salary workers.
- Expand Health Insurance coverage to informal sector employees (independent workers) and poor community, with the goal to cover up to 50% of population by the year 2015 .
- Create and improve Social Security legislations in order to promote and develop social security incipiently.
- Create coordination mechanism and sound and appropriate computer database to strengthen social security services efficiently.
- Improve social security administration system in central and provincial levels, develop efficient monitoring and evaluation systems.

3) Toward Universal Coverage



Capacity building and strategic arrangement, pilot merging

4) Work plan on improving social security system

- Merged project between the State Authority for Social Security(SASS) and the Social Security Organization (SSO) to become the National Social Security;
  (Social Security Law)
  Merged between health insurance SASS, SSO, CBHI and HEF. (National Health Insurance Funds).
- Project on expansion of the health insurance for independent workers and poor community in informal sector.
- Project on improvement of Social Security administration and services.

4. Challenges

1. Coherence of difference schemes
- Merging of SHP schemes
2. Extension of coverage
- Financial support for the extension
- Institutional support and capacity
3. Provider on board
4. Professionalize

- Implementation challenge
  - extend from 5% (2010) to UC by 2020
  - Making the provider on board and improvement of quality of healthcare facilities
  - Capacity building for scaling up
  - System design (IT, benefit, payment system)
  - Financial support for scaling up
- Policy challenge
  - -Institutional design
  - Organizational arrangement
  - Health Financial sustainability

Key Challenges

- Remove the key barriers (fees, transport, information, uncertainty, cultural and language, indirect costs, quality of service)
- Develop a demand side pro-active, social and flexible HEF (not only a fund)
- Adequate targeting system
- Ensure accountability & transparency
- Ensure enough, reliable, predictable funding
- Choice of management body (policy, trade off)
- Keep management cost acceptable, avoid cost-inflation
- Adequate links with other schemes, free MNCH/U5

Thanks For Your Attention

The Study Programme
for the Improvement of Social Insurance System
- Health Security and Vulnerable people-

Mongolia

Improvement of Social Insurance System

Country: Mongolia

Improvement of Social Insurance System

1. Geographical and Political features of Mongolia

Mongolia is the world's 19th-largest country Situated in the Central Asia and landlocked country between the Russian Federation to the north and the People's Republic of China to the south. It is the fifth largest country in Asia with a total area of 1,565 million square kilometers. Overall population density was 1.7 persons per square km, making it the least densely populated country in the world.

The country is also subject to occasional harsh climatic conditions known as *zud*. The annual average temperature in Ulan Bator is 0°C, making it the world's coldest capital city.[1] Mongolia is high, cold, and windy. It has an extreme continental climate with long, cold winters and short summers, during which most of its annual precipitation falls. The country averages 257 cloudless days a year, and it is usually at the center of a region of high atmospheric pressure. Precipitation is highest in the north (average of 200 to 350 millimeters (7.9 to 13.8 in) per year) and lowest in the south, which receives 100 to 200 millimeters (3.9 to 7.9 in) annually. The highest annual precipitation of 622.297mm occurred in the forests of Bulgan province close to the border with Russia and the lowest of 41.735mm occurred in the Gobi Desert (period 1961-1990). The sparsely populated far north of Bulgan Province averages 600mm in annual precipitation which means it receives more precipitation than Beijing (571.8mm) or Berlin (571mm).

Socio-economic changes during the transition from a centrally planned to a market economy were accompanied by increased rural-to-urban migration. As of 2007, 39.4% of the population of Mongolia resided in rural areas as compared to 42.8% in 2000.

Political situation

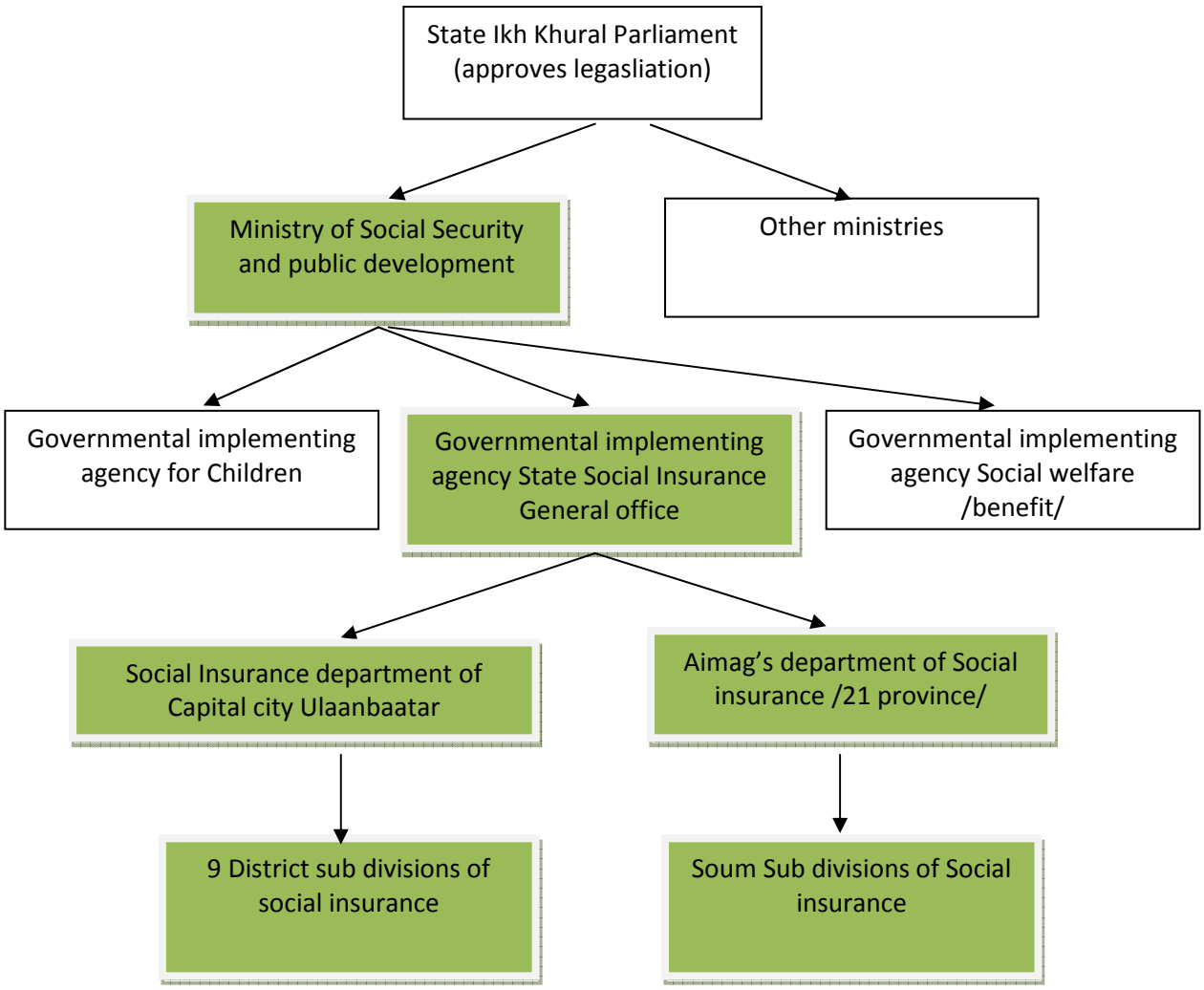
Mongolia is a democratic parliamentary country. The centralized governmental structure is divided into three branches: the executive branch or the Government chaired by the Prime Minister; the legislative branch or the Ikh Khural (the Parliament); and the judicial branch led by the Supreme Court.

The President of Mongolia is a figurehead for the country and is elected for a four-year term. Political parties that have seats in the Parliament are eligible to nominate their candidates to the Presidential election. Although most political power is held by the Prime Minister and the Parliament, the President of Mongolia is a commander-in-chief of the armed forces and heads the National Security Council as well as appoints all the judges, the Prosecutor General, the Deputy Prosecutor General and ambassadors. The parliamentary and presidential elections take place once every 4 years and elections held in 2012 respectively.

2. Statistical Data

(Please fill in the attached FORM1-4 and go back to years as far as you can do research)

3. Outline of the Social Security System



4. Outline of the Object Tax for Social Security Fund

(If there is, please describe it's outline)

5. Outline of the Medical Insurance System (MIS)

Please describe MIS in your country including following items.

5.1 Historical development of MIS

One of the many socio-economic changes and reforms that Mongolia implemented during its transition in the 1990s from the centrally planned economic system into market relations was establishment and development of the social health insurance (SHI).

Introduction of social health insurance created conditions to mobilize additional funding sources as many other countries, increase individual's responsibility for their health, and to support stability of health financing.

The social health insurance was established in 1994 at "Mongol Daatgal" Company which printed the certificates, collected premiums from individuals and entities and pooled them into a fund, and financed expenses of the hospitals on health care provided to the insured.

Once the package law on social insurance started being implemented the Government issued a resolution No. 195 in 1995 whereby the health insurance services were transferred from "Mongol Daatgal" Company to Social Insurance Organization from 1st January 1996.

The transfer of the work to implement the Citizens' Health Insurance Law to the social insurance organization enabled creation of integrated system of financial resources, legal arrangements and organization. This transfer enabled one point services for insurance fund income collection and premium transactions of employers and insured, their registration and reporting. This reduced administrative costs and relatively facilitated registration and transaction work. It also enabled integrated electronic database and software at national, aimag and capital city level.

Because the social insurance organization has an independent registration, transaction and reporting system and experience in collecting premiums of employers and insured, therefore, it facilitated collection of premiums from employers and insured, finance health care, especially serving local herders.During this time health insurance has become one source of reliable and stable financing of health organizations.

5.1.1 Types of the financial resources for the system, and current situation and outlook for the revenue and expenses of the system.

Health Insurance fund revenue and Expenditure, by income sources, by type of expenditure /mln, tog/

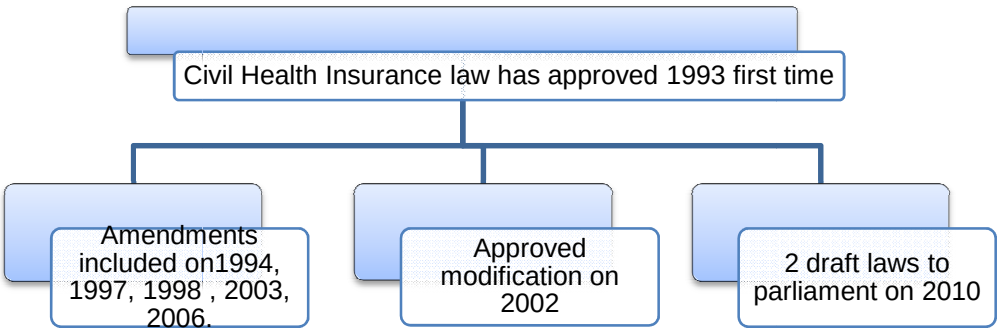
	2000	2001	2005	2006	2010	2011
Total revenue of which :	18156.9	19925.2	32574.2	40268	90131.9	121576.4
Contribution income	13259.5	14946.6	27398.5	34597.4	75264.4	105584.21
Contributions paid by government	4856.6	4856.6	4856.6	4856.6	10906.1	10906
Fines and arrears imposed on late payment of SI contributions	6.5	34.5	44.7	58	75	115.92
Bank deposit returns of the fund surplus	1.7	19.1	195.2	667.5	3823.20	4849.5
Other income	32.7	68.4	79.2	88.5	63.1	120.67
Total expenditure of which :						
Hospital expenditure	11772.0	14250.8	23118.2	25963.7	76075.8	84194.2
Discounts of pharmaceuticals	252.4	378.6	571.1	564.5	2045.4	2988.3

5.2 Laws and regulations for MIS. A list of laws and regulations regarding MIS in your country should be presented which gives the name/title, legislated year, and description/purpose of each.

The Citizens' Health Insurance Law of Mongolia was approved on 8 July 1993 and implementing since 1 January 1994, which became the legal foundation to establish the health insurance system.

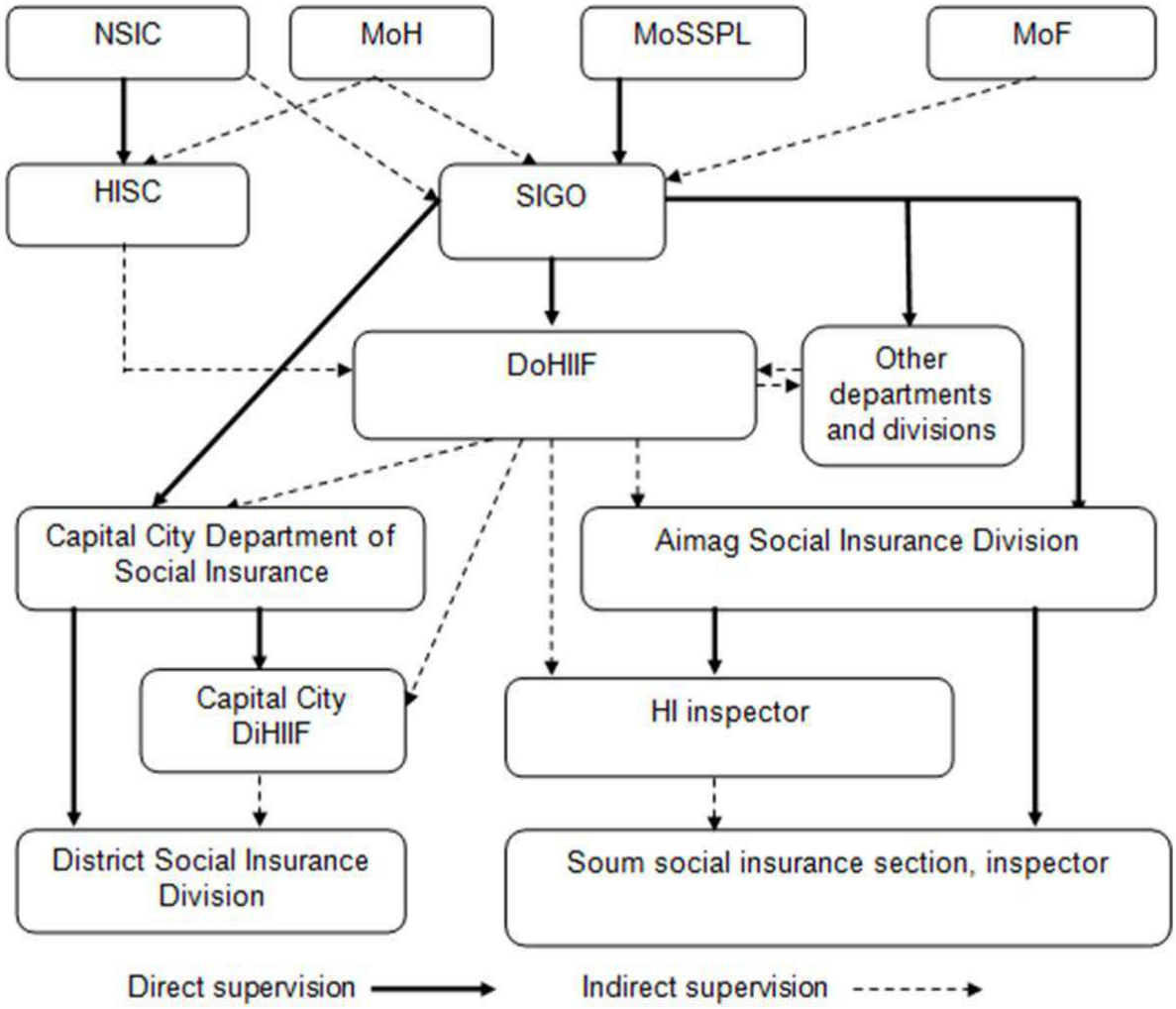
The purpose of this law stands for set the types and scope of health insurance and arranging related matters with public, civil, entity, health organization and insuree with related on paying contributions by insured, mobilizing and expending health insurance fund.

The Citizens' Health Insurance Law was revised once and amended 9 times to strengthen health insurance system and improve its operations in order to resolve pressing problems presented by changing circumstances.



5.3 Administration and management of MIS (Central level): An organizational chart of the government should be provided that indicates the ministries/ departments/ divisions responsible for administrating MIS.

Diagram 1.Current organizational structure for SHI



The management structure of the SHI, carried out by the social insurance organization is as follows: DoHIIF is one department of the SIGO under its direct supervision and performs its legally specified mandate under direct and indirect supervision of NSIC, HISC, MoH, MoSSPL and MoF. It does not have any direct affiliates under it. In other words, HI functions are performed under numerous

instructors by departments and units with no power except professional technical assistance and methodological supervision.

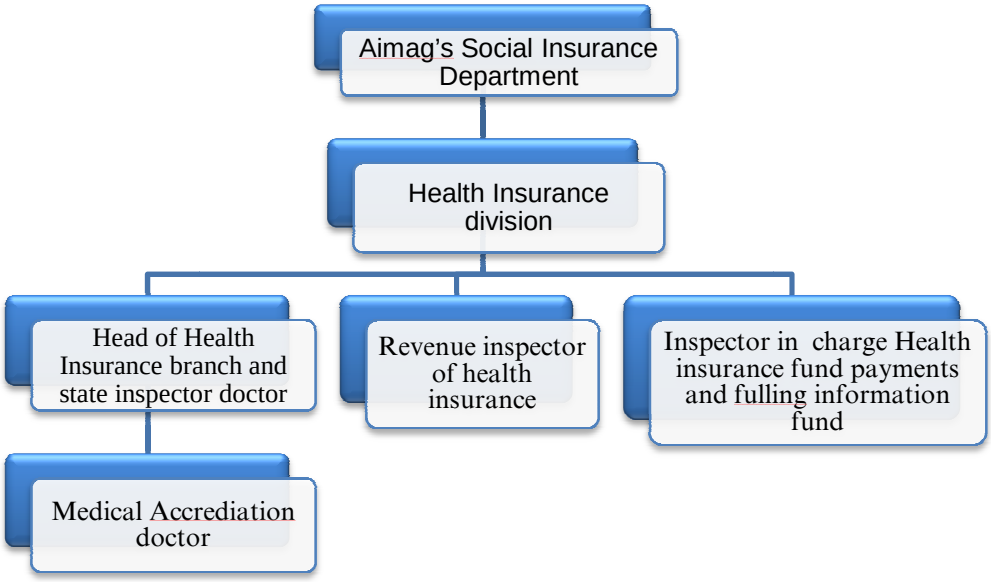
- Health Insurance Inspecting and financing department of SIGO-14 officers /Order no B/19 in 2012/

The Governing Body of the Social Insurance Organization is Social Insurance National Commission (SINC) consisting of 9 members. It is a tripartite body representing the Government, Employer and Insured set up by the Parliament of Mongolia for a duration of 6 years. Health Insurance Sub Council under the SINC oversees health insurance policies. Three seats representing Government include representatives from the Ministry of Finance, Ministry of Justice and the Ministry of Social Security and public development . Mongolian Trade Union has also 3 seats while the remaining 3 are represented by Mongolian Employer's Confederation. MLAC protects the rights of the social insurance organization, employers and insured by determining the reason, percentage and length of loss of working capacity. MLAC consists of members representing specialized doctors, organizations protecting the rights of the SI, employers and insured.

5.4 Administration and management of MIS (Local level, private sector) : An organizational chart of local government and/or private sector that specifies organizations responsible for MIS at the local level and/or private sector should be provided.

- Capital City Social Insurance Department - Health insurance inspecting and financing division – 22 officers /Order no B/20 in 2012/

- Aimag's Social Insurance Department – Health Insurance division – 3 officers

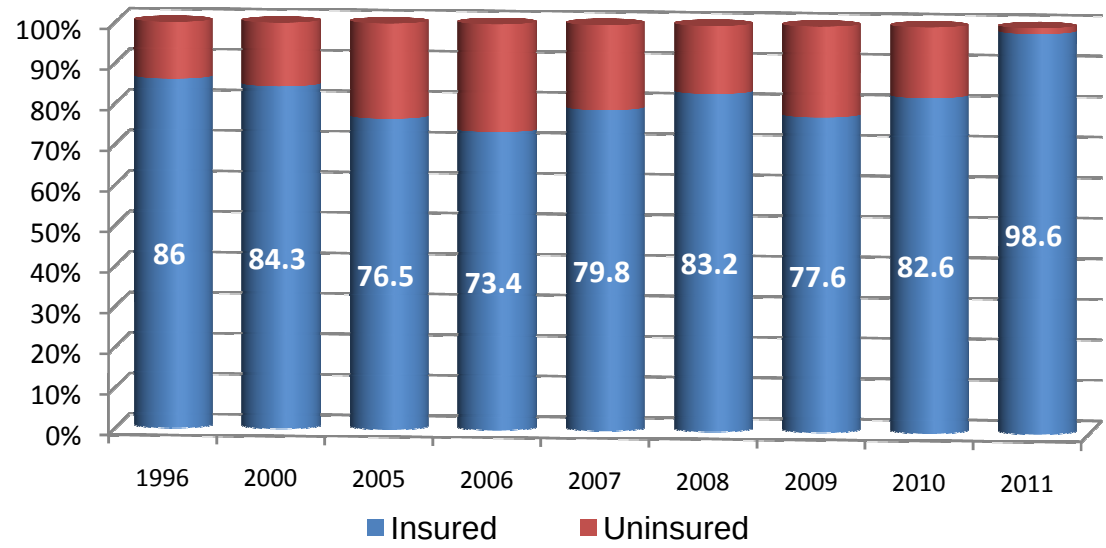


5.5 Structure of the systems.

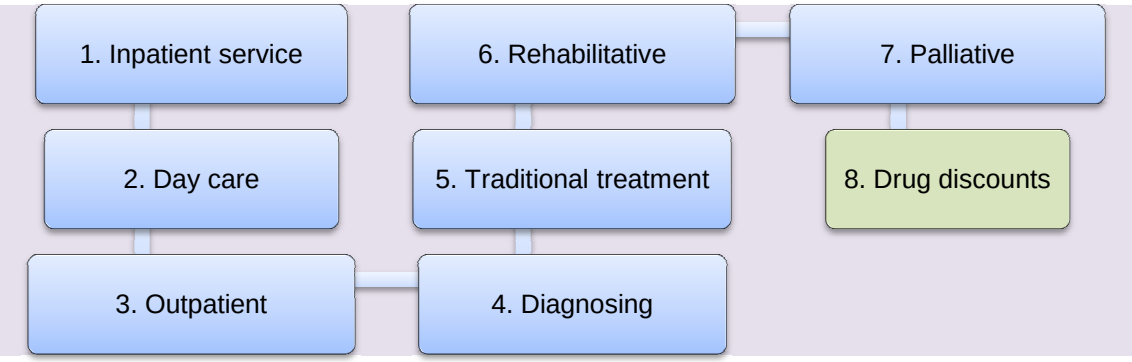
/-Type, Insurer, number of the insured, recipient qualification and contents of the benefits, etc./

The coverage since the establishment of SHI fluctuated between 73.4% and 95% in 1996-2010 whereas it reached 98.6% in 2011. This is a high level compared to similar countries. The reason behind the high coverage is that vulnerable groups occupy 60% of the insured and these people are directly subsidized by the state budget.

The employees of the public and official sectors are fully insured. However, a certain group of people like people working in informal sector, herders and unemployed are not insured. In 2011 Human Development Fund allowances were distributed in the form of health insurance premium, a work successfully organized by the social insurance organization pushing the coverage towards 98 percent.



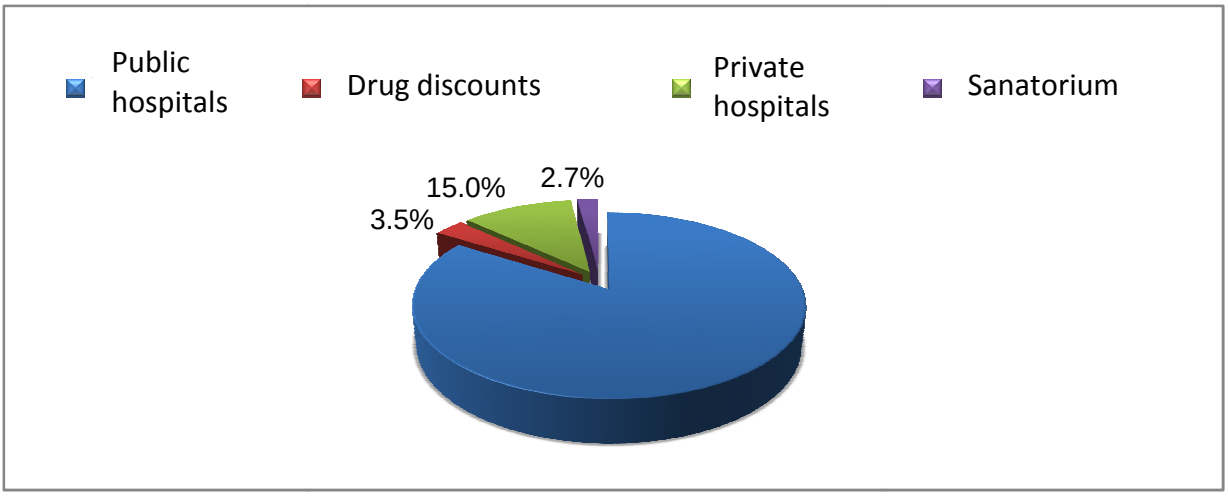
Contents of the benefits are below.



As a result of the Minister for Health resolution N 180 of 2010, starting from 2010, health insurance covers 115 diagnoses by groups, an 8.1% increase of average diagnosis net cost, an increase in the number of essential drugs at reduced cost from 107 to 365, and a 35.0% increase in the average cost of drugs. All these have impacted on the increase of the HIF expenditure The health care service's expenditures as directly related to the number of people who received these services. For outpatient services and care, expenses for health care and services and the number of people who used these services have a reverse correlation. This reverse correlation may be attributed, on one hand, to an increase of base tariffs of

health care and inpatient services of one insurer with group diagnosis at similar cost, and on the other hand, to larger percentage of high cost of outpatient health care services.

Total health insurance expenditure, 2011

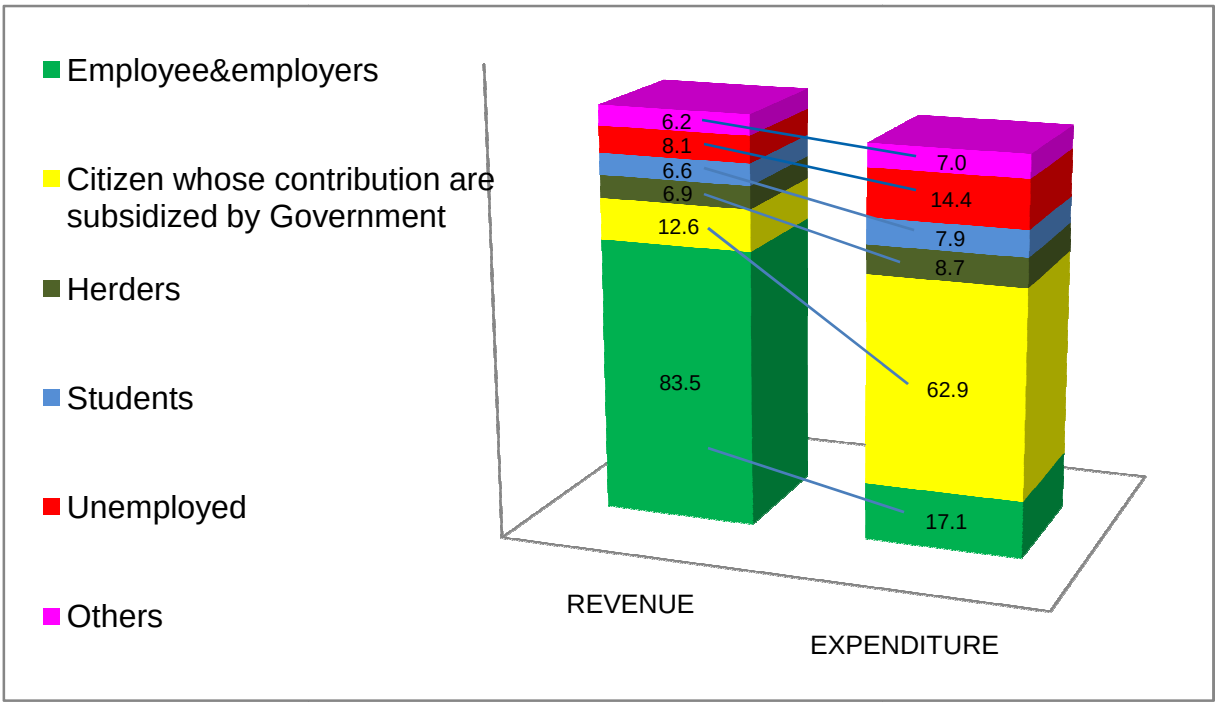


Graph shows that most of the funding (78,8%) is received by the public hospitals. The HIF funds over 700 health organizations and funds health care for 3.1 million (double count) insured.

Most of the HI funding (79.3%) is spent on hospitalization expenses of the insured and insufficient funds are invested in conditions that prevent population from falling sick or i.e. in prevention care .

The collection of premiums from employees of official sector is organized effectively together with all kinds of social insurance. However, the case is different for coverage and premium collection among employees of unofficial sector.

Health Insurance Fund revenue and Expenditure /comparison/



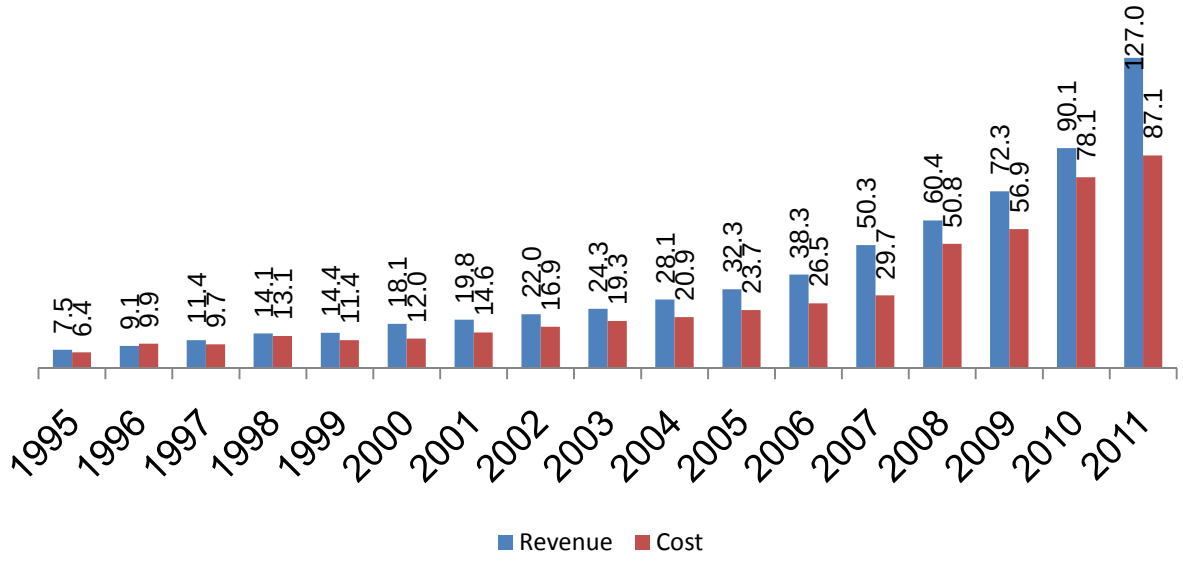
Though the financing process of health insurance funded health care is stabilized which is good, but as a whole it does not aim at purchasing health care on behalf of insured and is limited to passive financing of expenses incurred by health organizations.

5.6 Financial situation of MIS.

-Types of the financial resources for the system, and current situation and outlook for the revenue and expenses of the system.

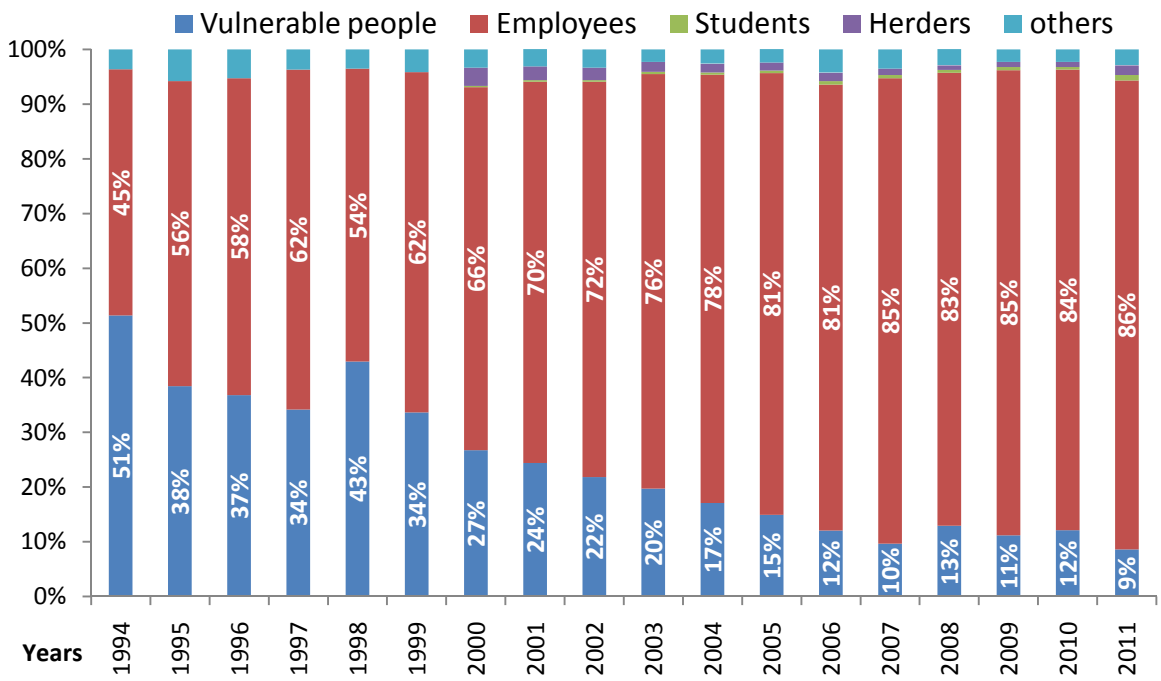
Revenue collection of the health insurance fund is done relatively well and its sustainability is ensured. The HIF surplus in 2011 was 133.9 billion MNT which equals to 105.4% of the annual revenue.

Cost and Revenue of Health Insurance Fund /billions MNT/



The income of health insurance fund (HIF) comprises mostly of salary-based premiums and state budget subsidies. A small group of the population, the employees of the official sector, is accounting for the most of the HIF revenue and as of 2009 this group occupied 25.7% of total insured and paid 80.5% of the revenue. The premium amount of employees working in informal sector was set too low and was held constant without connection to increasing inflation level.

HIF revenue by the categories of insured



5.7 MIS related policy within the National Development Plan : Indicate whether MIS- related policy is included in your country's National Development Policy, and if it is, give an explanation of its contents.

Midterm Strategy for Social Health Insurance 2012-2016 jointly with the German International Development Cooperation (GIZ) to intensify the activities to implement mandates provided by the Law on Citizen's Health Insurance, strengthen the social health insurance scheme and to achieve the goal to purchase quality health services on behalf of the insured.

This strategy is specific as the first document to define the strategies to be implemented in coming 5 years in order to develop the social insurance organization as a purchaser of the health services subsequently to improve quality and

accessibility of the health care provided to insured and to protect them from health-associated financial risks.

The strategic plan was developed by the working group established by Order No.256 of 4 October 2011 with diverse compositions consisting of the deputy director of SIGO, heads of the departments, relevant officials, teachers of the Management Academy, consultants of the international organization and relevant officials of the Ministry of Social Welfare and Labor using the participatory and capacity building approaches.

5.8 List of aid projects of MIS with other donors : Indicate the title, implementing organization, donor country, duration, budget, and purpose, activities for each project.

"Mongolian Social Health Insurance Reform of the German International Cooperation Agency" (GIZ) project implementing on Social Insurance General Office.

This project implement and expected outcomes in 7 key areas such as improving the health insurance services, insurance funded care quality and its management, information technology, organizational relations, culture and social dialogue, human resource development, financial and organizational development management within the wide range of important issues like to raise the reputation of the health insurance, communicate its significance to the public, to purchase quality health care that meets the needs of the insured, to provide prompt and efficient insurance services to the insured and to introduce e-services based on the current level attained in the health insurance activities.

6. Please describe these points.

6.1 Problems to be solved in your current MIS.

1. Improving Health insurance services, widening benefit package

2. Inspection of quality of health insurance funded services and its management

3. Information technology

4. Organizational relations, culture and social consensus

5. Human resource development

6. Financial management

7. Organizational development, management

6.2 Contents of the reform to solve the problems.

1. Cover with HI the workers in unofficial sector, unemployed and herders, improve registration of citizens subsidized by the Government, increase health insurance coverage by introducing family insurance system, improve premium collection activities
2. Purchase health care that meets the needs of the insured by using payment method or proper mix of methods that serve as a mechanism to improve the quality, effectiveness and efficiency, and by contracting that links financing with satisfaction of the insured

3. Get actively involved in improving quality of health care services through cooperating with organizations that inspect and affirm quality of health care services
4. Improve the process of contracting safe and quality health care services that meets the needs of the insured on their behalf
5. Integrated health insurance database is built real time
6. Introduce E-card system containing the main information of the insured
7. Provide technological possibilities to provide necessary evidence based information to the insured and health insurance stakeholders and receive feedback and complaint
8. Computerize inspection of health care providers
9. Improve perception of the insured on health insurance by providing health insurance information to the insured, and building an open information system that is insured-centered and regularly studies their needs and satisfaction by electronic means
10. Continuously build relations and cooperation capacity of the health insurance staff in accordance with the mission and vision of the organization through comprehensive management planning and performance evaluation
11. Improve capacity of social partners participating in health insurance relations (trade union, employers) on social consensus in health insurance
12. Create an open relations mechanism that delivers quality health care to the insured according to the package jointly determined with health care services providers and the contracts with health organizations and hospitals
13. Make client-friendly health insurance services provided to citizens who are paying the premiums themselves

14. Develop and implement health insurance human resource development program, continuously renew and improve human resource management based on needs
15. Establish and operationalize a needs based continuous professional training system
16. Improve social security of the staff working in health insurance sector and improve incentive system
17. Set organizational operational costs at no less than 5 percent of the total revenue collected in HIF in the particular year, strengthen effective and efficient independent expenditure of operational cost based on needs and its accounting system, set up an open and responsible system of external audit and proper internal inspection mechanism
18. Set realistically the amount of HI premiums based on needs and realities taking into account the evidence, in particular, link the premium amount of citizens subsidized by the Government with the minimum wages, and establish an open mechanism that discuses and approves the premium amount by the Health Insurance Sub-council
19. Establish conditions to purchase health care services from providers through contracts according to properly determined benefit package and payment method, setting the tariff realistically
20. Create a proper mechanism to protect the health insurance fund from potential risks, ensure sustainable and security of the fund, and establish legal environment to dispose the free residual of the fund

21. Create an integrated information management system including statistics, relevant information of performance evaluation, and research information date completing each other
22. Set up an evidence-based planning system with joint and comprehensive planning approach that pays particular attention to implementation of the annual operational plan developed in accordance to the organization's development strategy and that widely involves stakeholders of HI relations
23. Use health insurance monitoring and evaluation based on proper set of indicators as means of supportive supervision that aims at effectiveness and efficiency
24. Prepare, print and disseminate to the HI stakeholders social health insurance yearbook that covers the pressing problems handled in the particular year, their solutions, new development trends and best practices of foreign countries

6.3 Problems for carrying out this reform.

Development of human resources in charge of health security system

Human resource policy for improvement of Skill and knowledge.

Making attitude and interest for good understanding of their work.

Systematically training program of developed countries for developing human resource in charge health medical insurance.

ANNEX 1- Form 1

State of Nation: Mongolia

Area size /km^2/: 1'564'116 km^2

Population by aged group

Year		2010
0-4	Male	146,3
	Female	141,8
5-9	Male	112,6
	Female	109,6
10-19	Male	250,1
	Female	248,6
20-29	Male	290,3
	Female	305,7
30-39	Male	227,3
	Female	246,5
40-49	Male	171,2
	Female	190,3
50-59	Male	98,2
	Female	113
60-64	Male	23,2
	Female	29,2
65-	Male	45,5
	Female	62,2
Total	Male	1364,7
Female		1446,9

ANNEX 1- Form 2

Year		1991	1996	2001	2005	2011
Population growth rate (% per annum)		2.7		1.5	1.23	1.74
Birth rate (per 1,000 population)		35.3			18.3	25.1
Mortality rate (per 1,000 population)					6.0	6.9
Infant mortality rate (per 1,000 population)		63.4		31.2	20.8	16.5
The rate of the population of 65 years and over to the total population (%)		0.19		0.15		3.8
Life expectancy at birth	M				62.11	64.68
	F				68.61	73.76
Life expectancy at 60 and 65	M					
	F					
Unemployment rate (per 1,000 population * average rate)						7.7

ANNEX 1- Form 3

Year		2011*
National Income (US $)		6’835’786’896.5
Average wage (US $)		324.8
Average wage of male and female (US $)	M	324.2
	F	267.8
Average income (US $)		
Total GNP (US $)		
GNP growth rate		
GNP per capita (US $)		
Total GDP (US $)		
GDP Growth rate		17.3
GDP per capita (US $)		3’886.7 /2’562 ATLAS method of WB/
The rate of Social Insurance of contribution as a percentage of National Income		7.62
Premium contribution of employee		163595.241
Premium contribution of employer		209’249’517.241
Premium contribution of self-employer etc		

ANNEX 1- Form 4

Year	2011
Primary Industry	Agriculture 33%
Secondary Industry	Wholesale and retail trade 14.7%
Tertiary industry	Industry 12.3%

Five leading causes of death

Year	1st	2nd	3rd	4th	5th
2000	Diseases of the circulatory system	Neoplasm	Injury, poisoning and certain other consequences of external causes	Diseases of the respiratory system	Diseases of the digestive system
2005	Diseases of the circulatory system	Neoplasm	Injury, poisoning and certain other consequences of external causes	Diseases of the digestive system	Diseases of the respiratory system
2010	Diseases of the circulatory system	Neoplasm	Injury, poisoning and certain other consequences of external causes	Diseases of the digestive system	Diseases of the respiratory system and certain conditions originating in the prenatal period

The Study Programme
for the Improvement of Social Insurance System
- Health Security and Vulnerable people-

Myanmar

COUNTRY REPORT ON

IMPROVEMENT OF SOCIAL INSURANCE SYSTEM

Country: Myanmar

Course: Improvement of Social Insurance System ~
Modernization of Health Security Administration

1. Geographical and Political features of Myanmar

Myanmar is the largest country in South-East Asia. It has a total land area of 676,578 square kilometers. The extent from North point to South point is 2200 kilometers and that from East to West is 925 kilometers. It is bounded on the north and north-east by the People's Republic of China, on the east and south-east by the Lao People's Democratic Republic and the Kingdom of Thailand, on the west and south by the Bay of Bengal and Andaman Sea, on the west by the People's Republic of Bangladesh and the Republic of India.

Myanmar is divided into 14 States and Regions but mainly three well marked areas i.e. the western hills, the central belt and the eastern Shan plateau continued to southern Tanintharyi land. These hilly regions and high lands are hard to reach due to rugged topography but the central plain and delta region are very easy to travel due to smooth pathway because of numerous rivers and tributaries making networks or webs like communication.

Myanmar has abundant natural resources including land, water, forest, coal, mineral and marine resources, and natural gas and petroleum. In Myanmar, there are three seasons named the summer, the rainy and the cold but mainly is tropical climate.

In Myanmar, Political features is changed since 2011 due to enormous changes within 63 years after attaining independence in 1948. It is led by Democracy Government performing ‘Good governance and Clean government’. In line with the marked oriented Economy, ‘Open door Economy Policy’ is set up and the Vision of our country is a modern and developed democratic nation .

2. Statistical data (Form 1 – 4)

The population of Myanmar in 2009-2010 is estimated at 59.13 million with the growth rate of 1.29 %. About 70 % of the population resides in rural areas, whereas remaining are urban dwellers. Myanmar is a large land area rich in natural and human resources. Mainly agricultural sector can contribute to overall economic growth of the country. And there is liberal economic reforms to ensure participation of industrial sector and private sector using modern machinery and technology. With expanding job opportunities, every citizen being able to work, increasing individual income will contribute to the growth of GDP. (Annex 1 Form 1-4)

3. Outline of Social Security System

(a) Name and contents of each Social Security System

1) Health and Social Care Insurance System:
2) Family Assistance Insurance System:
3) Invalidity Benefit, Superannuation Pension Benefit and Survivors' Benefit Insurance System:
4) Employment Injury Benefit Insurance Systems:
5) Unemployment Benefit Insurance System:
6) Other Social Security Insurance Systems:

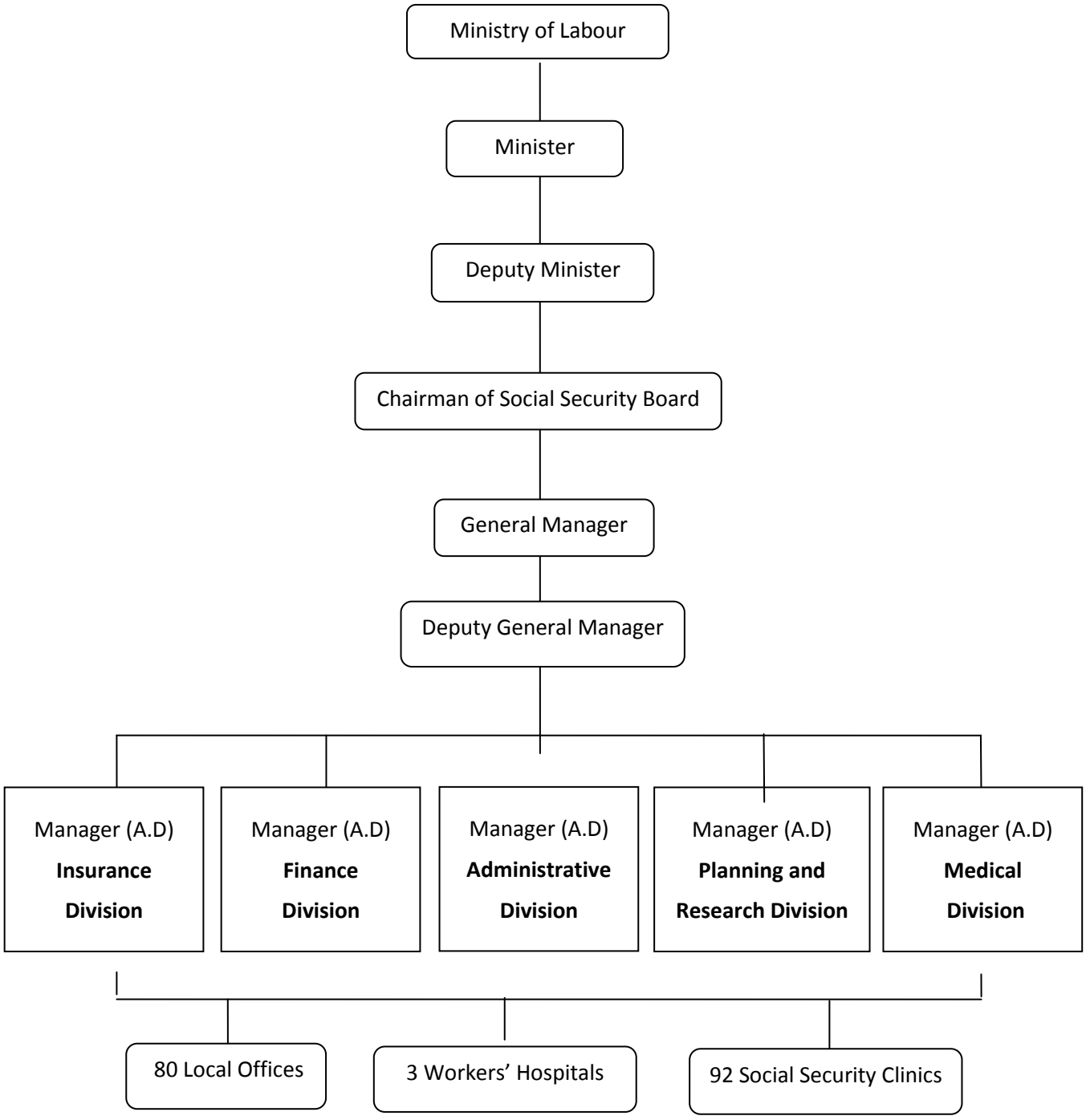
(b) Supervisory Ministry of the system

Ministry of Labour is supervisory Ministry of system including 5 main departments;

1) Department of Labour
2) Social Security Board
3) Central Inland Freight handling Committee
4) Factories and General Labour Laws Inspection Deparment
5) Department of Labour Relation

Ministry of Labour acts in collaboration with Ministry of Health at implementation of Social Security Affairs for Insured Persons.

(c) Organization Chart of Social Security Board



4. Outline of Object Tax for Social Security Fund

The Social Security Scheme is financed by compulsory contribution from the employers and the employees of the establishments applied to the Social Security System. They have to pay their contributions in the ratio of 6.5 : 5.5 of the employees' actual income for four insurance systems named (a) Health and Social Care Insurance System (b) Family Assistance Insurance System (c) Invalidity Benefit, Superannuation Pension Benefit and Survivor's Benefit Insurance System and (d) Unemployment Benefit Insurance System. Although the person who works in establishments not applied to the Social Security System is can contribute voluntarily for each insurance system which allowed systems. If the Social Security Board's Fund is not adequate to provide health care and medical treatment to insured persons, the expenses may be borne under the capital sanctioned from the Union Budget, or grant aid, or loan as Government Subsidies.

5. Outline of the Medical Insurance System (MIS)

5.1 . Historical development of MIS

5.1.1 . Types of financial resource for the system

Medical Insurance System was established since implementation of the Social Security Act (1954). The Social Security Board collected contributions from establishments covered by the Act in the ratio of 2.5:1.5 which was 4 % of the insured wages according to 15 wage classes. (minimum wage class is 3000 kyats and maximum wage class is 31000 kyats and above). And The Social Security Board provided benefits for insured employees especially free medical care and cash benefit for their social contingencies. Therefore this social insurance

system is also called health insurance or medical insurance system. All of the contributions collected from employers and employees were kept into three main separate accounts of the Social Security Fund:

1) General Insurance (sickness, maternity and death) Account

2) Employment Injury Insurance Account

3) Administrative Expenditure Account

The State supported nearly 250 million kyats annually for capital expenditure to be utilized in building hospitals, clinics, medical centers, offices and purchasing medical equipments, vehicles, furniture and office equipments up to 1988. After these period, the State stopped supporting the fund.

Now, the new Social Security Law (2012) is currently enacted on 31st August 2012 and will be implemented in accordance with renewed Rules and Regulation.

There are five Social Security Fund as following;

1) Health and Social Fund including Family Assistance Fund

2) Invalidity Benefit, Superannuation Pension Benefit and Survivor's Benefit Fund

3) Unemployment Benefit Fund

4) Employment Injury Benefit Fund

5) Fund for Social Security Housing Plan

Current situation and outlook for the revenue and expenses of the system

In current situation, upto 2011-2012 Fiscal year, the collected contribution is (6821.81) kyat in millions and expenditure for Social Security Scheme is (3646.14) kyat in millions. But the

Social Security Board has authority to utilize owned budget for insurance system after starting time of application of New Social Security Law (2012).

5.1.2 Payment system of medical care expenditures

From Health and Social Fund, the cost effective medicines are purchased and distributed to Workers' hospitals, social security clinics and enterprise clinics by arrangement of Social Security Board. The medical instruments and equipments are also installed.

The insured persons can be enjoy free primary health care at Social Security Clinics and Enterprise Clinics and free hospitalization at Workers' Hospitals and Government Hospitals. The investigation fees and any cost paid by patients as out of pocket are reimbursed within one month. There are no health care provider fees and incentives because all health persons are government staffs and their salaries are paid by Government.

5.2 Laws and regulations for MIS

Laws and regulations regarding MIS are Social Security Act (1954) and Social Security Law (2012) and related Regulations.

5.2.1. The Social Security Act (1954)

The Government requested technical assistance from the ILO to draw up a social security plan. The expert mission from ILO came to Myanmar and drew up a plan for introducing a number of social security measures and drafted the Social Security Act. The Social Security Act was enacted in 1954 and came into force in Yangon area on 1st January 1956. Then the Scheme was gradually extended to other areas of the country.

The objectives of the Social Security Scheme are

(a) to improve the health of the insured workers,

(b) to enhance their working ability and to boost productivity;

(c) to provide effective benefits in times of social contingencies such as sickness, maternity, employment injury, unemployment, old age and death etc;

(d) to support the insured workers and their family members for living when the former are unable to work;

(e) to make the Social Security Scheme concern the entire people.

5.2.2. The Social Security Law (2012)

This Law is enacted by the Union Parliament and very recently signed by the President on 31.8.2012.

The purpose of this Law are as follows:

(a) to make collective insurance of employer, employee and the State to provide workers' health and social need so that the workers who are major productive force of the State may enjoy more social security for social life and health care so that production may increase and be of support to the development of State's economy;

(b) to allow the public may insure voluntarily that they may enjoy more security for social life and medical care;

(c) to make the public have more faith upon the social security scheme by providing benefits correspond to realities;

(d) to have the opportunity to draw back some of the contributions paid by the employer and the employee as saving, in line with specifications;

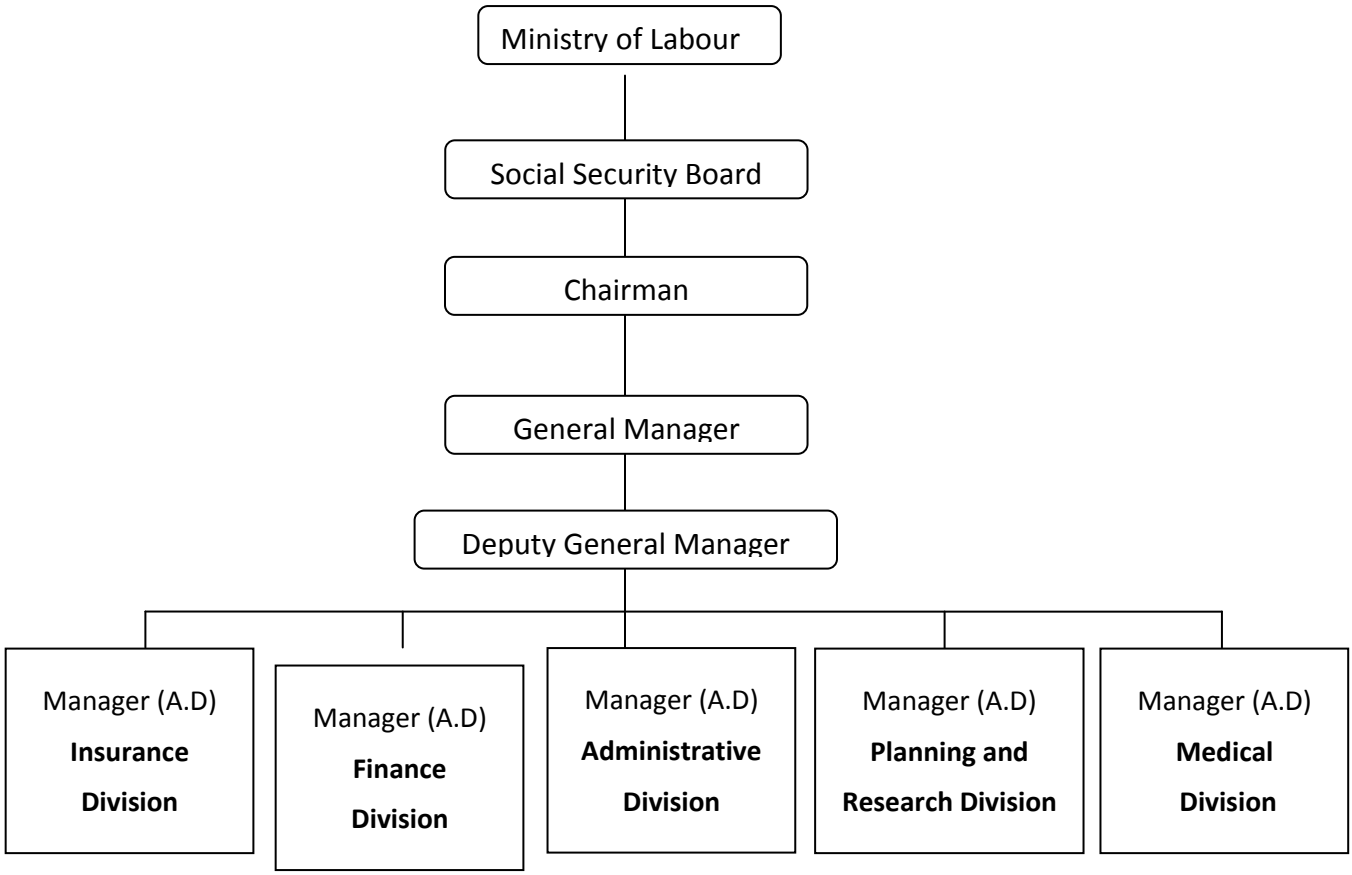
(e) to make the workers have health care and cash benefits relating to sickness, maternity, employment injury, and moreover, the right to continued medical

treatment after retirement, family assistance benefit, invalidity benefit, superannuation benefit, survivors' benefit, unemployment benefit, and also the right to residency and ownership of housing.

5.3 . Administration and management of MIS (Central levels)

An organizational chart of the government

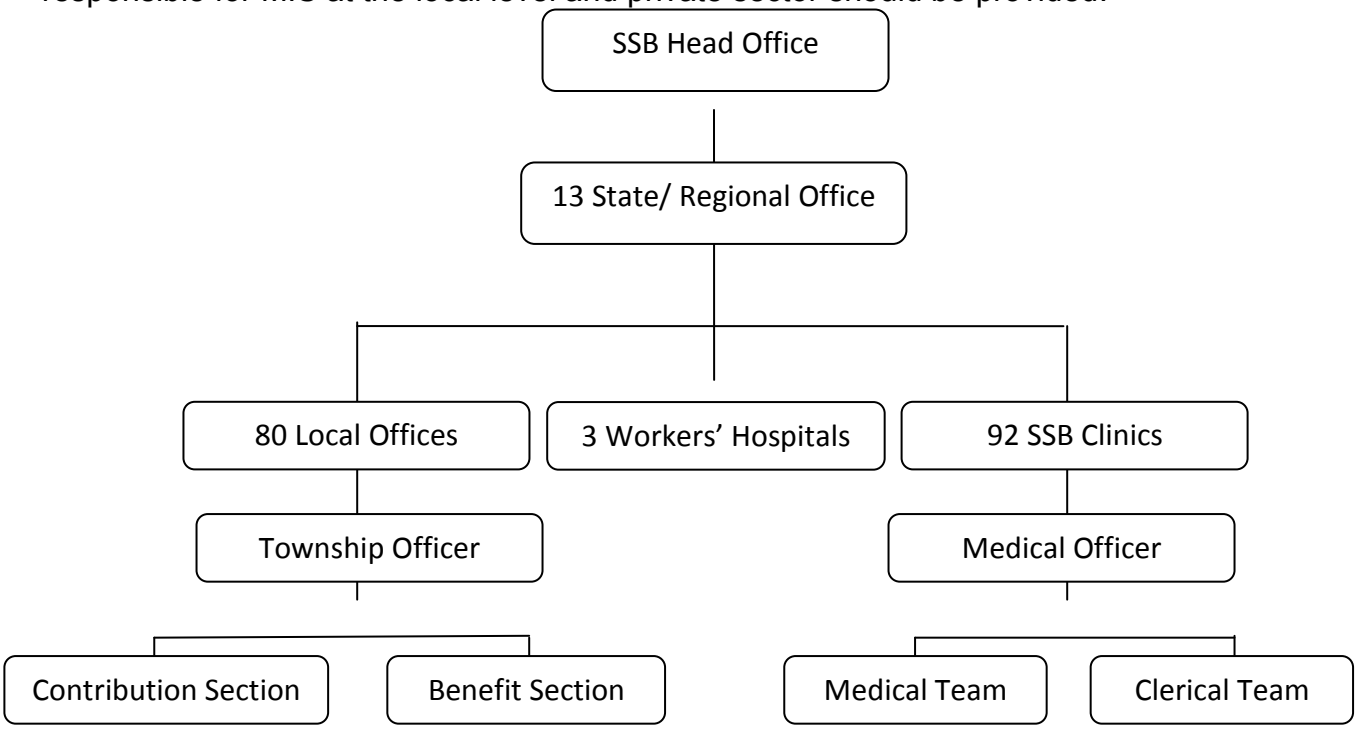
(ministries/ departments/ divisions responsible for administrating MIS)



The brochure and the annual report giving an outline of governmental measure in MIS will be submitted later.

5.4 Administration and management of MIS (Local levels)

An organizational chart of local government and private sector that specific organizations responsible for MIS at the local level and private sector should be provided.



5.5 Structure of the systems

-type/ insurer/ number of the insured/ recipient qualification/ contents of the benefits

The Social Security Act (1954) has two types of insurance system;

(a) General Insurance System

(b) Employment Injury Insurance System

All persons employed in the establishment to which the Social Security Act applies are covered by the Act. The number of insured workers covered by the social Security Scheme in August 2012 was 58600 in public, cooperative and private sectors.

Contents of the Benefits are as follows;

(a) Free medical care; Outpatient health care, Hospital care, Specialist consultation, Investigation, Medical certification, Health education, Preventive measure and Rehabilitation

(b) Cash benefit; benefits for sickness, maternity, employment injury and death

The Social Security Law (2012) has five types of insurance system;

(a) Health and Social Insurance system

(b) Invalidity Benefit, Superannuation Pension Insurance system

(c) Unemployment Insurance system

(d) Employment Injury Benefit Insurance system

(e) Social Security Housing Insurance system

The Law has already been enacted on 31.8.2012. The Rules and Regulation corresponding to this new law are still drawing and the new law will be implemented approximately next year. In this new law, there are two types of insured person. One group, compulsory contribution is all formal sectors of public and private enterprise which work with five and above employees and another group, voluntary contribution is informal sectors of self employees, vendors and public. The Social Security Housing system is also voluntary.

5.6 Financial situation of MIS

The financial resources for new Social Security System are mainly two sources;

Type of Insurance	Employer	Employee	Total
a) Health & Social	1.5 %	1.5 %	3 %
b) Invalidity	3 %	3 %	6 %
Superannuation Pension			
Survivors' Pension			
c) Unemployment	1 %	1 %	2 %
d) Employment	1 %	0 %	1 %
Total	**6.5 %**	**5.5 %**	**12 %**
e) Housing plan	0 %	20 %	20 %

Under previous Social Security Act (1954), the financial status was budget allotment by Government and with the new Social Security Law (2012), the Social Security Board has opportunity to manage owned budget.

The current Revenue and Expenses are as following;

Description	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**	**2011-2012**
Contribution	4069916	4404047	4911844	5823522	6821815
Total Expenditure	1793385	2257080	2595017	3534581	3646136
Balance	2276531	2146967	2316827	2288941	3175679

5.7 MIS related policy within the National development Plan

MIS related policy within the National Development Plan indicates the country's National Development Policy. The health activities are in accordance with the National Health Policy to achieve one of the social objectives namely, "Uplift of health, fitness and education standard of the entire nation" in developing MIS, Ministry of Labour and other related ministries, Social and non-governmental organizations perform to undertake plan formulating activities in a coordinated way. There is necessary to establish a system for financing health that will protect people from financial burden in seeking health care. The State supports in development of the Health professionals, equipments and technology. MIS related policy i.e. implementation of Social Security Act has been developed with the leadership of the State, guidance and supervision of the Social Security Board, support of the organizations and enterprises and collaboration of the whole community. The Ministry of Labour will keep in raising the health status of employees and to expand the coverage of scheme up to entire Nation. The priority will be given to low income employees and vulnerable persons

Four Objectives of Social Security Scheme;

1) To improve the health condition of workers and to improve working power & production
2) To obtain the comprehensive benefit when the employees are facing with social difficulties like illness, delivery, employment injury, unemployment, old age and death etc.
3) To support employee and his family when he cannot work
4) To cover the whole nation under the social security scheme

5.8 List of aid projects of MIS with other donors

There is no foreign support and aid for Social Security Program, but this year 2012, the workshop named ' **Future Medical Care of Social Security Scheme'** on 25th May 2012 in Yangon and the Conference named '**Social Protection Conference'** on 25th June to 26th June 2012 in Nay Pyi Taw are sponsored by UNICEF Myanmar. At recent time, the State arranges for foreign aids, supports and loans for the development plan all over the country.

6. Problems with MIS

6.1 Problems to be solved in current MIS

6.1.1. In the Social Security Act (1954), according to 15 wage classes i.e. 3000 kyat to 31000 kyat, the contribution rate 4 % is un-modernized with current situation of country. The amount of cash benefits and funeral grant are poor attractable for the employees and employers. Therefore, some employers avoid to contribute in real number of employees and their real salary. Within 56 years, the number of insured persons covered by Social Security Scheme is nearly 600000 only. It is just less than 1 % of total population of Myanmar.

6.1.2. There are 3 Workers' Hospitals and 92 Social Security clinics under Social Security Scheme. The comparison with 324 townships in country is shortage in implementation of health insurance system. And the distribution of health care centers especially industrial zones is required.

6.1.3. At recent condition, all funds collected from contribution of the employers and the employees are given to the State's Budget and all expenses are allotted by Government.

Therefore limited budget allotment makes the insufficient for medical expenditure for health care of insured persons.

6.1.4. According to old Law (1954), in case of sickness, free medical care is provided to insured persons up to 26 weeks for one spell of sickness. In case of diseases considered as a special importance from the point of view of public health, it is prolonged until the insured person is totally cured or till his death. Therefore, the high cost medical expenses for severe diseases are unlimitedly reimbursed as regardless of their contribution class, duration and amount. The cardio-valvular diseases are repaid up to 2 million kyat and the renal failure up to 8 million kyat.

6.2 Contents of the reform to solve the problems

6.2.1. Under the new Social Security Law (2012), the contribution will be collected with actual income of employee and the contribution rate will be changed according to extended Insurance systems. i.e. 6.5 % by employer and 5.5 % by employee. Similarly, the cash benefits will be increased in line with contribution rate. Therefore, the coverage will be expected to expand more.

6.2.2. According to New Law (2012), the contract hospitals and clinics will be put into service with Social Security Board so that the health care and health insurance system can be provided all required areas including out reached areas and industrial zones.

6.2.3. Nowadays the Social Security Board has an authority to utilize the owned budget of contributory funds. As a result, the medical expenditure for health care of insured persons will be adequately offered.

6.2.4. The high cost treatment for severe and life threatened conditions are limited in accordance with ceiling cost of medical care and treatment regime recommended by Medical Advisory Committee reformed in this new Social Security Law.

Problems for carrying out this reform

6.3.1. Public awareness for New Social Security Law (2012) is required because of the modernized and internationalized insurance system is unfamiliar to public within 56 years. And preparation of Regulations and Rules appropriate to new Law need enough time to operate practically among community.

6.3.2. The establishment of contract hospitals and clinics also require advocacy meeting because the agreement may be difficult between the Social Security Board and these medical centers. The Government Hospitals have no will to contract because of limited budget allotment for their performances and the Private Hospitals are practicing via high medical care costs. Therefore higher authority to contract with the Hospitals and Clinics.

6.3.3. The Social Security Board shall stand on the Social Security Fund and Employment Injury Benefit Fund. If it is not sufficient to give benefits from that fund, the Board may submit and request for government subsidy.

6.3.4. The Medical Advisory Committee is only one authorized committee to set up ceiling cost of medical treatment according to Diagnosis Related Group (DRG) and requires to provide advocacy meeting with expertise from various aspects.

ANNEX 1 – Form 1

The State of the Nation

Area size (676,578 Km^2) Unit: thousands

Population by aged group

Year		1990	1995	2000	2003	2004	2005	2006	2007	2008	2009
0-4	Male	2652	2769	3050	3193	3235	3278	3323	3364	3418	3283
	Female	2586	2736	3016	3115	3172	3235	3285	3344	3397	3263
5-9	Male	2398	2501	2759	2925	2974	3020	3075	3119	3169	3233
	Female	2401	2304	2735	2927	2959	2993	3040	3074	3122	3184
10-19	Male	4550	4724	4987	5157	5227	5306	5397	5537	5624	5736
	Female	4619	4511	4655	4873	4979	3093	5224	5378	5462	5570
20-29	Male	3754	3996	4422	4633	4694	4748	4802	4795	4872	4968
	Female	3836	4031	4357	4505	4544	4572	4596	4650	4722	4816
30-39	Male	2654	3078	3569	3823	3904	3983	4066	4059	4121	4203
	Female	2709	3210	3700	3926	5675	4056	4122	4987	4117	4197
40-49	Male	1691	2157	2589	2853	2944	3036	3130	3169	3215	3279
	Female	1739	2280	2733	3009	3120	3195	3292	3294	3340	3407
50-59	Male	1264	1465	1717	1907	1979	2054	2129	2218	2250	2295
	Female	1322	1606	1857	2055	2132	2211	2290	2385	2418	3501
60-64	Male	478	538	623	676	698	721	741	1534	154	1585
	Female	509	615	709	760	780	803	823	1857	1881	1918
65 and above	Male	776	999	1191	1300	1345	1394	1434	1534	1554	1585
	Female	850	1224	1456	1587	1640	1698	1743	1857	1881	1918
Total	Male	20215	22227	24907	26467	27000	27540	28097	28586	29026	29400
	Female	20571	22517	25218	26757	27299	27856	28418	28918	29351	29730

Source: Department of Population.

ANNEX 1 – Form 2

Year		1990	1995	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Population growth rate (% per annum)		1.88	1.87	2.02	2.02	2.02	2.02	2.02	2.02	2.02	1.75	1.52	1.29
Birth rate (per 1,000 population)		27.2	26.8	26.2	25.7	23.8	21.8	21.1	20.4	20.2	19.8	15.4	16.2
Mortality rate (per 1,000 population)		7.5	7.4	7.1	6.9	6.8	6.3	6.1	5.9	5.8	5.6	8.4	5.6
Infant mortality rate (per 1,000 opulation)		50.9	50.4	50.2	49.3	50.0	46.5	46.5	46.5	46.3	45.5	29.5	27.2
The rate of the population of 65 years and over to the total population (%)		6.4	7.56	7.94	7.99	8.05	8.12	8.22	8.33	8.39	8.80	8.79	8.85
Life expectancy at birth	Male	59.0	60.4	61.1	61.5	61.8	62.1	62.4	62.5	62.9	64.0	65.1	65.5
	Female	63.2	64.3	65.1	65.6	66.0	66.2	66.5	66.6	67.3	69.0	70.5	70.7
Life expectancy at 60 and 65year	Male	15.9	16.0	16.2	16.2	16.3	16.4	16.4	16.5	16.6	17.2	18.1	17.8
	Female	18.0	18.1	18.1	18.2	18.0	18.0	18.1	18.1	18.3	20.4	18.7	21.0
Unemployment rate (per 1,000 population) *average rate		36.2	36.1	36.0	35.7	36	36.2	36.4	36.4	36.1	36.4	36.3	36.5

Source: Central Statistical Organization.

ANNEX 1 – Form 3

Year	1991	1995	2000	2003	2004	2005	2006	2007	2008	2009	2010
National income (Kyat)			2521724	76326975	8975280	1215139					
Average wage (Kyat)	Not Available										
Net Output per Worker		34385	127509			547807					
Total GNP (Kyat)	Not Available										
GNP growth rate	Not Available										
GNP per capita (Kyat)	Not Available										
Total GDP (Kyat)	50259.5	66742	100275	3624926	4116635	4675220	13893395	15559413	17155078	18970327	20946337
GDP growth rate	2.8	6.9	13.7	13.8	13.6	13.6	13.0	12.2	10.2	10.5	10.3
GDP per capita (Percent)	0.9	5.0	11.5	11.6	11.3	11.3	10.8	10.1	8.6	9.2	9.2
GDP per capita (Kyat)	1232	1492	2000	68107	75814	84396	245836	270580	293867	320824	350390
The rate of social insurance of contribution as a percentage of National Income											
Premium contribution of employee (Kyat Million)	9.46	47.51	86.61	273.7	295.78	535.26	1386.70	1517.81	1640.82	1830.19	2170.48
Premium contribution of employer (Kyat Million)	28.37	79.69	144.35	456.2	826.30	892.10	2311.21	2529.46	2734.87	3050.82	3617.47
Premium contribution of self-employer etc.		-	-	-	-	-	-	-	-	-	-

Source: Planning Department, Social Security Board.

Myanmar National Health Accounts (2010-2011) WHO

ANNEX 1 – Form 4

Number and percentage of workers engaged in industrial classification

Year	1990	1995	2000	2005	2010
Primary industry					
Secondary industry			Not Available		
Tertiary industry					

Insured persons and Establishment

Year	1990	1995	2000	2005	2006	2007	2008	2009	2010
Registered Insured Persons	504885	434418	648809	967350	965705	972580	965349	966383	978576
Actively Insured Persons	329890	340320	508877	502263	500618	507493	500262	501296	516072
Establishment	13129	13305	23010	31009	31994	33011	34116	35717	36938

Five leading causes of death

(Year)	1st	2nd	3rd	4th	5th
1990	Senility without mention of psychosis	Disease of the heart	Pneumonia	Certain condition in the peri-natal period	Intestinal infectious disease
1995	Senility without mention of psychosis	Disease of the heart	Pneumonia	Certain condition in the peri-natal period	Intestinal infectious disease
2000	Senility without mention of psychosis	Disease of the heart	Pneumonia	Certain condition in the peri-natal period	Intestinal infectious disease
2005	Infectious & parasitic diseases	Injury, Poisoning and External causes	Certain condition in the peri-natal period	Pneumonia	Tuberculosis (all forms)
2010	Infectious & parasitic diseases	Disease of the heart	Injury, Poisoning and External causes	Certain condition in the peri-natal period	Disease of the Digestive system

Source: Central Statistical Organization.

Benefit from Social Security Board (Kyat in millions)

Type of benefit	**1990**	**1995**	**2000**	**2005**	**2010**
Sickness Benefit	2.95	9.58	6.93	30.52	137.69
Maternity Benefit	1.07	2.81	3.58	19.47	10.94
Death Grant	0.94	1.25	1.19	33.06	6.51
Temporary Disability Benefit	0.29	0.82	0.65	3.62	1.61
Permanent Disability Benefit	0.96	1.79	2.52	4.66	12.99
Survivor Pension	0.69	1.29	1.45	2.23	11.87
Medical Expenditure	21.35	23.27	151.05	380.13	846.24
Total Benefit in Cash	**28.25**	**40.81**	**167.37**	**473.69**	**1027.85**

Source: Annual Statistical Report of Social Security Board

The Study Programme
for the Improvement of Social Insurance System
- Health Security and Vulnerable people-

Thailand

COUNTRY REPORT

(THAILAND)

Improvement of Social Insurance System ~ Modernization of Health Security Administration ~

(J 1200718)

JICA Tokyo, Japan

17 September – 6 October 2012

Ministry of Public Health,

Thailand.

Contents

List of abbreviations and acronyms

BoB	Bureau of Budget, Thailand
CGD	Comptroller General's Department, Ministry of Finance, Thailand
CPI	Consumer Price Index
CUP	Contracted Unit for Primary Care
CSMBS	Civil Servants Medical Benefit Scheme, Thailand
DRG	Diagnosis-Related Group
GFMIS	Government Financial Management Information System
GDP	Gross Domestic Product
GGHE	General Government health Expenditure
GNI	Gross National Income
HCS	Health Card Scheme
HSRI	Health Systems Research Institute, Thailand
IHPP	International Health Policy Program
IMF	International Monetary Fund
LIS	Low Income Scheme
MoPH	Ministry of Public Health, Thailand
MoF	Ministry of Finance, Thailand
MWS	Medical Welfare Scheme
NESDB	National Economic and Social Development Board, Thailand
NHSB	National Health Security Board
NHSO	National Health Security Office, Thailand
NSO	National Statistics Office
PCU	Primary Care Unit
PID	Personal Identification Number
PHC	Primary Health Care
PHO	Provincial Health Office
P&P	Preventive and health Promotion
SES	Socio-economic Survey
SHI	Social Health Insurance
SQCB	Standard and Quality Control Board
SSO	Social Security Office, Ministry of Labour, Thailand
SSS	Social Security Scheme, Thailand
UC	Universal Coverage
UCS	Universal Coverage Scheme, Thailand

1. Geographical and Political features of Thailand

The kingdom of Thailand is located in the center of the Indo-Chinese Peninsula, and covers an area of about 514,000 square kilometers. It is the third largest country among the South Asian nations, compared to Indonesia and Myanmar. It is bordered by the Lao Peoples' Democratic Republic on the North, Kingdom of Cambodia on the East, Malaysia and gulf of Thailand on the South, and Myanmar on the West.

Geographically, Thailand is divided into four regions: Central, North, Notheast, and South, and is administratively divided into provinces. Each province is divided into district and each district is also divided into sub-district. Currently there are 77 provinces; one of which Bangkok Metropolis, the capital of Thailand, 877 district and 7,255 sub-districts.

The central region (including Bangkok Metropolitan Region) comprising the basin of the Chao Phrya River which runs from north to south and after crossing Bangkok flows to the Gulf of Thailand. The central region is often called the "rice bowl" of Thailand being the most fertile area of the country. After the Bangkok Metropolitan Region, it enjoys the highest per capita income in the country.

The northern region is mountainous and was traditionally the most heavily forested area of the country. In the recent years, however, overcutting has considerably reduced its forest resources. The main centres of population are in the narrow alluvial valleys along the four north-south flowing rivers which unite in the northern central plain to form the Chao Phraya.

The north-eastern region (Isarn) constitutes approximately one third of the area of the Kingdom and comprises the Korat Plateau which is bounded on the north and east by the Mekong River and the south by the Dongrek escarpment. The region is drained by the Mun and Chi rivers, both tributaries of the Mekong. Largely owing to lower and erratic rainfall and poorer soils than in other parts of the country, the north-eastern provinces have the lowest per capita income in the country.

Approximately one third of the population of Thailand lives in the north-east. The south-eastern region: the south-east, which comprises the hilly countryside from Bangkok to the Cambodian border, is characterized by higher rainfall and poorer soils than the adjoining central region. It is an important fruit, maize and cassava-growing area and its coastline offers extensive opportunities for fisheries and tourism. The high rainfall also permits some rubber to be grown.

The southern region: the southern peninsula has the highest rainfall in the country. It is the principal rubber-growing area and contains extensive alluvial deposits of tin. The forests of the south have been seriously overcut as elsewhere in the Kingdom. In recent years, the region has suffered from severe floodings which are believed to have been amplified by deforestation and subsequent soil erosion.

Climate

Located outside the typhoon belt, Thailand can be divided into two climatic zones. The north, north-east, south-east and central regions including Bangkok have a climate with three distinct seasons: rainy, from June to October; cool, from November to February; and hot of highest temperatures and sunny weathers from March to May.

Temperatures in Bangkok vary between 20 C in December and 38 C in April with an average humidity of 82 percent. Winter temperatures in the north can fall to 10 C or lower. The average rainfall in these regions is 1,250 cms per year.

The southern region has a characteristic tropical rainforest climate. Rainfall occurs virtually throughout the year, although a number of micro-climates can be found. There is little variation in temperature, which is on average 28 C throughout the year. March and April are normally the driest months in the south. The periods of maximum rainfall in these areas vary according to climatic sub-regions.

Population

The estimated population is 64 million of which approximately 9.3 million live in Bangkok and its vicinities. Ninety-four percent of the population are Thai-speaking Buddhists; Thai is also the official language of the country. Four distinct dialects of the Thai language are spoken, in the central, northern, southern and in the north-eastern regions, the latter being closely related to the Lao language. In the four southern provinces of Pattani, Satun, Yala and Naratiwat near the Malaysian border, the majority of the population is Muslim and speaks "Pattani" Malay. In the mountains of the northern region there are approximately 525,000 highland people who speak distinct languages.

From about 1850 until the Second World War there was a steady flow of immigrants from China who established themselves in commerce and as artisans throughout the country. The population of Chinese origin now comprises 10-15 percent of the total population. The Thai Government has successfully encouraged the assimilation of the Chinese, and the younger generations are Thai citizens and speak Thai.

Bangkok (Krung Thep) has been the capital since 1782. Bangkok metropolitan area is by far the most significant urban area in the country. The per capita income in Bangkok is almost triple the national average of US$ 8,135 per year (2009). The next largest city, Nakhon Ratchasima in the northeast, has a population of 2.5 million.Large provinces, apart from Bangkok and Nakhon Ratchasiama, are Khon Kaen, Ubon Ratchathani and Udon Thani in the north-east, Nakhon Si Thammarat and Songkla (where Hat Yai city is located) in the south, and Chiang Mai, Chiang Rai in the North.

Religion

The Theravada or Hinayana Buddhism is the state religion of Thailand. About five percent of the population is Muslim residing mainly in the south along the Malaysian border. Other religious groups include Taoists, Christians, Hindu and Sikhs.

The Politics of Thailand

The politics of Thailand are conducted within the framework of a constitutional democratic monarchy, whereby the Prime Minister is the head of government and a hereditary monarch is head of state. The judiciary is independent of the executive and the legislative branches.

Thai kingdoms and late Kingdom of Siam were under the absolute rule of the kings. However, after the 'democratic revolution' in 1932, the country officially became under a constitutional democratic monarchy with a prime minister as the head of government. The first written constitution was issued.

Politics of Constitutions

All of Thailand's charters and constitutions have recognized an undivided kingdom with the constitutional monarchy, but with widely differing balances of power between the branches of government. Most of them have stipulated parliamentary systems. Both unicameral and bicameral parliaments have been used, and members of parliament have been both elected and appointed. The direct powers of the monarch have also varied considerably.

The current monarch of Thailand is His Majesty King Bhumibol Adulyadej. The king has reigned since 9 June 1946, making him the world's longest reigning current monarch and the world’s longest serving head of state. Most of the king's powers are exercised by his elected government in accordance with the current post-coup constitution. The king still retains many powers such as: being head of the Royal Thai Armed Forces, the prerogative of royal assent and the power of pardon. He is also the defender of the Buddhist faith, commands enormous popular respect and moral authority in Thailand.

Government of Thailand

According to the constitution, the three major independent authorities holding the balance of power are executive, legislative, and judicial.

The head of government is the Prime Minister. Under the present constitution, the Prime Minister must be a Member of Parliament. Cabinet members do not have to be Members of Parliament. The legislature can hold a vote of no-confidence against the Premier and members of his Cabinet if it has sufficient votes. The cabinet is responsible for the administration of thirteen ministries and the Office of the Prime Minister. Each ministry is headed by a politically appointed minister with one or more deputy ministers. The Prime Minister is assisted by Deputy Prime Ministers as well as a number of ministers holding the portfolio of "Minister to the Prime Minister's Office."

2. Statistical Data (Attached Form 1- 4)

3. The Social Security System in Thailand

In 1954, the Social Security Act was enacted. However, the then Government considered that the economic condition of the country at that time was not favorable for enforcement of the Social Security Act 1954. As a result, the ROYAL DECREE was enacted in lieu of the said Act. (Social Security Office : http://www.sso.go.th)

In 1972, the Government by the Revolutionary Party decided that employees who sustained injuries or illness or who died as a result of working for the employer should be secured that they would receive compensation money. The Compensation Fund has started its management of the fund since 1 January 1974 under the supervision of the Department of Labor. This was the first step of actual social security. Efforts to push for full realization of social security have been made continually consistently through the appointment of several committees to review the matter. Until 1981, the Committee charged with the preparation of social security scheme under the chairmanship of the Permanent-secretary of Interior, finally completed the draft of the Social Security Act A.D ..... in which the operation of the Act, the establishment of an administrative organization and the Contributions Fund; but unfortunately, this draft of the Social Security Act was not successful.

Until 1990, the Draft of the Social Security Act 1990 was approved by the National Assembly and went into force on 2 September 1990. Under this Social Security Act, the employees would receive protection in the capacity as the insured under a total of 7 circumstances, namely: illness or accident; physical disability; death not related to performance of work; child delivery; old age, child assistance and unemployment. In the initial stage tentative protection coverage shall be provided to places of business with over 20 employees and afterwards in 1993, it was extended to places of business with over 10 employees; and provides protection particularly in the case of illness, disability, and death which is not resulted from work performance and to child delivery on tentative basis. For this purpose, the employer, and employee and the Government have made contributions at equal rate: at 1.5 percent for old age and child assistance was covered in 1996 and the coverage of unemployment shall be provided protection coverage by means of enacting a Royal Decree when the operation was ready.

The Office of Social Security is attached to the Ministry of Interior and was established on 3 September 1990. The work related to social security was transferred from the Department of Public Welfare; and the work of the Office of Compensation Fund, the Department of Labor, was then transferred to be under the management of the Office of Social Security. The Office of Social Security was transferred to be under the Ministry of Labor and Social Welfare on 23 September 1993.

Figure 1 Organization structure of the SSO

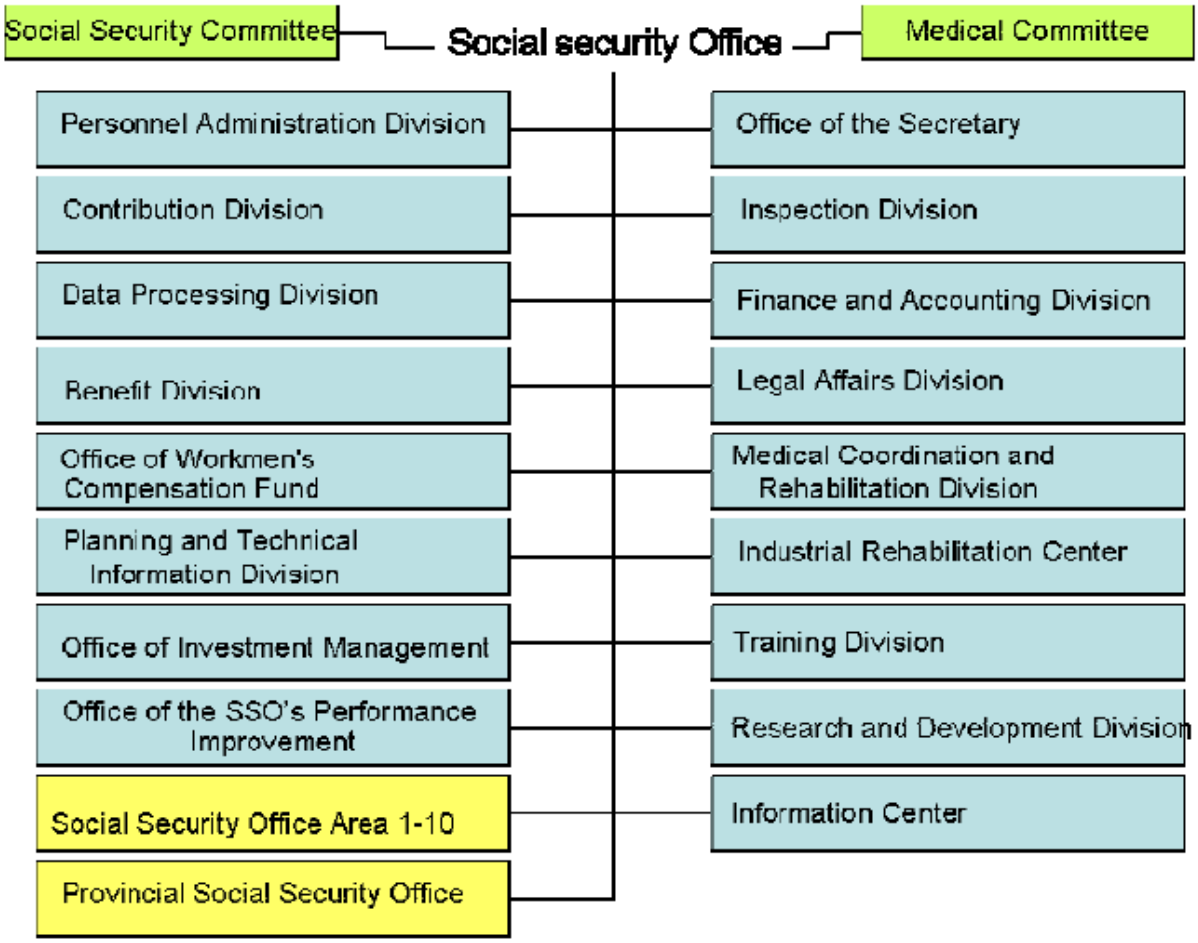
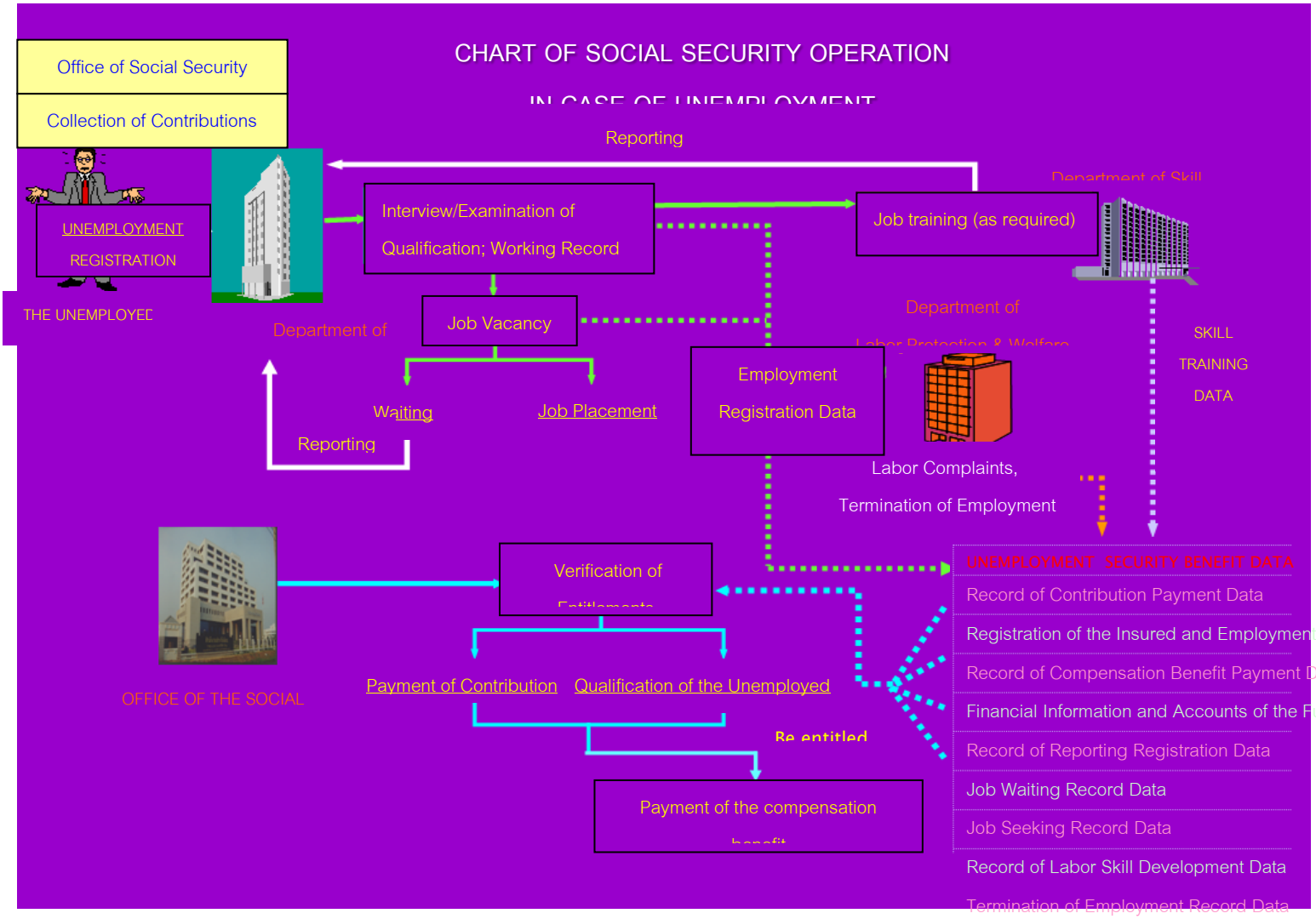


Figure 2 : CHART OF SOCIAL SECURITY OPE ¯ ON IN CASE OF UNEMPLOYMENT

(For Example)



Source : Social Security Office : http://www.sso.go.th

4. The Object Tax for Social Security Fund.

(Exchange rate: US$1.00 ~ 31.36 baht. at 9/9/12)

The Social Security Fund was established under the Social Security 1990 to institute security and stability of livelihood for Thai citizens.

The Social Security Office, established by virtue of the Act, has duty to manage the SSF for the best interest of all members. The coverage is divided into seven types: sickness, maternity, disability, death, child allowance, old age and unemployment.

Categorized under the Defined Benefit System, the SSF regulates member benefits at the very outset regardless of the amounts of contributions or returns on investment of any parties. Every employer with at least one employee and all workers except those exempted by the Act such as civil servants, state enterprise employees and private school teachers are required to make equal contributions while the government subsidizes additional levy to the fund.

As long as wages are paid, employers are duty bound to submit the contributed sums to the Social Security Office within 15 days of the month following the month when the contribution is deducted.

- **Contribution Rate**

<table>
<tr><th>Conditions</th><th>Government</th><th>Employers</th><th>Employees</th></tr>
<tr><td>1. Sickness</td><td colspan="3" rowspan="4">Every party made a contribution of 1.5% of wage.</td></tr>
<tr><td>2. Maternity</td></tr>
<tr><td>3. Disability</td></tr>
<tr><td>4. Death</td></tr>
<tr><td>5. Child allowance</td><td rowspan="2">1% of wage</td><td rowspan="2">3% of wage</td><td rowspan="2">3% of wage</td></tr>
<tr><td>6. Old-age</td></tr>
<tr><td>7. Unemployment</td><td>0.25% of wage</td><td>0.5% of wage</td><td>0.5% of wage</td></tr>
</table>

Note: Base wages for calculation range from 1,650 to 15,000 baht per month.

Sickness and Maternity

Regulatory Framework

First and current laws: 1990 (social security), implemented in 1991 and 1998; and 1990 (sickness and medical benefits).

Type of program: Social insurance system.

Coverage

Employees aged 15 to 60.

Voluntary coverage for self-employed persons and for persons who cease to be covered after at least 12 months of compulsory coverage.

Exclusions: Employees of foreign governments or international organizations; agricultural, forestry, and fishery employees; temporary and seasonal workers; and Thai citizens working abroad.

Special systems for judges, civil servants, employees of state enterprises, and employees of private schools.

Source of Funds

Insured person: 1.5% of gross monthly earnings (1.06% finances sickness and maternity benefits; 0.44% finances disability and survivor benefits). For voluntary contributors, see source of funds under Old Age, Disability, and Survivors.

The minimum monthly earnings used to calculate contributions are 1,650 baht.

The maximum monthly earnings used to calculate contributions are 15,000 baht.

Self-employed person: See source of funds under Old Age, Disability, and Survivors.

Employer: 1.5% of monthly payroll (1.06% finances sickness and maternity benefits; 0.44% finances disability and survivor benefits).

The minimum monthly earnings used to calculate contributions are 1,650 baht.

The maximum monthly earnings used to calculate contributions are 15,000 baht.

Government: 1.5% of gross monthly earnings (1.06% finances sickness and maternity benefits; 0.44% finances disability and survivor benefits).

The minimum monthly earnings used to calculate contributions are 1,650 baht.

The maximum monthly used to calculate contributions are 15,000 baht.

Qualifying Conditions

Cash sickness and medical benefits: Must have at least 3 months of contributions in the 15 months before the incapacity began or the date of treatment.

The insured must provide medical certification of the incapacity.

Cash maternity, childbirth grant, and medical benefits: Must have at least 7 months of contributions in the 15 months before the expected date of childbirth.

Cash maternity benefits are paid to an insured woman. The childbirth grant is paid to an insured woman or to the wife of, or a woman who cohabits with, an insured man. The childbirth grant is paid to cover the cost of medical expenses related to childbirth.

Maternity benefits are paid for two childbirths only.

Sickness and Maternity Benefits

Sickness benefit: The benefit is 50% of the insured's average daily wage in the highest paid 3 months of the 9 months before the incapacity began. The benefit is paid from the first day of certified absence from work (after the end of entitlement to statutory sick pay, usually 30 days, under the labor law) for up to 90 days for each illness and for up to 180 days in any calendar year; may be extended up to 365 days for a chronic condition.

The minimum monthly earnings used to calculate benefits are 1,650 baht.

The maximum monthly earnings used to calculate benefits are 15,000 baht.

There is no minimum benefit.

Maternity benefit: The benefit is 50% of the insured's average daily wage in the highest paid 3 months of the 9 months before maternity leave and is paid for up to 90 days for each childbirth.

The minimum monthly earnings used to calculate benefits are 1,650 baht.

The maximum monthly earnings used to calculate benefits are 15,000 baht.

There is no minimum benefit.

Childbirth grant: A lump sum of 12,000 baht is paid.

Workers' Medical Benefits

Medical examination and treatment, hospitalization, medicine, ambulance fees, rehabilitation, and other necessary expenses are provided under the healthcare system.

The insured must register with a hospital under contract with the healthcare system to receive benefits from the hospital. Medical care outside this hospital is provided in case of emergency and accident only, in which case costs are reimbursed according to fixed rates.

There are no provisions for cost sharing.

Disability pensioners are entitled to receive subsidized medical care and rehabilitation.

Dependents' Medical Benefits

Necessary medical care related to childbirth for the wife of, or a woman who cohabits with, an insured man.

Administrative Organization

Ministry of Labor (http://www.mol.go.th) provides general supervision.

Social Security Office (http://www.sso.go.th) collects contributions and pays cash benefits.

Hospitals under contract to the Social Security Office deliver medical benefits.

Work Injury

Regulatory Framework

First law: 1972 (announcement of the revolutionary party), implemented in 1974.

Current law: 1994 (workmen's compensation).

Type of program: Employer-liability system, involving compulsory insurance with a public carrier.

Coverage

Employees of industrial and commercial firms.

Exclusions: Agricultural, forestry, fishery employees; and self-employed persons.

Special systems for government employees, employees of state enterprises, and employees of private schools.

Source of Funds

Insured person: None.

Self-employed person: Not applicable.

Employer: 0.2% to 1% of annual payroll, according to the degree of risk.

The contribution is made annually. Beginning with the 5th year of contributions, the company's accident rate is taken into account when assessing the degree of risk.

There are no minimum earnings used to calculate contributions.

The maximum annual earnings used to calculate contributions are 240,000 baht.

Government: None.

Qualifying Conditions

Work injury benefits: There is no minimum qualifying period.

Temporary Disability Benefits

Temporary disability benefit: The benefit is 60% of the insured's monthly wage before the disability began, according to a schedule in law. The benefit is paid after a 3-day waiting period for up to 1 year; the benefit is paid retroactively if the incapacity lasts more than 3 days. The insured must be unable to work.

There are no minimum earnings used to calculate benefits.

The maximum annual earnings used to calculate benefits are 240,000 baht.

The minimum monthly benefit is 60% of the minimum daily wage multiplied by 26 and must not exceed 60% of the monthly average wage.

The maximum monthly benefit is 12,000 baht.

Permanent Disability Benefits

Permanent disability benefit: For a total disability, the pension is 60% of the insured's monthly wage before the disability began and is paid for up to 15 years. Permanent disability benefits are paid according to a schedule in law.

The minimum monthly benefit is 60% of the minimum daily wage multiplied by 26 and must not exceed 60% of the average monthly wage.

The maximum monthly benefit is 12,000 baht.

Permanent partial disability benefit: The pension is 60% of the insured's monthly wage before the disability began. The benefit is paid from 2 months to 10 years, according to a schedule in law. In certain cases, the benefit may be paid as a lump sum.

The degree of disability is assessed annually by medical officers assigned by the Social Security Office.

Benefit adjustment: Benefits are adjusted on an ad hoc basis.

Workers' Medical Benefits

All necessary medical, surgical, and hospital services.

Up to 45,000 baht is paid for each incident of work injury or occupational disease; up to 300,000 baht in certain specified cases, depending on the decision of the medical committee of the Office of Workmen's Compensation Fund.

Rehabilitation services are provided for a cost of up to 20,000 baht.

Survivor Benefits

Survivor benefit: The pension is 60% of the deceased's last monthly wage and is paid for up to 8 years. (A reduced benefit may be paid as a lump sum.)

Eligible survivors include parents, the spouse, and children younger than age 18 (no limit if a student or disabled). The pension is split equally among all eligible survivors. In the absence of eligible survivors, any other dependent persons may qualify.

The minimum monthly benefit is 60% of the minimum daily wage multiplied by 26 and must not exceed 60% of the average monthly wage.

The maximum monthly benefit is 12,000 baht.

Benefit adjustment: Benefits are adjusted on an ad hoc basis.

Funeral grant: A lump sum of 100 times the highest minimum daily wage is paid. The benefit is paid to the person who paid for the funeral.

Administrative Organization

Ministry of Labor (http://www.mol.go.th) provides general supervision.

Social Security Office (http://www.sso.go.th) administers the program through the Office of Workmen's Compensation Fund, which collects contributions and pays cash benefits.

Hospitals under contract with the Social Security Office and meeting the standards of the Office of Workmen's Compensation Fund provide medical benefits.

Old Age, Disability, and Survivors

Regulatory Framework

First and current law: 1990 (social security), implemented in 1991 and 1998.

Type of program: Social insurance system.

Coverage

Employees aged 15 to 60.

Voluntary coverage for self-employed persons and for persons who cease to be covered after at least 12 months of compulsory coverage.

Exclusions: Employees of foreign governments or international organizations; agricultural, forestry, and fishery employees; temporary and seasonal workers; and Thai citizens working abroad.

Special systems for judges, civil servants, employees of state enterprises, and employees of private schools.

Source of Funds

Insured person: 3% of gross monthly earnings for old-age and family benefits. Disability and survivor benefits are financed under Sickness and Maternity.

Voluntary contributors pay an annual flat-rate contribution of 3,360 baht. Voluntary contributions finance disability, survivor, and maternity benefits.

The minimum monthly earnings used to calculate contributions are 1,650 baht.

The maximum monthly earnings used to calculate contributions are 15,000 baht.

Self-employed person: An annual flat-rate contribution of 3,360 baht.

The self-employed person's contributions finance disability, survivor, and maternity benefits.

Employer: 3% of monthly payroll for old-age and family benefits. Disability and survivor benefits are financed under Sickness and Maternity.

The minimum monthly earnings used to calculate contributions are 1,650 baht.

The maximum monthly earnings used to calculate contributions are 15,000 baht.

Government: 1% of gross monthly earnings for old-age and family benefits only. Disability and survivor benefits are financed under Sickness and Maternity.

The minimum monthly earnings used to calculate contributions are 1,650 baht.

The maximum monthly earnings used to calculate contributions are 15,000 baht.

Qualifying Conditions

Old-age pension: Age 55 with at least 180 months of contributions. Employment must cease. If a pensioner starts a new job, the pension is suspended until the end of employment.

Old-age pension increment: Paid if the insured had more than 180 months of contributions at the pensionable age.

Deferred pension: The pension may be deferred.

Old-age settlement: Age 55 with at least 1 month, but less than 180 months of contributions. Employment must cease.

Disability pension: Must be incapable of work and have at least 3 months of contributions in the 15 months before the total physical or mental disability began. The benefit is paid after entitlement to the cash sickness benefit ceases.

Medical officers assigned by the Social Security Office assess the degree of disability annually. The benefit may be suspended if the medical committee of the Social Security Office determines that the disability pensioner is rehabilitated.

Survivor benefit: Paid if a pensioner dies within 60 months after becoming entitled to the old-age pension.

Eligible survivors include the surviving spouse, legitimate children, and a surviving father or mother.

Death benefit: Paid if the deceased had at least 1 month of contributions in the 6 months before death or was a disability pensioner. The death must be the result of a nonwork-related injury or illness.

The eligible survivor is the deceased's named beneficiary; in the absence of a named beneficiary, the surviving spouse, children, and parents are eligible.

Funeral grant: Paid if the deceased had at least 1 month of contributions in the 6 months before death or was a disability pensioner. The death must be the result of a nonwork injury or illness.

Old-Age Benefits

Old-age pension: The pension is 20% of the insured's average monthly wage in the last 60 months before retirement.

The minimum monthly earnings used to calculate benefits are 1,650 baht.

The maximum monthly earnings used to calculate benefits are 15,000 baht.

Old-age pension increment: The old-age pension is increased by 1.5% of the insured's average monthly wage in the last 60 months for each12-month period of contributions exceeding 180 months.

There is no minimum pension.

Deferred pension: The old-age pension is increased by 1.5% of the insured's average monthly wage in the last 60 months for each 12-monthperiod of contributions exceeding 180 months.

Permanent Disability Benefits

Disability pension: 50% of the insured's average daily wage in the highest paid 3 months of the 9 months before the disability began. The benefit is paid until death.

The minimum monthly earnings used to calculate benefits are 1,650 baht.

The maximum monthly earnings used to calculate are 15,000 baht.

There is no minimum pension.

Benefit adjustment: Benefits are adjusted on an ad hoc basis according to changes in the cost of living.

Survivor Benefits

Survivor benefit: A lump sum of 10 times the deceased's monthly old-age pension is paid.

The amount is split among eligible survivors, according to the number and category of survivors.

Death benefit: With between 36 months and 10 years of contributions, a lump sum is paid of 50% of the deceased's average monthly wage in the highest paid 3 months of the 9 months before death multiplied by 3. With at least 10 years of contributions, a lump sum is paid of 50% of the deceased's average monthly wage in the highest paid 3 months of the 9 months before death multiplied by 10.

In the absence of a named beneficiary, the amount is split equally among the eligible survivors.

Funeral grant: 40,000 baht is paid to the person who paid for the funeral.

Administrative Organization

Ministry of Labor (http://www.mol.go.th) provides general supervision.

Social Security Office (http://www.sso.go.th) collects contributions and pays benefits.

Unemployment

Regulatory Framework

First and current law: 1990 (social security), implemented in 2004.

Type of program: Social insurance system.

Coverage

Employees aged 15 to 60.

There is no voluntary coverage.

Exclusions: Judges; employees of foreign governments or international organizations; employees of state enterprises; agricultural, forestry, and fishery employees; temporary and seasonal workers; Thai citizens working abroad; and self-employed persons.

Source of Funds

Insured person: 0.5% of gross monthly earnings.

The minimum monthly earnings used to calculate contributions are 1,650 baht.

The maximum monthly earnings used to calculate contributions are 15,000 baht.

Self-employed person: Not applicable.

Employer: 0.5% of monthly payroll.

The minimum monthly earnings used to calculate contributions are 1,650 baht.

The maximum monthly earnings used to calculate contributions are 15,000 baht.

Government: 0.25% of gross monthly earnings.

The minimum monthly earnings used to calculate contributions are 1,650 baht.

The maximum monthly earnings used to calculate contributions are 15,000 baht.

Qualifying Conditions

Unemployment benefit: The insured must have at least 6 months of contributions in the 15 months before unemployment.

The insured must be registered with the Government Employment Service Office, be ready and able to accept any suitable job offer, and report at least once a month to the Government Employment Service.

Unemployment must not be due to performing duties dishonestly; intentionally committing a criminal offense against the employer; seriously violating work regulations, rules, or lawful order of the employer; neglecting duty for 7 consecutive days without reasonable cause; or causing serious damage to the workplace as a result of personal negligence.

The Social Security Office may suspend benefit payments for failure to comply with conditions.

Unemployment Benefits

If involuntarily unemployed, the benefit is 50% of the insured's average daily wage in the highest paid 3 months in the 9 months before unemployment and is paid for up to 180 days in any 1 year; if voluntarily unemployed, the benefit is 30% of the insured's average daily wage and is paid for up to 90 days in any 1 year.

The benefit is paid from the 8th day of unemployment.

The maximum daily benefit is 250 baht.

Administrative Organization

Ministry of Labor (http://www.mol.go.th) provides general supervision.

Social Security Office (http://www.sso.go.th) collects contributions and pays benefits.

Department of Employment (http://www.doe.go.th), under the Ministry of Labor (http://www.mol.go.th), registers the unemployed insured persons for job placement and training through the Government Employment Service Office.

Department of Skill Development (http://www.dsd.go.th), under the Ministry of Labor, trains unemployed insured persons for new jobs.

Regulatory Framework

First and current law: 1990 (social security), implemented in 1998.

Type of program: Social insurance system.

Coverage

Employees aged 15 to 60.

Voluntary coverage for persons who cease to be covered after at least 12 months of compulsory coverage.

Exclusions: Employees of foreign governments or international organizations; agricultural, forestry, and fishery employees; temporary and seasonal workers; Thai citizens working abroad; and self-employed persons.

Special systems for judges, civil servants, employees of state enterprises, and employees of private schools.

Source of Funds

Insured person: See source of funds under Old Age, Disability, and Survivors.

Self-employed person: Not applicable.

Employer: See source of funds under Old Age, Disability, and Survivors.

Government: See source of funds under Old Age, Disability, and Survivors.

Qualifying Conditions

Child allowance: The insured must have at least 12 months of contributions in the 36 months before the month of entitlement.

The benefit is paid for legitimate children younger than age 6, but for no more than two children at a time. If the insured becomes disabled or dies while the child is younger than age 6, the allowance is paid until the child is age 6.

Family Allowance Benefits

Child allowance: A monthly allowance of 350 baht is paid for each child.

Administrative Organization

Ministry of Labor (http://www.mol.go.th) provides general supervision.

5. Medical Insurance System (MIS) in Thailand

5.1 Historical Development of MIS

The timeline for expansion of MIS in Thailand is:

1975: Free Medical Care for the poor (Medical Welfare Scheme), drawing lessons, gradual expansion and amendments in the health systems;

1980: Royal Decree for CSMBS;

1983: Voluntary health insurance (Voluntary Health Card) scheme: transitional measures, building up the social capital and institutional capacity to manage insurance fund;

1990: Social Security Act: Introduction of SHI for employed sector, capitation, and predecessor of the current universal coverage (UC) design;

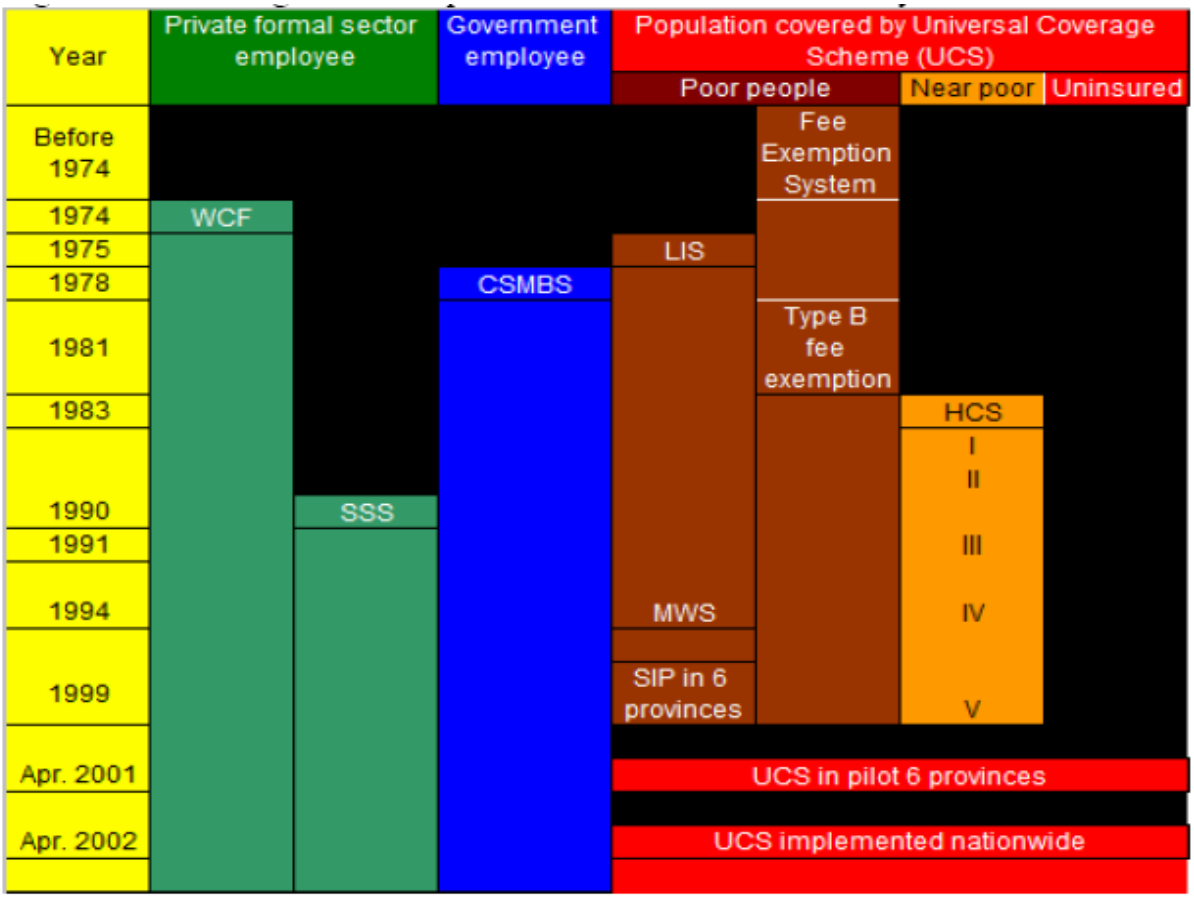
1992: Reform of CSMBS - not very successful;

1996: Reform of health systems including financing (drafting national health insurance act), and

2001: Political will to adopt universal coverage of health care – financed from general revenue.

Thailand reaches the universal coverage for health care in 2002. It started from user fee with exemption, and gradually moved from this out-of-pocket payment to prepayment system (Figure 3). Various forms of prepayment systems were introduced and tested in Thailand. These implementations are huge differences in terms of contribution, public subsidy, benefits and quality of services. Anyway, Thailand could reach the coverage of social protection in health around 70% with these pluralistic approaches, and there were weakness in terms of efficiency, quality and equity. Figure 3: chronological development of the health insurance system in Thailand

Figure 3: Chronological development of the health insurance system in Thailand



Regarding movement of technocrats and civil societies, then Universal coverage for health care was stated as a national strategic policy. In 2001, regarding the commitment to rapidly raise the coverage of health care to all Thai citizens under the slogan “30 Baht to cure every disease” as one of key campaign promises, the government at that time provide Thai citizen the universal coverage for health care . As a matter of fact, the design to reach the universal coverage for health care is more comprehensive than the slogan. For the Transition State, there are two action plans. First is the expansion of the coverage with the Social Security Scheme. Second is the reform of the existing welfare scheme for indigent people and voluntary health insurance for self-employed people to the new compulsory scheme, “the 30 Baht scheme”. After the Universal Coverage Policy was totally introduced in April 2002, the social health protection can be divided in to three groups, schemes for public employees, schemes for private employees and scheme for the rest of Thai (informal sector). Currently, Public health protection schemes Cover all Thai citizen, 7% of population are covered by public employee benefit schemes, The SSS covers 16% of

population, and the rest (75%) are in the UCS. It should be noted that private health insurance companies play very limited additional role in Thailand due to their high premium rate and very strict under-write policies.

5.1.1 Types of the financial resources for the system, and current situation and outlook for the revenue and expenses of the system

After the UC scheme was launched in 2002, Thailand had three public health insurance schemes covered the whole population. The CSMBS provides health care free at point of service for 5.2 million government employees and their dependants [including parents, spouse and not more than two children less than 20 years old, and the pensioners. The SHI protects 9 million private sector employees in any firm having more than one employee, for non-work related conditions, while Workmen's Compensation Fund covers work related injuries, illnesses or deaths. Note that SHI covers individual worker, excluding their dependants except maternity benefit which covers spouse of male beneficiaries. Finally, the UC scheme covers the residual population who are neither CSMBS nor SHI beneficiaries. UC replaces all previous government subsidized health insurance schemes prior to 2001, namely the Low Income Card (LIC) scheme for the poor, the Voluntary Health Card (VHC), the disabled, the elderly, and children aged less than 12 years. However, private health insurance covers the affluent groups, 2.2% of total population.

Table 1: Characteristics of three public and private health insurance schemes

Insurance scheme	Population coverage		Financing source	Mode of provider payment	Access to service
Civil Servant Medical Benefit Scheme	Government employees plus dependants (parents, spouse and up to two children age <20)	9%	General tax, non-contributory scheme	Fee for service, direct disbursement to mostly public providers and DRG for inpatient care	Free choice of public providers, no registration required
Social Health Insurance	Private sector employees, excluding dependants	16%	Tri-partite contribution, equally shared by employer, employee and the government	Inclusive capitation for outpatient and inpatient services plus additional adjusted payments for accident and emergency and high cost care, utilization percentile and high risk adjustment	Registered public and private competing contractors
Universal coverage	The rest of the population not covered by SHI and CSMBS	75%	General tax	Capitation for outpatients and global budget plus DRG for inpatients plus additional payments for accident and emergency and high cost care	Registered contractor provider, notably district health system
Private health insurance	Additional health insurance scheme for those who can afford premiums	2.2% (additional insurance)	Health insurance premiums paid by individuals or households	Retrospective reimbursement	Free choice of health care providers, either public or private providers

Source: Modify from Prakongsai et al

Refer to Thai National Health Account, there are five main funds of finance: general government health expenditures (GGHE), social health insurance (SHI), private health insurance, out-of-pocket (OOP) and the rest of world (ROW).

In 1994, the share of health care spending by GGHE was less than the private spending (private health insurance and OOP). However, the proportion of GGHE gradually increased and overtook the private spending, and became the dominant financing source after the 1997 Asian economic crisis and the emergence of the UC scheme in 2002 (Table 2). SHI was not a major contributor in health expenditure. SHI accounts for 2.9% of THE in 1994 and gradually increased to about 7% in 2007. Household OOP had a lion share in 1994, 44.5% of THE, until the 1997 Asian economic crisis and then slowly and steadily dropped to 19.2% in 2007. Funding size from the rest of the world is negligible.

Table 2: Percent distribution of five sources of finance, 1994-2007

Year	GGHE excluding SHI	SHI	Private Health Insurances	Out-of-Pocket	Rest of the World	THE	THE (Million Thai Baht)
1994	41.7%	2.9%	10.9%	44.5%	0.1%	100%	127,655
1995	43.6%	3.3%	10.4%	42.6%	0.1%	100%	147,837
1996	43.8%	3.4%	10.3%	42.5%	0.0%	100%	177,103
1997	50.5%	3.4%	9.2%	36.9%	0.1%	100%	189,143
1998	49.8%	5.0%	9.8%	35.4%	0.0%	100%	172,811
1999	50.0%	4.9%	10.6%	34.5%	0.0%	100%	162,124
2000	50.8%	5.3%	10.1%	33.7%	0.0%	100%	167,147
2001	49.6%	6.6%	10.5%	33.1%	0.1%	100%	170,203
2002	57.7%	5.6%	9.3%	27.2%	0.3%	100%	201,679
2003	57.4%	6.2%	9.4%	26.8%	0.3%	100%	211,957
2004	58.1%	6.5%	9.0%	26.1%	0.2%	100%	228,041
2005	56.2%	7.9%	8.4%	27.2%	0.3%	100%	251,693
2006	60.3%	7.5%	9.3%	22.6%	0.3%	100%	291,294
2007	65.8%	7.1%	7.6%	19.2%	0.3%	100%	315,531

Source: NHA Working Group 2009

Note:

1 General Government Health Expenditures (GGHE) comprised of health expenditure spent by the ministry of public health and other ministries, local government agencies, CSMBS, state enterprise and universal coverage scheme since 2002.

2 Social Health Insurance (SHI) comprised of health expenditures through social health insurance fund and workmen compensation fund.

3 Majority of private health insurances were voluntary basis (about 57% of all private insurances) while the rest (43%) were compulsory traffic accident protection fund managed by private insurance companies.

4 Out-of-Pocket (OOP) were paid by household at point of services.

5 Rest of the World (ROW) means grants from bilateral and multilateral donors.

5.1.2 Payment system of medical care expenditures.

Table 3 describes how different health services were paid for by three public insurances schemes as well as the voluntary health insurance schemes. We observe that there are harmonization of payment for health services by NHSO and SSO as they applied the close ended provider payment contract mode while the CGD applied fee for service opened ended provider payment for outpatient services and conventional DRG for inpatient services.

Table 3: Paying for health services

Paying for services	Universal Coverage scheme	Social Health Insurance	CSMBS*	Voluntary health insurances
1. Primary/ ambulatory care	Capitation to contractor provider network (mostly district health providers including the district hospital + all health centres or Primary care units in the district) based on number of registered beneficiaries. Capitation rate is based on utilization rate and unit cost of services in the previous year, annual negotiated between NHSO and Budget Bureau. Downstream allocation to contractor provider network is based on age adjusted capitation for OP services. Additional fee-for-service payments in case of specific services and medical equipments	Inclusive capitation for ambulatory care, admission based on number of registered beneficiary to competing public and private hospitals (having more than 100 beds and other facility and professional requirement). Additional risk-adjusted fix pay per beneficiary for effective managing chronics and high cost diseases, additional pay per beneficiary for utilization in the past year Additional fee-for-service payments in case of specific services and medical equipments	Fee for services, directly reimbursed to providers not beneficiaries. Note, only public providers are eligible.	Fee for services with varying conditions, more favourable benefit for higher premium
2. Inpatient care	Annual global budget was set based on utilization and unit cost, within this budget, case base payment based on actual relative weight points earned by providers (mostly public) Additional fee-for-service payments in case of specific services and medical equipments	Inclusive capitation for ambulatory care, admission Additional fee-for-service payments in case of specific services and medical equipments	Prior to 2008, conventional fee for services for items of services, with combination of fee schedule for room and board, medical appliances, and other specialised services. Conventional DRG was applied recently 2008, Baht per relative weight was announced upfront.	Fee for services with ceiling of total reimbursement per admission
3. Prevention and health promotion [personal preventive and health promotion services]	Capitation for providers (mostly public) covers the whole Thai population (not only UC members) as a national scheme	Covered by NHSO	Covered by NHSO	Not covered

Paying for services	Universal Coverage scheme	Social Health Insurance	CSMBS*	Voluntary health insurances
4. Maternity and pregnancy including antenatal care and post-natal care	Covered in inpatient care	Additional fix pay for antenatal services, delivery and post-natal care, per confinement to beneficiary, not more than 2 confinements	Covered in inpatient care	Mostly covered in inpatient care
5. Renal replacement therapy	NHSO negotiate purchase of peritoneal dialysis solution through Government Pharmaceutical organization deliver to district hospitals. NHSO purchases hemodialysis from public private centres based on fix fee, copayment is fixed per hemodialysis session by NHSO	Additional pay, fix fee per session of dialysis, free choices by beneficiaries, no control of provider fee, implicit copayment when actual fee beyond the rate given by SSO	Similar arrangement to SHI, separate additional pay, fix fee per session of dialysis (but higher than SHI), free choices by beneficiaries, no control of provider fee schedule, implicit copayment when actual fee beyond the rate given by CGD.	Not covered
6. Antiretroviral services	NHSO purchases anti-retroviral medicines through Vendor Managed Inventory, additional pay to providers for VCT, viral load tests, registration of patients required	SSO purchases and distribute anti-retroviral medicines to providers, additional pay to providers for VCT, Viral Load tests, registration required	Fee for services methods, covered in ambulatory care	Not covered
7. Public health services	National program responsible by MOPH e.g. diseases surveillance, covered the whole population	By law, services not covered, it is covered by national program	By law, services not covered, it is covered by national program	Not covered
8. Pharmaceutical care	Pharmaceutical benefit referred to medicines in the national Essential Drug (ED) List is fully covered in capitation fee for ambulatory care and global budget + case base payment for inpatient services	Drug benefit referred to National ED lists. Drug payment is included in the inclusive capitation for ambulatory and inpatient services	Drug benefit referred to National ED lists. Fee for services for drugs in ambulatory care, and DRG for admissions	Covered in ambulatory and admission care
9. Rehabilitation	covered in OP and IP budgets, fee schedule for community rehabilitation from a separated rehabilitation and disabled budget.	covered in the capitation budget	fully covered in facilities	
10. Long term care	Not covered	Not covered	Not covered	Not covered
11. Emergency Medical Services [pre-hospital care]	NHSO proposes budget for pre-hospital care and referral to its beneficiaries, fee per three different types of services	Not covered	Not covered	

Paying for services	Universal Coverage scheme	Social Health Insurance	CSMBS*	Voluntary health insurances
12. Dental care	Covered except costmetic procedures and integrated in the ambulatory care payment	Fee for services with ceiling, two services per annum	Not covered except a few basic dental services	Mostly not covered
13. Mental health care	Fully covered in ambulatory care. For admission, acute psychotic is covered not more than 15 days of admission [though this is abolish and will take effect in November 2010], beyond this limits, covered by national Psychiatric program based on annual budget allocation	Aute psychotic is covered not more than 15 days of admission	No limitation, fully covered by ambulatory and admission	Not covered
14. Healthcare for special population, e.g. prisoners, military personnel	Not covered, medical services for prisoners are covered by Department of Correction, routine budget allocation, the Department also manages some hospitals, or referral to MOPH hospitals for which payment is mostly fee for services		Civil servants, military personnel and their dependants are fully covered by CSMBS	

* There are increasing numbers of local government officials and employees of independent public organizations. The provider payment mechanism often applies
the CSMBS reimbursement model. Any reform in the CSMBS may have effects to these groups.

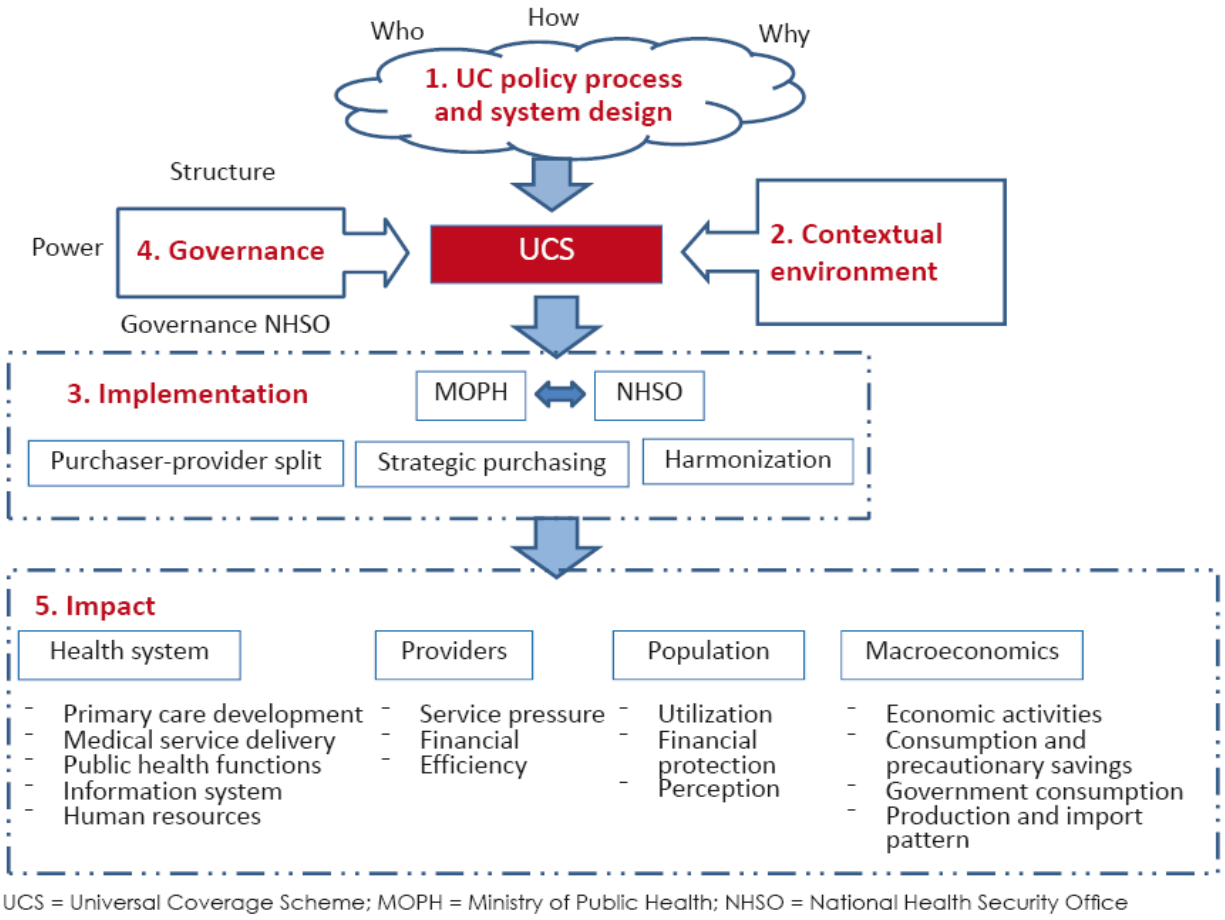
5.2 Laws and regulations for MIS: A list of laws and regulations regarding MIS in your country should be presented which gives the name/title, legislated year, and description/purpose of each.

National Health Security Act B.E. 2545 (A.D. 2002) Given on the 11th Day of November 2002 The reasons for the promulgation of this Act are as follows: Whereas Section 48 of the Constitution of the Kingdom of Thailand provides that the Thai population shall enjoy an equal right to receive standard Health service and the indigent shall have the right to receive free medical treatment from Health centers of the State, as provided by law. Health service by the State shall be provided thoroughly and efficiently and, for this purpose, participation by local government organizations and the private sector shall be promoted insofar as it is possible.

5. 3 Administration and management of MIS (Central Level): An organizational chart of the government should be provided that indicates the ministries/departments/divisions responsible for administrating MIS. A brochure or annual report that gives an outline of governmental measure in MIS, if any, these materials would be appreciated.

The comprehensive assessment of the UCS's first 10 years (2001-2010) focused on five areas of inquiry: policy formulation, contextual environment, policy implementation, governance and impacts. The scope of the study is shown in Figure 3.

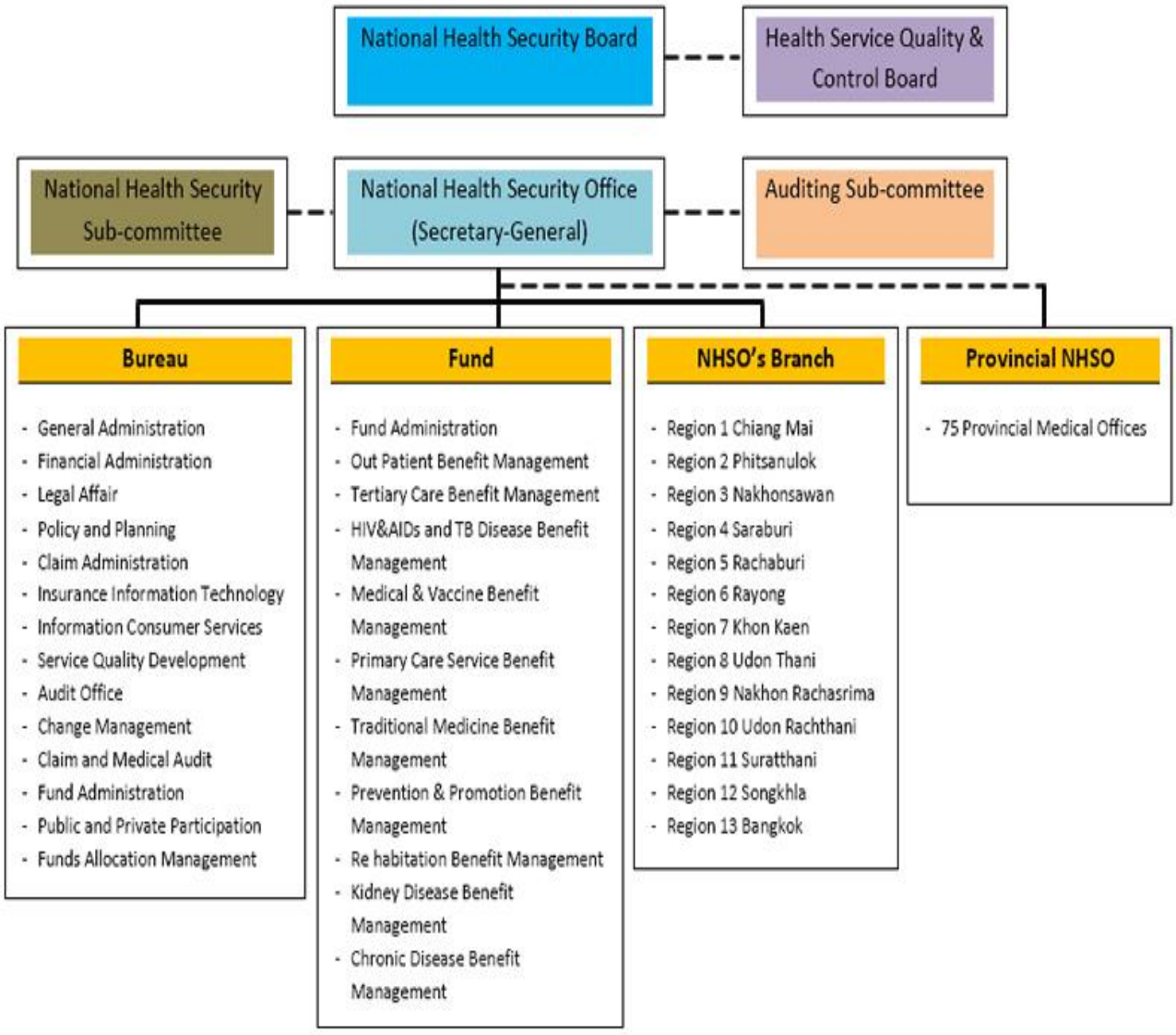
Figure 4: Scope of the UCS assessment, 2001-2010



Source : Thailand's Universal Coverage Scheme: Achievements and Challenges (2010)

The National Health Security Act B.E. 2545 (2002) is the legal basis for the UCS. The Act stipulates the establishment of the National Health Security Office (NHSO) and the National Health Security Fund. Actually, this act stipulates that every Thai citizen has entitlement to medical care under a public health protection scheme. However, Thai citizens who already have entitlement to use any existing social health protection scheme have to use those schemes

Figure 5: Organization structure of the NHSO



Source : National Health Security Office (NHSO) Thailand : http://www.nhso.go.th

Responsibilities

The National Health Security Act. 2002 Section 26 authorizes the National Health Security Office (NHSO) with the following responsibilities

1. Responsible for administrative work of the National Health Security Committee, and the National Committee for Quality Accreditation.
2. Compile and analyze data on health services.
3. Organize systems for registration of beneficiaries service provider and their networks.
4. Administer the fund according to the regulations.
5. Pay service expenses to health providers and their network under regulation determined by the National Health Security Committee.
6. Carry out claiming process for medical services provided by the service providing units.
7. Make service registration for people and aloe them to change their registration as required.
8. Monitor and control service quality to be at standard level and make convenience to people when complaining.
9. Process authority, ownership and assets.
10. Organize rights and legal procedures concerning with its assets.
11. Able to collect fees and services fees.
12. Authorize other organizations to carry out activities under the responsibility of the office.
13. Dan an annual report of the National Health Security committee and the National Committee for quality Accreditation.
14. Carry out other duties.

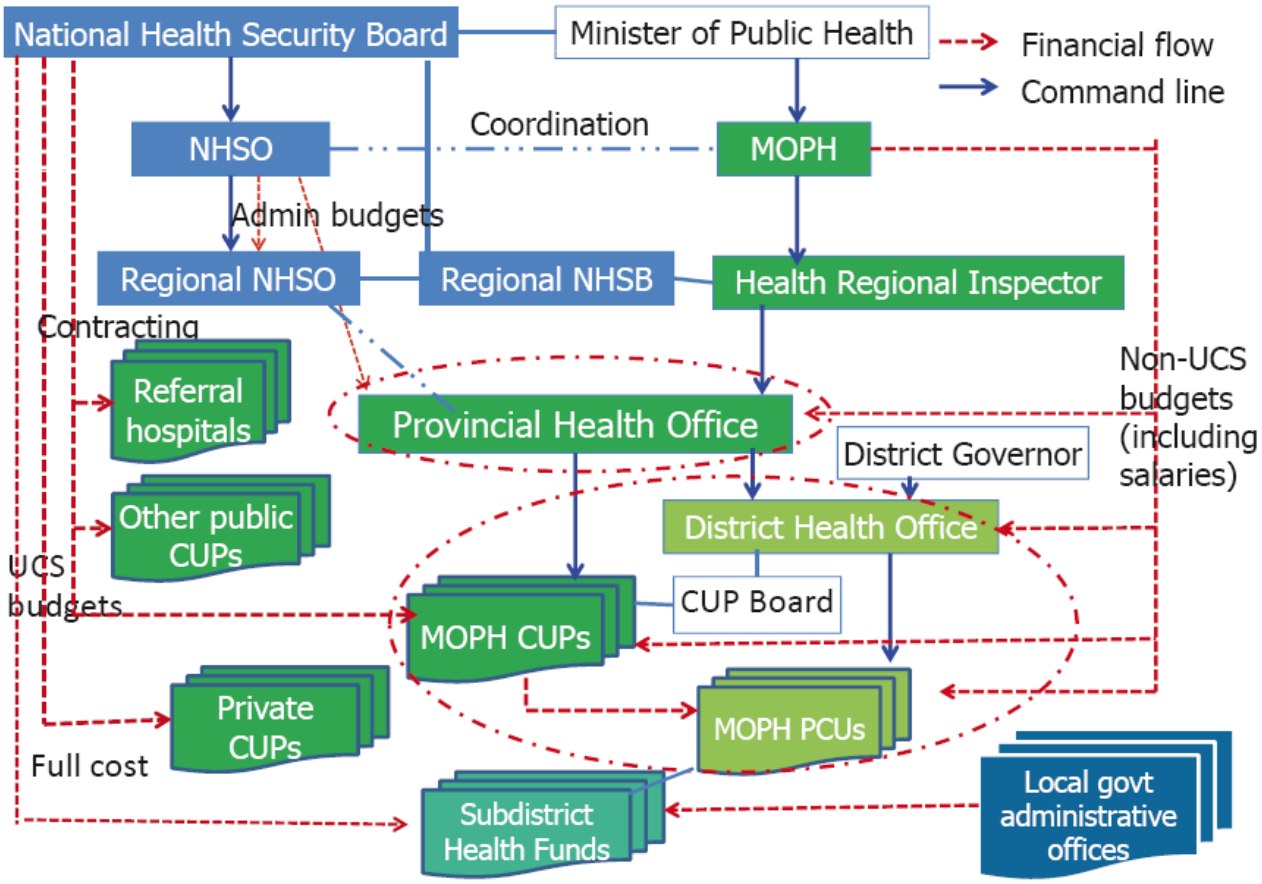
5.4 Administration and management of MIS (Local level, Private Sector): An organizational chart of local government and/or private sector that specifics organizations responsible for MIS at the local level and/or private sector should be provided.

The original vision for the UCS was that the NHSO, rather than the MOPH, would act as the fund manager and that the MOPH would relinquish its authority over

MOPH health-care facilities, which would come under the devolved control of local government or “area health boards”. However, the plan to establish autonomous hospitals did not progress beyond a single pilot institution and the MOPH continued functioning as the major provider (see Figure 6). With financial authority transferred to the NHSO, it is understandable that the MOPH did not favour the devolution of its health facilities.

As the following chapter elaborates, the purchaser-provider split proved to be the biggest challenge faced by the UCS during its first decade, far more difficult, for example, than registering 47 million people in the new scheme and finding the public resources to cover 18 million previously uninsured people. The latter was done in the first year; the former has yet to be completed and may be further delayed by ongoing power struggles and institutional conflicts between the MOPH and the NHSO.

Figure 6: UCS institutional arrangements



Source : Thailand's Universal Coverage Scheme: Achievements and Challenges (2010)

5.5 Structure of the systems

- **Type, Insurer, Number of the insured, Recipient qualification and contents of the benefits, etc.**

Table 4 summarizes the characteristics of the three health insurance schemes that have covered all Thai citizens since 2002. The UCS and SSS capitation rates are similar but the UCS rate should be higher as it draws members from all age groups, including children under 5 and adults over 60, while the SSS covers only adults aged 15-60 years. CSMBS expenditure is thought by most analysts to be more than four times higher than the other two schemes because fee-for-service payment creates incentives for providers to prescribe more diagnostics and edicines. Research evidence shows large practice variations between the UCS and CSMBS17. For instance, the CSMBS spends more on branded drugs and less on

generics, has a higher caesarean section rate and has longer hospital stays for most DRGs.

Table 4: Characteristics of Thailand's three public health insurance schemes after achieving universal coverage in 2002

Scheme	Population coverage		Financing sources	Benefits package	Purchasing relation	Access to service	Per capita expen-diture 2010
Social Security Scheme (SSS)	Private sector employees, excluding dependants	16%	Payroll tax financed, tri-partite contribution 1.5% of sal-ary, equally by employer, employee and govern-ment	Comprehensive: outpatient, inpatient, accident and emergency, high-cost care, with very minimal exclusion list; excludes prevention and health promotion	Contract model: inclusive capitation for outpatient and inpatient services	Registered public and private competing contrac-tors	US$ 71
Civil Ser-vant Medi-cal Benefit Scheme (CSMBS)	Govern-ment em-ployees plus dependants (parents, spouse and up to two children age <20)	9%	General tax, non-contributory scheme	Comprehensive: slightly higher than SSS and UCS	Reimburse-ment model: fee for service, direct disbursement to public providers for outpatients; conventional DRG for inpatients	Free choice of public providers, no registration required	US$ 367
Universal Coverage Scheme (UCS)	The rest of population not covered by SSS and CSMBS	75%	General tax	Comprehensive: similar to SSS, including prevention and health promotion for the whole population	Contract model: capitation for outpatients and global budget plus DRG for inpatients	Registered contractor provider, notably within the district health system	US$ 79

Source : Thailand's Universal Coverage Scheme: Achievements and Challenges (2010)

5.6 Financial situation of MIS (Types of the financial resources for the system, and current situation and outlook for the revenue and expenses of the system)

Taxation is the main source of Thai government's revenue. A large part of tax collection is responsible by three Department of the Ministry of Finance—The Revenue Department, the Excise Department, and Customs Department - which collectively account for about 85-90% of the government's revenue collected. The Revenue Department responsible for personal and corporate income tax collection, contributes more than half of the total tax collected. Liability of tax payers are prescribed by rules and regulations stipulated in the Revenue Code.

In the tax revenue structure, the direct tax (personal income and corporate tax) is the largest portion, follows by consumption tax (including value added tax—VAT and a very small role of business tax for small enterprises), excise tax and import and export duties respectively. However, indirect tax combining all items has a large share than direct tax. This tax profile has not changed between 1994 and 2007, except in the year 1998 and 1999, two years after the 1997 Asian economic crisis; the consumption tax was larger than direct tax. The main source of direct tax is from personal income tax which applies very progressive tax rates (Table 5).

Revenue Department had demonstrated an improved effectiveness of tax collection, now totally in electronic submissions by March every year for personal income tax. However the tax base is still narrow. There is no political will to introduce property and inheritance tax though this was discussed by the Parliament in 2009.

There is only one earmark tax to healthcare, 2% levies on tobacco and alcohol consumption was transferred by the Excise Department on a daily basis to the Thai Health Fund. The Fund is governed by a Board chaired by the Prime Minister, aiming to campaign against tobacco, alcohol and active health promotion activities by funding NGO and civil society and government agencies to strengthen healthy enabling environment (Tangcharoensathien V., Prakongsai P., Patcharanarumol W., 2008).

Table 5: Structure of government revenue, 1994 and 2007

	A	A1	A2	A2.1	A2.2	A2.3	B	C=A+B	
Year	Tax	Direct tax	Indirect tax	Consumption tax, including VAT	Excise tax	Import-export duties	Non-tax revenue	Total	Total (Million Baht)
1994	88%	29%	59%	23%	20%	16%	12%	100%	707,546
1995	89%	30%	59%	24%	19%	16%	11%	100%	815,143
1996	90%	32%	58%	25%	19%	14%	10%	100%	895,291
1997	88%	31%	57%	26%	20%	11%	12%	100%	909,049
1998	88%	28%	61%	33%	19%	8%	12%	100%	815,681
1999	86%	28%	58%	29%	21%	8%	14%	100%	793,346
2000	87%	30%	57%	26%	20%	10%	13%	100%	817,595
2001	88%	31%	57%	26%	20%	10%	12%	100%	874,766
2002	89%	31%	57%	26%	22%	10%	11%	100%	958,373
2003	89%	31%	58%	25%	22%	10%	11%	100%	1,104,627
2004	91%	34%	57%	27%	22%	8%	9%	100%	1,258,805
2005	90%	35%	55%	28%	19%	7%	10%	100%	1,472,935
2006	90%	38%	52%	29%	17%	6%	10%	100%	1,581,524
2007	90%	39%	51%	29%	17%	5%	10%	100%	1,666,824

Source: Fiscal Policy Office, Ministry of Finance http://www.fpo.go.th/fiscaldata/Revweb.xls, access 20 December 2009

An EU funded EQUITAP study and subsequent studies conducted (O'Donnell, O., van Doorslaer, E., 2007), estimates a Concentration Index of various sources of healthcare finance in Thailand, using NSO SES data and National Health Account in its estimates, see Table 10.

Table 6: Financing Sources for healthcare and their progressivity

Financing sources	2002		2004		2006	
	CI*	Fraction**	CI*	Fraction**	CI*	Fraction**
Direct tax	0.8221	0.20	0.8162	0.21	0.7687	0.23
Indirect tax	0.5594	0.38	0.5958	0.37	0.5512	0.33
Social insurance contribution	0.4975	0.06	0.4561	0.07	0.4492	0.08
Private insurance	0.3785	0.09	0.4221	0.09	0.4188	0.08
Direct payment	0.4883	0.27	0.4626	0.26	0.4705	0.28
Total	**0.5719**	1.00	**0.5822**	1.00	**0.5593**	1.00

Source : Thailand. Bulletin of the World Health Organization 85, 8(2007)

Note: * Concentration Index (CI) based on Socio-Economic Survey (SES: 2002, 2004 and 2006). CI ranges from – 1 to +1

1, the closer to 1 the more progressive of financial contribution.

** Fraction of health expenditures by source was derived from Thailand National Health Account (figures in 2006 were estimated from 2005 data)

CI, an index of the distribution of payments, ranges (-1 to 1), a positive (negative) value indicates the rich (poor) contributes a larger share than the poor (rich), a value of zero is everyone pays the same irrespective of ability to pay.

Between 2002 and 2006, the proportion of total expenditure made up from direct tax payments increased from 20% to 23% while the share from indirect tax payments fell from 38% to 33%. The proportion from household direct payments remained unchanged, at 27-28%. Direct tax was the most progressive funding source, where the rich paid proportionally more than the poor, followed by indirect tax, and SHI contribution. Private

insurance premiums and household OOP payment were both regressive. General tax finance (direct, indirect tax and other government revenues) was therefore progressive. As indicated in Table 10, the dominant share of general tax as a source of total health expenditure in Thailand resulted in an overall progressive system. The overall CI remained virtually unchanged over the three observations: 0.5719 in 2002, 0.5822 in 2004 and 0.5593 in 2006.
The main reason why the SHI contribution was less progressive was the 15,000 Baht (approximately US$428) per month ceiling placed for the assessed contribution. This ceiling has never indexed or revised since the 1990 SHI inception, resulting in consistent movements towards less progressivity as workers' wages have increased.

5.7 MIS related policy within the National Development Plan: Indicate whether MIS-related polity is included in your country's National Development Policy, and if it is, give an explanation of its contents.

It can be said that one of the main reasons, which Thailand can reach universal coverage for health care, comes from continuous and strong commitment of public policy. This public policy for population health care had history of evolution. From the ideology of using health care to strengthen State power in 19 century toward considering health care as an important part of long-term investment for economic growth. Finally, health is considered as an entitlement of Thai citizens. Every steps pushed the Thai health system forward to universal access to care and to protect the rights of the people.

Table 7: Cause and effect of health policy in Thailand

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

6. Please describe these points

6.1. Problems to be solved in your current MIS.

- Reduce inequities in benefits and level of expenditure, and address inefficiencies across the schemes.
- Continue building institutional capacity for health technology assessment to inform the purchase of cost-effective interventions and thereby improve value for money.

6.2. Contents of the reform to solve the problems.

- Explore whether more local commissioning of health services would be more efficient than provincial purchasing, especially for primary health care.
- Identify innovative ways to minimize the reliance on high-cost tertiary care through greater investments in disease prevention and health promotion and by addressing the social determinants of health outside of clinical settings. In addition, appropriate long-term care models need to be developed, which will require adapting the character and range of health facilities and services.
- Improving care system or local activities on effective health promotion.

6.3. Problems for carrying out this reform.

- Generate evidence on the strengths and weaknesses of each scheme to inform ongoing and future scheme harmonization.
- Develop methods to use routinely collected data to monitor, assess and improve quality of care, including clinical outcome assessment. At present this is an unexploited opportunity in Thailand.

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United Nations hailand : http://www.un.or.th/thailand/geography.html

World Health Organization, WHO Thailand : http://www.whothailand.org

ANNEX1- Form 1

The State of the Nation : Thailand
Area size (Area size 510,890 K m^2) Unit : thousands
Population by aged group

Year		1991		1996	2001	2006	2011
0 – 4	Male		5,872	2,726	2,585	2,052	2,027
	Female			2,674	2,540	1,930	1,905
5 – 9	Male		6,096	2,740	2,660	2,307	2,091
	Female			2,687	2,632	2,177	1,972
10 – 19	Male		12,420	5,811	5,515	4,934	4,934
	Female			5,639	5,416	4,685	4,672
20 – 29	Male		11,454	5,663	5,711	5,289	4,967
	Female			5,465	5,544	5,184	4,846
30 – 39	Male		8,415	4,806	5,050	5,505	5,412
	Female			4,777	5,028	5,644	5,479
40 -49	Male		5,316	3,492	4,065	4,749	5,064
	Female			3,583	4,186	5,024	5,384
50 -59	Male		3,775	2,311	2,595	3,047	3,563
	Female			2,479	2,776	3,338	3,934
60 – 64	Male		1,343	867	952	952	1,105
	Female			963	1,079	1,067	1,262
65 -	Male		2,262	1,406	1,685	1,768	2,208
	Female			1,697	2,072	2,643	2,875
Total	**Male**		**56,923**	**29,826**	**30,819**	**30,913**	**31,372**
	Female			**29,962**	**31,275**	**31,710**	**32,329**

Source: Bureau of Policy and Strategy, Ministry of Public Health (http://bps.ops.moph.go.th/)

ANNEX1- Form 2

Year		1991	1996	2001	2006	2011	
Population growth rate (% per annum) Source: World Development Indicators (WDI) & Global Development Finance (GDF), April 2012		1.1	1.0	1.2	0.9	0.6 (2010)	
Birth rate (per 1,000 population)		17.0	15.8	12.7	12.7	12.0	
Mortality rate (per 1,000 population)		4.7	5.7	6.0	6.2	N/A	
Infant mortality rate (per 1,000 population)		8.3	5.5	6.5	7.4	7.0	
The rate of the population of 65 years and over to the total population (%)		4.6	5.2	6.1	7.0	7.9	
Life expectancy at birth	M	65.85	67.35	68.51	70.59	71.93	
	F	70.55	71.80	75.82	77.54	78.82	
Life expectancy at 60 and 65	60	N/A	N/A	N/A	N/A	M 19.4	F 21.9
	65	N/A	N/A	N/A	N/A	M 16.1	F 18.1
Unemployment rate (per 1,000 population *average rate Source: World Economic Outlook, April 2012		2.1	1.5	3.3	1.5	0.7	

ANNEX1- Form 3

Year		1991	1996	2001	2006	2011
National Income (US$)		1,912,873 (Baht)	3,727,690 (Baht)	3,689,512 (Baht)	5,644,699 (Baht)	7,440 US
Average Wage of Male and Female (US$)	NA	NA	NA	8,326	NA	
	NA	NA	NA	7,554	NA	
Average income (US$)		NA	NA	NA	7,978	NA
Total GNP (US$)		2,540,178 (Baht)	4,514,260 (Baht)	5,184,655 (Baht)	8,053,052 (Baht)	NA
GNP growth rate		1.0	1.6	0.8	1.3	1.1
GNP per capita (US$)		56,574 (Baht)	60,000 (Baht)	62,836 (Baht)	65,574 (Baht)	NA
Total GDP (US$) / (current price billion (US$)		96.2	181.9	115.5	207.1	345.6
GDP growth rate		8.1	5.9	2.2	5.1	0.1
GDP per capita (US$)		1688.7	3026.6	1854.3	3296.1	5394.4
The rate of social insurance of contribution as a percentage of National Income						
	Premium contribution of employee					
	Premium contribution employer					
	Premium contribution of self-employer etc.					

ANNEX1- Form 4

Number and percentage of workers engaged in industrial classification

Year	1991	1996	2001	2006	2011
Primary industry					
Secondary industry					
Tertiary industry					

Five leading causes of death (rate per 1,000 population)

(Year)	1st	2nd	3rd	4th	5th
1991	Heart disease (54.7)	Accidents and incidents (45.6)	Malignant neoplasm, all forms (41.2)	Hypertension and Cerebrovascular disease (15.9)	Suicide and murder (14.8)
1996	Heart disease (77.4)	Accidents and incidents (62.0)	Malignant neoplasm, all forms (50.0)	Hypertension and Cerebrovascular disease (15.6)	Suicide and murder (13.8)
2001	Malignant neoplasm, all forms (68.4)	Accidents and incidents (50.9)	Heart disease (30.3)	Hypertension and Cerebrovascular disease (24.5)	Pneumonia and other diseases of lung (18.0)
2006	Malignant neoplasm, all forms (83.1)	Accidents and incidents (59.8)	Heart disease (28.4)	Hypertension and Cerebrovascular disease (24.4)	Nephritis, nephritis syndrome and nephrosis (20.6)
2011	Malignant neoplasm, all forms (91.1)	Accidents and incidents (51.6)	Hypertension and Cerebrovascular disease (31.4)	Heart disease (28.9)	Pneumonia and other diseases of lung (25.7)

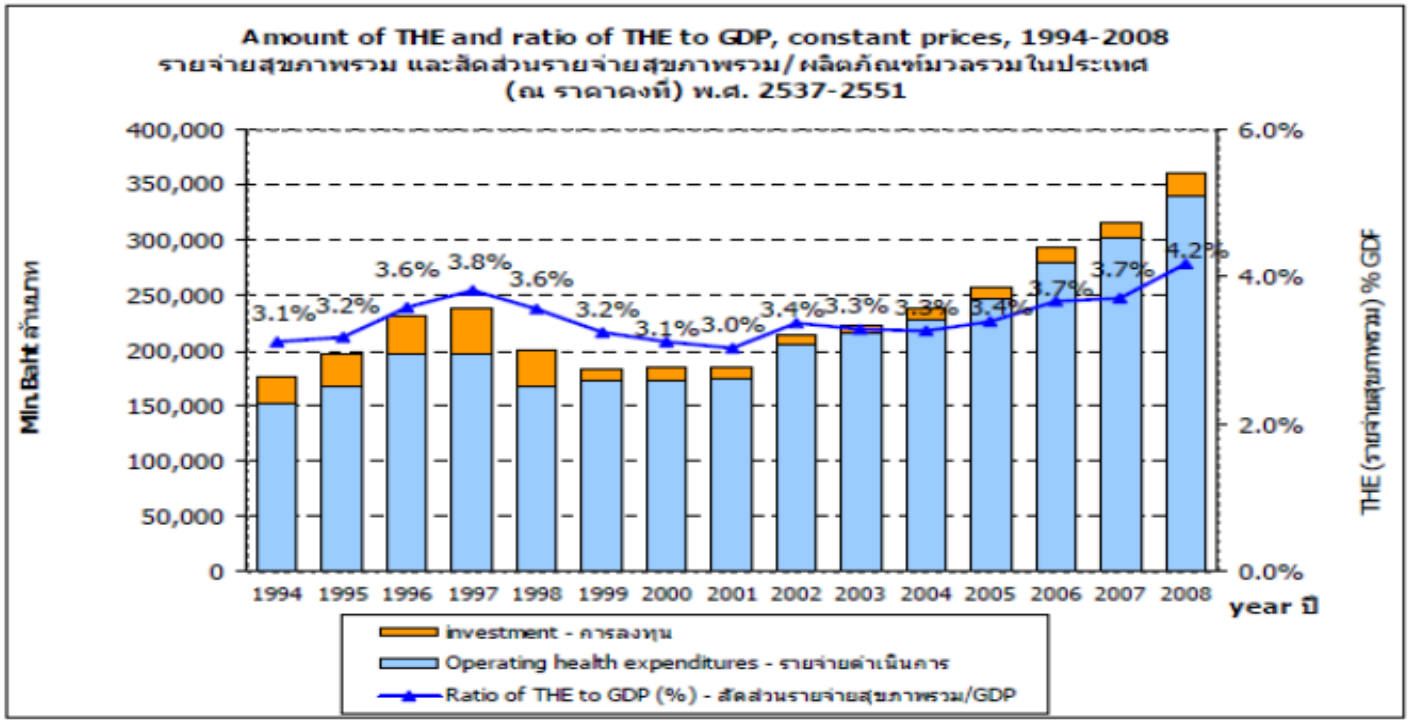
Table 1: Total health expenditure and selected indicators on health spending, 1994-2007, current prices

Indicator	1994	1997	2001	2002	2005	2006	2007	2008
THE, Total health expenditure (million Baht)	127,655	189,143	170,203	201,679	251,693	291,294	315,531	363,771
THE as % of GDP	3.5%	4.0%	3.3%	3.7%	3.5%	3.7%	3.7%	4.2
THE from public financing agencies (million Baht)	56,885	101,937	95,779	127,534	161,282	197,342	230,056	272,203
THE from private financing agencies (million Baht)	70,771	87,206	74,424	74,146	90,411	93,953	85,476	91,568
THE from public financing agencies (%)	45%	54%	56%	63%	64%	68%	73%	75%
THE from private financing agencies (%)	55%	46%	44%	37%	36%	32%	27%	25%
THE per capita (Baht per capita per year)	**2,160**	**3,110**	**2,732**	**3,211**	**4,032**	**4,636**	**5,005**	**5,739**
THE per capita (USD)	86	99	61	74	100	122	144	171
Exchange rate (Baht per 1 USD)	25	31	45	43	40	38	35	33

Source: NHA Working Group 2009 [4]

Total health expenditure (THE), as percent of Gross Domestic Product (GDP), has not been much changed in 1994 to 2008. The ratio of THE to GDP ranged from 3.1 percent in 1994 to 3.8 percent in 1997 prior to Asian financial crisis. The ratio decreased in the subsequent years to be 3.0 percent in 2001 as health expenditure grew less than the overall economy. However, after the UC scheme, the ratios increased again and reached 3.4 percent in 2002 and increased to 3.7 and 4.2 percent in 2007 and 2008, respectively (Figure 2).

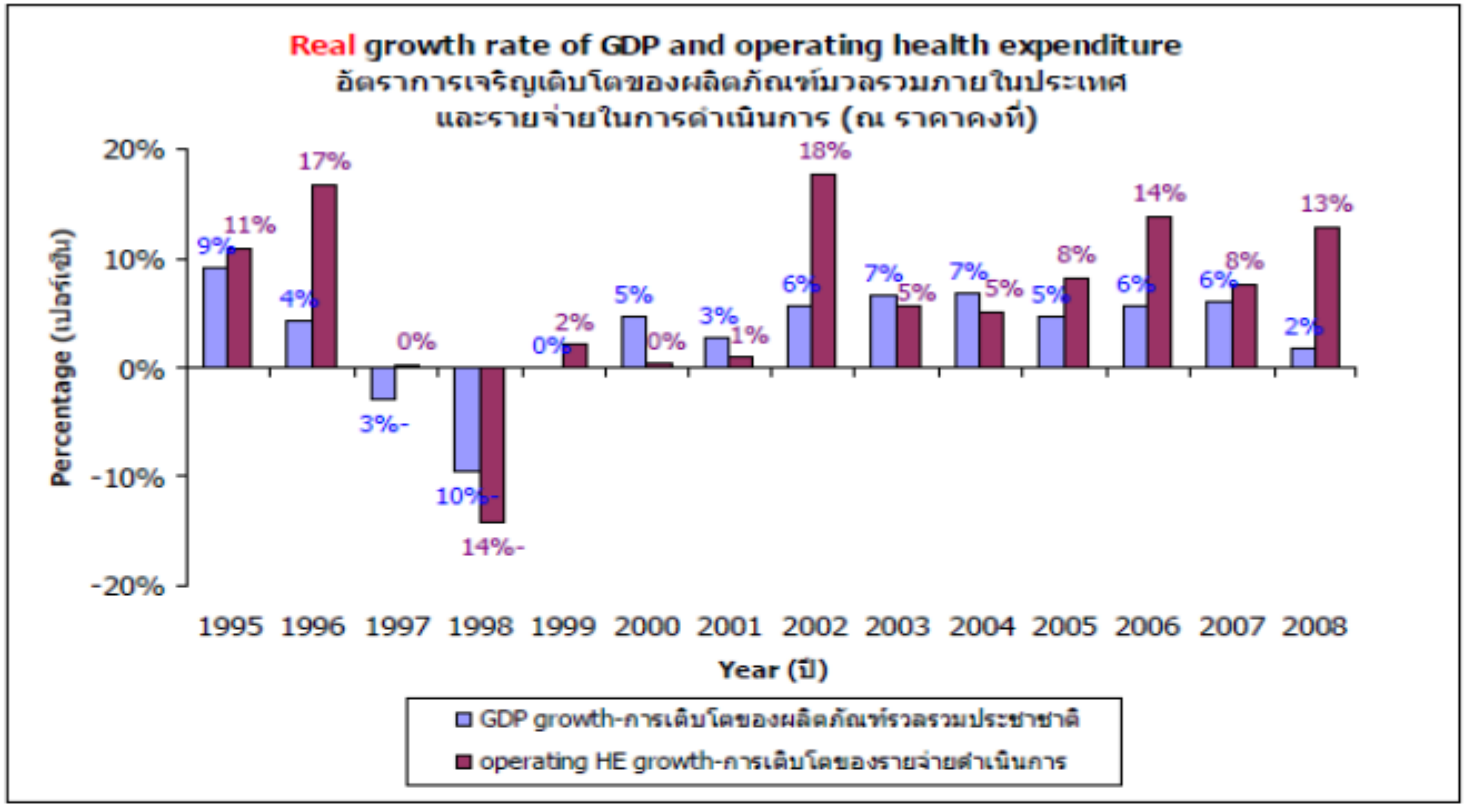
Figure 2 Total health expenditure of Thailand as percent of GDP, 1994 to 2008, at 2008 constant price



Source: NHA Working Group 2009 [4]

The real growth rate of operating health expenditure from 1995 to 2008 was not associated with that of GDP. Prior to the 1997 financial crisis, the real growth rate of GDP ranged from 5% to 10%, while that of operating health expenditure ranged from 11% to 17%. However, GDP fell significantly to -3% and -10% in 1997 and 1998, respectively as a result of Asian economic crisis, but the government health budget was safeguarded from cut. The growth rate of GDP slightly increased after the year 2001 showing a sign of recovery from crisis. Furthermore, the growth rate of operating health expenditure was significantly increased from 0-1 % during 1999-2001 to 18% in 2002, when the UC policy was first implemented. After that period, the average growth rate of operating health expenditure was approximately 8% per year (Figure 3).

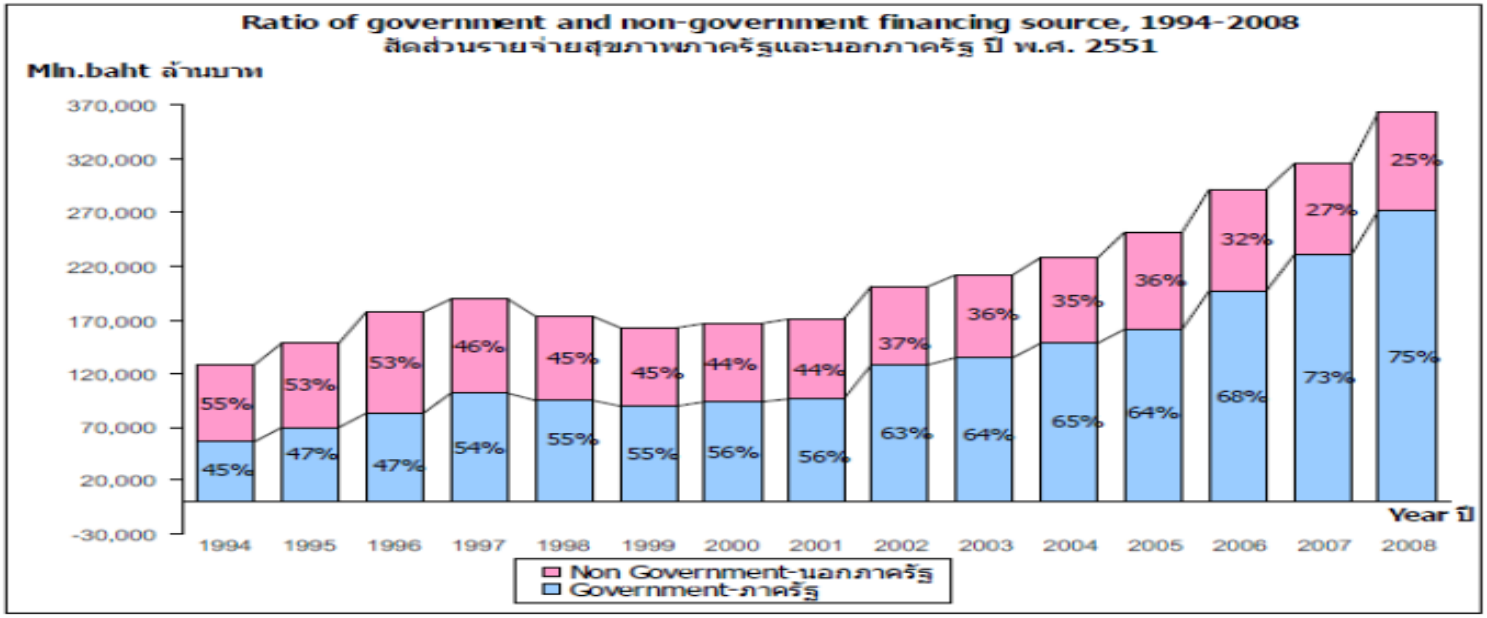
Figure 3 Real growth rate of GDP and operating health expenditure, 1994 to 2008



Source: NHA Working Group 2009 [4]

The proportion between government and private (non-government) financing sources significantly changed twice in 1997 after the Asian financial crisis and in 2002 after the introduction of UC scheme. Prior to 1997, the share of public health financing sources ranged from 45% to 47%. After the economic crisis, despite budget cut, government health budget was protected, the share of public financing sources increased to approximately 54-56% from 1997 to 2001. As a result of UC policy introduced in 2002, the proportion of public financing sources has been considerably increased from 63% in 2002 to 75% in 2008 (Figure 4) and vice versa, household out of pocket reduced significantly.

Figure 4 Share of government and non-government health financing sources from 1994 to 2008



Source: NHA Working Group 2009 [4]

When the annual growth rate of THE and GDP is grouped into two sets between the period of 1995-2000 and 2000-2007, the geometric mean of annual growth rate of THE during 2000-2007 is equivalent to 10.84% which is higher than that of GDP (8.75%). The Asian financial crisis in 1997 reduced the annual growth rate of GDP during 1995-2000 to be only 3.29%, and the crisis also led to the greater reduction in THE to only 2.49 %. It is noteworthy that in the normal situation, annual THE growth rate is higher than that of GDP, but during the financial crisis, households significantly reduced their health expenditure, also government reduced spending on capital investment due to prior heavy investment on this item during the economic boom.

The government health spending (inclusive of all public financing agencies, MOPH, other ministries including local government, government spending on CSMBS, SHI and UC) as percent of total government spending increased from 18% during the period of 1995-2000 to 20.26% during 2000-2007. Table 2 indicates that the Thai government invested more on health during 2000-2007 as reflected by the proportion of government health spending as a percentage of GDP increased from 1.92% during the period prior to 2000 to 2.32% in the period from 2000 to 2007. As a result of more investment in health by the government; the proportion of household out-of-pocket payments to THE significantly decreased from 37.6% during the period prior to 2000 to 26% during the period after 2000, see Table 2. There are positive effects on the incidence of catastrophic health expenditure and impoverishment in particular the government health spending directly benefited the poor, through district health systems development, functioning primary healthcare [5].

Table 2: Selected parameters of health care financing between the period of 1995-2000 and 2001-2007

	1995-2000	2001-2007
Mean nominal annual growth rate in THE, geometric mean %	2.49%	10.84%
Mean nominal annual growth rate in GDP, geometric mean %	3.29%	8.75%
Mean total government spending, percent of GDP	10.67%	11.46%
Mean government health spending, percent of total government spending*	17.99%	20.26%
Mean government health spending, percent of GDP	1.92%	2.32%
Mean out-of-pocket payments, percent of total expenditure on health	37.59%	26.04%

Note * inclusive of all public financing agencies: MOPH, other ministries including local government administrations, spending on CSMBS, SHI and UC.

Table 3 demonstrates a consistent pattern that expenditure on curative services dominates total health spending, increased from 38.4% in 1997 to 43.5% in 2006; expenditure for inpatient services increased from 26.2% in 1994 to 38.7% in 2007. The medical goods dispensed to out-patient had gradually decreased from 6.5% in 1994 to approximately 4% in 2007 (Table 3). At the same time, spending on capital formation had substantial reduction, from 13.7% in 1994 to 5% in 2001. Even after UC, capital investment stayed around 3% to 5%.

The prevention and the public health services accounted 7% to 8% of total spending during 1994-2001. It increased sharply to 12.4% in 2002 when UC was launched, but declined to 6.6% and 4.5% in 2007 and 2008, respectively.

Table 3: Healthcare spending profile, % of Total Health Expenditure, 1994 to 2008

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
In-patient care*	26.2	25.9	26.6	25.6	26.1	31.5	30.8	32.6	30.2	34.1	33.4	33.8	35.3	37.0	36.2
Outpatient care	42.6	41.7	42.0	38.4	37.3	41.4	40.7	40.3	43.8	44.7	43.9	43.3	41.5	40.9	42.3
Ancillary services	0.0	0.0	0.0	0.0	0.2	0.2	0.1	0.2	0.3	0.2	0.4	0.4	0.2	0.2	0.2
Medical goods**	6.5	6.4	4.9	4.4	5.7	5.6	6.3	6.1	4.0	3.9	4.2	4.3	4.8	3.9	4.4
Prevention, public health services	7.1	7.5	7.3	7.3	7.5	8.0	8.2	8.0	12.4	8.7	8.3	4.9	4.5	6.6	4.5
Health administration	3.9	4.1	4.4	6.7	7.3	7.6	7.9	7.9	4.8	5.0	5.6	8.9	9.1	6.9	6.8
Total recurrent	86.3	85.6	85.2	82.4	84.1	94.2	94.1	95.0	95.4	96.7	95.7	95.6	95.3	95.5	94.4
Gross capital formation	13.7	14.4	14.8	17.6	15.9	5.8	5.9	5.0	4.6	3.3	4.3	4.4	4.7	4.5	5.6
THE	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Note * including long term care and rehabilitation services
** Expenditure on medicines and medical devices paid by households only. Note that spending on outpatient and inpatient are inclusive of medicines and medical devices
Source: NHA Working Group 2009 [4]

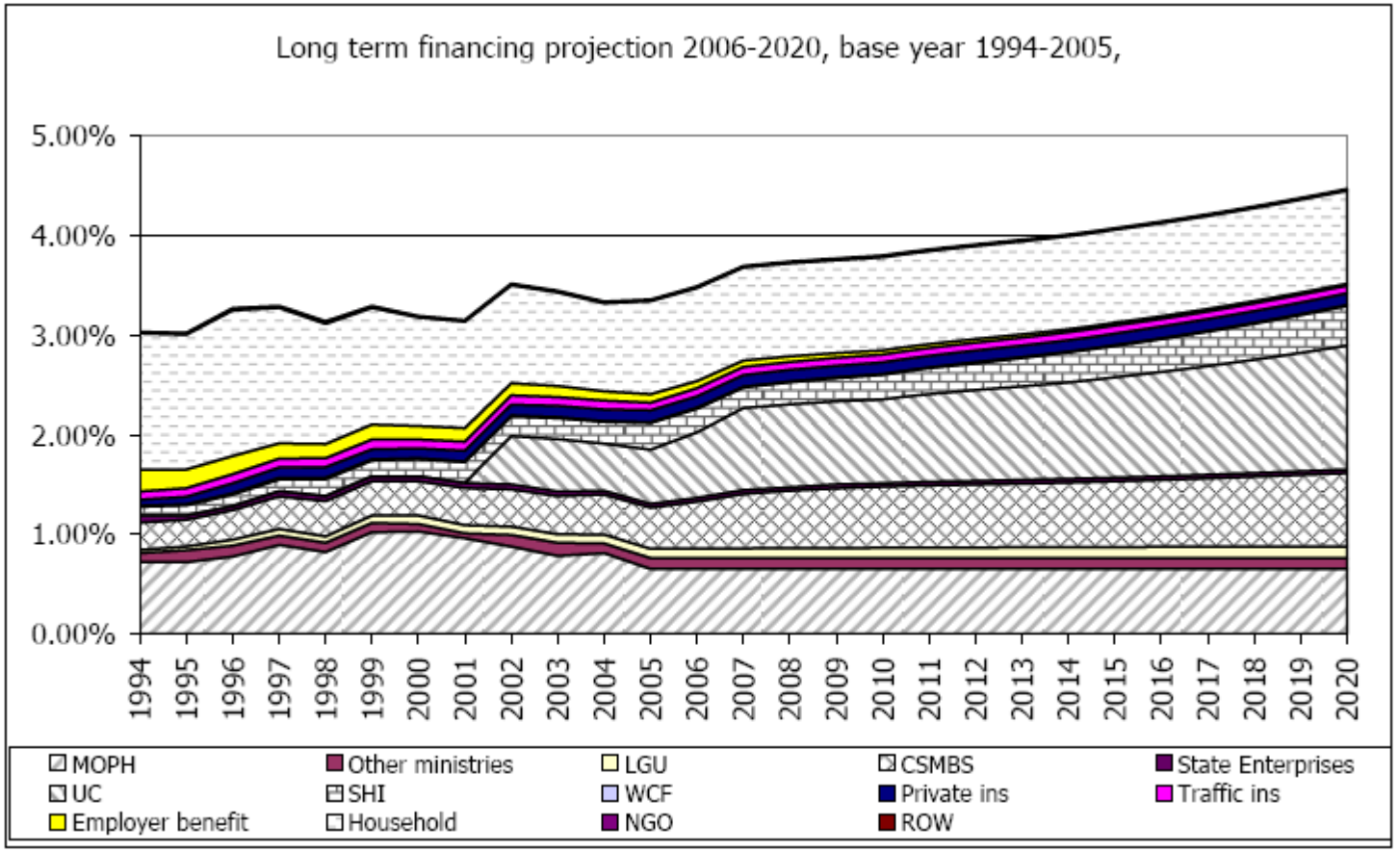
In 2008, spending on ambulatory services and in-patient care was the lion share, public health and disease prevention activities shared only 4.5%. The proportion of health administration and capital investment was 6.8% and 5.6% respectively. The ancillary service was a tiny amount, 0.2 percent. Based on hospital database; most expenditure on

ancillary services was included in outpatient care. Also expenditure on long-term nursing care was included in inpatient and rehabilitation services and did not present in a separate item.

In the light of scientific advancement, new technologies such as pharmaco-genomics, surgical procedures and diagnostic imaging are expensive and unaffordable. OECD experiences have shown that technology advancement is one of the very important cost drivers [6] for which appropriate mechanisms should be introduced to generate evidence on cost effectiveness and other information to guide decisions on technology adoptions.

As a result of these concerns, a long term, twenty-year financial projection was done, based on analyses of data from various sources including health and welfare survey, national health account 1994-2005, hospital input-output report and administrative inpatient database, and the use of social budgeting models of International Labour Organization. By 2020, total health expenditure will be within the capacity of the government to afford, less than 4.5% of GDP, whereby the general tax will be the highest share of financing sources for universal coverage followed by CSMBS expenditure. Private household spending will be equivalent to that of Social Health Insurance Scheme [7]. Historically, donors' resources have played insignificant role in financing health in Thailand, less than 0.05% of total health spending since 1994, see Figure 5.

Figure 5 Long term health financing projection, 2006-2020 base year 1994-2005



Source [7]

3. Revenue collection and sources of funds: where does money come from?

Refer to Thai National Health Account [4], there are five main funds of finance: general government health expenditures (GGHE), social health insurance (SHI), private health insurance, out-of-pocket (OOP) and the rest of world (ROW).

In 1994, the share of health care spending by GGHE was less than the private spending (private health insurance and OOP). However, the proportion of GGHE gradually increased and overtook the private spending, and became the dominant financing source after the 1997 Asian economic crisis and the emergence of the UC scheme in 2002 (Table 6).

SHI was not a major contributor in health expenditure. SHI accounts for 2.9% of THE in 1994 and gradually increased to about 7% in 2007. Household OOP had a lion share in 1994, 44.5% of THE, until the 1997 Asian economic crisis and then slowly and steadily dropped to 19.2% in 2007. Funding size from the rest of the world is negligible.

Table 6 Percent distribution of five sources of finance, 1994-2007

Year	GGHE excluding SHI	SHI	Private Health Insurances	Out-of-Pocket	Rest of the World	THE	THE (Million Thai Baht)
1994	41.7%	2.9%	10.9%	44.5%	0.1%	100%	127,655
1995	43.6%	3.3%	10.4%	42.6%	0.1%	100%	147,837
1996	43.8%	3.4%	10.3%	42.5%	0.0%	100%	177,103
1997	50.5%	3.4%	9.2%	36.9%	0.1%	100%	189,143
1998	49.8%	5.0%	9.8%	35.4%	0.0%	100%	172,811
1999	50.0%	4.9%	10.6%	34.5%	0.0%	100%	162,124
2000	50.8%	5.3%	10.1%	33.7%	0.0%	100%	167,147
2001	49.6%	6.6%	10.5%	33.1%	0.1%	100%	170,203
2002	57.7%	5.6%	9.3%	27.2%	0.3%	100%	201,679
2003	57.4%	6.2%	9.4%	26.8%	0.3%	100%	211,957
2004	58.1%	6.5%	9.0%	26.1%	0.2%	100%	228,041
2005	56.2%	7.9%	8.4%	27.2%	0.3%	100%	251,693
2006	60.3%	7.5%	9.3%	22.6%	0.3%	100%	291,294
2007	65.8%	7.1%	7.6%	19.2%	0.3%	100%	315,531

Source: NHA Working Group 2009 [3]

Note:
1 General Government Health Expenditures (GGHE) comprised of health expenditure spent by the ministry of public health and other ministries, local government agencies, CSMBS, state enterprise and universal coverage scheme since 2002.
2 Social Health Insurance (SHI) comprised of health expenditures through social health insurance fund and workmen compensation fund.
3 Majority of private health insurances were voluntary basis (about 57% of all private insurances) while the rest (43%) were compulsory traffic accident protection fund managed by private insurance companies.
4 Out-of-Pocket (OOP) were paid by household at point of services.
5 Rest of the World (ROW) means grants from bilateral and multilateral donors.

出典：平成 24 年度 JICA 集団研修カントリーレポート

- 平成 24 年度 JICA 集団研修「社会保険行政」

Japan International Corporation of Welfare Services (JICWELS) was established with the sanction of the Minister for Health, Labour and Welfare in July 1983 and implements international technical cooperation programmes with purpose of contributiing to the promotion of health and social welfare activities in the friendly nations.

Japan International Corporation of Welfare Services (JICWELS)
Toranomon YHK Bldg. 4F, 2-3-20, Toranomon
Minato-ku, Tokyo 105-0001 JAPAN
Phone: +81-(0)3-6206-1137
Fax: +81-(0)3-6206-1164
http://www.jicwels.or.jp

公益社団法人国際厚生事業団（JICWELS）は、国際的な保健・福祉分野の国際協力に貢献することを目的として、1983 年（昭和 58 年）7 月 7 日に厚生省（現厚生労働省）から社団法人の認可を受け設立されました。開発途上国の行政官研修や WHO フェローの受入れ、調査企画や研究開発並びに情報の交換及び広報活動など、海外諸国との国際交流活動を推進しています。

公益社団 国際厚生事業団 JICWELS
広報活動委員会

〒105-0001
東京都港区虎ノ門 2-3-20 虎ノ門ＹＨＫビル 4 階
電話 03-6206-1137（事業部）　Fax03-6206-1164
http://www.jicwels.or.jp