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Lessons from Thailand : Designing Universal Health Care Coverage for Access to Mental Healthcare

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I. Introduction

In 2001, Thailand introduced the Universal Coverage Scheme ("UCS"), healthcare reform to provide healthcare to those who were previously uninsured—approximately one-quarter of the people in Thailand.[1] Just one year later, the UCS had spread to all provinces, providing outpatient, inpatient, and emergency care for all according to need.[2]

So, how successfully has the UCS expanded access to Thailand's mental health system? The answer to this question is a mixed bag, deeply intertwined with the limits of the UCS itself. Since the 2014 coup, the future of the UCS has been uncertain—military government leaders have characterized the scheme as an unwieldy financial burden. The UCS faces an ever-growing budget and a perennial shortage of medical providers, particularly in rural areas, which in turn has cast doubt on the long-term sustainability of the program and the quality of care UCS beneficiaries receive. These issues translate to the mental health system, where limited expenditure on mental health and a lack of staff have restricted access to mental health services, even if they are freely available in theory.

Still, these are the very issues plaguing other countries, even high-income, highly developed countries like the U.S., whose total expenditure on health per capita and total expenditure on health as a percentage of GDP are significantly higher than that of Thailand.[3] In 2014, the U.S.'s total expenditure on health per capita was more than fifteen times that of

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[1] Sue George, *What Thailand Can Teach the World About Universal Healthcare*, The Guardian, https://www.theguardian.com/health-revolution/2016/may/24/thailand-universal-healthcare-ucs-patients-government-political (May 24, 2016).
[2] *Id.*
[3] Susan Brink, *What Country Spends the Most (And Least) On Health Care Per Person?*, NPR, https://www.npr.org/sections/goatsandsoda/2017/04/20/524774195/what-country-spends-the-most-and-least-on-health-care-per-person (Apr. 20, 2017).

Thailand, and the U.S.'s total health expenditure on health as a percentage of GDP was more than quadruple that of Thailand.[4] But despite the vast differences in spending, the U.S. does not have vastly better health outcomes, indicating that higher spending does not necessarily translate to better outcomes.

Thailand's Universal Coverage Scheme has, in many ways, been incredibly successful in designing coverage with limited resources so as to be more sustainable than not. The UCS has been described as "one of the most ambitious healthcare reforms ever undertaken in a developing country."[5]

> The lessons in Thailand: a well-researched system with a dedicated leadership can improve health, and in an affordable way. As of 2011, the country's health scheme cost just $80 per person annually, primarily funded by general income tax; it effectively reduced infant mortality, decreased worker sick days and lightened families' financial burden for healthcare.[6]

Thailand serves as an example of strategic healthcare design: learning through inefficient healthcare frameworks to develop policies and laws that foster cost-reducing incentives. Still, the political instability of Thailand—evidenced since Thailand became a constitutional monarchy in 1932 by the country's twenty different constitutions, many of which were adopted following military coups—has contributed to the malleability of law, leaving the UCS vulnerable to the political whims of the latest military government.

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[4] *See Thailand Statistics*, World Health Organization (2015). *See also United States of America Statistics*, World Health Organization (2015).
[5] *What Thailand Can Teach the World About Universal Healthcare*, *supra* note 1.
[6] *Id.*

II. Designing the Universal Coverage Scheme

A. Learning Through Inefficient Healthcare Frameworks

Table 1: Population Covered by Various Health Insurance Schemes From 1991-2001[7]

Health Insurance Schemes	1991	1996	2001
The Low Income Scheme	12.7	12.6	32.4
Voluntary Health Card Scheme	1.4	15.3	20.8
Civil Servant Medical Benefit Scheme	15.3	10.2	8.5
Social Security Scheme	-	5.6	7.2
Private Health Insurance	4.0	1.8	2.1
Total % Insured	**33.4**	**45.5**	**71.0**
Total % Uninsured	**66.6**	**54.5**	**29.0**

It took nearly three decades of piece-meal insurance coverage for Thailand to achieve universal health coverage. Before the inception of the universal coverage program in 2001, Thailand's health insurance system was fragmented, duplicated, and inadequate. There were five main categories of health insurance: (1) the Low Income Card Scheme, (2) the Civil Servant Medical Benefit Scheme, (3) the Voluntary Health Card Scheme, (4) the Social Security Scheme, and (5) the relatively small private health insurance market.[8]

Of the five categories, the Low Income Card Scheme and the Voluntary Health Card Scheme provided lessons on the kinds of schemes that are not sustainable for those in the informal employment sector. Introduced in 1975, the Low Income Card Scheme was a publicly subsidized program initially targeting the poor and later in 1992 extending its coverage to the

[7] Viroj Tangcharoensathien, Phusit Prakongsai, Supon Limwattanon, Walaiporn Patcharanarumol, & Pongpisuit Jongudomsuk, *Achieving Universal Coverage in Thailand: What Lessons Do We Learn?*, Health Systems Knowledge Network, at 2 (Mar. 2007).

[8] Kannika Damrongplasit & Glenn A. Melnick, *Early Results from Thailand's 30 Baht Health Reform: Something to Smile About*, Health Affairs, at 458 (March 31, 2009) [hereinafter *Early Results from Thailand's 30 Baht Health Reform*].

elderly.[9] Similarly, the Voluntary Health Card Scheme was established in 1983 as a maternal and child health fund and later expanded as a government-subsidized health insurance scheme targeting groups in the informal employment sector who were not eligible for other types of health insurance.[10] This scheme was funded by equal payments between households and the Ministry of Public Health, with households purchasing a health card for 500 baht (approximately 16 USD today) and the government contributing another 500 baht.[11]

Operational issues in these programs resulted in approximately 18 million, or about 30% of the population, being uninsured in early 2001.[12] First, the Low Income Card Scheme had difficulties assessing the incomes of those working in the informal employment sector.[13] A household survey from 2000, for instance, indicated that only 35% of the Low Income Card Scheme's beneficiaries met the program's eligibility standards[14] and that only 17% of the poor were being covered by the Low Income Card Scheme.[15] Second, the Voluntary Health Card Scheme faced adverse selection in its beneficiaries, with one study showing that the presence of illness was positively associated with the purchase and utilization of the program.[16] As a voluntary program, the Voluntary Health Card Scheme saw an increase in the number of sick who joined,[17] while those who were healthy left the scheme.[18] Consequently, the scheme could not sustain itself financially.

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[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] Seung Chun Paek, Nathan Meemon, & Thomas T. H. Wan, *Thailand's Universal Coverage Scheme and Its Impact on Health-Seeking Behavior*, SpringerPlus 5:1952, at 2 (2016).
[13] *Id.*
[14] *Id.*
[15] *Achieving Universal Coverage in Thailand: What Lessons Do We Learn?*, *supra* note 7, at 2.
[16] *Thailand's Universal Coverage Scheme and Its Impact on Health-Seeking Behavior*, *supra* note 12, at 2.
[17] The Voluntary Health Card Scheme performed relatively well in increasing population coverage, from 1.4% in 1991 to 20.8% in 2001. *Achieving Universal Coverage in Thailand: What Lessons Do We Learn?*, *supra* note 7, at 2.
[18] Renu Khanna, *Universal Health Coverage in Thailand: What Lessons Can India Learn?*, MFC Bulletin, at 1 (Dec. 16, 2010).

Amidst this backdrop, the Thai government considered integrating the Low Income Card Scheme and the Voluntary Health Card Scheme, as well as covering those still left uninsured, in what would become the Universal Coverage Scheme. The Universal Coverage Scheme would attempt to circumvent the administrative difficulties of assessing incomes in the Low Income Card Scheme, as well as the adverse selection issues of the Voluntary Health Card Scheme. The UCS, financed through general tax revenue, would cover everyone not already covered by the Civil Servant Medical Benefit Scheme and Social Security Scheme.

B. Reducing Costs & Aligning Incentives

Table 2: Health Insurance Schemes When Universal Coverage Was Achieved in Early 2002[19]

Schemes	Target Population	Coverage	Source of Fund	Payment Method
Civil Servant Medical Benefit Scheme	Government employees, retirees, and dependents	6 million (10%)	General tax	Fee for service reimbursement model
Social Security Scheme	Private sector employees	8 million (13%)	Payroll tax	Capitation
Universal Coverage Scheme	The rest of the population	47 million (74%)	General tax	Capitation

1. Capitation As A Cost-Reducing Measure

When the UCS was implemented in 2001, individuals paid no more than 30 baht per visit for outpatient or inpatient care,[20] ranging from medication to open-heart surgery,[21] although

[19] *Achieving Universal Coverage in Thailand: What Lessons Do We Learn?*, *supra* note 7, at 10.
[20] Early Results from Thailand's 30 Baht Health Reform, *supra* note 8, at 458.
[21] Pichet Udomratin, *Mental Health and Psychiatry in Thailand*, Bulletin of the Board of International Affairs of the Royal College of Psychiatrists 4:1, at 12 (Jan. 2007).

some costly procedures were not covered.[22] The goal was to provide, regardless of one's income or socioeconomic status, equal access to quality care according to one's needs.[23] Later, even the 30 baht per visit requirement was abolished, so that visits involved no cost.

One may wonder how the UCS remained afloat if individuals were paying 30 baht per visit in 2001 and later no baht per visit since 2009. In extending the UCS to nearly three quarters of its population, Thailand chose a financing mechanism based on capitation: fixed prepayments per patient covered by contracted healthcare facilities.

To receive services, individuals were required to register with a public health unit, such as a health center or community hospital in their residential area, and to use that facility as their primary point of contact.[24] This set-up strengthened the referral system—doctors at the primary public health unit were supposed to refer patients to a larger hospital only if they could not treat the patient, and the larger hospital was supposed to send the bill for reimbursement back to the primary public health unit.[25] Primary care facilities received annual funding from the government based on the number of registered patients, and this funding was meant to cover all expenses, including salaries, equipment, and materials.[26] The primary care unit would thus function as a gatekeeper for referrals[27] and thus help control the cost of medical care.

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[22] Examples of procedures outside coverage included renal dialysis, cosmetic care, obstetric delivery beyond two pregnancies, organ transplant, and chemotherapy. Early Results from Thailand's 30 Baht Health Reform, *supra* note 8, at 458.
[23] *Id.*
[24] *Id.*
[25] *Mental Health and Psychiatry in Thailand*, *supra* note 21, at 12.
[26] *Id.* The yearly budget per registered patient was 1202 Baht in 2003, 1308 Baht in 2004, 1396 Baht in 2005, and 1659 Baht in 2006. *Id.*
[27] Without a referral letter from the registered facility, those under the UCS could not visit a doctor in a secondary or tertiary care setting, unless they were prepared to pay expenses out of pocket. *Id.*

In choosing capitation instead of fee-for-service payments, Thailand designed its budget to follow the people, and designing capitation from general tax revenue allowed the Thai government to fund universal coverage without overspending beyond its means.

In a fee-for-service payment system, providers are incentivized to use more expensive treatment options over less expensive treatment options, since providers are not required to internalize such externalities. But capitation, unlike fee-for-service, disincentivizes providers from overtreating a patient (i.e., providing as much care as possible, notwithstanding whether such care is necessary or optimal). Capitation thus seems more efficient if a key goal is to curb expenditures. Capitation incentivizes providers to do more on the front end rather than the back end since preventative healthcare is presumably less costly than treatment.

On the other hand, the fixed payment method may bias providers in the opposite direction: undertreatment, as opposed to overtreatment. Although capitation generally serves as a cost-containing measure, providers are forced to swallow those costs when capitation rates are not high enough to cover the cost of care, which seems to be one of the issues facing the UCS—the current budget, despite substantial growth over the years, is simply not large enough to cover the rising cost of care. Inevitably, patients cannot and do not consistently receive high quality care.

So in addition to analysis of optimal capitation rates, the financial viability of the UCS may depend on analysis of the likely growth in demand for services (especially if the UCS were to expand its coverage of certain high-cost medical treatments) in order to understand the extent to which the UCS is underfunded. Such studies would help establish a basis for allocating additional sources of revenue to the UCS so that government spending on health care is not so tightly bound.

2. Incentivizing Human Resources Toward Rural Areas

Table 3: Availability of Mental Health Facilities & Beds in 2011[28]

Facility/Beds	**Total Number of Facilities/Beds**	**Rate per 100,000 population**
Mental Health Outpatient Facilities	93	0.14
Day Treatment Facilities	2	0.003
Psychiatric Beds in General Hospitals	60	0.09
Community Residential Facilities	2	0.003
Beds in Community Residential Facilities	Information unavailable	Information unavailable
Mental Hospitals	18	0.03
Beds in Mental Hospitals	8714	12.79

Table 4: Persons Treated or Admitted in 2011[29]

Persons Treated/Admissions	**Rate per 100,000 population**
Persons Treated in Mental Health Outpatient Facilities	117.74
Persons Treated in Mental Health Day Treatment Facilities	0.09
Admissions to Psychiatric Beds in General Hospitals	0.21
Admissions to Mental Hospitals	131.13
Persons Staying in Community Residential Facilities at the End of the Year	Information unavailable

[28] *Mental Health Atlas 2011*, World Health Organization, Department of Mental Health and Substance Abuse, at 2 (2011).
[29] *Id.*

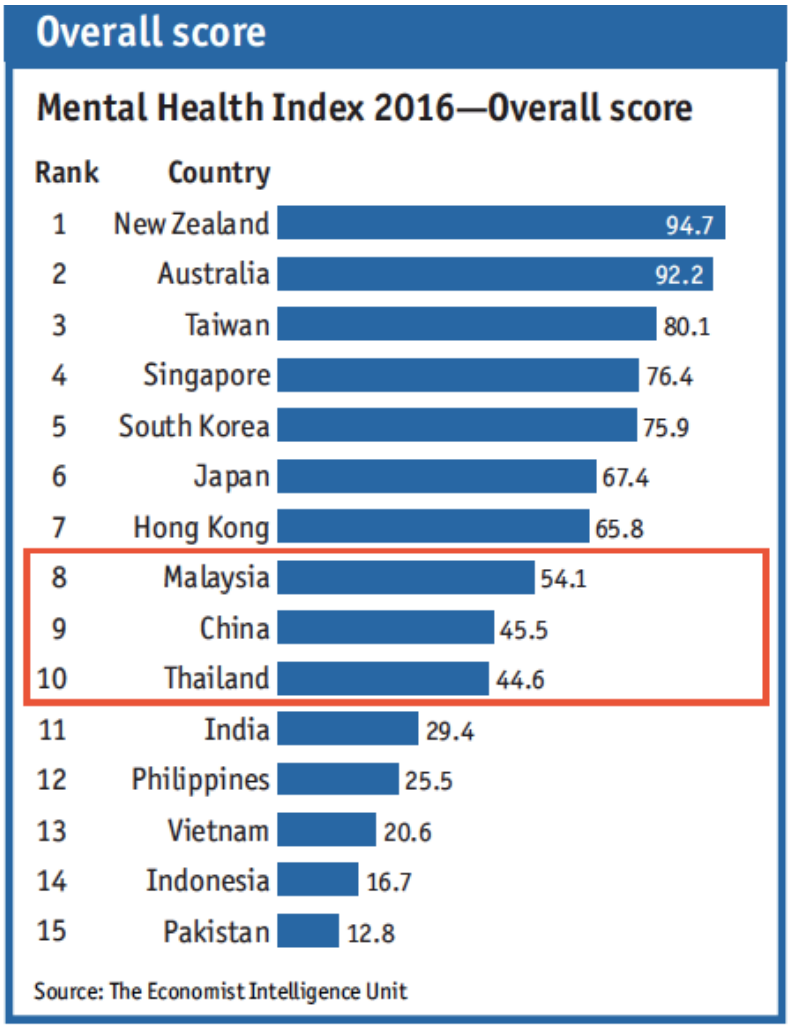
Table 5: Number of Psychiatric Patients, 2006-2011[30]

Inpatients/ Outpatients	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Inpatients (admission cases)	90,862	87,664	87,776	89,250	91,340	83,338
Total Outpatient Visits	942,240	942,480	942,720	1,022,504	1,055,548	1,091,646
New Outpatient Cases	100,575	122,821	102,830	80,227	70,717	88,432

Thailand faces an insufficient number of mental health workers, the consequences of which is intensified by the high concentration of those mental health workers in Bangkok.[31] According to a 2006 World Health Organization Report on the Mental Health System in Thailand, there were 7.29 personnel working in mental health for every 100,000 population.[32] Although a large part of human resources were directed to mental hospitals, the ratio of human resources per bed were low for all professional groups and particularly low in mental hospitals, where the majority of beds were located.[33]

[30] Pongpisuit Jongudomsuk, Samrit Srithamrongsawat, Walaiporn Patcharanarumol, Supon Limwattananon, Supasit Pannarunothai, Patama Vapatanavong, Krisada Sawaengdee, & Pinij Fahamnuaypol, *The King of Thailand Health System Review*, Health Systems in Transition 5:5, at 157 (2015).
[31] *Mental Health and Psychiatry in Thailand*, *supra* note 21, at 13.
[32] *WHO-AIMS Report on Mental Health System in Thailand*, World Health Organization & Ministry of Public Health, Thailand, at 5 (2006) [hereinafter *WHO-AIMS Report*].
[33] *Id.* at 24.

In response, Thailand has taken measures to increase the number of mental health workers. The Department of Mental Health, for instance, responding to the limited number of psychiatrists, implemented a postgraduate training in psychiatry that increased the number of psychiatrists from 419 in 2005 to 679 in 2014.[34] Still, these numbers are low for an upper middle-income country like Thailand.[35] And human resources in mental health remain largely concentrated in major cities like Bangkok, which limits access to mental health services for those in rural areas.[36]



This phenomenon is not limited to Thailand's mental health system. Human resources in health fields generally are skewed toward urban areas, with Thailand's Minister of Public Health estimating one doctor for every 850 people in Bangkok and one doctor for every 5,308 people in Thailand's northeast provinces. [37] Here, too, the government has taken notice

[34] *The King of Thailand Health System Review*, *supra* note 30, at 159.
[35] *Mental Health and Integration*: *Provision for Supporting People with Mental Illness: A Comparison of 15 Asia Pacific Countries*, The Economist, Intelligence Unit, at 31 (2016).
[36] *Id.*
[37] Noah Leavitt, *Thailand Seeks to Address Shortage of Rural Health Care Providers*, Harvard School of Public Health, https://www.hsph.harvard.edu/news/features/thailand-seeks-to-address-shortage-of-rural-health-care-providers/ (May 11, 2015).

and has created policies that shuttle doctors and nurses to work in rural areas. Thailand, for instance, implemented a three-year mandatory rural health service placement for doctors, dentists, and pharmacists.[38] Additionally, Thailand has been working on a homegrown approach to train future doctors and nurses by seeking out high-performing students already living in rural areas and offering them scholarships on the condition that they work in their home districts upon graduation.[39]

Like capitation as a cost-reducing measure, the partnership between the Ministry of Education and Ministry of Public Health to increase the number of health workers in rural areas seems focused on feasibility and efficiency. Mandatory service in a rural area, as well as special recruitment of those with existing ties to rural areas, increases the likelihood that health professionals will continue to work in rural areas, even when they are no longer required to. On the other hand, the three-year mandatory rural health service placement, in particular, seems designed to be somewhat of a revolving door. The financial incentives often favor moving to the private sector upon fulfilling one's commitment to the public sector in a rural area. Thus, that measure, even if strongly enforced, seems more like a stopgap measure rather than a long-term solution.[40] The homegrown approach looks more promising but imposes a rather high cost on individuals who receive full government scholarships to pursue a 6-year medical degree in exchange for 12 years of mandatory service in their home districts (or a fine of $56,000 USD in lieu of service).[41]

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[38] *Id.*
[39] *Id.*
[40] *See* Olga Khazan, *Why Are There So Few Doctors in Rural America?*, The Atlantic, https://www.theatlantic.com/health/archive/2014/08/why-wont-doctors-move-to-rural-america/379291/ (Aug. 28, 2014).
[41] *See* Viroj Tangcharoensathien, Rappepong Supchanchaimat, Noppakun Thammatacharee, & Walaiporn Patcharanarumol, *Thailand's Universal Health Coverage Scheme*, Economic & Political Weekly (Feb. 25, 2012).

III. The Evolving Legal Framework

A. The UCS Legislation: Law Passed Shortly After Implementation

"30 Baht[42] Treats All Diseases"
Thai Rak Thai Party's 2001 campaign slogan,
and promise to cover the uninsured

Leading up to the 2001 elections, the populist Thai Rak Thai Party campaigned vigorously for a radical change in access to healthcare.[43] The Thai Rak Thai Party's campaign slogan became "thirty Baht treats all diseases" because its proposed healthcare scheme, at very low cost to its beneficiaries, would protect Thais who had inadequate insurance or no insurance. The proposed healthcare reform enjoyed strong support from policy researchers and officers from the Ministry of Public Health who worked closely with the reformists.[44] Strong civic support also increased the prospects of a universal healthcare scheme.

In January 2001, the Thai Rak Thai party won a landslide victory, opening the path for universal coverage. Implementation was rapid,[45] starting with six provinces in mid-2001 and extending to seventy-five of the seventy-six provinces by the end of the year.[46] To facilitate this rapid implementation, the Thai Rak Thai Party made the pragmatic decision of funding universal coverage through general tax, which further eased costs on the poor.[47] By 2002, less than 3% of the Thai population had no insurance coverage.[48]

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[42] 30 Baht is the equivalent of approximately 1 USD today.
[43] Amanda Glassman & Miriam Temin, *Thailand's Universal Coverage Scheme*, Millions Saved: New Cases of Proven Success in Global Health, http://millionssaved.cgdev.org/case-studies/thailands-universal-coverage-scheme (2016).
[44] *Universal Health Coverage in Thailand: What Lessons Can India Learn?*, *supra* note 18, at 3.
[45] The rapid implementation can be credited, at least in part, to strong party leadership that thought it imperative to quickly reduce inequity in social benefits. *Achieving Universal Coverage in Thailand: What Lessons Do We Learn?*, *supra* note 7, at 8.
[46] *Thailand's Universal Coverage Scheme*, *supra* note 41.
[47] *Achieving Universal Coverage in Thailand: What Lessons Do We Learn?*, *supra* note 7, at 9.
[48] *Thailand's Universal Coverage Scheme*, *supra* note 41.

Notably, the Universal Coverage Scheme was implemented prior to passage of any legislation. The legislative process started at the end of 2001 and ended in November 2002 when the Senate endorsed the National Health Security Act.[49] This law received strong civic support—it was the first law under Thailand's new constitution to have more than 50,000 voters sign onto a proposal bill presented to the House of Representatives and Senate.[50]

B. Mental Health Legislation: Law Passed Long After the UCS

Five years after the passage of the National Health Security Act[51] in 2002, Thailand passed the National Health Act in 2007,[52] Thailand's principal healthcare law. The National Health Act codified important rights and duties on health, such as the right to live in a healthy environment and the right to receive sufficient information to make an informed decision on health services. The concept of health was extended from the medical and public health sectors to other sectors under the principle of "all for health and health for all."[53] It was against this backdrop that the Mental Health Act[54]—Thailand's first mental health legislation—was passed the very next year.

For years, Thailand had a mental health policy that favored community-based care, but no mental health legislation.[55] Only in 2008 did Thailand enact the Mental Health Act, the aim of which was to protect the rights of mentally ill patients to receive care, treatment, and rehabilitation. With the passage of the Mental Health Act, mental health costs came under the

[49] *Achieving Universal Coverage in Thailand: What Lessons Do We Learn?*, *supra* note 7, at 9.
[50] *Id.*
[51] *See* National Health Security Act, B.E. 2545 (A.D. 2002).
[52] *See* National Health Act, B.E. 2550 (A.D. 2007).
[53] *See International Guide on Health Industry Laws: Thailand*, Tilleke & Gibbons Internatinoal Ltd. (2016).
[54] *See* Mental Health Act, B.E. 2551 (A.D. 2008).
[55] *Mental Health and Integration, supra* note 35, at 30.

country's universal health coverage scheme and required officials to monitor and measure implementation.[56]

The Mental Health Act, however, has been particularly difficult to implement in practice, perhaps due in part to the more muted political and civil support. The Mental Health Act is certainly no National Health Security Act. Changes in the perception of mental health have been slow-moving, and stigma persists, disincentivizing individuals from seeking mental health care.

As with the UCS, the mere availability of mental services does not translate to usage. The Department of Mental Health has taken measures to reduce stigma attached to mental health—it launched, for example, a campaign called the National Mental Health Campaign: Destigma, which created mass media networks for the dissemination of knowledge and research on mental health.[57] Still, perhaps inevitably, stigma persists, with some equating mental health issues with psychosis or attributing symptoms to spiritual possession.[58] Buddhist- and animist-influenced understandings of mental illness are fairly common in Thailand.[59] In response, the Department of Mental Health has worked with local monks on programs to recognize and treat people with mental health conditions, in addition to cooperating in programs that integrate Buddhist concepts of mindfulness and meditation with Western treatments.[60]

Thailand has long placed significance on community mental health in its mental health system. This outward significane, as well as the increasing number of people with mental disorders who are assessed and treated at the primary care level, is intended to not only reduce stigma, but also to reduce the maltreatment of people with mental illness. It is difficult, however,

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[56] *Id.*
[57] Chosita Pavasuthipaisit, Varoth Chotpitayasunondh, & Arpaporn Ussanarassamee, *Thailand Mental Health System*, ASEAN Mental Health Systems, at 147 (2016).
[58] *Id.* at 139.
[59] *Mental Health and Integration, supra* note 35, at 32.
[60] *Id.*

to see this in practice. A gap divides the legal framework from the reality of the mentally ill. In theory, Thailand has a Thai National Human Rights review body, which has the authority to review involuntary admissions, discharge procedures, complaints, and investigations.[61] In practice, this review body neither oversees regular inspection of mental health facilities nor has the authority to impose any sanctions.[62]

C. The 2014 Military Coup: Ongoing Amendment of the National Health Security Act

In 2014, the Royal Thai Army launched its twelfth coup since Thailand became a constitutional monarchy in 1932. Currently, the National Council for Peace and Order ("NCPO") governs Thailand. The NCPO quickly imposed martial law, repealed part of the 2007 constitution, and issued an interim constitution that granted itself amnesty and wide-sweeping power. In 2017, a new constitution drafted by the NCPO was ratified. The newest constitution, Thailand's twentieth, introduces a different electoral system that gives the NCPO substantial power in determining the membership of Parliament. Significantly, also in 2017, the National Health Security Bill was introduced to amend the National Health Security Act of 2002.

The National Health Security Bill has been the subject of much debate, as critics worry that the introduction of co-payments would drastically limit access to healthcare. But Thailand's Public Health Minister, Dr. Piyasakol Sakolsatayadorn, has insisted that the amendment is not intended to reduce people's rights to healthcare, but that limited healthcare budgets mean that access to "more than basic" healthcare services would merely involve a cost, a move "for the sake of sustainability and long-term efficiency."[63]

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[61] *Thailand Mental Health System*, *supra* note 57, at 146.
[62] *Id.*
[63] Chularat Saengpassa, *Co-Payments Near Reality As Universal Healthcare System Reformed*, The Nation, http://www.nationmultimedia.com/detail/national/30335227 (Jan. 3, 2018).

Although it appears that access to mental healthcare has not been at the forefront of debate on the National Health Security Bill, changes to the National Health Security Act of 2002 indicate parallel, if not more serious, changes to come for access to mental healthcare, which may not necessarily be considered "basic" healthcare.

> Like it or not, indications are that patients will have to pay a portion of the medical expenses if and when the proposed National Health Security Bill is passed under the junta government.[64]

Part of the impetus behind the co-payments seems to be the desire to separate those who can pay for services from those who cannot pay for services. While the bill was pending in October 2017, the government launched welfare cards for the poor. Identity cards were provided to over 11.4 million registered people who could show their cards to get free transport and commodities worth 300 baht per month for each beneficiary.[65] Perhaps bureaucratic machines have become more accurate at assessing incomes, but the launch of welfare cards is reminiscent of the Low Income Card Scheme of 1975, where assessment issues resulted in less than one-fifth of the poor being covered by the Low Income Card Scheme.

Moreover, co-payments create different incentives for providers, incentives that may not run parallel to those of patients. Co-payments sound like a return to the funding mechanisms before implementation of the UCS, where the budget would follow providers rather than patients. This will likely alter the scope of the UCS significantly, as those most in need of treatment forego treatment due to prohibitively high costs. What's more, the National Health Security Bill may be only the first of wide-sweeping changes to Thailand's healthcare system, as

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[64] *Id.*
[65] Paritta Wangkiat, *Health Care on Life Support*, Bangkok Post, https://www.bangkokpost.com/news/special-reports/1367099/health-care-on-life-support (Nov. 26, 2017).

the UCS's goal of providing equal access to quality care, regardless of one's income or socioeconomic status, is seen as financially untenable.

IV. Conclusion

Thailand has come a long way in expanding access to healthcare. In implementing the UCS, Thailand made strategic decisions, such as a capitation payment method funded through general tax revenue, which facilitated rapid implementation and helped contain costs. The budget followed the people, not the provider, and providers were incentivized to provide preventative care so as to curb healthcare costs. Still, the ever-increasing costs of funding healthcare have led the military government to have doubts about the viability of the UCS, at least as it currently stands. The latest amendments to the National Health Security Act demonstrate the malleability of law to accommodate the shifting government.

Thailand, of course, is no stranger to political instability. A newly elected government in 2019 may attempt to undo changes to the UCS, but given the significant power of the military government to shape the membership of Parliament and the repeated delays since 2015 in holding elections, the amendments to the National Health Security Act may be here to stay indefinitely. It remains to be seen how this shift in design will affect access to mental healthcare and usage of mental health services, but if the UCS is any indication, access to and usage of mental healthcare will likely be circumscribed.