# Chapter 8

# Health Security in Thailand

This chapter analyzes the development of health security in Thailand in the past, at present, and in the future as to how it should be implemented. It includes four parts: (1) evolution of health security system in Thailand before 2002, (2) the 2001 transition to universal coverage of health care, (3) development of subsystems to support the universal coverage of health care, (4) achievements of the operation of health security, and (5) the outlook.

## 1 Evolution of Health Security System in Thailand before 2002

After the establishment of the Ministry of Public Health in 1942, the government specified that, in 1945, the people had to copay for health care provided by state health facilities. Later several health insurance schemes were developed for specific population groups, which can be classified into six major schemes as follows:

1) Medical Service Welfare for the People Project, formerly known as the Medical Services for the Poor Project, started in 1975.
2) Voluntary Health Insurance with Government Subsidies Project for the people in the non-formal employment sector who were ineligible to receive any medical services normally provided by the government for those in the formal sector. It was actually transformed from community health insurance funds of the MoPH that began in 1983.
3) Civil Servants Medical Benefits Scheme for civil servants and state enterprise employees beginning in 1978.
4) Compulsory health insurance schemes required by the government for employees in the private sector, including the Workmen's Compensation Fund (beginning in 1974) covering illnesses from work-related activities and the Social Security Scheme (beginning in 1990).
5) Compulsory Motor Vehicle Accident Victims Protection Project covering illnesses or injuries from traffic accidents beginning in 1993 as required by the 1992 Act.
6) Private voluntary health insurance operated by private health insurance companies, originated from health insurance businesses of transnational companies operating in Thailand before 1910.

### 1.1 Medical Service Welfare for the People (MSWP) Project

The prime objective of this project was to provide medical services to the poor and underprivileged. Initially, in 1975 the project covered only poor people, but later was extended to cover the elderly in 1989 and children under 12 years of age, the disabled, war veterans, and religious leaders in 1992, and community leaders as well as village health volunteers including their families in 1994. At the beginning stage, free medical service cards were issued to the poor at the discretion of healthcare providers; until 1979, the people's income was used to determine the poverty level when a 3-year card was given only to those who were considered to be poor as determined by subdistrict and district-level officials. This project covered 30% of the population in 2001.

The benefits of the project included outpatient and inpatient medical care except for certain services. In the beginning, the cardholders could obtain services only at MoPH health facilities with health centres saving as the front-line providers. In 1997, the eligible person can receive health services directly at the hospital with health centres as its network members, the reason being every individual should be eligible to see a physician. In the meantime, state-run health facilities under other ministries also joined the scheme under the overall management of the MoPH. In the beginning, the financial management was undertaken at the central level, which allocated the budget to the provincial level for further allocation to health facilities under their respective jurisdiction. Beginning in 1997 there were cooperative efforts in the financial management of the scheme through the national project management committee and provincial committees, according to the Regulations of the Prime Minister's Office on the Management of the Medical Service Welfare Project. Provinces were allotted a capitation budget according to the number of people registered under the project. Around this period, Thailand faced an economic crisis and had to take loans from the World Bank under the Social Investment Project (SIP); and the MoPH requested a loan for medical service fee payments to health facilities in six provinces, according to the capitation rate, on a pilot scale, for outpatients and DRG-weighted global budget for inpatients. This model was later adopted as the universal healthcare scheme.

However, the major problems of the project were the lack of coverage and accuracy in card issuance for the poor. An evaluation of the card issuance process for each round indicated that a lot of poor people did not receive the healthcare cards while a rather large number of card-receivers were not really poor.

### 1.2 Voluntary Health Insurance with Government Subsidies Project (VHIP)

The MoPH implemented this project (commonly known as voluntary health card project) between 1983 and 2001 in two major phases. In the first ten years (1983-1992), the scheme was operated as community funds aimed at increasing access to essential primary health services by setting low-priced health cards including maternal and child health cards, family medical care cards, and individual medical care cards (later on only family cards were used). It was expanded rapidly during

the first two years but slowed down steadily after that due to MoPH's unclear policy on his matter. During the second half of the scheme (1993-2001), as a result of the project evaluation, a systematic improvement in the scheme operations was undertaken to become a full-scale voluntary health insurance scheme beginning in 1994. Under the new scheme, the national and provincial health insurance funds were established with the government subsidizing half of the health-card price (1,000 baht each); each one-year card was valid for a family of not exceeding five members. In the last phase of the scheme, the government subsidy was increased to two-thirds of the card price (1,500 baht each).

The scheme was popular among the people and expanded widely particularly in rural areas. In 2001, the scheme coverage was 23.4% of Thai population.

The benefits of the scheme were not quite different from those for the MSWP scheme. During the initial stage, which was administered by the community fund, there was a limitation on the number of visits for medical care and a ceiling of coverage; and the cardholder was required to attend the health centre first and, if referred by the health centre, he/she might go to hospital for further medical care. When the full-scale voluntary health insurance scheme was implemented, such limitation and requirements were abolished; and the cardholder could go directly to the district hospital in their area. Moreover, a new card could be obtained from another province in case the person temporarily or permanently migrated during the year.

However, the problem of this scheme was a lack of good risk distribution as it was a voluntary insurance scheme and only one premium rate, resulting in a larger-than-normal proportion of cardholders with health risks and a low rate of cost recovery, particularly in the provinces with low coverage rates in relation to the population.

### 1.3 Civil Servants Medical Benefits Scheme (CSMBS)

The government and state enterprises have had a medical service welfare system for civil servants and state enterprise employees as well as their spouses, children and parents since 1978. Its aim is the provide welfare to boost morale for state officials and employees using the budgets of the government and state enterprises, covering approximately 8.5% of Thai population in 2001.

The benefits under this scheme are better than those under other schemes in that the eligible person can seek medical treatment at any state-run health facilities and, in case of emergency, at a private hospital (with a limitation on reimbursement) for civil servants. But for state enterprise employees, mostly they are free to choose any hospital as they wish; and their benefits are not much different from other schemes. However, there may be fewer exceptions; for example, they are eligible to the treatment for chronic kidney failure and organ transplantation.

The medical service welfare for civil servants of central and provincial administration agencies is managed by the Comptroller-General's Department, while that for officials of local administration organizations and state enterprises is managed by each particular organization or

enterprise. For outpatients, they have to pay for medical expenses first and get reimbursed later; for an inpatient, with a letter of eligibility certification from his/ her parent agency, the hospital can submit a claim for medical expenses directly to the Comptroller-General's Department. (Since 2005, eligible persons with chronic illness and pensioners have been able to register with a hospital to directly claim medical expenses from the Comptroller-General's Department, without paying for services first, for outpatient care; this mechanism is being extended to other groups of civil servants). Under this scheme, fee-for-services payments are made to the hospital; but for state enterprises, the benefits might vary according to their financial status and mostly have a cap on maximum coverage.

The major problem of this scheme is the rapid increase in the medical expenditure resulting from the fee-for-services payment mechanism.

### 1.4 Public Sector Compulsory Health Insurance Scheme

In the private employment sector, there are two funds: (1) Workmen's Compensation Fund covering work-related illnesses or injuries of employees with premiums paid only by employers and (2) Social Security Fund (SSF) covering employees' illnesses, disabilities, deaths, and retirements, with premiums jointly paid in equal proportion by the employees, employers, and the government. The SSF's aim is to provide security for employees when they get sick based on the principles of risk sharing and support for each other between the people with better and poorer economic status and between the healthy and the sick. In the initial stage, this scheme covered only employees in business places with 20 employees or more. Later on, it has been extended gradually to cover businesses with 10 employees, 5 employees, and 1 employee, respectively. In 2001, the SSF covered 7.6% of Thai population.

The benefits under this scheme are similar to those under other schemes provided by the government for outpatient/inpatient, maternity, and dental services. The eligible person may choose to register at any public or private hospital under the scheme and may change the hospital registered once a year.

This scheme is managed by the Social Security Office of the Ministry of Labour through the Social Security Commission. The medical service fees are paid to contracted hospitals in different forms, i.e. capitation for general inpatient/outpatient care; additional payments according to types of services, chronic illness and high-cost care; and compensation for childbirth, dental care, and emergency medical care for accident victims outside the contracted hospital.

### 1.5 Motor Vehicle Accident Victims Protection (VAVP) Act

Health insurance for injuries from traffic accidents is compulsory insurance required of all owners of motor vehicles and motorcycles registered to pay insurance premiums. The scheme aims to protect persons injured from road traffic accidents and provide them with suitable medical services

and also provide compensation for cases with disabilities or deaths. It is a compulsory insurance scheme for all registered vehicle owners and managed by a private company. Its major problem is the duplication of eligibility with other health insurance schemes; and it has complex steps and regulations for reimbursements, resulting in a transfer of payments to other insurance funds or state hospitals.

### 1.6 Private Voluntary Health Insurance

In Thailand most private health insurance plans are an integral part of life insurance or accident group insurance. The purpose of private health insurance is to cover the risk of medical care payment that may occur in the future. The premiums are usually dependent on the risk level of the individual or group of individuals. The role of private health insurance is rather limited and its market is confined only to groups of people with a rather good economic status who can pay the premiums. In 2001, only 1.2% of Thai population were reported to have private health insurance.

The benefits of private health insurance mostly cover inpatient medical expenses, which are generally higher than outpatient medical expenses, with a cap on protection coverage while income-loss compensation is also paid during illness.

Significant features of different health insurance schemes prior to the launch of the universal healthcare scheme are as shown in Table 8.1.

### 1.7 Conclusion

Prior to 2002, with a segregated development approach, Thailand had several health insurance schemes with different objectives; the Medical Service Welfare for the People Project focused on providing protection for the poor, the elderly and children. Generally, it was an important social projection scheme, but it could not protect the poor as expected. Moreover, it had inadequate budgetary support to provide suitable medical services. The Civil Servants Medical Benefits Scheme for government officials and state enterprise employees, including their family members, faces a problem of efficiency because hospitals tend to over-provide medical services (beyond the need) under the fee-for-service payment mechanism, resulting in a considerable increase in medical care expenditure each year. As for the Social Security Scheme, a payment system for hospitals has been rather good; it is a capitation payment which should be an option for the long-term reform in Thailand. The Government-subsized Voluntary Health Insurance System was problematic in terms of risk sharing, resulting its financial unsustainability in the long run. Findings from research studies and political will leading to the financing system reform in 2002 will be discussed in section 2.

**Table 8.1** Major characteristics of health insurance schemes before 2002

| Characteristics | MSWP | VHIP | CSMBS | SSF | VAVP | Private insurance |
|---|---|---|---|---|---|---|
| Type | State welfare | Voluntary insurance with govt. subsidies | Welfare | Compulsory insurance with govt. support | Compulsory for vehicle owners | Private voluntary insurance |
| Target group | The poor and underprivileged | People living above poverty line with no insurance | Govt officials and state enterprise employees and families | Employees in private sector | All people affected by vehicle accidents | General public |
| Coverage rate of all Thai population (2001) | 30% | 23.4% | 8.5% | 7.6% | All | 1.2% |
| **Benefits** | | | | | | |
| • Outpatient services | State | State(MoPH) | State/private | State/private | State/private | State/private |
| • Inpatient services | State | State(MoPH) | State/private | State/private | State/private | State/private |
| • Registration with hospital | Required | Required | Not required | Required | Not required | Not required |
| • Benefit exceptions | 15 cases | 15 cases | - | 15 cases | - | diseases |
| • Childbirth | Covered | Covered | Covered | Covered | None | None |
| • Physical checkups | None | None | Covered | None | None | Maybe |
| • Services not covered | Special room | Special room | - | Special room | - | - |
| **Financing** | | | | | | |
| • Sources of funds | Govt budget | Household and 1/2 to 3/4 of govt subsidies | Govt budget | Employees, employers and state in equal proportion | Vehicle owner | Household |
| • Payments for services | Govt budget | Capitation & performance-based | Fee for service | Capitation & performance-based | Service-based | Service-based |
| • Copayment | None | None | When attending private hospital | Amount exceeding ceiling, childbirth, emergency | Amount exceeding ceiling | Amount exceeding ceiling |
| **Major problems** | Accuracy and coverage of the poor | Lack of good risk sharing | Rapid increase in expenditure | Cover only during employment | Duplication of eligibility and payment | Risk selection |

## 2. Transition in 2001 to Universal Health Care

### 2.1 Processes for Policy Formulation and Drafting National Health Security Bill

#### 1) Policy Formulation Process

The significant change in the Thai Health Service system happened after the Thai Rak Thai Party announced the universal coverage of health care policy, commonly kwon as "30-baht health care", in its general election campaign and decided to keep its promise when its won the 6 January 2001 election. Then the universal health care policy become one of the nine urgent policies of the government.

In March 2001, the government held a workshop to develop guidelines for implementation of the universal health care policy, which are in summary as follows:

*"The universal health security policy aims to establish a health insurance scheme for the people by creating a service quality control system which separates service purchasers from service providers (MoPH). The state has the duty to distribute health risks and expenditure, using the government budget. Besides, this scheme has a mechanism for the containment of medical care cost using pre-negotiated, close-ended system of payment to health facilities. There are two funds under the health security scheme: (1) for the employment sector, expanding the social security fund to cover medical service welfare for civil servants and state enterprise employees including their families and (2) for the non-employment sector, using the universal health security scheme. Both funds will provide similar benefits and finally will become a single payment and benefit package system or will be merged as a single fund."*

The universal health care scheme (30-baht health care) has covered 45.40 million people (73% of Thai population) with a budget from taxpayers' money of 55,000 million baht each year (2002). During the transition period, the budgetary management was undertaken by the MoPH, allocating the budget for all provinces. At the provincial level, the provincial health office was responsible for managing the fund at the area level under the guidance of the area health board. After the National Health Security Office (NHSO) was established in 2003, the MoPH has gradually phased out its management role. The expansion of the universal health care coverage has been carried out step by step. During the initial stage, it was implemented on a pilot scale in 6 provinces with only state hospitals providing medical services; in the second stage, the scheme was extended to another 15 provinces with some private hospitals participating; in the third stage, the scheme covers the entire country and some (13) districts of Bangkok; and in the fourth stage, it covered all districts of Bangkok and the entire country in April 2002.

The policy was actually implemented, leading to changes, because of three aspects of development: the policy for problem-solving or policy stream, raising of problems or problem stream, and political support or political stream. When all the three aspects of development converged,

a window of opportunity was open. The general election was regarded as a major opening of opportunity that caused the universal health care policy to be adapted on a state policy agenda.

❑ Policy stream. A group of technical staff of the MoPH had been working continuously since 1993 to seek ways to solve the problems and push for the adoption of the policy that they desired. They also tried to revise the policy for problem-solving until it was acceptable to all sectors concerned, the public and politicians.

❑ Problem stream. The problem related to access to health care was recognized by the public and decision-makers and it had to be resolved. The mechanism that caught the attention of all concerned to the provision of health care in the universal health security system was the decreasing income of the people resulting from the economic crisis, coupled with the presentation of the sufferings in the health system by a nongovernmental organization as well as the network for universal healthcare.

❑ Political stream. This is the change in the government and having a political party that was interested in health system reforms and proposed a policy that was in response to the problems and people's needs.

It is noteworthy that the building of knowledge was important in formulating the policy. Besides, the linkage with civil society and other networks created powers for policy adoption, while politicians were the people who opened the window of opportunity. All these factors supported the "triangle moving a mountain" strategy in the public policy movement.

### 2) Legislative Process

In 1995-1996, the MoPH and the House Commission on Public Health once drafted a universal health insurance bill, but could not got it passed into law.

A new effort was made again after the promulgation of the 1997 Constitution which prescribed that no less than 50,000 eligible voters could jointly proposed a law to the Speaker of the House of Representatives for deliberation. At that time 60,000 people signed the legislation proposal; so a group of academics, NGO representatives and interested members of the public drafted the National Health Security Bill. A statement supporting the universal health care was signed by all NGO representatives in October 2000 (before the January 2001) general election, The Bill was submitted to the House Speaker in 2001.

During that period of time, the political party that adopted the universal health care policy for its election campaign actually expanded the health insurance scheme in April 2001. The party also drafted a National Health Security Bill and then submitted it for the cabinet's approval and later on submitted it to the parliament.

In the meeting of the House of Representatives, there were six bills on universal health care for the House deliberation: one from the cabinet, four from political parties and one from the people (supposed to be submitted directly to the House, but the process of examination of the names of 60,000

eligible voters/signatories could not be completed in time, the House decided to submit it on behalf of the people).

The Bill was reviewed in four sessions of public hearings in the North, Northeast, South and Bangkok; then it was revised and submitted to the Senate. During the Senate's deliberation, there were news coverage, meetings, talks and discussions on the Bill by health professionals, government officials and eligible persons under the Social Security Scheme. They all called for revisions in the Bill as they deemed appropriate. The labour group wanted to delete the provision related to the workmen's compensation and social security funds; representatives of health professionals, despite their support for the Bill, wanted to reduce the Bill's role in controlling their operations and giving some monetary assistance to the health care recipients who were adversely affected by the medical treatment provided by the health facility. Based on the comments from all concerned, the Senate Commission revised some points of the Bill as requested.

Finally, the National Health Security Act was enacted and published in the Government Gazette on 18 November 2002 and coming into force on the next day, 19 November 2002. The main features of the Act are as shown in Table 8.2.

**Table 8.2** Main features of the National Health Security Act, B.E. 2545 (2002)

| Feature | National Health Security Act |
|---|---|
| 1. Definition of health services | Services for disease prevention, disease diagnosis, medical treatment, health promotion, and rehabilitation, including Thai traditional and alternative medicine services. |
| 2. Right to receive health services | Every person has the right to receive health services that are of good standard and in an efficient manner as prescribed in this Act. |
| 3. Fixed health service unit | A primary care unit located in residential or working district/ subdistrict of the eligible person is the fixed health service unit, except for a good reason, accident or emergency and patient referral. |
| 4. Management of the state health insurance schemes existing before the Act comes into force | Any eligible person under any existing law will have the right to receive health services according to that law. The National Health Security Board shall be prepared and set up a mechanism for the provision of health services according to this Act. |
| 5. National Health Security Board (NHSB) | The Board has 30 members, including the Public Health Minister as chairperson and five representatives of the civic sector as members. |
| 6. National Health Security Office (NHSO) | A state agency and juristic person under the supervision of the Public Health Minister. The NHSB selects for appointment and dismisses the Secretary-General of NHSO. |
| 7. Funding sources of the National Health Security Fund | The funds for service provision come from the annual government budget and other incomes. The NHSB regrets the annual budget from the cabinet as the operating cost of NHSO. |
| 8. Preliminary monetary assistance in case a service recipient is damaged by the medical treatment provided by the service unit | Not exceeding 1% of the budget that will be paid to service units will be withheld for use as preliminary assistance money for the service recipient who is damaged by the medical treatment provided by the service unit. |
| 9. Quality and Standard Control Board | The Board comprises 35 members, including the president elected from among the members and five representatives of the civic sector. |
| 10. Health facilities and standards of medical treatment | - Service units and their networks are to be registered.<br>- Criteria are set for payments for health services. |
| 11. Standard control for health facilities | An investigation committee is established to investigate, make recommendations, and report to the Quality and Standard Control Board. |

**Source** : Sirivan Pitayarangsarit, Pongpisut Jongudomsuk, Thavorn Sakulpanich and colleagnes. The Process for Formulating Universal Coverage of Health Care Policy and the National Health Security Act, 2004.

## 2.2 Major Essence of Reform

### 1) Principles of the Universal Coverage of Health Care

The goal of the universal health care is to guarantee that every citizen will have access to essential health care as fundamental right of the people, and to set up a system for members of society to "share suffering and happiness" due to illness, which will promote fraternity and helpfulness in society.

The three principal targets are: (1) universal coverage, (2) all Thai citizens receive health care according to the standardized benefit package, and (3) there is a master plan as well as coordination mechanism for all agencies on the basis of policy, financial and institutional sustainability.

The design of the universal health care scheme is as follows:

(1) The budget for medical treatment will be from the tax system. Eligible persons will pay 30 baht per visit when receiving health care except for health promotion and disease prevention services. Exemption of the fee is extended to the people who were previously covered under the Medical Welfare for the Poor and Underprivileged Project such as poor people, children, the elderly, monks and veterans.

(2) A primary care unit near people's residences is the front-line service unit that serves as the main service contractor and the unit for registration of eligible persons.

(3) The financing system is a cost-containment system on a long-term basis with a close-ended and performance-related system of payments to health facilities.

(4) The benefit package is the same as those under other state health insurance schemes.

(5) The quality assurance system is used in monitoring the service quality development programme.

(6) For policy administration, the decentralization of management authority to provincial administration is used, under the responsibility of the area fund management committee.

(7) There is a clear purchaser-provider split in order to make the examination, monitoring and evaluation system more efficient.

### 2) Restructuring of the Health Security System

**(a) Establishment of the National Health Security Office (NHSO) as the Service Purchaser**

The NHSO uses the service purchasing mechanism in efficiently managing the scheme and serves as the representative of consumers in examining service quality and checking the balance of power in the service system, which was previously under the MoPH (which acted as both system monitor and service provider, having no incentive to assess its own service quality as consumers' representative).

According to the recommendations for the administrative structure reform of the universal health care scheme, there should be a national health security committee charged with the monitoring of policies of all state-run health insurance schemes, i.e. Social Security Fund, Civil Servants Medical Benefits Scheme, and the Universal Coverage of Health Care Scheme. The purpose was to standardize the benefit packages and payment mechanism to health facilities. At the local level, an area health board is used serve as the representative of the three funds in contracting health facilities under the scheme (Figure 8.1). However, during the transition period (2001-2002), there was no royal decree on practical guidelines for other funds and thus the NHSC supervises only the policy implementation of the universal health care scheme.

**(b) Establishment of the Medical Injury Compensation System**

This kind of fund is regarded as an innovation aimed at providing compensation to an individual damaged by medical treatment without proving any fault first (pure no-fault system). This is to relieve the suffering of the damaged person. The fund has the following advantages:

1. Preliminarily providing relief from suffering for damaged persons, without restricting their right to compensation from other system.

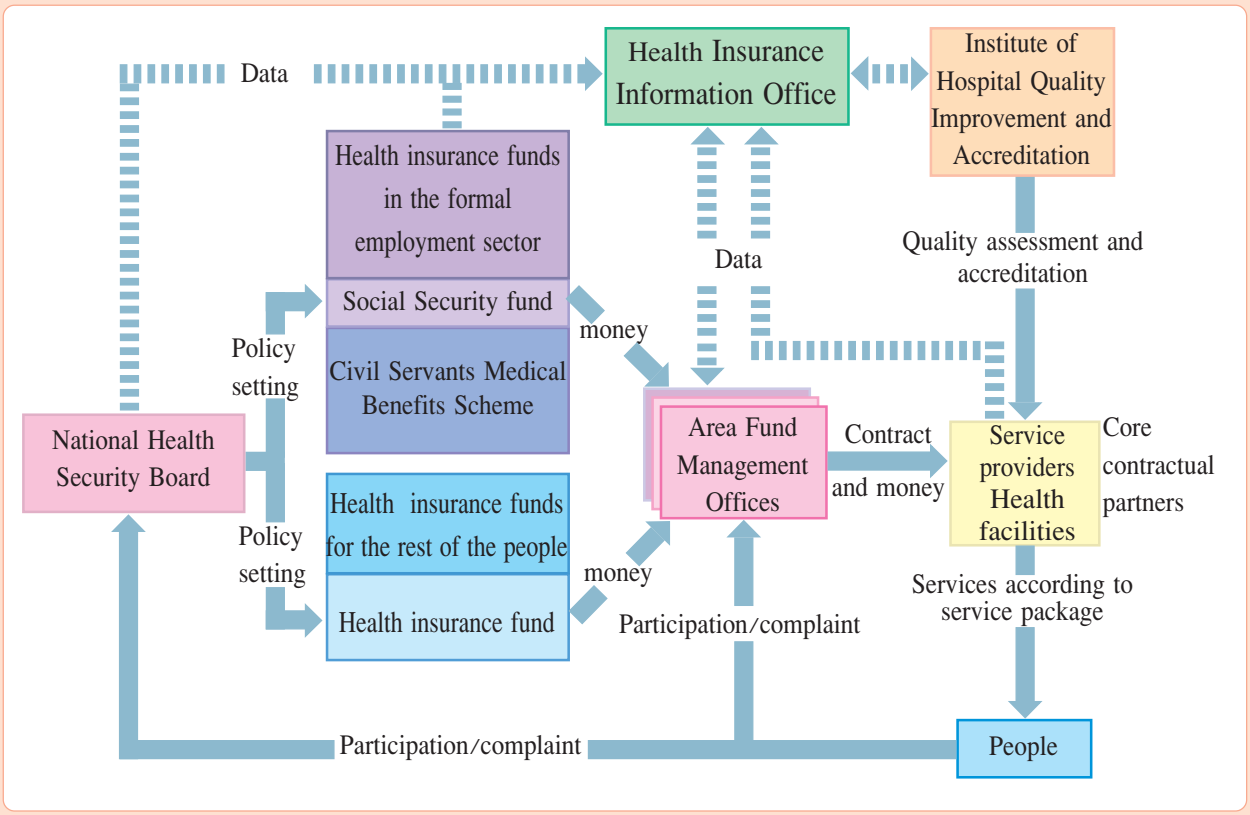
2. Promoting the development of medical care quality, making service providers become aware of the damage that may occur the service recipients. The NHSO uses two measures for this purpose: monitoring the quality of health facilities for preventing the damage due to an inevitable cause and having recourse to the wrong-doer or the negligent person.

3. Protecting physicians or service providers from undue litigation, using the mediation and reconciliation principle.

4. Managing the risk sharing effect by using the money earmarked or withheld from the universal health care fund (1% of medical expenditure) so that health service providers used not pay high premiums on insurance from a private firm.

Results of the operations are yet to be seen.

**Figure 8.1** Proposed restructing of the health insurance system




**Source**: Working Group on Development of Structure of the Universal Coverage of Health Care Scheme, MoPH (2001).

## 2.3 Health Insurance System in Thailand after April 2002

In summary, after the change in cabinet and the implementation of the universal health care scheme, covering eligible persons under the medical service welfare scheme and the health card project and expanded to cover those who had never had any insurance before, the coverage of health insurance has risen to 92.5% of the Thai population, including 74.2% under the universal health care scheme, 6.6% under the civil servants medical benefits scheme, and 11.5% under the social security scheme, while the rest are under small systems such as politicians and Thais residing in other countries. Approximately 4.6 million people or 7.5% of entire population are not registered in any health insurance scheme.

A brief comparison of the three major schemes (see Table 8.3) is as follows:

1) Benefits: There is similarity in the benefit packages under the social security scheme and the universal health care scheme. Basically, the benefits cover inpatient and outpatient services, childbirth service and dental care, with exceptions for 15 specific cases, annual checkups, and special room changes. The universal scheme does not cover kidney dialysis for cases with chronic kidney failure, while the medical service welfare scheme had no exceptions. Disease prevention and health promotion services are included in the benefit package of the universal scheme. All three schemes use the national essential drug list in the benefit packages.

2) Sources of financing and co-payments: The universal health care scheme is financed by the government taxation system and requires that the eligible person pay 30 baht per visit, except for the underprivileged. Similarly, the civil servants medical benefits scheme is financed with tax money, but requires co-payment when attending private hospital. The social security scheme receives funding from three parties: employees, employers and the government; co-payments are required when the medical expenditure exceeds the established ceiling as well as for childbirth or emergency care.

3) Methods of payment to health facilities: The method for the universal coverage scheme is similar to that for the social security scheme, i.e. capitation as well as performance-related payment such as DRG for inpatients. The method used in the civil servants medical benefits scheme is fee for service.

However, there have been efforts to further improve the three schemes so that they have similar features to ensure equitable access to health care, which has to be pursued in the future.

**Table 8.3** Major characteristics of health insurance schemes in Thailand, September 2002

| Characteristics | Universal health care | Civil servants medical benefits | Social security |
|---|---|---|---|
| Type | State welfare | Fringe benefit | Social insurance, compulsory |
| Target group | People outside the civil servants and social security schemes | Civil servants, state enterprise employees, and their families | Employees in the private sector |
| Population coverage * | 74.2% | 6.6% | 11.5% |
| **Benefits** | | | |
| • Outpatient services | Public/private | Public/private | Public/private |
| • Inpatient services | Public/private | Public/private | Public/private |
| • Registration with hospital | Required | Not required | Required |
| • Benefit exemptions | 15 events | - | 15 events |
| • Childbirth | Covered | Covered | Covered |
| • Physical checkups | None | Covered | None |
| • Services not covered | Special room, kidney dialysis | - | Special room |
| **Financing** | | | |
| • Sources of funds | Government budget | Government budget | Employees, employers and state |
| • Payment method | Capitation and performance-related | Fee-for-service | Capitation and performance-related |
| • Co-payment | Fee, 30 baht per visit | When using private hospital | Amount exceeding the ceiling, childbirth and emergency services |

*__Note__: Total population of 61.2 million, National Health Security Office, September 2002.

## 3. Development of Subsystems in Support of the Universal Health Care System

### 3.1 Development of Personal Information Database

The social security system is the first state health insurance system that has and use the personal information database for eligible persons. Later in 2001, the MoPH created a preliminary personal information database for use in the universal health care scheme, used on the personal database of the Registration Administration Bureau of the Department of Provincial Administration of the Ministry of Interior. According to the Social Security Office and the household survey, the database of the universal health care scheme in the initial stage had some problems related data accuracy. Duplication of eligibility was found in 12.4% of all eligible persons (April 2002). Later, with the NHSO's correction, the duplication rate went down to less than 1%.

In July 2005, the government set a policy to integrate the administration of all state health insurance schemes and assigned the NHSO and the Comptroller-General's Department to jointly manage the Civil Servants Medical Benefits Scheme. Then the effort for improving the personal information database for eligible persons under the CSMBS began to be seriously made and it was expected to be completed by December 2006.

In summary, the personal information database has been improved after using it in the management of the universal health care scheme. It has been actually used and linked to databases of other agencies concerned, causing checking and updating the information on a regular basis. Such checking also occurred as a result of the people being allowed to access and check the information even though the correction can be made only the by authorized official.

### 3.2 Development of Primary Care and Referral Systems

Recently, there have been policies and operations for development of primary care units in the following aspects:

#### 1) Development of standard criteria for fixed service units and assessment for recognition of service units

The standard criteria of service units reflect the basic need for improving and monitoring the quality of service units in the health insurance system. In the past, the standard criteria focussed primarily on inputs, such as infrastructure, number of personnel, equipment, etc, being stipulated according to the size of population in the designated area (for example, a service unit with one physician is to cover a population of not exceeding 10,000).

The assessment for recognition of service units according to the established criteria prier to providing services under the health insurance system, in the past, focused on private hospitals (as the scheme could not deny the participation of public hospitals). Until 2006, a policy was set to assess both public and private hospitals; the results of assessment of public hospitals will be used for designing a development plan for the next phase.

### 2) Support for innovations and development of primary care units (as ideal PCUs)

In 2004, NHSO organized a Universal Coverage Innovation Award (UCIA) programme aimed at boosting morale of operational staff and collecting/disseminating outstanding activities for use as examples for other agencies. Also organized was the program for improving the quality of PCUs to become PCUs of excellence or ideal PCUs. Moreover, this effort also aimed to promote the learning process and self-development of each PCU in a continuous manner, under which each PCU was to assess itself according to the developed assessment tool and then prepared a request for funding for improvement of what deemed to be deficient. Out of 1,451 PCUs applying, 562 PCUs were supported, one-third of them being projects related to development of diabetic and hypertensive patient care.

Moreover, in 2005, NHSO and the MoPH's Department of Health Service Support initiated a programme on health centres' quality development according to the MoPH standards of community health centres. The aim was to develop 800 health centres; after programme implementation, 530 health centres or 66% of the target met the assessment criteria.

### 3) Development of a model for development and quality assurance of primary care

During the past decade, hospital quality improvement and accreditation (HA) was the trend that was widely recognized. Most public and private hospitals voluntarily participated in the HA programme. And all state-run health insurance schemes agreed to use the HA system and the central quality development system.[1]

However, the HA system focused on quality development of hospitals, not covering services at primary care units. So the NHSO recognized the importance of the development of a system for improving primary care quality and accreditation by supporting the Health Care Reform Project[2] to conduct a research project on this mater. At present, a project proposal is being developed.

### 4) Development of Personnel Capacity and Infrastructure

During the first phase of the universal health care system, the capital replacement fund was part of the capitation budget and allocated for structural improvement at the primary and specialized[3] care facilities. Mostly, it was for the expansion of excellent centres, but there was no policy on investment in primary care structure.

Later, the NHSC gave more importance to investment in human capital. In 2005, a capital replacement fund of 100 million baht (2.8% of total capital replacement fund) was allocated for manpower development at the primary and specialized care levels. But, actually only 10% of such

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1 Resolution of the coordinating committee of the Comptroller-General's Department, the National Health Security Office, and the Social Security Office, No.5, 29 March 2006, Novotel Thipwiman Resort and Spa, Phetchaburi Province.

2 This Project Office has been renamed as Community Health System Development Institute.

3 Initially, 30% of capital replacement fund was allocated for investment in specialized care facilities, especially cancer centres, heart disease centres, and emergency medical service centres. Later, the proportion has gradually declined to only 10% in 2006.

budget was used for workforce development at the primary care level. At the regional level, 130 resource persons were trained so that they would help establish 12 regional training centres and further train 1,800 trainers at the provincial and district levels. In 2006, the NHSC allocated another 1,062 million baht or 17.2% of total capital replacement fund for the development of infrastructure and personnel at the primary care level, aimed at establishing 200 community medical centres (CMCs), expanding training programmers for primary care units, providing compensation for trained personnel and supporting the reduction of outpatients' numbers at large hospitals.

Giving importance to primary care units recently, especially when the universal health care policy is implemented, has resulted in a change at primary care units to a certain extent, particularly an increase in the number of personnel (Table 8.4).

**Table 8.4** Proportion of personnel at primary care units before and after the implementation of universal health care policy (excluding physicians, dentists and pharmacists), 2004

| Item | Health Centres | PCUs at community hospitals | PCUs outside community hospitals | PCUs at reginal-general hospitals | PCUs outside regional-general hospitals | Total |
|---|---|---|---|---|---|---|
| Sample size | 442 | 76 | 17 | 3 | 3 | 577 |
| Proportion of PCUs with personnel: | | | | | | |
| declining (%) | 11.09 | 14.47 | 5.88 | 0.00 | 33.33 | 11.61 |
| unchanged (%) | 42.53 | 38.16 | 35.29 | 33.33 | 33.33 | 41.77 |
| rising (%) | 46.38 | 47.37 | 58.82 | 66.67 | 33.33 | 46.62 |

**Source**: Supattra Srivanichakorn et al. Assessment of Situations at Primary Care Units in 36 Provinces, August 2004.

**Note**: "personnel" in this study include technical nurses, technical staff, health administration officers, health officers, and dental hygienists.

Besides the investment in the development of primary care units, recently there have been efforts to develop other mechanisms that are supportive of primary care services including:

### 1) Policy on reduction of workload of outpatient departments at large hospitals

In 2006, the MoPH announced its commitments to the Thai people,[4] one of which was developing state hospitals as "modernized hospitals" according to the "quick and non-crowded service" principle. The aim is to reduce overcrowding at 12 large hospitals using the strategy on developing primary care units in urban areas and distributing patient care workloads to such primary care units. In this effort, the target hospitals are to improve the quality of primary care units, create public confidence in the units, and establish an efficient referral system.

### 2) Development of referral systems and admission coordination centres

A referral system links to each other the health services at all levels to ensure continuous care and access to essential care. An efficient referral system must have a two-way mechanism for referring "patients" and "information" about health problems and medical treatment the patient has received at leach level.

In the past, the referral system in Thailand was efficient to a certain extent. After the implementation of the universal health care policy, the rural referral system has been improved and become more efficient with the establishment of the geographical information system (GIS) and the categorization of contracted service units of the NHSO, which has established "referral service units" and a private hospital can participate as a "referral service unit" resulting in the availability of more channels for referrals.

A "referral coordination centre" was established to coordinate with hospitals with capacity to care for heart disease patients and a register of patients waiting for heart surgery. In this effort, the centre can coordinate with another hospital with fewer patients on its waiting list for surgery and the patient can undergo a surgery faster. Besides, the centre has coordinated inpatient admissions at hospitals in Bangkok. According to the cumulative data of the NHSO as of March 2006, patients in Bangkok needed assistance in seeking beds for admission for various reasons, namely, admissions at private hospitals not participating in the project (72.99%), no beds available at treating hospitals (11.01%), patients requiring care beyond first hospital's capacity (13.69%), seeking beds for patients under other welfare schemes (2.04%), and others (0.28%). It was found that beds could be obtained for 64.4% of the cases. The centre can coordinate with a number of private hospitals to join the bed reservation project by revising the payment system as a special incentive for hospitals participating in the project.

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[4] MoPH's commitments to Thai people in 2006. A document on MoPH performance for 2005, 30 December 2005.

### 3.3 Coordination among Various Health Insurance Schemes

The three state-run health insurance schemes have different characteristics, creating management difficulties for health facilities and double standards of medical care. The universal health care scheme was created based on the lessons learned from other schemes, especially the social security scheme. So both systems are not quite different.

Although there are tides against the integration for solidarity in the management of state health insurance schemes, agencies responsible for the three schemes, including the social Security Office, the National Health Security Office, and the MOF's Comptroller-General's Department see the importance of coordination so that the management systems of the schemes are in the same direction, supportive of each other for their maximum efficiency, and minimizing inequalities among the schemes. So there was a cooperation agreement among the three agencies[5] to establish a committee on coordination for development of health insurance systems in 2004, comprising executives from the three agencies, with the top administrator of each agency taking turn as chairperson on a one-year term basis. The Secretary-General of NHSO was chairperson for the first year. As a result of the establishment of the committee and other working groups set up at a later date, some joint development outputs are as follows:

**1) Central standards of health insurance funds.** The standards include the standard data set and coding system, the standard fee schedule, use of the hospital accreditation system as the central system for quality development of contracted hospitals, and the standards of contracted hospitals at different levels.

**2) Development of databases for common use.** The databases developed are the health insurance eligibility database of Thai people, the hospital profile of all hospitals participating in the schemes, and the database on service utilization of eligible persons.

**3) Coordination for reduction of duplication.** The achievements of this effort include the development of health service practice guidelines (HSPG), assessment visits to tertiary hospitals,[6] analysis of data on service utilization of eligible persons under the Civil Servants Medical Benefits Scheme for reduction of duplication of personal data, development a system for hospitals to serve as claimants for eligible persons in case of outpatient service (no need for an outpatient to pay first as practised in the past), and examination of service fee compensation for appropriate cost containment with the NHSO taking the lead in such an effort.

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[5] Cooperation agreement among the Comptroller-General's Department, the Social Security Office and the National Health Security Office for development of health service systems, 19 January 2004.

[6] Initially, there was an effort to coordinate joint visits for assessing contracted hospitals, but there were some problems related to differences in health insurance systems; so the universal health care scheme uses the area-based mechanism for this purpose while the social security system uses the central mechanism.

### 3.4 Revisions of the National Essential Drug List, 1996, 1999 and 2004

The drug expenditure estimate for Thailand in 2001 was 46,639 million baht or 27.4% of overall health expenditure, which is rather high compared with those for other countries or even developed countries. Measures for controlling the use of non-essential drugs are necessary; and one of the measures is to develop a "national drug list" to select and compile a list of drugs essential for health of Thai people. The sub-committee on national drug list development, under the National Drug Committee, was the key mechanism in this effort.

Drug list development has been continually undertaken from the "1979 MoPH Drug list" and the "1981 National List of Essential Drugs" to the "1996 National List of Essential Drugs" that was based on the WHO guidelines covering basic drugs significantly required for people's health care and resolving national health problems. It was later on revised in 1997, in accordance with the 1997 economic crisis, based on the ability to pay and socio-economic impact. The 1999 National List of Essential Drugs included four lists, one of which is for hospitals and health care facilities including drugs that were classified according to their pharmacological and therapeutic properties into 23 groups, totaling 932 items.

The most recent revision of the national drug list was undertaken in 2004, taking into consideration several aspects of changes in the health system, namely: (1) burden of disease, (2) health service reforms, especially with the universal health care system, (3) improvement of efficiency under the "good health at low cost" policy, and (4) development and promotion of rational drug use according to the health service practice guidelines (HSPG). The drugs in the 2004 National List of Essential Medicines are classified into five sub-lists or lists as follows:

**List A** means a list of medicines for use at all levels of health facilities.

**List B** means a list of medicines for indications or certain diseases for which medicines on **List A** cannot be used or inefficacious, or which can be used in lieu of **List A** temporarily in case **List A** medicines cannot be procured.

**List C** means a list of medicines that are used for treatment in areas of specialty by an expert or by someone who has been authorized by the director of that particular health facility with an established measure for monitoring their use.

**List D** means a list of medicines which have several indications, but only some indications are appropriate or have a tendency to be incorrectly prescribed, or have a high cost and their indications and conditions for use have to be specified.

**List E** means a list of medicines for a special project of a state agency.

In the early stage, the process of revising the drug list was quite slow. In 2005, the NHSO supported the process so that the list is up to date and medical professionals as well as the general public are more confident in the quality of medicines.

## 4. Achievements of the Health Security System

The achievements of the universal health care scheme being described in this section are derived from the summary report of the study on equity of financing system in Thailand conducted by the International Health Policy Programme which was based on an analysis of the 2004 database.

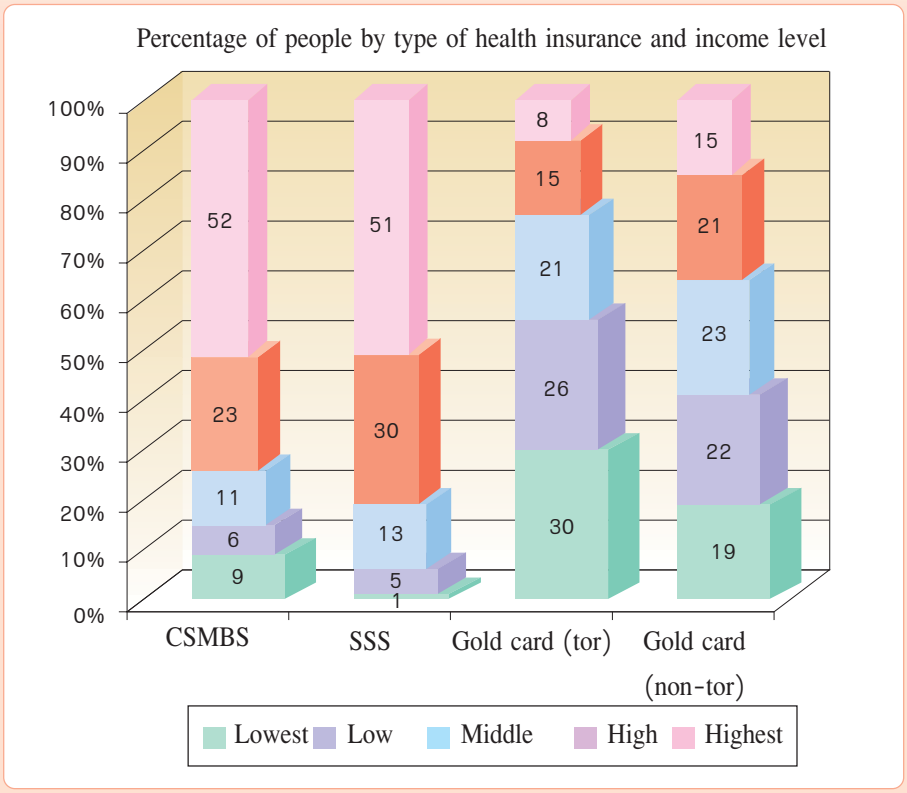
### 4.1 The Health Security System and the Rich and Poor

According to the 2004 health and welfare survey conducted by the National Statistical Office, when the population is divided into five groups according to household income, the universal health care cards (category "Tor" which exempts 30-baht-per-visit payment) have been distributed to the lowest income group as many as 30% and to higher income groups in lower proportions, respectively. The eligibility for universal health care is more widely spread among the poor than those for welfares under the civil servants benefit and social security funds.

For the universal health care cards of "non-Tor" category which require a 30-baht-per-visit payment have been distributed in general to all income groups in the proportions which are not so different (Figure 8.2).

However, there are some people in the lowest income group that have no exemption for the 30-baht payment; on the contrary, some people in the highest income group receive exemption for such a payment as a result of the Medical Welfare for the Poor and Underprivileged originally of the MoPH which could not effectively screen the poor into the scheme and excluding the non-poor from the scheme.

**Figure 8.2** Proportions of poor and rich people in deferent medical welfare systems



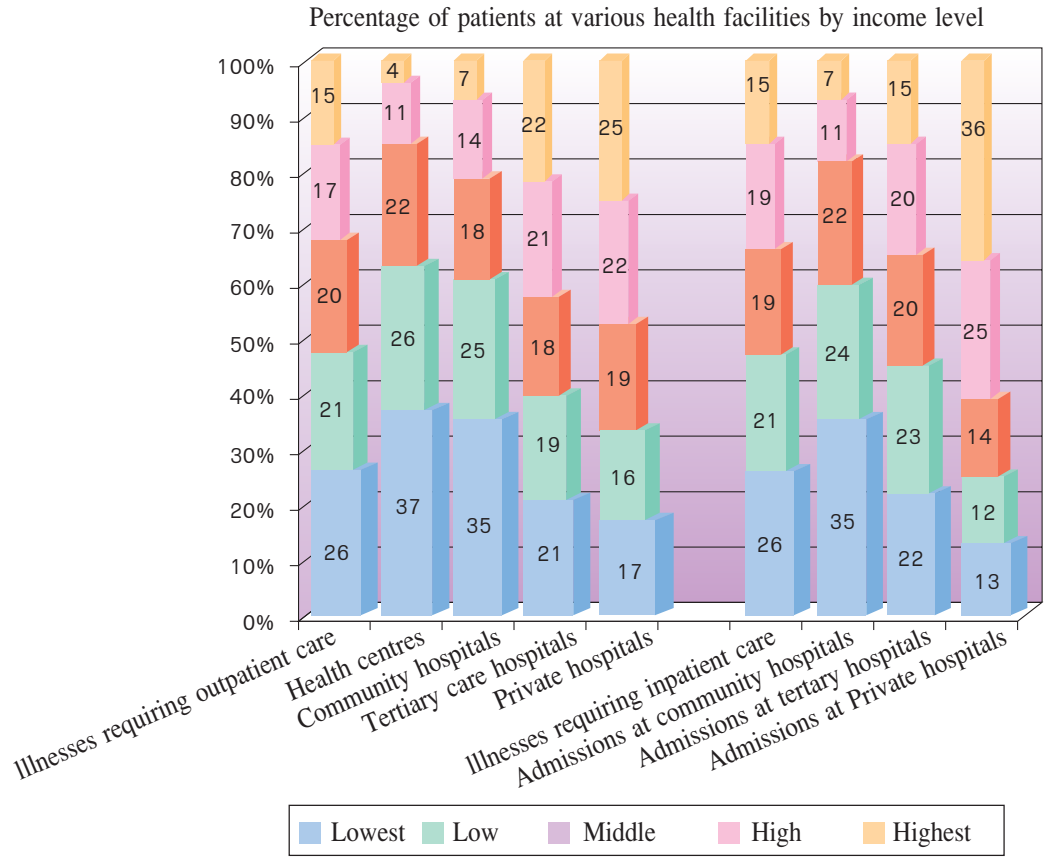

**Source**: Report on Health and Welfare Survey, 2004. National Statistical Office.

### 4.2 Illness and Service Utilization of the Rich and Poor

For the lowest-income group, their illness rate was highest at 26% of all patients while the illness among the highest income group was only 15% (Figure 8.3). The distribution of outpatients was close to that for inpatients.

While the proportion of illness for lowest-income group was 26%, their proportion of outpatient services was as high as 37% at health centres, 35% at community hospitals, 21% at state tertiary care facilities, and 17% private hospitals. For the highest income group, their illness rate was 15% and the proportion of their service utilization at state tertiary care facilities was 22%. This is due to the fact that most low-income population live in rural areas and have difficulty accessing tertiary care facilities that are normally located in Mueang Districts (in provincial cities). So when they get sick, mainly with illnesses that only require outpatient care, low-income population tend to seek medical care at the subdistrict or district level.

**Figure 8.3** Proportions of people reporting illnesses (percent)




**Source**: Report on Health and Welfare Survey, 2004. National Statistical Office.

An analysis of inpatient services revealed that the proportion of low-income people using inpatient care was similar to that for outpatient care at state hospitals. At tertiary care hospitals, the proportion of high-income people using inpatient services was consistent with their illness proportion, i.e. The highest-income group had an illness proportion of 15% and an inpatient service proportion also of 15%, while their proportion of using outpatient services was as high as 22%. That was due to the fact that the highest-income group tended to use inpatient services at private hospitals at a high proportion of 36%.

### 4.3 Either Rich or Poor People Benefit from the State Health Budget

This study estimated the benefits the people received from the government health budget, based on the analysis of the differences of the costs of health services at various levels of state health facilities and the out-of-pocket household health expenditures. The concentration curve can illustrate the relationship between the proportion of health care subsidies and the proportions of five groups of people (poorest to richest) according to their household's economic status. The horizontal axis represents the commutative number of people by economic status order, from poorest to richest;

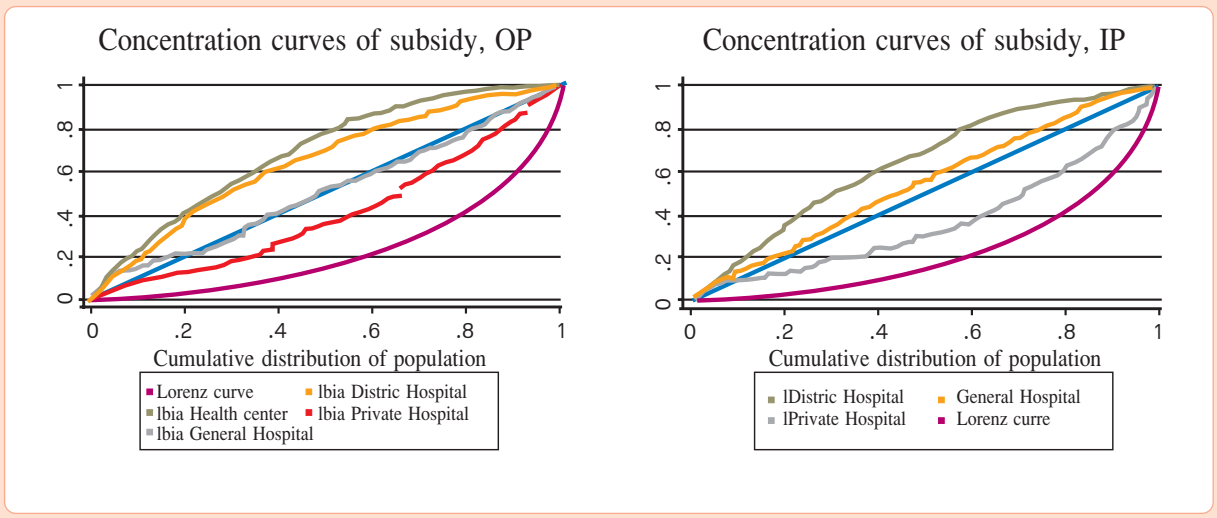
the vertical axis represents the cumulative budget for health care for such people. If the subsidy has a perfect equity between the rich and poor, the relationship will be above the equity line, which is the 45° diagonal between the two axes. That means the subsidy amount is in the same proportion as the number of people in each economic status level. For example, the poorest group (first 20% of entire population) receives 20% of the total subsidy and the richest group (last 20% of entire population also receives 20% of the total subsidy (Figure 8.4).

If the poor receive a larger proportion of subsidy than the rich, the concentration curve will be above the 45° diagonal line. That means the poorest group (first 20% of entire population) receive more than 20% of total subsidy; on the contrary, if the subsidy is mostly concentrated in the rich group, the concentration curve will be under the 45° diagonal.

In addition to using the concentration curve, the comparison of the proportion of subsidy and the proportion of five population groups can be illustrated by using the concentration index (CI), which is two times the area between the diagonal line (equity line) and the concentration curve, ranging from -1.0 to 1.0. If the concentration curve is above the diagonal line, i.e. the poor having a higher proportion of subsidy, the CI will have a negative value, but if the concentration curve is under the diagonal line, i.e. the subsidy being concentrated among the rich rather than the poor, the CI will have a positive value.

Besides, if we want to see whether the health care subsidy can bridge the economic gap between the rich and the poor, a comparison can be made between the concentration line and the Lorenz curve, which shows income distribution in the population. If the income is concentrated among the rich, the Lorenz curve will be under the 45° diagonal. The higher the concentration line of health care subsidy is above the Lorenz curve, the more the subsidy can help bridge the economic gap between the rich and the poor. In such a case, the relative equity or Kakwani index will have a negative value.

**Figure 8.4** Concentration curves of health care subsidies for outpatient and inpatient services at different levels of health facilities



The analysis of the data on outpatient care subsidy at public health facilities from the 2004 health and welfare survey revealed that at the health centre and community hospital level, the CI was negative. That means the proportion of subsidy for the low-income group was higher than that for the high-income group (CI -0.357 for health centres and CI -0.276 for community hospitals). For state tertiary hospitals, the healthcare subsidy for the low-income group was close to that for the high-income group (CI 0.003, the concentration line was close to the diagonal or the equity line).

The subsidy of healthcare expenditure for inpatients at community hospitals was similar to that for outpatients, i.e. the low-income group received a higher proportion of benefits than the high-income group (CI -0.272). Regarding the subsidy of inpatient care at provincial hospitals and other state hospitals, the benefit for the low-income group was also higher than that for the high-income group, but at a lower level than that at community hospitals (CI -0.087).

On the contrary, the health care subsidy at private hospitals was mostly concentrated among the high-income group (CI 0.184 for outpatients and 0.256 for inpatients). It is noteworthy that even though the CI values for private hospitals were positive, the concentration curve was closer to the equity line than the income distribution Lorenz curve was. So it can be stated that financing and health services in Thailand have helped reduce relative economic inequity even at private hospitals: Kakwani index being -0.352 for outpatients and -0.277 for inpatients.

## 5. The Outlook

The review of the achievements of the universal health care scheme has revealed that it is a good project and beneficial for the people, especially those in income quintiles 1 (the poorest) and 2 (the poor). The district health services system comprising the community hospital and health centres in its network has translated policies into action in a concrete manner effectively for eligible persons as it is easily accessible, near their houses, and of good quality to a certain extent. To maintain the role and expand the services at the district level to increase equality in the health system, it is necessary that the budget and human resources be adequately allocated and suitable for their operations.

In 2007, kidney replacement services (haemodialysis, perinatal dialysis and kidney transplantation) are not part of the benefit package of the universal health care scheme despite the fact that such services are available under the civil servants Medical Benefits Scheme and the Social Security Scheme. This is due to the high costs of services, approximately 200,000 to 300,000 baht per year and the government is not in a financial position to provide such services to all the patients. However, if any eligible person under the universal healthcare scheme struggles to buy such services out of pocket, his/her family will become penniless as the service fee is very high and they have to borrow some money from other people or sell their property or production factors to cover the expenses. So the government should make a decision to do something to help relieve the financial burden of the needy family. For example, the kidney replacement services may be provided to some patients with potentially high

returns, such as someone who is young and the head of household; or various financing sources should be sought for this purpose from such agencies as the state, foundations, or donations with some co-payments from the patients. Providing or not providing services to a patient has drawn some criticism about social fairness and ethics of resource allocation.