



Healthcare System Country Notes Asian Region

Thailand

The purpose of the IMSA National Health Insurance (NHI) web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This series of Country Notes is a collation of material submitted by independent researchers who are willing to place their research notes in the public domain. The collated notes, together with other studies found in the public domain are presented as a service to researchers, policy-makers and stakeholders who are looking at health reforms around the world.

A. Research Notes on Thailand

Context

- GNI per capita : \$5990 (PPP adjusted) (2008)
- Infant mortality ratio : 11.3/1000 (2006)
- Maternal mortality ratio : 9.8/1000 (2006)
- Male life expectancy : 77.6 (2006)

Healthcare reform trajectory

- The process of health reform began in 1975 with strong political will to increase voluntary health scheme coverage from 1.45%, ultimately leading to universal coverage.
- Reform process was incremental over the period in achieving coverage for more and more people, and followed a consistent pattern of: Research → Discussion → Reform → Evaluation → Research → Discussion, etc.
- The first step was the introduction of the Low Income Scheme in 1975, to provide insurance coverage first to the poor, and then extended over time to cover the elderly and children.
- Thailand has a relatively long history of splitting the purchasing and providing functions in healthcare, and this has been built on in the reform process over the years.
- Successive governments applied an incremental approach of gradually increasing insurance coverage using a voluntary insurance scheme (called the Voluntary Health Card Project) from the mid 1980s, under which 50% of the premiums payable were subsidised by the state.
- In 1990, coverage of formal sector private employees was secured through a mandatory Social Health Insurance (SHI – also known as the Social Security Scheme or SSS) payroll tax for firms with more than 20 employees. This and the Civil Servants Medical Benefit Scheme (CSMBS) mainly covered the richer section of the population.
- By 2001, coverage in the system was split between different elements as follows: Low Income Scheme (32% of the population), CSMBS (9%), SHI/SSS (7%), Voluntary Health Card (21%), and Private Health Insurance (2%). The insured population constituted 71% and the uninsured 29%.
- Some of these elements (like the CSMBS) used fee-for-service reimbursement, others (SHI/SSS) used capitation payments to providers for covered members (with additional schedules for accident and emergency care, and high cost care)
- In 2002, Thailand achieved universal coverage by combining previous social welfare health services, like the Low Income Scheme, and the Voluntary Health Card system into what was called the Universal Coverage Scheme (UCS). The result was a multi-purchaser model for health coverage including: the UCS (74% of the population), CSMBS (10%), SHI/SSS (13%), and Private Health Insurance (3%).

- Measured from the first strong policy direction in favour of increasing coverage (the establishment of the Low Income Medical Scheme in 1975 – LIMS), it took almost three decades for Thailand to achieve universal coverage. Measured from first mandatory cover, it took about 12 years.

Universal Coverage Scheme

- The UCS pays providers on a capitated basis for outpatient services, and uses global budgets based on DRGs to reimburse inpatient care. These have been set at provincial level.
- The benefit package is comprehensive and compares favourably with the SHI/SSS benefits.
- A National Health Security Office designs benefit packages and payment arrangements.
- The UCS is funded from general taxation as it was built from tax funded or publicly subsidised entities, and this is also the most progressive mechanism for healthcare financing, and recognises the difficulty in collecting contributions from low income individuals.
- Co-payments were required for some outpatient services under the UCS (though exempted for poor groups) to better control more discretionary utilisation. Registered providers also have to be used and compliance the upwards referral rules required, otherwise the patient is liable for costs.
- Individuals have to register with a public or private ‘primary contractor’, which can refer further upwards or purchase required outpatient care for the patient.
- The UCS purchasers care from both public and private providers, but mainly from public.
- Extensive use of modern information and communication technology to streamline registration of beneficiaries and providers, transfer funds, allocate funding, keep patient records, etc. A complaint hotline allows transparent tracking of problems in the system.

Research driven reform and consultation process

- The reform process involved high levels of engagement within a range of actors: technical experts, government bureaucrats, civil society groups, and political parties.
- Several actors were involved in capacity building and policy research:
 - USAID supported health care financing research,
 - PEW foundation supported the establishment of the International Health Policy Program (IHPP), which gleaned useful learnings from other countries’ experiences
 - The Health Systems Research Institute and the Thailand Research Fund jointly supported a Senior Research Scholar Program (SRS) on Health Systems and Policy Research.
 - Strong research programs and institutional collaborations between the health planning division of the Ministry of Public Health (MOPH), SRS and IHPP with the London School of Hygiene and Tropical Medicine Health Economic and Financing program.
- The Thai process of health reform combined policy making, capacity management and a phased implementation process. As a result, universal coverage was widely supported by stakeholders because it was accepted as legitimate, it was possible with the existing infrastructure, and it was fiscally plausible.
- Systems design and monitoring and evaluation were guided by researchers, and these results were fed back into the reform processes.
- Political leadership achieved a balance between 1) running an inclusive and consultative process taking views of relevant stakeholders into account and 2) keeping sufficient momentum to drive the process forward and ensure that it was not stalled by special interests.

Success factors

- Evidence based research was utilised by leaders to advise policy making. Researchers worked closely with bureaucrats and politicians, so promising research could be transformed into policy practice.
- Established a national capacity to coordinate data producers (like the National Statistical Office) and data users (like the Ministry of Public Health).

- The consultative process adopted ensured that policymakers were responsive to concerns of stakeholders who participated in the process of policy formulation and implementation.
- Pro poor focus of the policy enabled full coverage by ensuring the supply side of health provision was sufficient - through long-term targeted funding allocation and infrastructure development of sub-district health centres (primary health care facilities consisting of a doctor, nurses and other practitioners) and district hospitals.
- Policy and extension of infrastructure was supported by a long term manpower production plan and actions to ensure that sufficient human resources were available.
- Financial feasibility was ensured through sound design, incremental increases in coverage, internal peace and economic growth.
- Experience with different provider reimbursement mechanisms allowed choice of an optimal combination in the Universal Coverage Scheme.

Outcomes

- Universal coverage was achieved through a gradual inclusion process that included LIMS, public subsidies for a Voluntary card insurance, a Civil Servants Medical Benefit Scheme, Social Health Insurance and Private Health Insurance.
- Universal coverage generated significant and underestimated increases in utilisation of outpatient and inpatient services – a good thing from an access point of view, but which put strains on public finances.
- The coverage also forced a major shift from secondary and tertiary level care to prior primary care facilities, which has made healthcare provision more efficient.
- Public sector health workers are still underpaid and overworked relative to private and international counterparts, leading to movement into these sectors.

Lessons for SA

- A high research component in the policy development process and wide stakeholder engagement can ensure optimal and viable solutions are realised, rather than those driven purely driven by political or private special interests.
- Ultimately, the structure for providing universal coverage made maximum use of existing institutions in the environment. As these institutions tended to operate based on a purchaser-provider split, it was pragmatic to continue with this approach.
- Debate and discussion about health reform in SA has been happening since the early 1990s with varying levels of intensity, and with varying levels of cooperation between stakeholders. The expertise and resources exist to quickly ramp dialogue up to a high level and progress relatively quickly to an optimal solution to SA's health challenges.

References

- Sauerborn R, Nitayaumphong S, Gerhardus A. Strategies to enhance the use of health systems research for health sector reform. *Tropical medicine and international health*. 1999;4:827-835.
- Tangcharoensathien V, Prakongsai P, Limwattananon S. Achieving Universal Coverage in Thailand: what lessons do we learn. *SSRM*. 2007.
- Tangcharoensathien V, Wibulpholprasert S, Nitayaramphong S. Knowledge-based changes to health systems: the Thai experience in policy development. *Bulletin of the World Health Organisation*. October 2004.
- Suraratdetcha C, Okunade A. Measuring operational efficiency in a health care system: A case study from Thailand. *Health Policy*. 2006;77:2-23.
- Preechachard, R. Thai experience with information technology: case study from the Social Security Scheme (SSS). Social Security Office. 2008.
- Banchuin, C. New Health Insurance Policy in Thailand. Ministry of Public Health. 2003.
- Sawasdivorn, W. Universal Coverage experience of Thailand. National Health Security Office. Prince Mahidol Award Conference, January 2010.

Thammatacharee, J. Provider payment of UC scheme. National Health Security Office. 2010.

Produced during 2009 and supplied to IMSA April 2010.

B. Medi-Clinic Research Notes: Health care system in Thailand

Background:

- In 2002, universal coverage (UC) was achieved by introducing a tax-funded health insurance scheme called “the UC scheme” to 47 million people, who were not beneficiaries of already existing schemes: the Civil Servant Medical Benefit Scheme (CSMBS) and the Social Security Scheme (SSS) for the formally employed.
- It took almost three decades to achieve UC since the instigation of a government pro-poor scheme (the Low Income Scheme) in 1975.
- Apart from the Low Income Scheme, the successive government applied a “piece-meal” approach of gradual insurance coverage extension to the non-poor by using a public subsidized voluntary insurance scheme (Voluntary Health Card Project) in 1983.
- In addition, the coverage of the formal sector private employee under mandatory tripartite payroll tax of Social Health Insurance (SHI) gradually extended.
- Approximately 30% of Thais were uninsured before implementation of the UC policy.
- Total health expenditure as a proportion of GDP during 2003-2005 ranged from 3.49% to 3.55%,
- Total health expenditure per capita was approximately 100 USD.
- Public funding of the total health care spend accounts for 64% in 2006.

Health insurance coverage prior to UC:

- Population covered by various health insurance schemes during 1991-2001:

Health insurance schemes	1991	1996	2001
The Low Income Scheme	12.7	12.6	32.4
Civil Servants Medical Benefit Scheme (CSMBS)	15.3	10.2	8.5
Social Security Scheme (SSS)	0	5.6	7.2
Voluntary Health Card	1.4	15.3	20.8
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

Source: Tangcharoensathien V., et al (2007)

- The Low Income Scheme was launched in 1975 to provide insurance coverage to the poor, and then extended to provide coverage to the elderly (>60) and children (<12), however, this scheme performed poorly as a high percentage of non-poor households obtained the Low Income card.
- The rapid increase in coverage of the voluntary health card scheme from 1996 to 2001 was due to strong political support resulting in 50% of the health insurance premium being subsidized by government.

- As a result of public sector downsizing, the proportion covered by the CSMBS shrunk over the period.
- The SSS had limited capacity to expand as formal employment was very small.
- Despite government efforts to extend coverage, almost 30% of the population was uncovered by 2001.
- Health insurance schemes when universal coverage was achieved, early 2002:

Scheme	Target Population	Coverage	Source of Fund	Payment Method
CSMBS (since 1963)	Govt. employee, retiree and dependants	6 million 10%	General tax, non contributory	FFS
SHI (since 1990)	Private sector employees	8 million 13%	Payroll tax tripartite contribution	Capitation (IP and OP)
UC Scheme (since 2002)	Rest of population	47 million 74%	General tax, non contributory	Capitation (OP) and Global budget and DRG (IP)

Source: Tangcharoensathien V., et al (2007)

- The CSMBS is a health insurance program offered as a fringe benefit to government employees, state enterprises employees, and their dependents.
- CSMBS, which continues under UC, provides more extensive coverage than other insurance programs. It is a fee-for-service plan, which reimburses public hospitals based on actual patient care, and pays a considerable share of the costs if the insured chooses to use private rather than public health care services.
- SSS provides insurance for private sector employees and the self-employed. It is a capitated system, covering about 13% of the population, half through private sector providers
- Comparison of systems design between the UC Scheme and SHI:

	UC Scheme	SHI
Service Contractor	Primary Care Network. Health centres and District hospital as mostly rural population	100 bed hospital, as mostly urban population
Referral	Ensure better referral	No referral
Payment mechanism	Capitation for OP, DRG and Global budget for IP (to prevent under-admission)	Capitation inclusive of OP and IP
Dental and maternity	Integrated into curative package	Separate package: maternity flat rate payment, dental FFS
Coverage	All family members	Contributors only

Source: Tangcharoensathien V., et al (2007)

Mechanisms of the UC Scheme

Funding:

- Financing the UC Scheme by general tax revenue was a pragmatic decision to achieve universal coverage rapidly. It is also the most progressive method for financing healthcare.
- Beneficiaries are entitled to free care at the registered contractor, whereas 30 Baht (0.74 USD) co pay for an OP or admission is required, with an exemption for the previously Low Income Card Holders as well as the elderly and children under 12.
- The 30 Baht co pay was abolished after the new government came into power in October 2006.
- However beneficiaries who bypass the registered primary contractor are liable to pay full charges.
- Beneficiaries have freedom to access any health care providers, if not registered at their own cost.

Benefits and Pooling:

- The beneficiaries covered by the UC Scheme are mostly the poor.
- In contrast, CSMBS and SSS covers mostly the rich group.
- Prior to the UC era, there were gaps of inequity across different schemes, in favor of CSMBS and SHI against the Low Income Scheme. This reform aimed to reduce inequities between schemes.
- Benefit packages were standardized between the UC Scheme and SHI and drugs published on the National List of Essential Drugs were provided only.
- There is also an exclusion list with certain services that are not provided by either scheme.

Purchasing:

- The payment methods designed for UC Scheme has a capitation mechanism for OP and global budget plus DRG for IP.
- The closed-ended provider payment method is one of the main features of the UC Scheme. Thailand pioneered capitation payment for SHI in 1991 and this was applied to the UC Scheme. There is also an additional payment for accident and emergency (A&E) and high cost care based on a fee schedule.
- The benefits offered were comprehensive including OP and IP.
- Registration with a preferred public or private primary contractor is a requirement of a contract model.
- UC Scheme advocates primary care contact and enforces the referral line process to secondary/ tertiary care facilities.
- The primary contractor ensures proper referral to upper level of care if needed. It serves as a fund holding for OP services, as it pays for referral OP services.
- Provider payment: capitation for outpatient services was adopted. Accident and emergency outside registered provider is paid on a fee schedule set and centrally managed by NHSO. IP services are paid by global budget and DRG. Currently, the global budget was set at a provincial level, but in the future the global budget will be set at a national level.
- Capitation rate was estimated based on utilization rate and unit cost of services at different levels of institutional care.
- At hospital levels, fiscal constraint is cross-subsidised by other schemes such as CSMBS and the balances from past year operations.
- The capitation in 2007 was based on actual utilization data from routine reports.

Provision:

- Purchaser provider split is another key feature of the UC Scheme design. The National Health Security Office serves as the healthcare purchasers, designs benefit packages and payment methods, while the MOPH, other public and private medical institutions are providers.
- SHI contracts with public and private hospitals with a minimum of 100 beds.

- UC Scheme contracts with Primary Care Network, notably District Health Systems (including health centres and the district hospital).
- Typically the primary contractor is a District Health System in a rural area (District hospital and 10-12 health centres in the district).
- There are about 725 rural districts, 95 urban provincial districts and around 80 other hospitals each responsible for an average of 50 000 people.
- About 75% of all beds are in government hospitals and about 21% are in private hospitals.
- The UC Scheme purchases care from predominately public providers and some accredited private providers.
- Most public hospitals are run by the Ministry of Public Health (MOPH) and are mandated by the MOPH to provide medical services to the poor and those enrolled in welfare programs.
- Larger regional hospitals provide tertiary and primary care services.
- Most large teaching hospitals are in Bangkok, and 40% of private hospitals are located in Bangkok.
- The competition in Bangkok (largely outside the UC system) is significantly higher than those in other provinces and the health care system in Bangkok is very different to that of the rest of the country.
- Under the new UC system, patients are assigned to hospitals by the MOPH.
- Physicians in public hospitals are employees of the hospital and as such are paid by the MOPH according to budgetary structures through the hospitals.
- There has been a significant increase in utilization of OP (40-50%) and IP once the UC Scheme came into operation.
- There was a major shift from tertiary provincial hospital to primary care units and district hospitals both for OP and IP. This design of the reform is very important for efficiency improvement for fostering the use of primary care.
- The functioning of district health systems is not possible without mandatory rural service for new graduates, which has been introduced since 1972. All new graduates are liable to serve three years in rural health services, notably in the DHS.
- Well developed private hospital sector provides alternate choices for urban elites to access by their own OOP payments, and not competing with the poor for public resources and services.
- Though problems of internal brain drain of low pay high work load public doctors are remaining a major problem.

Some Problems with the Reform

- Too rapid expansion of the depth of the benefit package, without adequate consideration to the financial health services burden.
- Too rapid, aggressive and inflexible reform: No actuarial costing was done prior to implementation, and the increase in demand was underestimated.
- Insufficient trained hospital personnel have led to ineffective financial and managerial personnel.
- Overworked health personnel, leading to dissatisfaction, despite salary remuneration incentives. Pay vs. productivity is not directly proportional.
- Internal brain drain from the public sector to the private sector increased due to increased demand in public sector and growing private sector.

Key question

- Despite the purchaser provider split in the public sector, how is the current Thai system different to the current South African system from a funding perspective:
 1. Civil Servants → GEMS
 2. Social Security → Medical Schemes
 3. UC Scheme → Public Sector (non-contributory funded via general tax)

References:

Tangcharoensathien, V., Prakongsai, P., Limwattananon, S., Patcharanarumol, W., and P. Jongudomsuk. (2007) Achieving universal coverage in Thailand: what lessons do we learn? A case study commissioned by the Health Systems Knowledge Network.

P. Gottret, G.J. Schieber and H.R. Waters, Good practices in health financing – lessons from reforms in low and middle income countries, World Bank, 2008.

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C. CDE Report on Reforms in Emerging and Mid-Income Countries

“The Centre for Development and Enterprise (CDE) is an independent policy research and advocacy organisation. It is one of South Africa’s leading development think tanks, focusing on critical national development issues and their relationship to economic growth and democratic consolidation. Through examining South African realities and international experience, CDE formulates practical policy proposals outlining ways in which South Africa can tackle major social and economic challenges.”

<http://www.cde.org.za>

A report was produced by Alex van den Heever for CDE, entitled:

Health Systems and Health System Reforms in Emerging and Mid-Income Countries: International Comparisons. Report Produced for the Centre for Development and Enterprise. January 2010.

The document has sections on Costa Rica, Cuba, Chile, Brazil, Republic of Korea, Malaysia, Vietnam and Thailand.

The document was not on the web-site as of March 2010.

D. The Joint Learning Workshop on Universal Health Coverage: Thailand

“The Joint Learning Workshop on Universal Health Coverage, held in Gurgaon, India on February 3-5, 2010, convened 120 representatives from six countries – Ghana, India, Indonesia, Philippines, Thailand and Vietnam – and several international organizations to share experiences in carrying out health coverage reform domestically, as well as to learn from the experiences and challenges of reform processes in other countries.”

<http://jlw.drupalgardens.com/>

The site has several reports on Thailand, including a country study, two reports on provider management and two on the use of technology.

<http://jlw.drupalgardens.com/category/tags/delegation/thailand>

Accessed March 2010.

E. WHO Regional and Country Experiences

Strategy on Health Care Financing for Countries of the Western Pacific and South-East Asia Regions (2006–2010)

http://www.who.int/health_financing/documents/cov-wprosearo-strategy2010/en/index.html

“Supporting adequate, sustainable, equitable and effective health financing to improve health outcomes is one of the most important goals of the World Health Organization. The Executive Board of WHO and the Fifty-eighth World Health Assembly have discussed and provided strategic directions on sustainable health financing, universal coverage and social health insurance.

The Strategy on Health Care Financing for Countries of the Western Pacific and South-East Asia Regions (2006–2010) is intended to translate this important policy direction into regional, national and subnational actions. The strategy aims to provide operational and practical guidance to Member States in improving overall health care financing policy development to achieve adequate, stable and effective health financing that provides equitable access to health services of assured quality.

The strategy is closely linked with broader health system and sector development issues. The WHO functional framework for health system financing is used to address health care financing issues and challenges together with international health and development goals. The strategy reflects the main findings and recommendations from international, regional and country-specific experiences, available evidence, regional and biregional meetings and consultations on health care financing.”

Country Experiences: Thailand

“A selection of countries' experiences with recent health financing policy reforms are included here. The examples, although by no means exhaustive, highlight specific concerns of policymakers from different countries, and related policies to address these concerns.”

A Macroeconomic View of Cost Containment: Simulation Experiments for Thailand

http://www.who.int/health_financing/countries/searo/en/index4.html

“Using a simulation model and the consolidated account approach to analyse Thailand's health financing system, this paper probes forecasted changes in health expenditure, and financing feasibility under a number of alternative scenarios. As demand for better quality of health services grows, health expenditure is likely to increase in Thailand. To balance any deficits, the article considers three key variables: government subsidies, co-payments from the 30 Baht Scheme and contribution rates of the Social Security Scheme. It also takes into account possible limitations and constraints of these financing sources.”

WHO on Thailand

<http://www.who.int/countries/tha/en/>

Accessed March 2010.

These notes have been collated for IMSA from submitted research material. The material has not been independently reviewed, checked or verified.

Professor Heather McLeod

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