Universal Health-care Coverage Scheme

International Labour Office

Thailand

In less than two years, Thailand implemented a health protection scheme covering 76 per cent of its population (about 47 million people).

The successful launch of the Universal Health-care Coverage Scheme (UCS) in 2001 benefitted from the convergence of three factors: political commitment, civil society engagement and technical expertise. The UCS is a tax-financed scheme that provides free health care at the point of service. The benefit package is comprehensive and includes general medical care and rehabilitation services, high cost medical treatment, and emergency care.

The UCS covers the people previously served by a collection of piecemeal schemes and the people who were without health protection particularly in the informal sector, the latter being equal to 30 per cent of the population.

The scheme has increased access to health services and reduced the incidence of catastrophic health expenditures. While it is not dedicated to the poor, its universal nature has pro-poor impacts. For example, the UCS benefits the lowest income quintile of the population more than any other segment.

National social protection floors (SPFs) guarantee access to essential health care and basic income security for children, persons of working age and older persons.

185 countries have adopted the Social Protection Floors Recommendation, 2012 (No. 202), an approach to achieve universal social protection.

This note presents a successful country experience of expanding social protection.

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Main lessons learned

- Civil society can play an important role in extending social protection to all by raising awareness among the population and actively lobbying politicians.
- Strong political commitment is crucial for the extension of social protection to all; this was clearly set as a priority in Thailand.
- A universal scheme can comprise cost containment mechanisms to ensure its affordability and long-term financial sustainability.
- The application of the universality principle and an emphasis on equity can result in pro-poor impacts.
- The implementation of the first guarantee of the social protection floor in Thailand has helped to develop the health-care infrastructure and generated a positive macroeconomic impact.
- Embedding the scheme in national law has made the human right to health care an enforceable legal right and contributed to ensuring regular budgetary allocations and institutionalization of the implementation structures, thus helping to make the scheme more sustainable.

1. Political commitment, civil society engagement and technical expertise shaped the UCS

The right of every Thai citizen to access health care and the right of the poor to free health care are addressed in the country's 1997 and 2007 constitutions. However, despite the gradual extension of health coverage since the 1970s and several pro-poor social protection and health policies, at the turn of the millennium approximately 47 million Thai people, mostly informal sector workers in lower socio-economic groups, had no health insurance or access to free health care. Furthermore, in 2001, out-of-pocket payments accounted for one third of total health expenditures.

Since the late 1990s, a group of reformists in the Ministry of Public Health (MOPH) and the Health Systems Research Institute had been documenting health inequities and developing evidence-based policy options to tackle them. Due to this knowledge and active communication, in October 2000 a group of 11 Thai NGOs formed a united front and declared their intention to support universal coverage.

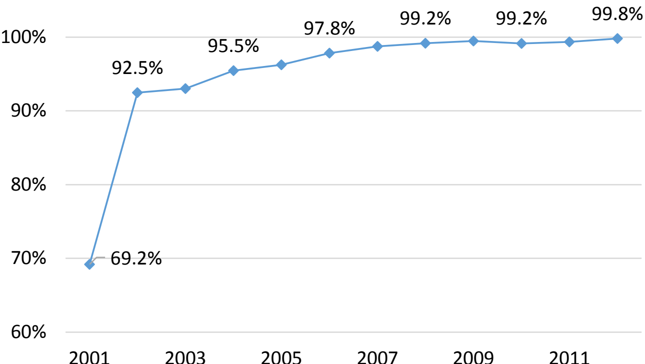
The political window of opportunity came during the 2001 national election. The campaign slogan of one of the contending parties, "30 baht treats all diseases", captured public attention. Following the election, the Government was eager to move quickly to consolidate public support. It put in place bold financing reforms to achieve universal health coverage within a year. The UCS was launched in six provinces in April 2001, in an additional 15 provinces by June 2001, and nationwide by April 2002.

The stated goal of the UCS is "to equally entitle all Thai citizens to quality health care according to their needs, regardless of their socioeconomic status". This goal is based on the universality principle: the UCS was conceived as a scheme for everybody, not one that targets the poor, vulnerable and disadvantaged.

2. UCS covers 76 per cent of Thai people through a comprehensive benefit package

The principle of the UCS is simple: it aims at covering the 76 per cent of the population not covered by other social health protection schemes, such as (a) the Social Security Scheme (SSS) for private sector employees, and (b) the Civil Servant Medical Benefit Scheme (CSMBS) for government employees and government retirees, as well as their spouses, dependants under 20 years old and parents.

Figure 1. Social health protection coverage in Thailand, 2001-12



Source: National Health Security Office, 2013.

Three features define the UCS:

- It is a tax-financed scheme providing free health care at the point of service (the initial co-payment of 30 baht per visit or admission was terminated in November 2006).
- It has a comprehensive benefit package with a focus on primary care.
- The budget is allocated based on a capitation payment mechanism for outpatient care and a global allocation based on diagnosis-related groups (DRGs) for inpatient care.

From the outset of the scheme, the package has been almost identical to that of the SSS, covering: outpatient, inpatient and accident and emergency services; dental and other high-cost care; and diagnostics, special investigations, medicines (at least including those in the National List of Essential Medicines) and medical supplies. The UCS also includes preventive and health-promotion services.

To control the cost and ensure the financial sustainability of the scheme, which requires more resources year on year, a fixed annual budget and a cap on provider payment were installed. The approved annual capitation rate tends to be lower than the amount requested by the health-care facilities, putting pressure on them to contain costs.

Even so, the budget allocated to support the scheme has increased steadily every year. Although the total number of UCS members remained constant between 2002 and 2011 at around 47 million, the UCS budget rose from 1,202.4 baht per capita in 2002 to 2,693.5 baht per capita in 2011. This increase was mostly driven by increased utilization and rising labour and material costs of providing medical and health services.

The development of the UCS was done alongside a significant expansion and improvement of the health-care supply side, to ensure that health-care facilities could absorb the increased demand for services.

The UCS design called for radically different governance, organizational and management arrangements with a view to ensure more transparency, responsiveness and accountability. The National Health Security Act promulgated in November 2002 mandated the establishment of the National Health Security Office (NHSO) and its governing body, the National Health Security Board (NHSB), chaired by the Minister of Public Health.

The NHSO is responsible for the implementation of the UCS and hosts a common registry based on the Ministry of Interior's population database. This registry is shared with other social health protection organizations. Combined with the use of smart cards to identify entitlements at delivery points, this central database is crucial to ensuring the coverage of the entire population and preventing fraud. It has also allowed NHSO to produce data on the use of health services with a view to request an appropriate budget allocation and thereby better serve the population.

3. Improved access to health care and contributions to economic growth

There has been a gradual increase in the use of health services due to UCS. The number of outpatient visits rose from 2.45 in 2003 to 3.22 in 2010, and the number of hospital admissions per member rose from 0.094 in 2003 to 0.116 in 2010. Empirical evidence shows that this increase is particularly salient among poor segments of the population, particularly at health centres and district and provincial hospitals.

The share of catastrophic health expenditures (defined as out-of-pocket payments for health-care exceeding 10 per cent of total household consumption expenditure) dropped from 6.8 per cent in 1996 to 2.8 per cent in 2008 among UCS members in the poorest quintile, and from 6.1 per cent to 3.7 per cent among members in the richest quintile. Furthermore, an analysis conducted at national, regional and provincial levels concluded that there was a decreasing trend in health-impoverished households with one or more UCS members and that the degree of poverty reduction in this group was stronger than the overall trend in the same period.

Moreover, the UCS contributed significantly to the development of Thailand's health information system through hospital electronic discharge summaries for DRG reimbursement, accurate beneficiary datasets and data sharing.

Public expenditures on goods such as medicines and medical supplies have had spill over effects in various sectors, particularly chemical, trade, electricity and water, mining and quarrying, and transportation and communication.

4. Next steps

The NHSO's health expenditure projections until 2020 indicate that total health expenditure as a percentage of GDP will continue to increase, mainly due to the ageing of the population. To ensure the financial sustainability of the system, new measures will need to be explored. A long-term care system with an appropriate financing strategy also has to be developed to address the long-term care needs of people and avoid overburdening public hospitals.

Furthermore, there is a need to progressively harmonize the benefit packages and the provider payment mechanisms across UCS, SSS and CSMBS to reduce fragmentation, address equity issues and have greater cooperation, including a shared registry.

Finally, unequal distribution of health-care facilities between rural and urban areas and across regions affects people's access to health care. New incentives should be introduced to attract medical personnel, especially skilled ones, to rural areas to reduce the imbalances.

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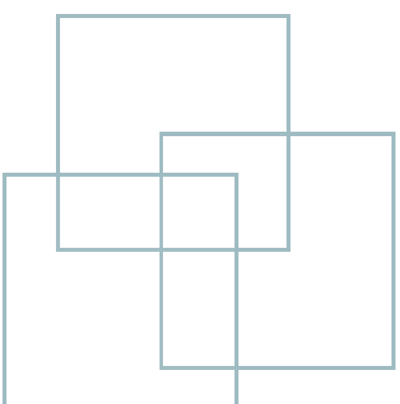

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