What Other Countries Can Learn from Thailand’s Path to Universal Health Coverage

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Introduction

Thailand is a universal health coverage success story, with 97 per cent population coverage as of 2007.

This brief describes the events, schemes and institutions that brought about the Universal Health Care Scheme (UHCS), with a focus on the financing aspects of resource collection, pooling and purchasing.

It is based on a review of the literature on the Thai health system and identifies lessons for other low- and middle-income countries on the path to universal coverage.

Background

Four social-protection schemes were operating prior to the establishment of the UHCS in 2001: a Civil Servants’ Medical Benefit Scheme, operated by the Ministry of Finance, provided access to health care for public sector workers and their dependents. Private formal sector workers were covered by the Social Security Scheme, which was funded by employer, employee and government contributions.

The Medical Welfare Scheme offered coverage to the poor and was funded by general taxation and managed by the Ministry of Public Health (MoPH). The voluntary Health Card Scheme, which began as community-based health insurance in 1983 administered by village communities, provided access to health care for the self-employed through a flat-rate fee per household, and was also funded by general taxation and run through the MoPH.

By 2000, 80 per cent of the population were in the informal sector, although only 49 per cent were covered by an informal-sector health insurance scheme. UHCS was designed to bridge this gap and eventually replaced the Medical Welfare Scheme and the Health Card Scheme.

The Civil Servants’ and Social Security Schemes continue to operate alongside the UHCS.

Institutional and Organisational Arrangements

The legal structure for the new universal coverage system (the National Health Security Office and the National Health Security Fund) was provided by the 2002 National Health Security Act. The act is clear but not comprehensive. While it puts administrative authority in the hands of the National Health Security Office (NHSO, with 13 regional offices nationwide), the rules for directing the operation of the UHCS are based more on administrative procedures than on legislation.

Under the UHCS, prospective patients are registered in a specified region and have free access to a health facility within that region. In practice, patients may register on admission to a facility, and in an emergency the patient may present at any facility in the network.

UHCS providers are public and private health facilities, which must register with the scheme. The benefit

KEY MESSAGES

• Thailand achieved universal coverage in 2007 by building on the experience of previous social health protection schemes, with a tax-funded scheme for the poor and the informal sector.

• The purchaser-provider split between the National Health Security Office and the Ministry of Health is fundamental to the success of this system.

• Strict enforcement of provider payment mechanisms and public-private competition have contributed to cost control and maintaining the quality of care.
network, adjusted for population age. The distinctiveness of each contract between each facility network and the NHSO allows some variation in conditions: for example, the board of the network can decide to direct funds to the community hospital or to particular health interventions at specific health centres depending on the local health needs.

**Conclusion**

The legacy of three main institutional arrangements derived from earlier schemes was crucial to the success of the UHCS. These include:

- the purchaser-provider split between the NHSO and the MoPH
- the provider payment mechanism (capitation is used for most preventive services and ambulatory care, and inpatient services are reimbursed using a case-mixed diagnostic-related groups system)
- competition between public and private facilities.

The closed-end demand-side capitation method of financing encourages facilities to enrol more people, which enhances standards of both public and private health facilities and enhances access to quality health care. Public-private competition encourages facilities to attract users, while unnecessary expenditures intended to increase profits are relatively limited. The risk of competition lowering the quality of care is reduced by modern quality assurance mechanisms.

The design of this system was premised on long-term experience and sound evidence provided by local research institutes working in collaboration with the MoPH and political actors.

The path undertaken by Thailand to achieve universal coverage provides a model to other countries in similar circumstances.