## Lessons learned from Thailand’s universal health care scheme: Institutional and organizational arrangements

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### Introduction

Thailand is well known as a middle-income country that has made remarkable progress in establishing universal health coverage. A process of development that began in the 1960s has in recent years culminated in institutional arrangements that provide the Thai population with affordable access to health services (up to 98% of the population covered by 2002).

This Issues Brief describes the institutional and organizational arrangements of the Universal Coverage Scheme (UCS) managed by the National Health Security Office (NHSO). The UCS now covers three-quarters of the population, including the large informal sector. The UCS together with the Civil Servants Medical Benefit Scheme (CSMBS) and the Social Security Scheme (SSS) are the components of Universal Health Coverage (UHC).

### Thai health schemes

Prior to establishment of the UCS in 2001, four social-protection schemes were operating. Under the Ministry of Finance, the CSMBS provided health financial risk protection for public sector workers and their dependents. The SSS, which ran alongside the Workmen’s Compensation Scheme through the Ministry of Labour and Social Welfare, provided health care benefits at contracted facilities to private formal-sector workers funded by employer, employee and government contributions.

Using tax funding, the Medical Welfare Scheme, managed by the Ministry of Public Health (MoPH), offered coverage to vulnerable groups (e.g. the poor, elderly, monks), and the voluntary Health Card Scheme, which began as a Community-Based Health Insurance program in 1983 administered by village communities, provided access to health care for the self-employed on payment of a flat-rate fee per household.

While 80% of the Thai population were in the informal sector by the year 2000, only 49% were covered by a health insurance scheme. The aim, therefore, was to expand the UCS (known as the 30-Baht scheme until the nominal fee was abolished in 2006) to cover all citizens not enrolled in the two formal-sector schemes.

### Institutional and organizational arrangements

The legal structure for the UCS, including the autonomous NHSO governed by the National Health Security Board, was established by the National Health Security Act of 2002. The Minister of Public Health is the chairperson of the Board, which is drawn from various sectors. The
Act is clear but not comprehensive. Although it puts administrative authority in the hands of the NHSO (which has 13 regional offices nationwide), the rules for directing the operation of the UCS are based more on administrative procedures than on legislation.

Beneficiary enrolment is automatic, but UCS members must register in their catchment area with the contracted unit for primary care (CUP) (comprising a district hospital and health centres covering ~50,000 people) for outpatient services and with referral services for inpatient care. The benefit package is comprehensive, including curative services, health promotion, disease prevention and rehabilitation.

Health services are provided to UCS members mainly through MoPH facilities, which comprise more than 70% of all health services, though private providers may also be contracted. The 30-Baht co-payment was reintroduced in 2012 for patients who receive prescriptions and are willing to pay.

Purchasing of services
Replacing the previous budget allocation from the MoPH to public health facilities, the NHSO now acts as a purchaser for the UCS, contracting with health providers for services offered to beneficiaries.

The NHSO receives government funds for the UCS, based on the estimated costs of service provision and the number of beneficiaries covered. First, the NHSO working group on budgeting prepares the estimated budget in discussion with the health financing sub-committee of the NH Board. The Bureau of Budget of the Ministry of Finance is a member of both the health financing sub-committee and the Board. The estimated budget agreed by the NH Board is then presented to the Cabinet for final approval.

Funds are channelled by the NHSO via its 13 regional offices to the 76 provinces. Different methods have been trialled for pooling and budget allocations from the NHSO to facilities for outpatient and inpatient care as well as health promotion and prevention activities. Since 2012, the budget allocation (fund pool) for inpatient care has been calculated at the regional level after which funds pass directly from the NHSO to hospitals. Funding for outpatient care is pooled by the CUP. Funds for health promotion and disease prevention activities are directed to the four different levels of government and pooled for area-based activities at the Provincial Health Office.

The NHSO uses many different methods of provider payment, among which the most common are capitation (for outpatient services) and case-based payment (for inpatient care) with a global budget ceiling. The contract between each facility network and the NHSO allows for 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.

Lessons learned
Thailand’s path towards universal coverage was influenced by politics, finances and health systems development. The experience gained from earlier UHC schemes was crucial in developing the institutional arrangements for the three current schemes—the SSS, CSMBS and UCS.

The success factors included strong political commitment, long-term investment in health infrastructure and human resources (particularly in rural and remote areas), establishment of an autonomous NHSO as a purchasing agency, use of the primary care facility as the gatekeeper and contracting unit, use of closed-end provider payment methods (with precisely calculated capitation or case-based funding and a global budget ceiling) and competition between public and private health providers.

The design of the system rested on both long-term experience and a sound evidence base provided by local research institutes working in collaboration with the MoPH and political actors. While technical difficulties remain, the way in which Thailand has addressed the challenges of implementing a universal coverage system provides lessons to similar countries.

Additional reading:

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