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Political and Policy Lessons from Thailand's UHC Experience

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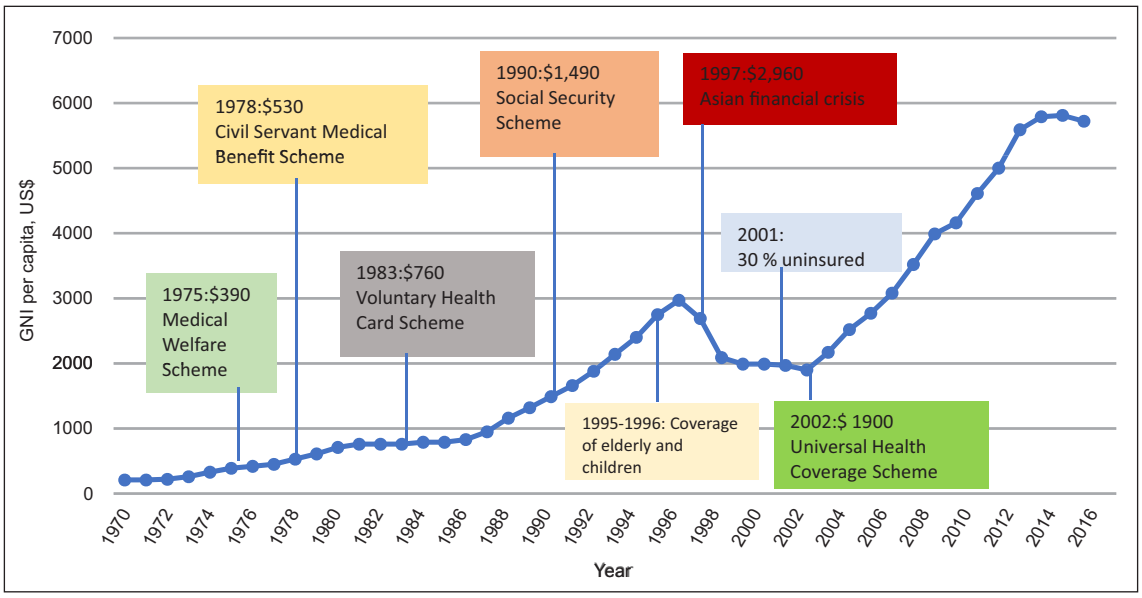
ABSTRACT Thailand is one of the few developing countries in the world that have successfully implemented Universal Health Coverage (UHC). Beginning three decades ago, Thailand's UHC first covered the poor, then the near-poor, the formal sector employees, and the children and the elderly, through various publicly funded and contributory schemes until it reached 71 percent of the entire population in 2000. The government elected in 2001 implemented full-population coverage, when the GDP per capita was a mere $ 1,900. Today, every Thai citizen is assured of universal access to a comprehensive benefit package of essential healthcare services. Overall improvements in health have been evident, and health expenditures are significantly reduced. Challenges remain, however, in the form of increased workload to providers and the burden of financial management for hospitals. This paper examines the history of Thailand's UHC and lists specific lessons that can be learned by other transitioning economies.

INTRODUCTION

Thailand is an upper middle-income country with a population of 64 million; of these, 60 percent live in urban areas. The citizens enjoy access to comprehensive essential healthcare with full financial protection. The population coverage of the country's Universal Health Coverage (UHC) gradually progressed over three decades, beginning with the "free medical care programme" in 1975 (Figure 1). At that time, Thailand's Gross Domestic Product (GDP) per capita was a mere $390.[1] The starting population coverage was 30 percent, but the service coverage, although comprehensive, was not deep. It then gradually covered the near-poor in 1985, based on a voluntary, publicly subsidised healthcare scheme. The formal-sector employees were covered by the contributory Social Security Health Insurance in 1992. Following this, the children and the elderly were covered with social welfare health

Figure 1: Evolution of finance protection coverage towards UHC in Thailand



Source : World Bank Data

insurance in 1995–1996. By 2000, 71 percent of Thailand's population was covered.[2] After the general election in late 2000, the new government decided to move forward to full-population coverage in January 2002, when the country's GDP per capita was still relatively low at $1,900.[3] Private health insurance, meanwhile, covers only a small proportion of the population at less than two percent. (Figure 1)

In 2001, in the midst of the Thai government's serious policy implementation of UHC, two analysts of the World Bank made a strong recommendation to reconsider it, warning of potential financial unsustainability.[4] The government, however, after taking stock of WB's comments, made a decision to continue the UHC policy, armed with strong commitment from the bureaucrats and health professionals, adequate technical capacity on health systems and policy research, and the involvement of civil society organisations (CSOs).

Cost sharing is minimal or almost nil in Thailand's UHC model. Following the implementation of UHC, previously massive health impoverishment has been significantly reduced; and healthcare has improved significantly, and with more equity. Challenges remain, however, with regards to ensuring a just system of financial contribution, as well as reducing geographic and social disparities in the access to essential services.[5]

This paper examines how Thailand's UHC policy was formulated and what factors contributed to the favourable outcomes, in an effort to provide policy lessons for other developing countries.

THAILAND'S HEALTH AND HEALTH INSURANCE PROFILE

Thailand is an upper middle-income country, with a GDP per capita of $5,814 in 2015.[6] The economy depends mainly on exports, as well as manufacturing and service industries while maintaining big agriculture systems. The Thai healthcare system is pluralistic and dominated by the public health facilities. The Ministry of Public Health is the major healthcare provider and owns most of the health facilities (60 percent in total and more than 95 percent in the rural areas). The private sector, with around 20 percent of health resources, participates by providing for 20 percent of the outpatients and 10 percent of the inpatients, for the more affluent urban population and for foreign nationals.[7]

Table 1: Characteristics of Thailand's health insurance schemes, 2016

	Civil Servant Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)	Universal Coverage Scheme (UCS)
Population coverage	4 Million (6.25%)	12 Million (18.75%)	48 Million (75%)
Beneficiaries	Civil servants + spouse + immediate relatives	Employees in private and public sectors	Those not covered by the CSMBS and SSS
Source of finance	General tax revenue (15,000 Baht/capita)	Tripartite: 1.5% of payroll each, (2,500 Baht/capita)	General tax revenue (3,344 Baht/Capita)
Financial supporters	Comptroller General's Department, Ministry of Finance	Social Security Office, Ministry of Labour	National Health Security Office (independent public agency)
Provider choice	Free choice of public providers, some services especially emergency and elective surgeries are also provided by the private providers	Annual choice of public and private hospitals (more than 100 beds) as main providers	Annual choice of mostly public primary-care based providers with referral system, mostly in the public systems
Benefit package	Comprehensive, excluding prevention and promotion services	Comprehensive, including some specific prevention services	Comprehensive, including extensive prevention and promotion services
Payment mechanism	OP: Fee-for- service IP: Diagnostic Related Group without budget ceiling Open-ended budget	Capitation with DRG for some in-patient care Close-ended budget	OP: Capitation IP: Global budget + DRG There are some fixed fee schedules to reduce providers' risks and promote access Close-ended budget

Source: [11, 12, 13]

There have been significant shifts in the country's health profile, and an increasing burden of chronic non-communicable diseases (NCDs).[8] Life expectancy at birth increased from 57/61 years in 1964 to 70/77 years in 2010 for men/women, respectively. The Infant Mortality Rate (IMR) declined from 49 per 1,000 live births in 1980 to 10.5 in 2016. The Maternal Mortality Ratio (MMR), meanwhile, declined from 98.5 per 100,000 live births in 1980 to 20 in 2015.[9] The leading causes of morbidity are cardiovascular diseases, traffic accidents, cancer, diabetes and HIV/AIDS.[10]

Healthcare services are largely financed by general taxation paid through three major public health-insurance schemes. The main characteristics of the three schemes are shown in Table 1.

It is clear from Table 1 that there are disparities in the per-capita expense, benefit package, service deliveries, payment mechanisms, as well as access to care among the three schemes. This is one of the main challenges facing Thailand's UHC. While there have been various movements towards the 'harmonisation' of the three schemes, progress has so far been slow.

DEVELOPMENT OF THAILAND'S HEALTHCARE SYSTEM

In the 1970s, the public health infrastructure could provide health services to only 15 percent of the population, while 51 percent still practiced self-care or else sought care from private providers and traditional healers. The rest were left untreated. In the early 1980s, the government started a "rural health development programme" to ensure adequate health services throughout the country.[14]

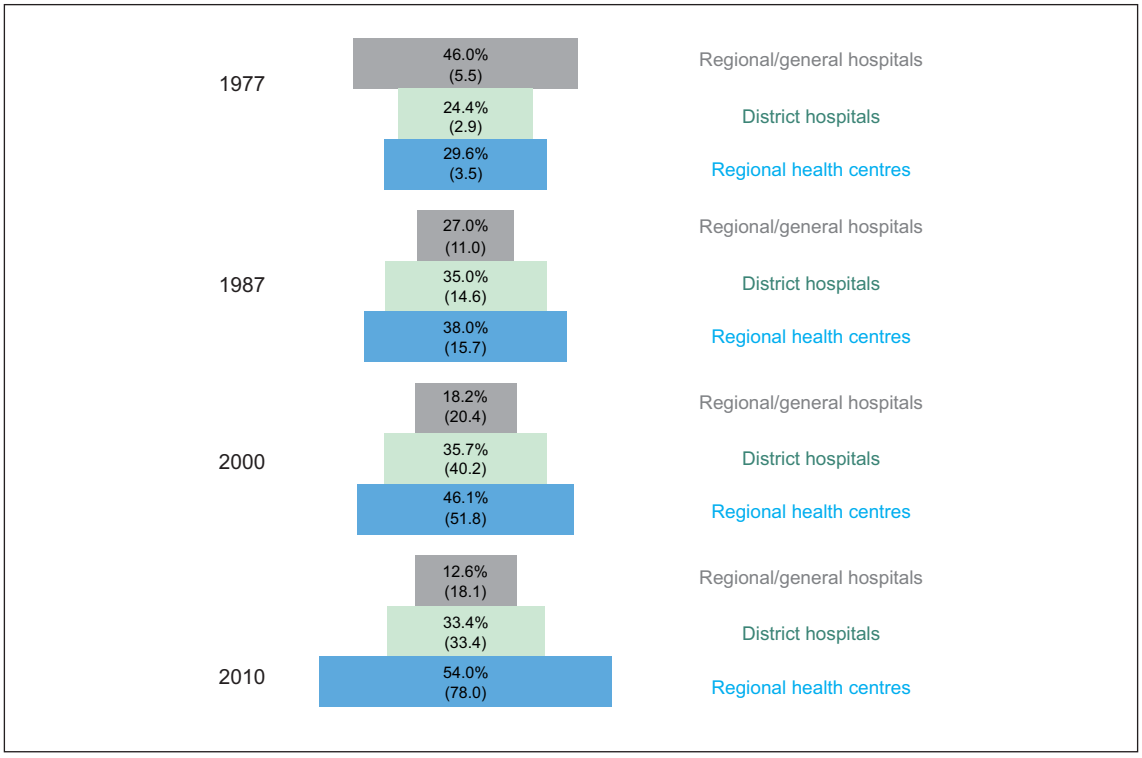
From 1982 to 1986, despite the economic crisis, the government decided to freeze all capital investment in the urban hospitals and shifted the limited resources to build rural district hospitals and health centres with extensive training of community-level health

professionals and rural doctors. This resulted in the rapid, nationwide expansion of rural health services and broadened access to essential health services at the community level[15] (Figure 2). Around one million "village health volunteers" were recruited and trained to assist health personnel in providing basic healthcare and health education to their communities. The volunteers helped distribute essential drugs and get children vaccinated; they also built sanitary latrines and clean-water reservoirs, and implemented nutrition programmes.[16] This committed rural health development programme, one of the many government strategies to regain the popular support it had partially lost to the communist guerrillas, met with success in improving access to basic healthcare services and laid down a strong public-health infrastructure, which made the UHC policy possible. In this period, public hospitals were allowed to charge user fees and keep the money for hospital renovation, employment of staff, and replenishment of pharmaceutical supplies.

From the late 1980s to mid-1990s, with double-digit economic growth and increasing purchasing power of the urban population, the private healthcare providers mushroomed, moving up from 10 percent to 20 percent share of the resources and services.[17] Thai patients who received services from the private sector were mostly well-educated urban dwellers with relatively higher incomes. They opted out of the UHC and began paying for their own medical expenses.

After the 1997 economic crisis, with a decreasing purchasing power of the population and less demand for private-sector services, the private sector started to move towards caring for foreign patients. The number of foreign patients rose from less than half a million in the early 1990s to around two million in recent years.[18]

Figure 2: Proportion and number of outpatient visits at various levels of health facilities, 1977–2010



Source: Thailand Health Profile 2010 Data.
Note: In parentheses are the numbers of outpatient visits in millions.

THE POLITICAL ECONOMY OF UNIVERSAL HEALTH COVERAGE

After the "free medical care programme"—started in 1975 by the elected democratic government—a few policy elites in the Ministry of Public Health (MOPH) started to work towards the formulation and implementation of UHC in the mid-1980s. These were the former student leaders who fought against the military in the 1970s and the leaders of the *Rural Doctor Society*.[19] In addition to working to extend health insurance coverage, they moved the parliamentary health commission to draft a National Health Insurance Bill in the early the 1990s. However, due to political changes, this bill was not considered. The 1996–97 political reform movements, with the promulgation of the new 'People's Constitution' in 1997, resulted in strong political movements demanding public-interest policies. The same group of policy elites in the MOPH—with connections to the Thai Rak Thai (TRT) party from their past engagement in the social movements against the military government in 1970s and in the Rural Doctor Society movement—was able to push UHC onto the political agenda. This became one of the main populist policies in the campaign for the first general election under the new Constitution in December 2000. The TRT party coined the motto, "30 Baht treats all diseases", to represent the notion underlying their proposed UHC policy. This motto became extremely popular in the campaign that won the party a landslide victory in the election.

Immediately after the formation of the new government, the plan for implementing the UCS, to ensure 100-percent UHC, was formulated, based on evidence and experience. After detailed study and discussion, the scheme was modified from the voluntary, publicly subsidised health-insurance systems, proposed during the election campaign, to an entirely tax-based social welfare system, with a minimal co-payment of ฿30 per visit. Subsequently, the ฿30 co-payment was abolished in 2006.[20] It was reinstated in 2009 but soon after failed due to strong resistance from the public.

Two months after the setting up of the new government in early 2001, the policy was implemented in six provinces that had experience testing the new systems under the Medical Welfare Scheme (MWS) financial reform, supported by the World Bank. Due to political pressure from the leadership of the permanent secretary of the MOPH and other relevant policy-makers, the new scheme was rapidly expanded to cover all other provinces within one year. Evidence from previous research as well as further synthesis of new information were used extensively in the implementation. For example, information from previous hospital costing research and from healthcare utilisation behaviour obtained from the Health and Welfare Survey were used to calculate the required budget per capita. To ensure long-term sustainability of the policy, and based on the new Constitution, 50,000 Thai citizens, led by the same former student leaders, submitted a National Health Security bill to Parliament. The National Health Security Act was promulgated in 2002, which established the National Health Security Office (NHSO) to manage the UHC systems.

1. POLICY CONTENT

The Benefit Package

As stated in the Constitution, all Thai citizens are entitled to equitable access to quality healthcare. The benefit package of the UCS includes a comprehensive set of health interventions stipulated in a contract between the NHSO and the providers, at every level of health service. It covers two components: the health promotion and disease preventive package, and the treatment and care package.[21]

The treatment and care package covers all

Table 2: UCS inclusion and exclusion list of high-cost interventions.

Inclusion list	Exclusion list
• Chemotherapy for cancers • Radiation therapy for cancers • Open-heart surgery including prosthetic cardiac valve replacement • Percutaneous Transluminal Coronary Angioplasty (PTCA) • Coronary Artery Bypass Grating (CABG) • Percutaneous Coronary Intervention with stent • Prosthetic knee and hip replacement • Neurosurgery, e.g. craniotomy • Antifungal treatments for Cryptococcal meningitis • A group of high-cost essential medicines, e.g. Antiretroviral treatment for HIV, Intravenous immunoglobulin (IVIG), Imiglucerase, Renal replacement therapy including kidney transplantation for patients with end-stage renal disease • Some effective organ transplant, e.g. Liver transplant for biliary atresia, Bone Marrow transplant for Thalassemia, Cornea transplant.	• Some organ transplantation with no evidence of effectiveness • Cosmetic surgery • Infertility treatment

Source: [23]

outpatient and inpatient services, including rehabilitation and palliative and long-term care. There are certain exclusions, such as cosmetic surgery, infertility treatments, some high-cost technologies, and the provision of private room and boarding. Many substantial high-cost interventions are also included in the benefit package (Table 2). However, for medicine coverage, the systems use an 'inclusion' list of National Essential Medicines, which covers around 800 items.[22]

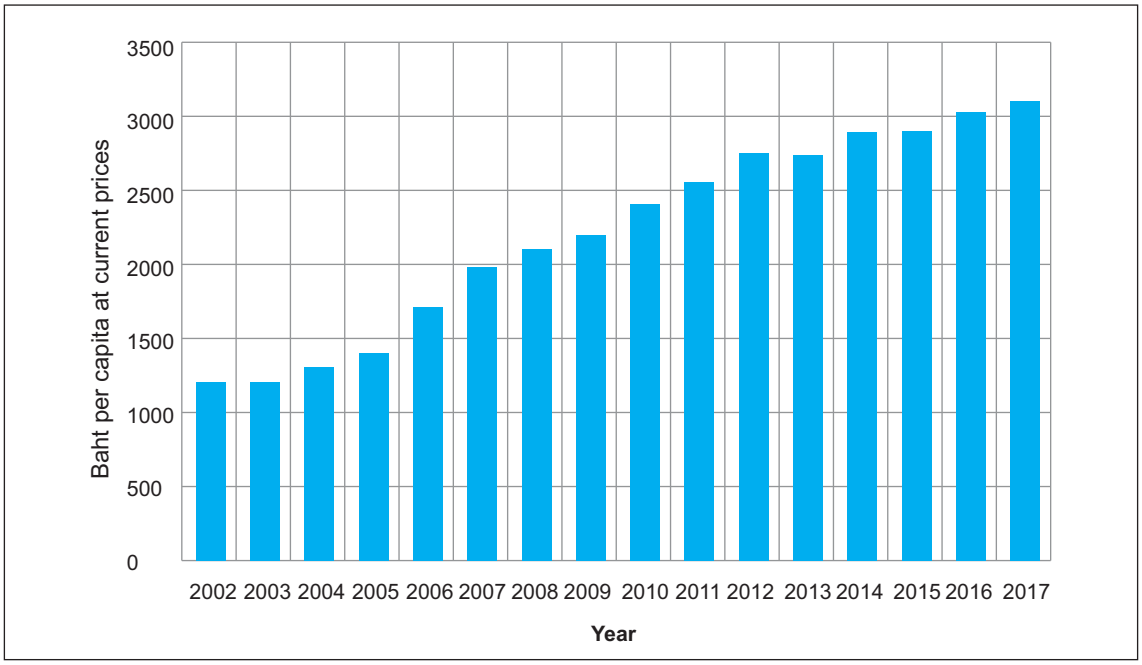
The UCS's health promotion and disease prevention package covers immunisations, annual physical check-ups, premarital counselling, voluntary HIV counselling and testing, antenatal care, family-planning services, and primary and secondary prevention for NCDs.

Budgeting and Provider Payment Methods

In the early days of UHC movement, from 1975 to 2001, a global budget system was used to provide financial support to public hospitals for social welfare services, while the CSMBS paid the provider based on the fee for services. After a thorough review of the advantages and disadvantages of all provider payment methods by the Health Systems Research Institute in 2001, it was decided that the UCS would use the capitation payment method[24] so that the expense can be controlled more efficiently. The expenses of the UCS are budgeted under an annual close-ended capitation system that includes each facility's labour costs to ensure a tight budget control. The rate of capitation budget of the UCS increased gradually in the first few years, and, more rapidly, since fiscal year 2006 (Figure 3).

The capitation budgeting system and payment method is expected to increase equity, because it depends on the population size in each locality. It is also expected to increase efficiency, as it includes all costs, and the hospitals must act like an insurer of registered beneficiaries. For financial survival, the hospitals need to improve their efficiency. To protect the providers, re-insurance systems have been applied for inpatient services as well as high-cost care and commodities. Over the years, the payment mechanisms have been gradually modified and is now a mixed system of

Figure 3: Capitation, Baht per capita, 2002–2017



Source: National Health Securiy Office Data

capitation for outpatients, DRG-based capped global budget for inpatients, and fixed-rate fees for some services to increase access and decrease financial risks for hospitals, both public and private.[25]

POLICY IMPLEMENTATION: PRIMARY CARE-BASED SYSTEM

The UCS employed a primary care-based system. Primary care provider units (PCUs) have been designated as gatekeepers to provide continuous and comprehensive care with a holistic approach. In principle, UCS beneficiaries receive services from their chosen primary providers with clear referral systems. However, in the case of accidents and emergencies, they can go to any health facility contracted under the UCS to seek emergency services.

Health facilities under the UCS can be classified into three groups according to the services they provide:

Contracting Unit for Primary Care (CUP)

The CUPs are primary healthcare facilities offering curative, promotive, preventive and rehabilitative services, such as ambulatory care, home care and community care. They can be facilities ranging from community hospitals to tertiary-care public or private hospitals. Each CUP has its own catchment area and population. However, in 2016, only 80 out of more than 400 private hospitals were functioning as CUPs, covering less than five percent of the beneficiaries.[26]

Contracting Unit for Secondary Care (CUS)

The CUSs are health facilities that offer secondary care, mainly inpatient health services. They can be facilities ranging from community hospitals to tertiary-care public or (a few) private hospitals.

Contracting Unit for Tertiary Care (CUT)

The CUTs provide expensive and specialised care with the aid of high technologies. They can be regional hospitals, university hospitals or specialised health institutes.

EVIDENCE OF UHC'S SUCCESS

Based on extensive coverage of healthcare service infrastructures, from primary to tertiary care, and the abolition of financial barriers, the UCS has significantly contributed to UHC and has helped in the improvement of both the population's health and the overall health system of the country.

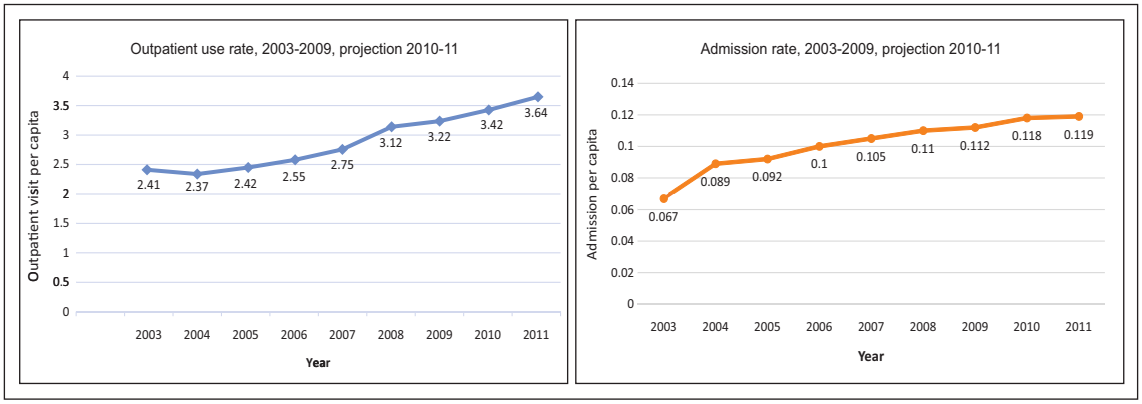
Near-Total Elimination of the Uninsured

The number of uninsured, as surveyed by the National Statistical Office, has dramatically decreased from 20 percent of the total population in 1998 to 0.1 percent in 2015.[27] In principle, coverage is universal. Anyone still uninsured can register at any time. An individual who needs health services can register at a health facility near their home and is eligible to receive free care immediately after.

Increased Access to Care

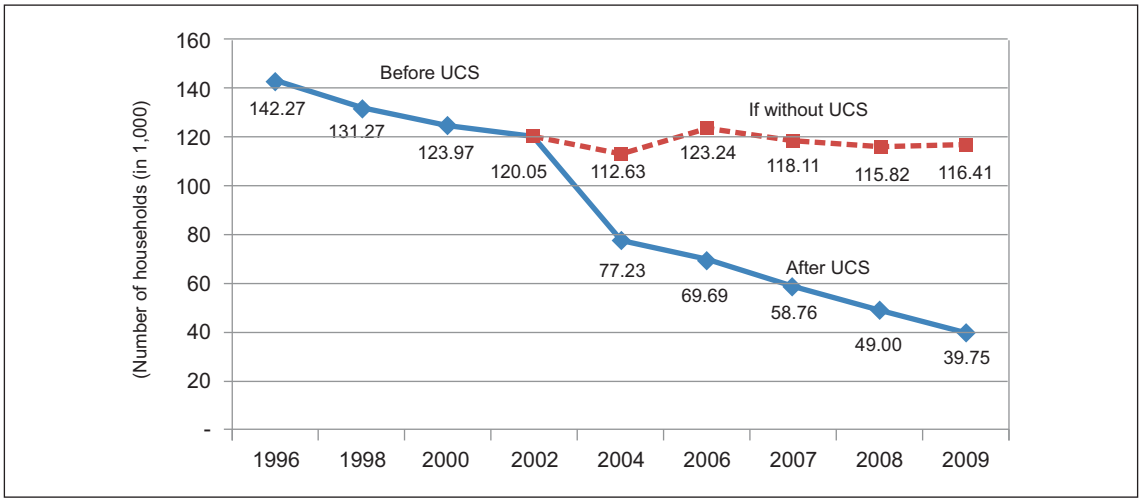
The utilisation rates of both outpatient and inpatient services gradually increased after the UCS implementation (Figure 4). The unmet healthcare needs decreased substantially. The prevalence of unmet need for outpatient and inpatient services in 2010 was 1.4 percent and 0.4 percent, respectively,[28] which is at par with OECD (Organisation for Economic Co-operation and Development) countries.[29]

Figure 4: Utilisation by UCS beneficiaries, 2003–2011



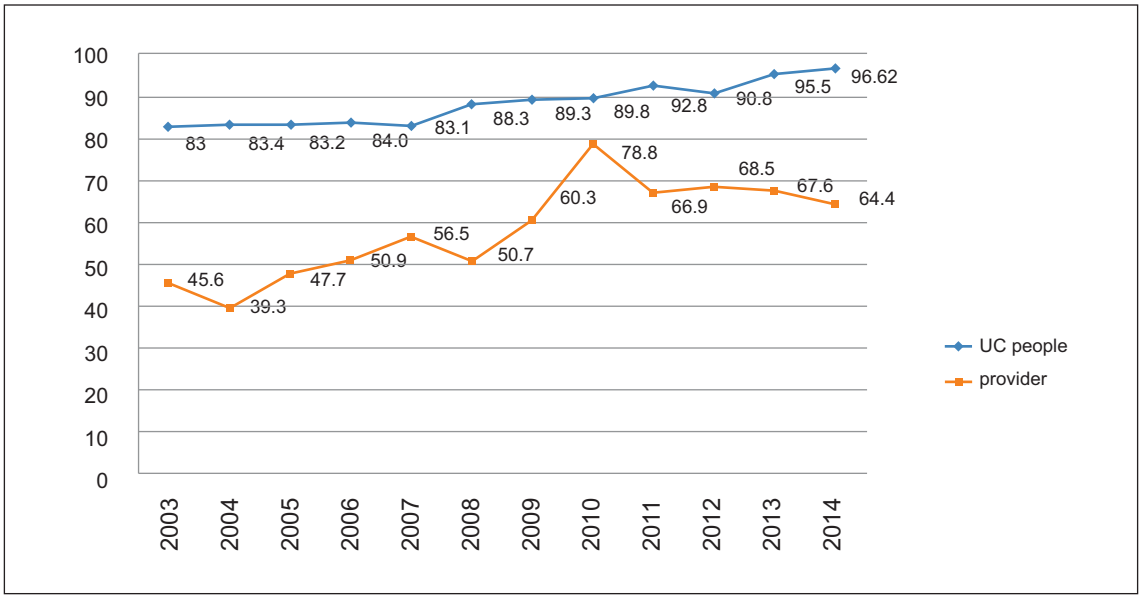
Source: National Statistical Office Panel SES dataset

Figure 5: Number of households protected from health impoverishment, 1996–2009



Source: Health Insurance System Research Office Data

Figure 6: % Satisfaction of UCS beneficiaries and healthcare providers, 2003–2014



Source: Health Insurance System Research Office Data

Significant Reduction in Out-of-Pocket Health Expenses and Impoverishment from Health Spending

A number of studies reported that the UCS has alleviated poverty for at least one million Thai citizens and protected a good number of households from health impoverishment[30] (Figure 5).

Consumer and Provider Satisfaction

Successive surveys of UCS beneficiaries and healthcare providers regarding their perceptions of the UCS conducted during 2003–2014 showed that their satisfaction increased over time (Figure 6).

Strengthening the Capacity for Knowledge Generation and Management

In support of the UCS implementation, the International Health Policy Program (IHPP), a joint programme between the MOPH and the Health System Research Institute (HSRI), was established in 2001 and has since played a significant role in generating evidence to support policy decisions.[31] To facilitate economic evaluation for the consideration of new high-cost care, a Health Technology Assessment Program (HITAP) was established in 2006.[32] Later on, the HSRI also established a Health Insurance Systems Research Office (HISRO). Many universities also joined in to generate evidence to support the implementation of UHC.

Strong Public Involvement and Support

To ensure sustainability, a network of civic groups began drafting the NHS bill and, with more than 50,000 signatories and the new article under the 1997 Constitution, submitted the bill in March 2001 to Parliament for its consideration.[33] The success in the first reading of the bill allowed them to gain some influential seats in the special parliamentary commission to consider the details of the bill. It also resulted in the allocation of five seats on the National Health Security Board to CSOs. They have actively participated in policy development, implementation and assessment process, and are now strong advocates of the UCS.

CHALLENGES TO UHC'S CONTINUED SUCCESS

Increased Workload and Dissatisfaction of Healthcare Personnel

The UCS has changed the relationship between the providers and the patients from that of a "vertical patron–client" to that of a "horizontal contractual relationship." However, this change of relationship and the increasing demand for health services led to negative feelings and dissatisfaction among providers (Figure 6). In 2009, a big financial incentive was given to the providers to resolve this issue. However, some conflicts between the MOPH and NHSO, as the main providers and financial supporters, has resulted in a new wave of dissatisfaction.

Adverse Effects of Resource Allocation Reform

The new budget allocation, shifting from a historical supply-based scheme to a need- or demand-based one, is aimed at achieving more equitable allocation of budgets. Due to a severe mal-distribution of health personnel, however, it has created significant concerns and conflicts. Under the capitation systems, facilities in small-population areas—both those in remote areas and those not too far from the capital—received inadequate budgets due to the small registered population size. Larger provinces in the northeastern regions, with a low concentration of health personnel, received huge budgets due to a larger registered population. A special contingency fund has been created to support the facilities in the small population areas.[34]

Financial Implications

In the first year of implementation, the UCS was criticised by healthcare providers for being under-financed, particularly for inpatient care. The capitation budget of ฿1,202 ($31.63) per registered person per year was inadequate. The rate was based on the 1996 service utilisation rate, which did not take into account the ageing population and the increase in inpatient admissions between 1996 and 2001.[35] It was also reported that more than 30 percent of public hospitals under the UCS were in financial trouble, with an accumulated debt of ฿1.365 billion ($35.9 million). In particular, small rural community hospitals in the north and northeast were severely affected. This was also due to the change in the resource-allocation system, as mentioned earlier. There was an increase in the number of hospitals with financial constraints, which had to rely on extra financial support from the Contingency Fund. The situation prompted the government to increase the capitation budget significantly from fiscal years 2006 to 2010. The financial situation of most hospitals has significantly improved since then.[36]

At the same time, due to the social-welfare nature of the UCS and the CSMBS, the health budget in 2016 amounted to 17 percent of the total government budget,[37] one of the highest shares among developing countries. This has now prompted the government to establish a Committee on Resource Mobilisation for Sustainable Universal Health Coverage. The committee recommends four goals—Sustainability, Adequacy, Fairness, Efficiency—together referred to as "SAFE".[38]

LESSONS LEARNED

Thailand has proved to the global community that 'universal health coverage' can be achieved even with a low GDP per capita. Many factors contributed to the success of the policy formulation and implementation, but the most important ones are political commitment, strong and equitable primary healthcare

facilities with committed health personnel, the technical capacity to generate evidence, and the active involvement of CSOs. While the UCS also created negative consequences in the form of increased workloads and financial burden to hospitals and the government, the Thai case offers at least three important lessons for other countries, which can develop their own paths towards UHC.

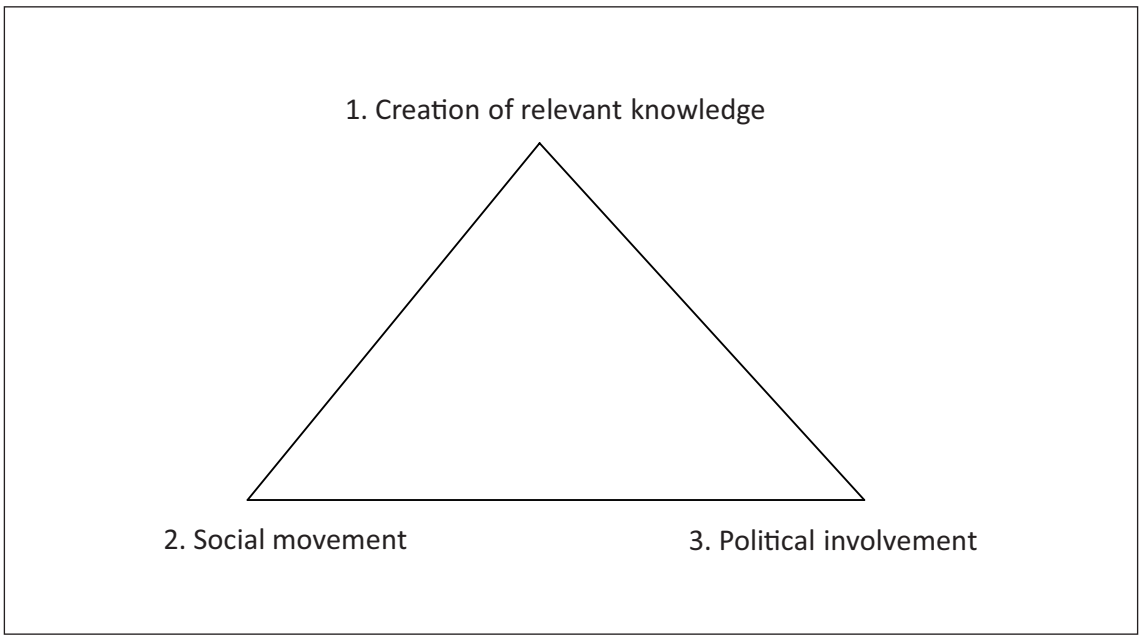
Using the Right Strategy: The "Triangle That Moves the Mountain"

The key strategy of the policy formulation process is the "Triangle That Moves the Mountain" (Figure 7). The Triangle is the interaction between (1) generation and management of relevant knowledge; (2) strong social movements; and (3) political commitment.[39] Knowledge is created through health systems research and is effectively communicated through some policy elites in the ministry, who have close connections with both strong CSOs and influential politicians. The "mountain" cannot be moved without political involvement, because politicians influence resource allocation and utilisation, and have a significant role in promulgating laws. Knowledgeable CSOs can mobilise public support to influence political decisions.

The Tipping Point and the Role of the Strategic Actors

Some other factors also helped tip the situation from 71-percent coverage in 2000 towards full universal coverage. These include the "stickiness" of the issue. The motto "30 Baht treats all diseases" has been so popular that it is embedded in the mind of every Thai citizen. This has resulted in strong social support for UCS' sustainability. Some policy elites and the civic actors who play the role of the 'Mavens', the 'Connectors', and the 'Salesmen'[41] also helped create strong intellectual capital, social movements and political commitment. Thus, the existence and the roles of these people in powerful government positions contributed greatly to building up evidence-based political commitment and social movements. The conducive political, social, and economic environments—especially after the 1997 economic crisis and the strong demand for social reform—also allowed for the acceptance

Figure 7: The "Triangle that Moves the Mountain" strategy



Source: [40]

of the idea of universal coverage and mobilisation of funds to support its implementation.

Long-Term Investment in Public Health Infrastructure and Health Workforce

Thailand started seriously investing in healthcare infrastructure in the public sector five decades ago. This investment enabled a rapid expansion of the basic public health infrastructure nationwide in the last three decades. A number of measures concerning education, finance, career development and motivation among health personnel were also implemented to ensure an equitable distribution of adequate number of committed and qualified health workers to run these public health facilities nationwide.

CONCLUSION

Thailand started to provide free healthcare services for the poor in 1975, at a GDP per capita of $390, and gradually increased the population coverage to 71 percent in 2000. It achieved full population coverage of UHC in January 2002, at a GDP per capita of around $1,900—a level that approximates that of India today. Thailand proceeded with a two-pronged approach: while it gradually increased the coverage of health insurance, it also expanded and improved its rural health infrastructures managed by trained, committed health workers. Political commitment, leadership of the policy elites and technical capacity in the Thai Ministry of Public Health, and strong CSOs, collectively made the UHC possible. Despite facing a number of challenges along the way, Thailand has proved to the international community that UHC can indeed reach full-population coverage, even for low-income countries.

The current Thai Public Health Minister said on UHC Day, 2016:

"Because we are poor, we cannot afford not to have UHC."[42]

After 14 years of implementation, the Thai UHC has gone through seven prime ministers, two leading political parties, and two military governments. All governments want to improve the UHC to make it more equitable, with deeper coverage and better quality, providing more efficient services and ensuring sustainability. Indeed, UHC has now become a 'People's policy' in Thailand. ORF

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