

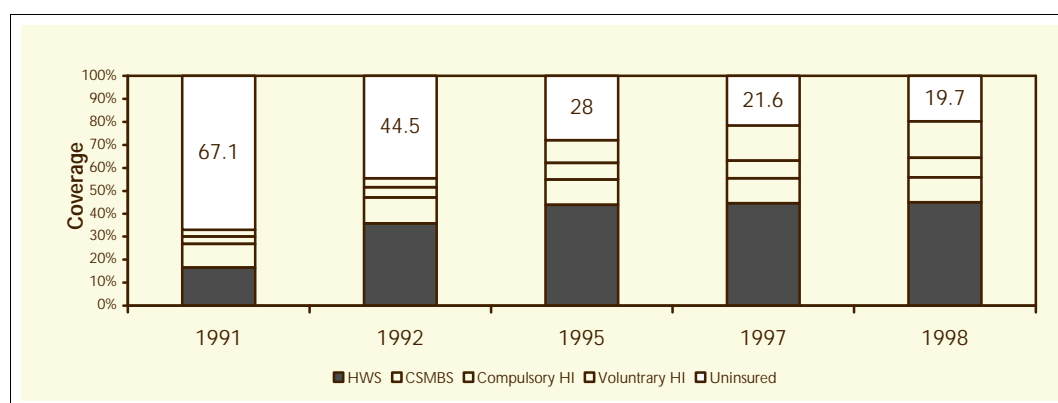
## Annex 6

## ACHIEVING UNIVERSAL COVERAGE OF HEALTH CARE IN THAILAND THROUGH THE 30 BAHTS SCHEME <sup>1</sup>

### Why Universal Coverage of Health Care

Information from various sources indicated that, during 1998-1999, about 20-30% of Thai population was still uninsured<sup>2 3 4</sup>. Health care coverage has been increased rapidly during the last decade due to the establishment of the Social Security Scheme (SSS) and the increasing coverage of Health Welfare Scheme (HWS) and the Health Card Scheme (HCS) (see Figure 1). Before the implementation of universal coverage of health care (UC) policy, the majority of population was covered by the Health Welfare Scheme. The existing insurance schemes are quite different in benefit packages, payment mechanisms, government subsidies and these result in different quality of care.

Figure 1. Health Insurance Coverage of Thai Population, 1991-98



Source: Bureau of Health Policy and Plan, Ministry of Public Health

<sup>1</sup> Pongpisut Jongudomsuk, MD., MPH, Health Care Reform Office, Ministry of Public Health, Thailand, Paper prepared for SEAMIC Conference 2001 FY, 14-17 January 2002, Westin Riverside Plaza Hotel, Chiang Mai, Thailand

<sup>2</sup> Wibulpolprasert S. (editor) Thailand Health Profile 1997-1998. Bangkok: Printing Press, Express Transportation Organization, 2000.

<sup>3</sup> Nittayarumphong S. and Pannarunothai S. Thailand Country Report. A paper prepared for international seminar on health care financing reform "Achieving Universal Coverage for Health Care through Health Insurance: Experiences from Middle and Upper Income Countries". Bangkok. 15-17 March 1998

<sup>4</sup> Tangcharoensathien V. et.al. Health Insurance System – An Overview: (mimeograph)

Universal coverage of health care has become an issue of increasing concern for the public because of many reasons. First, the people under less privileged health insurance schemes (HWS and HCS) and the uninsured started to complain more about the quality of care provided and their inaccessibility to necessary care. In 1999, the Foundation for Consumers conducted a research project, supported by the Health System Research Institute (HSRI), to document cases who suffered from the existing health care system. These documents<sup>5</sup> were published and distributed in the first National Forum on Health Care Reform, organized by the Health Care Reform Office (HSRO), and created a lot of public criticism and public concern about the quality and equity in access to care under the existing health care system. Second, the Constitution of 1997, which was the result of political reform, clearly stipulated health as a human right, which must be protected by the State. Health services under the new constitution must respect equity, efficiency and quality, as well as transparency and accountability. The constitution also permits the submission of law to the Parliament through the collection of 50 000 signatures. This constitution provides ground for civic groups to move further in getting their rights.

### **Previous Attempts to Achieve Universal Coverage of Health Care (UC)**

In fact, during the last decade, the Ministry of Public Health (MoPH) has made many attempts to achieve universal coverage of health care. In 1996, the first draft of the National Health Insurance Act was prepared by a sub-committee of the Parliament for its consideration. Unfortunately, because of inadequate policy support, this attempt failed to achieve the stage of policy consideration and adoption. Many efforts were made to increase the coverage of the Health Card Scheme (HCS) to cover the uninsured. However, because of the voluntary basis of the HCS which led to its being a non-recovery scheme, the HCS could only achieve a limited population coverage. Fee exemption for persons who could not afford public health facilities could help improve the access to care of uninsured, but with unacceptable quality. Several research studies focusing on financing and managing health care system under UC policy have been supported by various research institutes

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<sup>5</sup> The documents contain a series of 3 books, namely, *Suffering from Hospital*, *Suffering beyond the Disease* and *Why the Patients Sue the Physicians*. The books documented 15 cases of patient who suffered from the existing health care system.

for example, the Health System Research Institute (HSRI), the Health Care Reform Office (HSRO) and the National Health Foundation (NHF). This accumulated knowledge and experiences have provided several options for the implementation of UC policy in the future.

Recently, after the first National Forum on Health Care Reform in December 1999, a network of civic groups was established to campaign for the UC policy. This network of civic groups started to draft their own law, the National Health Insurance Act, with the support of some technical people. The campaign for 50 000 signatories in favour of this law was started in October 2000 and could get more than 50 000 signatories in March 2001. The draft law has already been submitted to the Parliament, with all the signatures, for its consideration.

In January 2001, the current government won landslide vote using universal coverage of health care as one of its major public policy gains. Campaign of the leading political party, Thai Rak Thai Party, used the slogan of "30 Bahts per visit / episode for every disease" or "30 Bahts Scheme" as representative of their UC policy. The policy was implemented in six pilot provinces in April 2001 and incrementally expanded to another 15 provinces in June 2001. In October 2001, the scheme could cover all provinces and part of Bangkok and it is planned to cover the entire country in April 2002.

### **How Much Do We Have to Pay and Can We Afford for the Cost of UC Policy?**

At the beginning of the year 2001, there were at least three proposals on resources needed for UC policy.

- (1) **Proposal using unit cost of autonomous hospital (AH):** Due to the economic crisis in 1997, autonomous hospital had been proposed as an alternative management model of public hospital to improve its efficiency and responsiveness.<sup>6</sup> Since universal coverage of health care is one aspect of AH model and the budget needed for AH, 782 Baht per capita<sup>7</sup>, had already been proposed. This unit cost has been used for

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<sup>6</sup> Chunharas S. et. al., Thai Autonomous Hospitals: Operation Manual, Thailand Health Financing and Management Study Project ADB # 2997-THA, December 1998.

<sup>7</sup> Pitayarangsarit S. et. al., Block Grant for the First Autonomous Hospital in Thailand: Why 782 Baht per Capita? Health Policy and Planning Journal (Thailand) Vol.3 No.1 Jan-March 2000. p 4-19.

further calculation by adding the unit cost of health centre which was 120 Baht per capita<sup>8</sup>. Therefore, it was proposed that the resources needed for UC is 900 Baht per capita.

- (2) **Proposal of Pannarunothai S. et al<sup>9</sup>:** In this proposal, the research team used sickness episode and health service utilization of population, obtained from the national survey in 1996-Health Welfare Survey 1996, and unit cost of health facilities at different levels for the calculation. Health service utilization in 1996 had been adjusted by using the change of population structure in 2001, increase of insurance coverage and etc. The team proposed that resources needed for UC in 2001 is 91 930- 148 650 million bahts or 1 482-2 397 bahts per capita based on the way the health care system, including provider payment method, has been organized. If unregulated health care system is selected with fee-for-service payment, the per capita budget needed will be at the high end.
- (3) **Proposal of the MoPH:** The MoPH submitted another proposal regarding the budget needed for the UC policy. This proposal used the approach similar to the previous one, using the pattern of health service utilization without any adjustment and unit cost of health facilities from the most updated study for calculation. The MoPH also used the experience of high cost care and accident and emergency care from the Social Security Scheme (SSS) to add to the calculated unit cost. According to the MoPH proposal the budget needed for the UC policy in 2001 was 1 202 40 Bahts per capita<sup>10</sup>.

All proposals were considered in the workshop arranged by the MoPH, which was chaired by the Prime Minister, on 17 March 2001. The Prime Minister accepted to use 1 202.40 bahts per capita as the starting estimated budget for the UC policy in Thailand. Details of budget are described in Box 1.

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<sup>8</sup> Pitayarangsarit S. et. al., Health Center Costing, 1999 Fiscal Year: Samutsakorn Province. A research supported by Health Care Reform Office, September 2000 (mimeograph).

<sup>9</sup> Pannarunothai S. et. al., Universal Health Coverage in Thailand: Options and Feasibility. Health Care Reform Office, July 2000.

<sup>10</sup> Tangcharoensathien V. et. al., Budget for Universal Health Care Coverage: How was the 1,202 Baht Capitation Rate Derived? Journal of Health Science Vol.10 No.3 July-September 2001: p.381-390.

**Box 1. Details of Capitation Rate: 1 202 bahts per capita per year**

| <b>Budget for curative care</b>            | <b>Budget for prevent/promotive care</b>         |
|--|--|
| - ambulatory care = 574 bahts/cap/year     | - preventive & promotive care 175 bahts/cap/year |
| - inpatient care = 303 bahts/cap/year      | <b>Capital investment</b> = 93.40 bahts/cap/year |
| - high cost care = 32 bahts/cap/year       | <b>Administrative cost</b> = 10% of total budget |
| - accident & emergency = 25 bahts/cap/year | <b>Contingency fund</b> = 10% of total budget    |

At present, there are 6 million people who are covered by the SSS and about 7 million people who are covered by the CSMBS. Considering the rest of the population of 48 million people, most of whom are already covered by the HWS and HCS, and who will be covered by this UC policy<sup>11</sup>, the country needs to pay at least 57.7 billion bahts to cover the uninsured. The country has already paid 8.7 billion bahts for the SSS (1 450 bahts per capita per year) and 16.44 billion bahts for the CSMBS (2 349 bahts per capita per year). Therefore, the total cost for this UC policy will be 82.84 billion bahts.

In fact, Thailand had already spent 179.69 billion bahts on health in 1998 and 70.5% of this health expenditure or 126.77 billion bahts was the cost of personal health care. Public sources of finance were responsible for 49.2% of total personal health care expenditure or about 62.4 billion bahts.<sup>12</sup> By adjusting this figure for the year 2001, public sources of finance would increase to 76.55 billion baht<sup>13</sup> and an **additional 7.29 billion bahts would be needed for the UC policy.**

It is arguable whether Thailand's current fiscal space could accommodate an approximate 10 per cent increase in public health expenditure on account of this UC policy. Considering the country's economic recovery after the serious crisis in 1997, there were warning signals about the country economic slowdown due to the delay of its structural adjustment and the slowdown of the world economy, especially the US economy.<sup>14</sup> The US economy started to slow down in the third quarter of 2000. The terrorist attack on the US in September 2001 even made the world economy worse than before. At the beginning of 2001, it was estimated that

<sup>11</sup> The government decides to merge all health insurance schemes under the responsibility of the MOPH and expands it to cover the uninsured.

<sup>12</sup> Phongpanish S. et. al. National Health Account in Thailand 1996, 1998. A research reported supported by the Health System Research Institute, December 2000.

<sup>13</sup> HSRI. Proposal on System of Universal Coverage of Health Care. Health System Research Institute, May 2001. p.30.

<sup>14</sup> National Economic and Social Development Board, Press Release, 19 March 2001.

economic growth rate of Thailand would be 3.5-4%. This estimation was adjusted many times because of changes in the situation in the National Economic and Social Development Board (NESDB) announced that the country's economic growth rate for 2001 would be 1.5% and will increase to 2% in 2002<sup>15</sup>. Under this condition, the government may have to reprioritize their previous budget plan and improve the efficiency of government's budget are spending, in order to get additional resources for the UC policy.

### **Ultimate Objectives and Main Characteristics of the UC Policy**

In addition to the finalization of budget needed for the UC policy, the workshop in March 2001 also considered the main objectives and characteristics of UC policy in Thailand. There was consensus among key stakeholders that the ultimate objectives of the UC policy are;

- (1) **Universal coverage:** All Thai citizens should be entitled and should have equal access to quality care according to their needs, regardless of their socioeconomic status and religion etc.
- (2) **Single standard:** The benefit package and quality of care provided for all Thai citizens should be of the same / single standard.
- (3) **Sustainable system:** system under the UC policy should be sustainable in terms of policy, financial and institutional sustainability. An efficient system, both allocative and technical efficiency, as well as an adequacy and stability of budget is needed for the financial sustainability. Legislation can be used to ensure the policy sustainability and, therefore, the government started to draft the law, the National Health Insurance Act, and submitted to the Parliament for consideration. Institutional sustainability can be secured only if the system, including personnel under the system, is well prepared and additional resources are needed for this preparation.

In summary, the proposed main characteristics of system under the UC policy are<sup>16</sup>:

- (1) promoting the use of primary care;
- (2) the use of close end provider payment method;
- (3) ensuring quality of care by using accreditation;

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<sup>15</sup> National Economic and Social Development Board, Press Release, 17 December 2001.

<sup>16</sup> MOPH, Guideline for the Management of Universal Coverage Policy during the Transitional Period. Ministry of Public Health, May 2001.

- (4) the use of standard benefit package and payment method;
- (5) merging of existing health insurance funds;
- (6) decentralization of fund management to the province.

### ***Promoting the use of primary care***

Primary care in Thailand have been neglected for a long time and this results in poor and unacceptable quality of care provided by primary care and overcrowding of outpatient department of big hospitals due to the bypass of unnecessary cases<sup>17</sup>. During the last decade, there have been continuous efforts to strengthen primary care in Thailand. In 1992, the first demonstrating model of primary care has been established in Ayutthaya province<sup>18</sup> and has become a successful model. The concept and management model of primary care has been gradually accepted nationwide. Recently, the Consortium of the Deans of Medical Schools has organized a national conference on medical education in April 2001 and has reached a consensus that changing medical curriculum to serve primary care is a priority issue. Unfortunately, existing incentive system, which still favors medical specialists in hospital, makes the reorientation of health care system more difficult. The establishment of the Social Security Scheme in 1990 could be a leverage for the change of health care system. However, because of the immaturity of primary care at that moment, the Social Security Office (SSO), then, decided to contract big hospital, more than 100 bed hospital, as a main contractor and financial incentive remained focusing on hospital care.

Primary care has been identified as a key mechanism for providing health care in UC policy because of two main reasons. First, primary care is a provider with the best setting for providing quality care based on holistic approach<sup>19</sup>. Its location close to the community makes the provider better realize the socio-cultural context of the people. Primary care provider also has better opportunity to perform their proactive role in the community. Second, it is expected that a system with primary care as a gatekeeper will have lower

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<sup>17</sup> Srivanishakorn S. et. al. Primary Care in Thailand: Situation and Recommendations for the Development. Health System Research Institute and Thailand Health Research Institute, 1996.

<sup>18</sup> Pongsuparb Y. Development of Family Practice in Thailand: Ayutthaya Case Study. Health Care Reform Office, 1996.

<sup>19</sup> Valayasewee A. et. al. Relevant Health Care System for Thai Society in the Next Two Decade: Proposal for Reforming Medical Education. Health Care Reform Office. November 1999.

overall health care cost.<sup>20 21 22</sup> Strengthening and promoting the use of primary care in the UC policy has been done through many policy details as follows:

- **primary care is the main contractor and unit for population registration:** instead of assigning a big hospital as a main contractor, a primary care unit will be a main contractor and a unit for population registration in the UC policy. Primary care provider is entrusted for the provision of comprehensive care for their registered population.
- **primary care is a gatekeeper:** direct access to hospital care is not permitted, except in case of accident and emergency care.
- **primary care is a fund-holder:** in addition to the provision of comprehensive care by their own health facilities, primary care providers can use their budgets to contract other health facilities to provide care for their catchment population- a fund-holder approach. This will promote the network of primary care providers.

A primary care unit will be responsible for no more than 10,000 registered population and minimum requirements of primary care provider who would like to be a main contractor in the UC policy (Contracting Unit for Primary Care –CUP) are described in Box 2.

| <b>Box 2. Minimum Requirement of CUP</b>   |  |
|--|--|
| <b>Inputs and Structure</b>  |  |
| 1. One facility for no more than 10,000 population                                   | - personnel work in CUP more than 75% of their working time        |
| 2. Facility is located close to the responsible pop. (transportation time < 30 min.) | - available laboratory system for the investigation                |
| 3. Adequate health personnel   | - available vehicle for the referral                               |
| - physician 1: 10,000-20,000*  | <b>Provision of Services</b>                                       |
| - dentist 1: 20,000-40,000*  | - service available at least 56 hours/week                         |
| - pharmacist 1: 20,000-30,000*   | - be able to provide comprehensive care                            |
| - register nurse 1: 5,000  | - be able to provide in-house service and community based services |
| - health personnel 1: 1,250  |  |

\* the lower proportion of health personnel to population are proposed to use in rural areas where there are severe shortage of health personnel

<sup>20</sup> Martin D.P. et. al. Effect of a Gatekeeper Plan on Health Services Use and Charges: A Randomized Trial. American Journal of Public Health. 1989; 79: 1628-32.

<sup>21</sup> Walker L. Is the Gatekeeper a Dying Breed? Business Health. 1998: 16: 30-36.

<sup>22</sup> Delnoij, D. et. al. Does General Practitioner Gatekeeping Curb Health Care Expenditure? Journal of Health Service Research Policy. Vol. 5 No.1 January 2000: 22-26.

### ***The use of close end provider payment method***

Experiences of countries with universal coverage policy confirm that health care cost of those countries would increase because of the moral hazard unless appropriate provider payment method and cost sharing system have been adopted. Cost sharing, as a demand side intervention, has limited effect on cost control especially when compare with supply side interventions. Introducing only co-payment of 30 Baht per visit, therefore, may not be enough to contain the health care cost. Thailand has quite impressive experiences in using capitation payment to control the cost of the Social Security Scheme (SSS) since all the financial risk has been transferred to the provider. Recently, the proposal on the reform of the Civil Servant Medical Benefit Scheme (CSMBS) has proposed a further modification of capitation payment by splitting payment for ambulatory care and payment for inpatient care. Capitation payment is proposed for ambulatory care while case payment, Diagnostic Related Groups (DRG) with global budget, is proposed for inpatient care.<sup>23</sup> Inclusive capitation, as still used in the SSS, and the new proposal, exclusive capitation, become the two main provider payment methods proposed for the UC policy. Payment in the UC policy can be divided into two levels.

- (1) **Budget allocation from central to province.** Budget needed for the UC policy will be allocated to the provinces on a capitation basis according to their registered population. Adjusted capitation rate, according to morbidity and mortality of provincial population and other related factors, was also proposed in the policy but it has been postponed for the implementation.
- (2) **Paying providers in the province.** There are two options, inclusive and exclusive capitation, which the provincial committee can choose for paying providers in the province. It's expected that there will be a single provider payment method in the future.

### ***Ensuring quality of care by using accreditation***

The use of capitation payment to control cost of health care system may have negative consequences on quality of care. The SSS has encountered the quality impairment under the capitation payment by using additional fee-for-

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<sup>23</sup> Sriratanaban, J. Civil Servant Medical Benefit Scheme: Unregulated Fee-for-service and Cost Escalation. Health System Research Institute, 2001 (mimeograph).

service and lump sum payments for some specific services for example; accident, emergency and high cost care. Accreditation is also needed for the participating hospitals to ensure good quality of care.

In fact, quality assurance and quality improvement of public health facility has become an issued concerned by the MOPH since the last two decades. The MOPH has tried many approaches until recently hospital accreditation (HA) has been accepted as the main approach for quality assurance and quality improvement for both public and private health facilities<sup>24</sup>. Hospital Accreditation Institute has been established for this long-term mission. HA is also accepted as a basic requirement of health facility who would like to participate the UC.

### ***The use of standard benefit package and payment method***

As mentioned earlier, one of the ultimate objectives of the UC policy is to have a single standard of health care for every Thai citizen. Standardization of benefit package of people under different health insurance schemes may be the first priority. However, this needs legislation change and may create a lot of resistance. Standardization of benefit package, therefore, has started from the schemes under the responsibility of the MOPH i.e., Health Welfare Scheme (HWS), Health Card Scheme (HCS) and 30 Baht Scheme. All these schemes cover the majority of Thai population, more than 75% of total population. The proposed benefit package has been derived from the benefit package of the SSS but includes personal preventive and promotive services as part of its package. It is expected that this proposed benefit package would be a standard for the adjustment of other schemes in the future.

Standardization of provider payment method is also necessary since it determines the quality of care provided. At the moment, there is a tendency that all schemes are going to reform their provider payments to a more acceptable one.

### ***Merging of existing health insurance funds***

Merging of existing health insurance funds is expected to increase the management efficiency and also to decreases problem of overlapping.

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<sup>24</sup> Supachutikul S. and Sriratanaban J. Quality of Health System. Health System Research Institute, August 2000. p.61-64.

Although single payer system is accepted as the most appropriate model, proposals on the optimal number of health insurance funds during the transitional period are quite controversial. Network of civic groups proposed to have only single health insurance fund while the academic people proposed that dual health insurance system for formal and informal sectors might be more appropriate during the transitional period.<sup>25</sup> The government agrees to have dual health insurance system during the transitional period and even proposes in the law that merging funds to be a single fund would be done on the voluntary basis.

### ***Decentralization of fund management to the province***

The UC policy proposes that the National Health Insurance Fund will act as a fund-holder while the purchaser will be a decentralized office. There are a lot of debates about where should be an appropriate level for this decentralized office. The academic people purposed that a decentralized office, Area Purchaser Board-APB, should be located in areas with more than 3 million populations to ensure adequate risk sharing and economy of scale. According to this proposal, APB will be a regional office and there will be 21 APBs nationwide.<sup>26</sup> The MOPH proposed to have a decentralized office at the provincial level where a devolved health structure, Area Health Board-AHB, is located. AHB has been established, according to the Decentralization Act of 1999, to manage all public services, including health service, in the province. Assigning AHB as a provincial purchaser will help improving the integration of personal health care and public health programs. The government decides to decentralize the fund management to the provincial level during the transitional period. The Provincial Health Office (PHO) is assigned to be a provincial purchaser while the AHB is just an advisory board due to its immaturity.

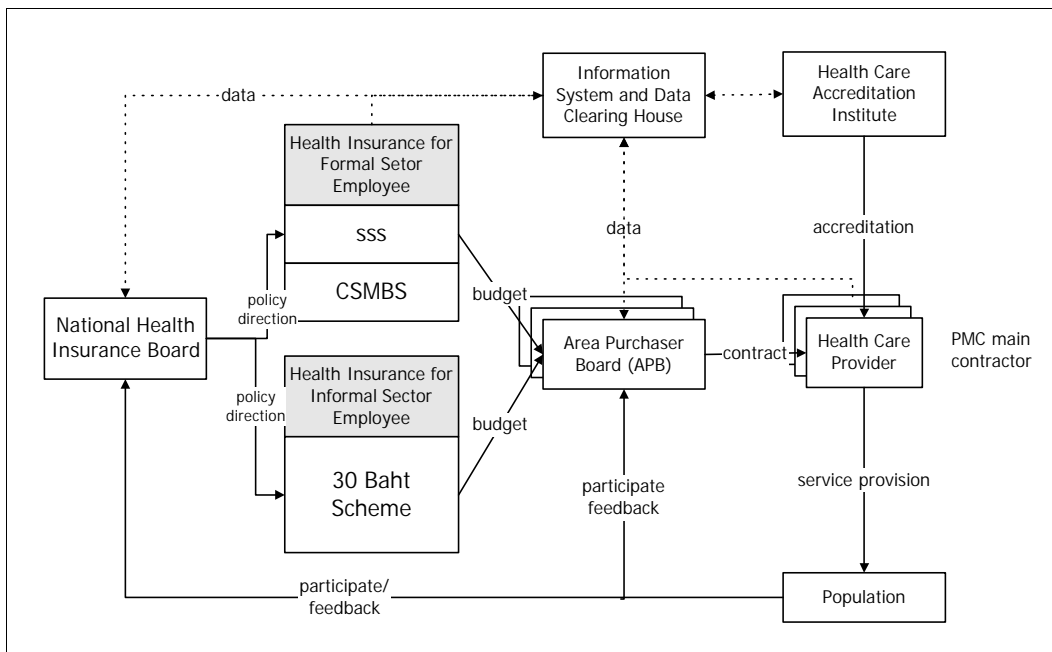
The proposed system under the UC policy during the transitional period, which will be a dual health insurance system for formal and informal sectors, can be described in Figure 2. The National Health Insurance Board (NHIB) will be the main mechanism to steer all reform processes of each scheme to ensure a single standard health care for every Thai citizen in the future. The National Health Insurance Office (NHI) will be the secretariat office of the NHIB and perform all supportive and coordinating tasks.

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<sup>25</sup> HRSI. *ibid.* p.67.

<sup>26</sup> HSRI. *ibid.* p.77-79.

Figure 2. Proposed system under UC policy during the transitional period



### Policy Development and Policy Implementation before the Establishment of the NHIB

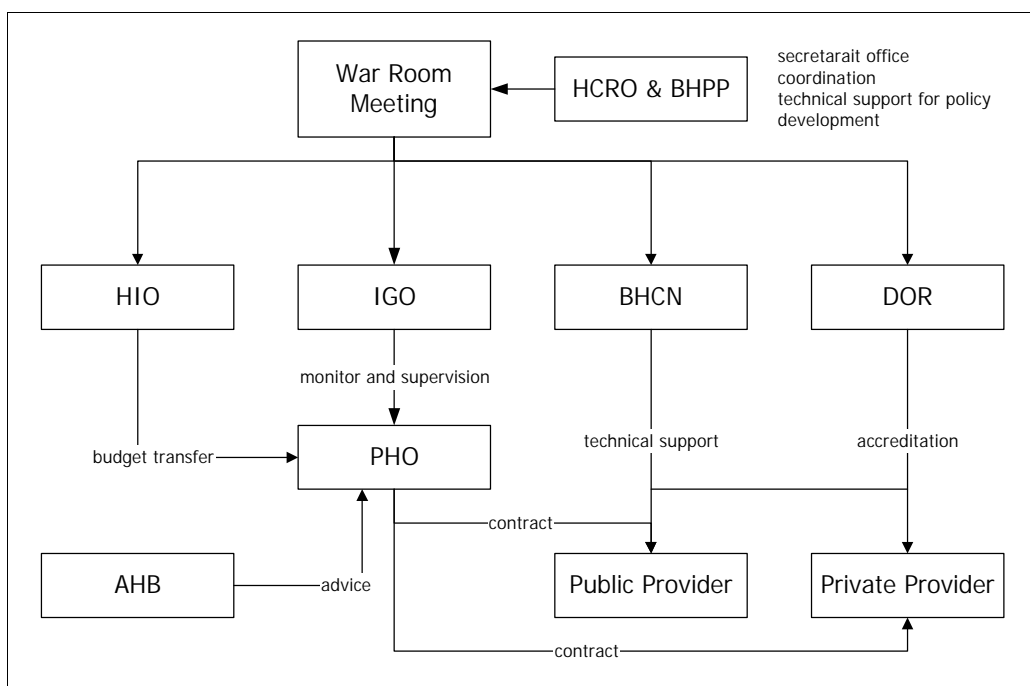
Although it has been proposed that the UC policy is a national policy and should be responsible by a national body which can coordinate all related organizations. The MOPH may have conflict of interest in performing this role since it own the majority of public health facilities. Assigning the MOPH to be a national purchaser/fund-holder will create a system without purchaser-provider split and it would be difficult for the MOPH to be an effective health care purchaser under this situation. However, because of the delay establishment of the National Health Insurance Board (NHIB) and the National Health Insurance Office (NHIO) and the need to have a rapid implementation of the policy. The MOPH, then, has become the most appropriate responsible agency for the implementation of the UC policy in the early stage.

At the beginning of the year 2001, the MOPH set up a core team responsible for the policy development. A proposal developed by the core team has been considered in the workshop in government house on March 17, 2001 and has been used as a framework for further policy development.

After the workshop, the MOPH set up 10 working groups, comprising of people from various sectors including representatives of consumer groups and private health care providers, to develop detail policy. The result of this participatory policy development process has been used as a guideline for further policy implementation<sup>27</sup>.

The main responsible organizations in the MOPH include; the Health Insurance Office (HIO), the Bureau of Health Policy and Planning (BHPP), the Bureau of Health Care Network (BHCN), the Inspector General Office (IGO), the Health Care Reform Office (HCRO) and Division of Registration (DOR). Role and responsibility of each organization can be summarized in figure 3. Since there are several organizations involved in this policy implementation, the MOPH decides to set up a committee, called War Room<sup>28</sup>, to coordinate and monitor policy implementation and to solve obstacles of policy implementation.

Figure 3. Internal structure of the MOPH for the Implementation of the UC policy



<sup>27</sup> MOPH *ibid*.

<sup>28</sup> The War Room committee is chaired by the Deputy Minister of Public Health and has a regular meeting on Monday morning.

The policy has been implemented in 6 pilot provinces in April 2001 and expanded to another 15 provinces in June 2001. Health care providers were limited only the MOPH's providers in the first six provinces but extended to other public health care providers and private providers in subsequent provinces. The policy has been implemented almost nationwide, 75 provinces and part of Bangkok, in October 2001. The rest of Bangkok will be incrementally covered in January and April 2002. Policy implementation in Bangkok has been delayed because of its system complexity.

## Immediate Effects of the UC Policy

### ***Population coverage and health service utilization of beneficiaries under the UC policy***

In the first six provinces, the scheme could cover about 1.47 million people or about 40.7 percent of population in those provinces. In the second phase of policy implementation in June 2001, it could cover additional 4 million people or 28.9 percent of population in provinces in the second phase. There were 97.6 percent of registered population registered with public providers while 2.4 percent of them registered with private providers. In October 2001, the scheme could cover 37.3 million people in 75 provinces and part of Bangkok and private providers still shared the same proportion, 2.3 percent of registered population. The MOPH's providers are the main public health care providers and are responsible for 95 percent of registered population.

Health service utilization of beneficiaries in the first 6 provinces can be presented in table 1. It was found that health service utilization of those who were covered by the scheme was quite low, 0.58 visits per capita per year for ambulatory care and 0.03 admission per capita per year for inpatient care, when compared with other schemes (table 2). Reported health service utilization of beneficiaries in the second phase in the first month was also low, 0.67 visits per capita per year for ambulatory care and 0.03 admission per capita per year for inpatient care<sup>29</sup>. For the uninsured, who should be the beneficiaries of the UC policy, the national survey in 1996 found that utilization of ambulatory care by the uninsured was 1.9 visits per capita per year and admission rate was 0.05 admission per capita per year. It means that

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<sup>29</sup> Bureau of Health Policy and Planning, MOPH, Universal Coverage Policy: Evaluation of Policy Implementation in the Second Phase. A reported prepared for the meeting on August 15, 2001.

some beneficiaries of the UC policy still utilize services outside assigned health facilities. Explanation for this low utilization may be because the beneficiaries don't realized about their right and also hesitate about quality of care provided by the scheme.

**Table 1.** Population covered by the UC Policy in the first pilot provinces and their health service utilization, April-September 2001

|              | Total population | Registered population | %    | Ambulatory care |                         |               | Inpatient care |                         |              | Utilization    |           |
|--------------|------------------|-----------------------|------|-----------------|-------------------------|---------------|----------------|-------------------------|--------------|----------------|-----------|
|              |                  |                       |      | OP visits       | OP reported expenditure | OP baht/visit | IP cases       | IP reported expenditure | IP baht/case | Visit/cap/year | Case/year |
| Pathumthanee | 655,095          | 306,557               | 46.8 | 81,607          | 9,022,218               | 110.56        | 3,286          | 9,161,309               | 2,787.98     | 0.53           | 0.02      |
| Samutsakorn* | 332,994          | 155,122               | 46.6 | 60,402          | 8,565,594               | 141.81        | 2,874          | 10,956,902              | 3,812.42     | 0.78           | 0.04      |
| Nakornsawan  | 1,128,574        | 551,124               | 48.8 | 123,406         | 16,993,531              | 137.70        | 8,089          | 10,358,744              | 1,280.60     | 0.45           | 0.03      |
| Payao        | 511,622          | 167,630               | 32.8 | 47,988          | 6,370,156               | 132.74        | 2,339          | 11,677,136              | 4,992.36     | 0.57           | 0.03      |
| Yasothon     | 554,932          | 191,979               | 34.6 | 71,104          | 6,545,932               | 92.06         | 3,267          | 8,767,440               | 2,683.64     | 0.74           | 0.03      |
| Yala         | 443,744          | 101,791               | 22.9 | 45,866          | 7,381,289               | 160.93        | 3,467          | 11,330,995              | 3,268.24     | 0.90           | 0.07      |
| Total        | 3,626,961        | 1,474,193             | 40.7 | 430,373         | 54,878,720              | 127.51        | 23,322         | 62,252,526              | 2,669.26     | 0.58           | 0.03      |

Source: Health Insurance Office

Provider payment in 6 provinces was capitation for ambulatory care and DRG with global budget for inpatient care.

Budget allocated to each province was 416 Baht/cap/year, excluding personnel cost

\* exclude population in Banphaew district where the first autonomous hospital is located

**Table 2.** Number of illness episodes and health service utilization of people under different health insurance schemes in 1996

|                                  | MWS*             | CSMBS            | SSS              | HC               | Private Insurance | Uninsured        |
|----------------------------------|------------------|------------------|------------------|------------------|-------------------|------------------|
| Number of illness                | 5.9              | 4.5              | 2.6              | 5.0              | 4.4               | 3.3              |
| Visit per capita/year (pub/priv) | 3.7<br>(3.0/0.7) | 3.2<br>(2.0/1.2) | 1.5<br>(0.7/0.8) | 3.2<br>(2.5/0.7) | 3.2<br>(0.8/2.4)  | 1.9<br>(1.1/0.8) |
| Admission/cap/year (% pub/priv)  | 0.09<br>(93/7)   | 0.08<br>(74/26)  | 0.05<br>(52/48)  | 0.09<br>(92/8)   | 0.15<br>(28/72)   | 0.05<br>(79/21)  |

Source: Health Welfare Survey, 1996, the National Statistical Office.

\* Only for LIC

### **Effect on public and private health care providers**

Public and private health care providers are extremely effected by the provider payment mechanism adopted the UC policy. The specific changes of provider payment method which effect providers are:

- (1) **The change of resource allocation criteria from supply to demand side:** The sudden change of provider payment method from supply to demand side resource allocation, capitation payment, makes providers face difficulty in adapting themselves since there are serious mal-distributions of health facilities among regions and among urban and rural areas. Health facilities in areas with over supply, therefore, will face the problem of budget deficiency. It was found that hospitals in big cities were forced to downsize their structures and to increase their management efficiency.
- (2) **The change of main contractor from hospital to primary care unit:** According to this change, resource will be re-channeled to the primary care unit first based on registered population. Secondary and tertiary hospitals will be paid, from primary care unit or provincial fund for inpatient care, according to their performances determined by number and type of referred cases. Hospitals are forced to provide primary care because of two main reasons. Firstly, there are severe shortages of primary care providers in urban areas where hospitals are located. Secondly, hospital managers are afraid of inadequate budget allocated to hospitals based on performance criteria. Performing dual functions, providing primary and hospital cares, of hospitals is expected to increase hospital revenue and to ensure hospital financial viability. However, because of limited experiences of hospital personnel in providing primary care, especially those in private hospitals, this will effect quality and coverage of basic services in some areas.

It is anticipated that with the new payment method there will be at least 26 provinces where the MOPH health facilities will face the financial problems<sup>30</sup>. The MOPH has realized this foreseeable problem and has requested a special additional budget, contingency fund, for solving this problem in public health facilities. In November 2001, there were requests

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<sup>30</sup> Estimation by a subcommittee appointed by the War Room. The estimation was made by using information available on November 9, 2001 which comprised of information from 60 provinces. The criteria for selection of province with financial problem are the provinces where regional/general hospital have deficit more than 50 million Baht and at least one district hospital has negative balance.

from 29 provinces for contingency fund in the amount of 3.2 billion Baht. Public health facilities who request for contingency fund need to submit plans to reform their health facilities to ensure long term survival.

#### ***Effect on the role of provincial health office***

During the transitional period, the Provincial Health Office (PHO) is assigned to perform as a provincial purchaser. This is quite a new role of the PHO and the present PHO now has no experience and very limited capability in performing this role. In addition, the rapid policy implementation and inadequate preparation of provincial health personnel even make the situation worse than expected. The PHO can be only a passive health care purchaser under this situation.

#### ***Effect on the MOPH budgeting system***

Since budget for the universal coverage policy has already included part of fiscal budget plan which used to be allocated directly to public health facilities according to proposed projects or programs. In order to follow the new provider payment method, it is necessary to have a clear separation of the previous fiscal budget plan for which part should be a budget for universal coverage policy (UC budget) and which part should not be (non-UC budget). The non-UC budget will be managed and allocated to the public health facilities in different ways. All budgets for providing personal care are identified as budgets for universal coverage policy and will be allocated to provinces according to the registered population, per capita resource allocation. The budget separation which leads to different ways of budget management according to their purposes, UC and non-UC budgets, creates another management difficulties.

- (1) **Limited space for vertical programs related to personal care:** since all budgets will be allocated to and managed by the provinces in a decentralized way. This effects some vertical programs which central management is still necessary because of its efficiency. Purchasing and managing vaccines to ensure their availability for the National Expanded Immunization Program (EPI) is an example of this necessity and it is agreed to separate cost of vaccines, 14.70 Baht per capita, from budget allocated to provinces and to manage it at the national level.

- (2) **Limited budget for administration and supporting activities:** at the provincial level, normally the PHOs will keep part of the budget, intentionally prepared for public health facilities in the provinces, and manage by themselves to cross subsidize their inadequate budgets for administration and supporting activities. In the new budgeting system, UC budget is clearly specified for health facilities and the PHOs can not use it for other purposes. Budgets for administration and supporting activities are separated budgets but their amounts are quite low when compared with the previous budgeting system. The same situation also occurs at the national office and limits the flexibility to mobilize supports for the policy implementation.

## **Conclusion**

Thailand may be one of a few countries who try to achieve universal coverage of health care policy during the economic slowdown period. Attempt to achieve universal coverage has had a long evolution but it has been speeded up during the past couple of years. The policy has been adopted and implemented incrementally, in terms of area and comprehensive of policy package, and has reached the national coverage rapidly within one year. The policy content seems to have a sound direction which is a result of accumulated experience and knowledge in the society. The policy development and policy decision making was a participatory process at the beginning but is limited to the MOPH personnel at the present time. Rapid policy implementation may threaten policy achievement since the existing structures have limited capabilities to perform their new roles and time is needed for the preparation. Time is also needed for the development of policy details and at the moment, there is limited technical support for this. Resources needed for all these preparations are also limited because most of them are mobilized to health facilities for providing services for the beneficiaries.

It is too early to conclude whether the universal coverage policy in Thailand is a successful or failure policy. It is obviously that this policy is welcome by the public and is also well supported by the politicians, both from the government side and the opposition parties. However, good intention may not be enough to make the policy succeed if without a good management system. Assigning the whole responsibility, for policy development and policy implementation for the universal coverage policy, to

the MOPH may limit the system capacity to handle this challenging policy. Despite the fact that the MOPH may have a conflict of interest in performing this role since it owns the majority of public health care providers, the bureaucratic system of the MOPH will also limit its flexibility and efficiency to manage the whole system. Establishment of the National Health Insurance Office, a new national body which doesn't own any health care provider and has an efficient management system indicated by law, can be an immediate solution to face with all difficulties.

