

Health system review: Achievements and challenges



Policy
Note

Thailand Health Systems in Transition



Asia Pacific Observatory
on Health Systems and Policies

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Acknowledgements

Three decades of sustained political commitment in 1970s to people's health has paid rich dividends in Thailand. Significant and well-planned investment ensured that health and social services responded effectively to the demographic and epidemiological transition. Universal Health Coverage was achieved more than a decade ago and the whole population is now protected from financial hardship when they need to use services.

At the same time, Thailand faces new challenges: ensuring effective services for a rapidly ageing and increasingly urban population; reducing adult mortality to levels commensurate with Thailand's upper-middle income status; and putting in place institutional structures that will continue to ensure efficient delivery and equitable benefits, but also respond to the need to ensure that health benefits from policies and practices in other sectors.

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Authors

Viroj Tangcharoensathien, Senior Advisor, International Health Policy Program, Ministry of Public Health, Thailand and Secretary General, IHPP Foundation.

Walaiporn Patcharanarumol, Senior Researcher, International Health Policy Program, Ministry of Public Health, Thailand.

Warisa Panichkriangkrai, Researcher, International Health Policy Program, Ministry of Public Health, Thailand.



The road to Universal Health Coverage



Since the 1970s, Thailand's political commitment to the health of its population has resulted in significant and sustained investment. In the early years, the focus was on the development of health infrastructure – particularly primary health care facilities, district and provincial referral hospitals - accompanied by complementary investment in the health-care workforce. A variety of incentives were used to promote rural retention of health staff, thus ensuring the functioning of district health systems across the whole country.

With extensive geographical coverage achieved, the next step was to improve financial risk protection by means of a comprehensive benefit package, free at point of delivery, and by increasing the capacity of public health-care facilities to provide essential services.

Services free at the point of care for all, in particular the poor rural populations minimized catastrophic health-care expenditure and impoverishment. Subsequent work has now extended financial

protection by targeting the stateless people and the migrant workers.

By 2002, Universal Health Coverage - in terms of access to health care and financial protection - was achieved through three public insurance schemes: the Civil Servant Medical Benefit Scheme (CSMBS) for civil servants and their dependents, Social Health Insurance (SHI) for formal sector employees, and the Universal Coverage Scheme (UCS) for the remainder of the population. The characteristics of the three schemes are set out in Table 1.

The establishment of these three schemes has changed the way health care is financed. A supply-led system, under which all Ministry of Public Health (MOPH) health facilities received an annual budget allocation from the MOPH, has now been completely replaced by a system in which the three public purchasers - separated through a purchaser-provider split - manage a demand-led system of financing.



Table 1. Characteristics of the three public health insurance schemes

	CSMBS	SHI	UCS
Population Covered (2015)	5 million (8%)	10 million (16%)	48 million (75%)
Beneficiaries	Civil servants and their dependents	Formal sector employees but not dependents except maternity benefits	Those not enrolled in CSMBS and SHI
Source of finance (2015)	General taxation Expenditure US\$ 400 per capita	Tripartite: employees, employers and government. 1.5% of salary up to a US\$ 500 ceiling Expenditure US\$ 106 per capita	General taxation Expenditure US\$ 84 per capita
Managing agency	Comptroller General's Department, Ministry of Finance	Social Security Office, Ministry of Labour	National Health Security Office (NHSO)
Provider choice	Free choice of public providers; private in emergency	Annual choice of contracted public and private hospitals (>100 beds and other required facilities are eligibility criteria as contractor hospitals)	Limited choice: Annual registration with Public and private contracting unit for primary care, mostly district hospital and its network of health centers in their domicile district
Benefit package	Comprehensive curative and rehabilitation, no prevention and health promotion services	Comprehensive curative and rehabilitation, no prevention and health promotion services	Comprehensive curative and rehabilitation services, Prevention and promotion was managed by NHSO for all Thai citizens
Payment	OP: Fee-for-service, reimbursement to providers IP: DRG since 2009 no global budget applied for IP Cannot apply hard budget	OP: Capitation inclusive for OP and IP where IP has additional pay for high DRG weights Hard budget was applied	OP: Age adjusted capitation IP: DRG + global budget Hard budget was applied

Note: OP = out-patient, IP = in-patient, DRG = Diagnosis-Related Group



The changing role of the Ministry of Public Health



The Ministry of Public Health (MOPH) is the national health authority responsible for formulating, implementing, monitoring and evaluating health policies. In early 1990s, various autonomous organizations with specific mandates were established by Law in order to work synergistically with MOPH and strengthen capacity of health systems. These autonomous health agencies include:

Health Systems Research Institute (HSRI): Established in 1992, HSRI progressively built capacity in health systems research through close collaboration with external academic and research agencies. Since then, it has been a key factor in the success of Thailand's health reforms by generating knowledge and increasing policy makers' demand for high quality evidence to guide their decisions.

Thai Health Promotion Foundation (ThaiHealth): was established in 2001. It manages "sin tax" revenues from a 2% additional surcharge on tobacco and alcohol excise taxes, and uses these funds to campaign on a wide range of issues designed to promote and protect people's health. A series of external assessments of the Foundation have confirmed its effectiveness.

National Health Security Office (NHSO): The NHSO was created under the National Health Security Act 2002. Main mandate of NHSO is to manage UCS including annual budget negotiation, strategic purchasing including provider payment mechanism design, benefit package development, audits and ensuring healthcare providers are accountable to UCS members. NHSO's strong institutional capacity in strategic purchasing has resulted in health systems efficiency, equitable access to certain high-cost interventions for UCS beneficiaries.

National Health Commission Office (NHCO): The NHCO was established in 2007 under the National Health Act. It is responsible to ensure that public policies, including health policies, are participatory and engage all actors through convening an annual National Health Assembly and other related Local Assemblies. Assessment was positive contributing to participatory evidence based policy formulations.

The Emergency Medical Institute of Thailand (EMIT): The EMIT was established by the National Emergency Medical Act of 2008 and is responsible for the management and financing of pre-hospital care and ambulance services throughout the country.



Healthcare Accreditation Institute (HAI): The Healthcare Accreditation Institute was established in 2009 by royal decree as mandated by the Public Organization Act (1999). It is mandated to improve quality of care, and accredit and re-accredit all public and

private healthcare institutions. Since its establishment, a growing number of hospitals have met the required standard and hospital standardized mortality rates have fallen.



Health systems performance



Health Financing: Health care is currently financed predominately from general taxation. This is the most progressive source of financing with people earning higher incomes paying proportionately more than those on lower incomes.

The achievement of universal health coverage in 2002 was accompanied by an increase in public spending on health and a decrease in out-of-pocket payments. Public spending as a proportion of total health expenditure (THE) increased from 63% in 2002 to 77% in 2011. Over the same period, out-of-pocket expenditure fell from 27.2% of THE to 12.4%.

After 2002, health also captured an increasing proportion of government spending: rising from 8–11% of general government expenditure in 2002–2003 to 11–13% in 2006–2011, and to 17% in 2013.

Empirical evidence during this period shows high levels of financial risk protection, as the incidence of catastrophic health expenditure and medical impoverishment consistently declined to a very low level – one of the significant achievements of Thailand's universal health coverage policy. Details of financial performance are set out in Table 2.

Table 2. Total health expenditure and selected indicators on health spending, 1994–2012, current year prices

	1994	2000	2001	2002	2005	2008	2009	2010	2011	2012
Total health expenditure (THE), million Baht	127 655	167 147	170 203	201 679	251 693	360 272	377 226	392 368	434 237	512 388
THE as proportion of GDP	3.5%	3.4%	3.3%	3.7%	3.5%	4.0%	4.2%	3.9%	4.1%	4.5%
Public expenditure as proportion of THE	45%	56%	56%	63%	64%	76%	74%	75%	77%	76%
Private expenditure as proportion of THE	55%	44%	44%	37%	36%	24%	26%	25%	23%	24%
THE per capita (Baht per capita)	2160	2701	2732	3211	4032	5683	5938	6142	6777	7949
THE per capita (US\$)	86	67	61	75	100	171	173	194	222	256
Exchange rate (Baht per US\$)	25	40	44	43	40	33	34	32	30	31

Source: Thai NHA Working Group (2013).



Health outcomes: In terms of maternal and child health, Thailand has performed better than many other low and middle-income countries. However, despite good health at low cost, adult mortality rates are not significantly lower than in neighbouring countries, and are actually higher than many countries in Central America.

Major causes of adult mortality that need to be urgently addressed include road traffic accidents, homicide and alcohol related diseases. Thailand was a leader in tobacco control long

before the 2004 ratification of the WHO Framework Convention on Tobacco Control, but levels of smoking have plateaued after an initial decline, and increases in tobacco prices have not kept pace with disposable incomes. The number of adolescent pregnancies is also increasing.

While there is much to be done in improving outcomes for conditions that are amenable to health care alone, this list indicates that a significant change in adult mortality will require action across many sectors and different parts of society.



Future challenges



- **Financing and service-provision policies for elderly people**
In recognition of Thailand's rapidly ageing society, health and social welfare systems need to prepare for long-term care policies. This will require adapting sources of finance and modalities of care, and developing more effective interface mechanisms between families and community care organizations, and between health and other social services.
- **Large gaps in urban primary health care (PHC)**
In contrast to rural health services, urban health systems are characterized by hospital-oriented care, private clinics and hospitals, and a lack of effective primary health care systems, particularly to treat chronic non-communicable diseases. The net effect is that those in need of healthcare in urban areas are unable to access institutional-based health care while PHC is weak. There is considerable room to strengthen urban primary health-care systems through the development of family care teams, and contracting qualified private clinics to provide health promotion and preventive services.
- **Risk of reliance on general taxation to finance health care**
Heavy reliance on general taxation as the main source of funding for the CSMBS and UCS runs the risk of incurring

shortfalls, especially during cyclical economic downturns and structural adjustment. Key policy challenges include: identifying new sources of funding and reducing nonessential outpatient elements within the benefit package, while safeguarding admission services and continuity of treatment for chronic conditions.

- **Harmonizing health insurance**
Harmonization of the three public insurance schemes has been slow, due to a lack of political will, and resistance from CSMBS members and mainly public hospitals that benefit from excessive CSMBS outpatient claims. The challenge of the future, is to establish a governance structure for health insurance schemes that involves all relevant stakeholders - including civil society. The Social Security Board of the SHI has equal representation for employers, employees and the government, but no representations from healthcare providers or civil society organizations. The National Health Security Act (2002) that provides the legal basis for the UCS, offers the effective approach where all relevant stakeholders – especially civil society representatives – fully engaged in the governing board, over sighting the UCS.



- **The role of the MOPH in a more complex system of health governance**

With the emergence of a range of independent agencies, governance of health in Thailand has become more complex. In particular, the role of the NHSO has separated two former functions of the MOPH: service provision and management of financing health services. There thus remains an unresolved institutional conflict between the two organizations. Rather

than seeking to protect its own territory and interests, the MOPH now needs to engage with a much wider network of stakeholders and moves to address the social determinants of health and ensure Health in All Policies. If the MOPH is to contribute to the achievement of national health goals and fulfill its mandate as the overarching national health authority it needs to engage more in effective intersectoral actions to address health determinants outside its direct jurisdiction.



Lessons learned



Two key factors emerge from this analysis.

First, Thailand's health reforms have been developed and implemented on the basis of solid evidence. Their success owes a great deal to the development of capacity for generating knowledge to support policy formulation and, in parallel, by increasing the demand for good quality evidence on the part of policy-makers. This capacity was systematically built through close collaboration with external academic and research agencies following the establishment of the Health Systems Research Institute in 1992.

Secondly policy development has benefitted from the link between policy entrepreneurs and civil society. "The triangle that moves the mountain", an idea that was proposed by Professor Wasi, describes three interlinked powers: wisdom and evidence generation, civil society movement, and involvement of politicians for political and policy decisions. Policy entrepreneurs have played a bridging role between these three forces to reach desirable decisions.

Thailand at a glance

Country Profile

Socio-demography (2014)

Population: 67 million
Fertility rate: 1.4
Rapid urbanization at 43.4%
Population aged >65 years old: 10%
Adult literacy rate: 93.5% (2010)

Economic context (2014)

GNI per capita: US\$ 5410 (UMIC)

Health status (2013)

Life expectancy at birth:
71 M, 78 F
IMR: 11 / 1000 live births
U5MR: 13 / 1000 live births



Map source: United Nations Cartographic Section (2009).

Note: GNI = gross national income, M = male, F = female, IMR = infant mortality rate, U5MR = under-five mortality rate

For more information from the Thailand HiT report, please visit:

http://www.wpro.who.int/asia_pacific_observatory/hits/series/tha/en/



