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Thai Universal Coverage Scheme: Toward a More Stable System

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Abstract

The Universal Coverage Scheme (UCS) (also known as the 30-Baht Scheme), one of the main Thai public health care benefit schemes, faces significant challenges from cost, equity and behavior change. The indications suggested that, at the current stage, there is a growing concern for moral hazards and over-utilization of health care services. The program's financial sustainability is endangered by two major cost drivers: the demographic transition and the technological advancement. Furthermore, there is evidence of inequity in current policy implementation. Those perceived challenges required immediate policy responses. This analysis examines five policy alternatives: (1) the status quo policy, (2) creating a policy-making body with a dual sector employment system, (3) a required 100 Baht monthly contribution, (4) privatization with a dual sector system, and (5) privatization with an insurance premium voucher for all citizens. All five policy alternatives are assessed in terms of their ability to meet the following seven goals: reasonable cost, administration effectiveness, equity in health-care features, equity in government subsidies, quality of care, financial sustainability, and political feasibility. Based on this assessment, the analysis concludes that the government should adopt privatization with a dual sector system (a tax-free health benefit from their employers for the formal sector and a 2,500 Baht insurance premium voucher for the informal sector). Privatization with a dual sector system will require less government budget; will create conscious use of the health care service; and, with open competition, will make the quality of the health care service better.

Keywords: Thailand's health care, Universal coverage scheme, policy analysis, health care benefit

BACKGROUND

Starting from 1978, health care benefits in Thailand were, for many years, were only for privileged government employees, pensioners and their dependents through the Civil Servant Medical Benefit Scheme (CSMBS) (Royal Decree for Civil Servant Medical Benefit Scheme of B.E.2553 (2010)) (Rojvanit 1993; Supachutikul 1996; Pitayarangsarit 2004). At one time a civil servant's job was the most desirable job in Thailand. This scheme is the oldest and, today, still considered as the most comprehensive scheme in terms of the benefit package offered. In 1990, the Thai parliament passed a law, the Social Security Act, establishing the Social Security Office and later in the year implemented the Social Security Scheme (SSS) for the formal sector employees. After the system was put into effect, all formal sector employees then enjoyed health benefit coverage. A year later, the law was amended to allow the self-employed to voluntary join the SSS. Under the SSS, the employer, the employee and the government, each need to contribute to the fund. As for a self-employed people, they would need to pay as if he/she were working with their own company. A decade later, with the landslide victory of Thai Rak Thai (Thai-love-Thai) party using the "30 baht treat all" policy as one of the promises of its political campaign, the "30-Baht Universal Coverage Scheme (30B)" was fully implemented in April 2002 to provide health care coverage for the rest of the population. Under this scheme, people pay 30 Baht (approximately $1) per visit or admission. Subsequently, four years later in November 2006, the 30 Baht payment was eliminated by the subsequent government and the system became totally free of charge and has been renamed as the Universal Coverage Scheme (UCS). The newly established scheme, for the first time, has provided all Thai citizens with access to health care. Nitayarumphong (1998) stated that the term "Universal coverage" can be described as "a situation where the whole population of a country has access to good quality services (core health services) according to needs and preference, regardless of income level, social status or residency." And due to Thailand adopting a piecemeal approach to extending health coverage to its citizens, it took more than 25 years to achieve universal coverage (Mills *et al.*, 2005)

THILAND'S THREE HEALTH CARE COVERAGE SCHEMES

The public health care benefit system in Thailand is divided into three major schemes; the Civil Servant Medical Benefit Scheme (CSMBS), the Social Security Scheme (SSS) and the UCS or the Universal Coverage Scheme (also known as the National Health Security Program or the 30-Baht Scheme). According to Prakongsai *et al*. (2009), approximately 9% of the total

population is covered under the CSMBS. The SSS covers all formal employees and self-employed with another 16%. The remaining 75% of the Thai population, the largest share, is covered under the UCS. There are three agents, each being responsible for one scheme's administration. The CSMBS is administered by the Comptroller General's Department, Ministry of Finance. The SSS is managed by the Social Security Office (SSO) and the UCS is operated under the National Health Security Office (NHSO), Ministry of Public Health. Table 1 provides a summary of each scheme's nature, population coverage, financial source, mode of provider payment and access to services.

Table 1 Characteristics of three public health benefit schemes

Insurance Scheme	**Population Coverage**		**Financial Source**	**Mode of Provider Payment**	**Access to Service**
Civil Servant Medical Benefit Scheme (CSMBS)	Government employees plus dependents (parents, spouse and up to two children)	9%	General tax, non-contributory scheme	Free for service, direct disbursement to mostly public providers	Free choice of providers, no registration required
Social Security Scheme (SSS)	Private sector employees, excluding dependents	16%	Tri-partite contribution, shared by employer, employee and the government	Inclusive capitation for outpatient and inpatient services	Registered public and private competing contractors

Table 1 Characteristics of three public health benefit schemes

Insurance Scheme	Population Coverage		Financial Source	Mode of Provider Payment	Access to Service
Universal Coverage Scheme (UCS)	The rest of the population not covered by CSMBS and SSS	75%	General tax	Capitation for out-patients and global budget plus DRG for inpatients	Registered contractor providers, notably district health system

Source: Prakongsai *et al*. (2009)

Each scheme provides a different benefit package as well as receives a different government budget allocation. Table 2 illustrates a summary of the benefit package details of the three major insurance schemes, the CSMBS, SSS and UCS. Table 3 shows the government's budget allocation for each scheme.

Table 2 Benefit package of the three major health care coverage schemes

Benefit features	Universal Coverage Scheme (UCS)	Civil Servant Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)
Ambulatory services	Designated providers, mostly Primary Care Unit	Free choice public only	Public and private contractors
Inpatient services	Designated providers, mostly starting first with District Hospital with referral	Free choice Public and private	Public and private contractors

Table 2 Benefit package of the three major health care coverage schemes (Cont.)

Benefit features	**Universal Coverage Scheme (UCS)**	**Civil Servant Medical Benefit Scheme (CSMBS)**	**Social Security Scheme (SSS)**
Choice of provider	Primary care contractor services, plus referral	Free choice	Contracted hospital or its network
Cash benefit for sickness and maternity leaves	No	No	Yes
Conditions included	All	All	Non-work-related illness, injuries
Conditions excluded	15 conditions	No explicit exclusions	Small number of limited conditions
Maternity benefits	Yes	Yes	Yes
Annual physical check-up	No	Yes	No
Services not covered	Private bed, special nurse	Private bed, special nurse	Private bed, special nurse

Source: Mills *et al*. (2005)

Table 3 Government budget allocation and per capital spending

Government Spending	**Universal Coverage Scheme (UCS)**	**Civil Servant Medical Benefit Scheme (CSMBS)**	**Social Security Scheme (SSS)**
Annual budget allocation	76,598 million baht	54,904 million baht	17,666 million baht
Per capita spending	2,100 baht / person	11,000 baht/person	2,133 baht/person

Source: Health news (2010)

Besides those major public health benefit schemes, there are other public schemes such as the Local Government Employees Health Coverage scheme, the Bangkok Metropolitan Administration Health Coverage scheme and state-owned enterprises health coverage schemes (Nikomborirak, 2013).

CHALLENGES TO THE UNIVERSAL COVERAGE SCHEME (UCS)

Despite an increase in health care access and improvement in health care quality through the provision of the Universal Coverage Scheme (UCS) to all Thai citizens, three major challenges below require immediate policy responses.

Behavior Change

There is a growing concern for moral hazards and over-utilization of health care services among people covered by the Universal Coverage Scheme (UCS). Chamchan & Kosuke (2006) found in their study that, out of respondents who are presently covered by the UCS, 79% of the them reported using the system. Certainly, the data above highlights the positive impact of the Universal Coverage Scheme (UCS) in improving the ability of patients to access medical care. However, it raises a concern about the over-utilization of care by patients, which may be the result of negligence in taking care of their personal health and too much dependency upon the health system.

Managing Cost

Since much of the financing of the Universal Coverage Scheme (UCS) comes from general tax revenue, two major cost drivers will continue to challenge long term financial sustainability. First, the demographic transition, in which the percentage of the elderly group (60-year-old up) has increased from 5.4% of the total population in 1960 to 11.8% in 2010 (Chen & Chunharas. (2008). With an increased proportion of the elderly, there will be a substantial increase in demand for health services. Second, the technological advancement, such as new surgical procedure techniques and new diagnostic tools, is also one of the most significant drivers of cost (Oxley and MacFarlan, 1994). Consequently, there is a need to find a mechanism to sustain the financial burden resulting from those two main cost drivers.

Managing Equity

Equity in health has been recognized by policy makers as an important objective of the health system. In their research on equity in financing contributions to Thai public health care benefit programs, Prakongsai *et al*. (2009) examined the equity in government subsidies and noticed that the results showed evidence of inequity. Even before the Universal Coverage Scheme (in 2001), public subsidies favored the poor with a share of 28% of public spending on health, and

the share increased to only 31% after the Universal Coverage Scheme. Both results showed evidence of inequity. Prakongsai *et* al. (2009) suggested that a redesign of the reforms had to be done to address the harmonization of the benefit packages and the level of government subsidies.

HISTORY OF PAST POLICY RESPONSES

Year 2000 Version of Thai Rak Thai (TRT) Party's Health Policy

The Universal Health Care Policy that TRT officially declared in February 2001 was different from the first policy announced in March 2000 (Pitayarangsarit, 2004). In 2000, the policy was that the source of finance was from a 100 Baht monthly contribution (1,200 Baht a year), so that it did not rely solely on general tax revenues as it does today. In the early version of the policy, the scheme's financial input did not largely depend on the government's budget to avoid public reaction to payment and it gained popularity by prompt implementation. At that time, the TRT health team was not even convinced that the government's budget could afford such a scheme. Furthermore, it was recommended at that time that a co-payment of around only 20 Baht would be collected to prevent the unnecessary use of services.

The 2001 Universal Coverage of Health Care Model

At an early stage during the transition period, the dual management of a public health insurance system for formal and informal sectors was chosen (Pitayarangsarit, 2004). The National Health Security Board (NHSB) would be the main mechanism to steer each scheme to ensure a single standard health care for every Thai citizen. The National Health Security Office (NHSO) needed to be created to serve as the secretariat office of the NHSB. Although it was proposed that the NHSB be a national policy body and it should be responsible for a national body, it was never implemented in that way. Because of the long delay in the establishment of the NHSB and the NHSO, plus the need to have rapid implementation of the policy, the Ministry of Public Health (due to its large number of public health facilities) then became the responsible agency to implement the Universal Coverage Scheme policy.

POLICY GOALS

As can be seen from the history of past policy responses, the original intent of the policy was having the Universal Coverage Scheme (UCS) as a fundamental right of all Thai citizens; in order to address the sustainability of the Universal Coverage Scheme (UCS) as a real universal health care system of Thailand, all current three health care coverage schemes need to be included as an equity model for this policy analysis. The following policy goals were chosen

to help form policy responses. First, the alternative policies need to provide universal health care with *Reasonable Cost*. Thai citizens should be able to enjoy their health benefits at a reasonable and affordable price. Second, the *Administration Effectiveness* goal will ensure an organizational efficiency of the responsible agent. Next, the *Equity in Health Care Feature* goal and *Equity in Government Subsidies* goal will be in place to tackle the challenge of inequity. The *Quality of Care* goal will help to guarantee health care quality for all beneficiaries. And with a large burden of cost, the purpose alternative policies should be able to deal with the *Financial Sustainability* in the future. Lastly, *Political Feasibility* is always important to be included as a policy goal. The policy that would require fundamental change may face some political tests.

A COMPARISON OF THE ALTERNATIVES

Status Quo: Continue implementation of the three schemes

The status quo will perform very poorly in administrative effectiveness due to the disharmonious way of administrative management among the three. The SSS will continue to perceive inequity in health-care features and government subsidies. The quality of care will vary from low to medium depending on the scheme.

Truly creating a policy-making body with a dual sector employment system

With a single national level policy-making body, this will make healthcare administration smoother. However, this policy approach still does not address equity in both health-care features and government subsidies for the formal sector group and the quality of care will again depend on each scheme. However, this option would be politically feasible to implement because it is a minor change.

Required 100 Baht monthly contribution

This alternative policy will create an equitable and fair perception for the formal sector employment and put the universal health care coverage in a better position in terms of financial sustainability. However, implementing this policy may face significant opposition from pro-poor groups.

Privatization with a dual sector system: Employee Benefits Health Insurance for formal sector employment and Insurance Premium Voucher for informal sector

The formal sector employee will certainly enjoy a free of charge insurance benefit. The company would be likely to increase health-care features above the compulsory level to attract employment. The informal sector also can enjoy quality health care from private health providers at any health care facility. This policy alternative provides higher long term financial

sustainability. However, to implement this policy we may face strong opposition from various concerned groups.

Privatization with insurance premium voucher for all citizens

The major advantage of this policy is the equity in government subsidies. All citizens receive a premium voucher for his/her private insurance coverage payment. The citizens will enjoy the benefits of today's private insurance coverage (high quality, no need for designated health care facility, and private room) However, with this policy approach, the low-income citizens may face a limit in health features if they can only just afford the price of private health insurance.

ASSESSMENT AND RECOMMENDATION

Table 4 A Summary of Thai Universal Health Care Alternatives in Terms of Policy Goals

Goals	Policy Alternatives				
	Current Policy: Continued implementation of the three schemes	**Truly creating a policy-making body with dual sector employment system**	**Required 100 Baht monthly contribution from 30B**	**Privatization with dual sector system: Employee Benefits Health Insurance for formal sector and insurance premium voucher for informal sector**	**Privatization with insurance premium voucher for all citizens**
Reasonable Cost	SSS: 1.5% payroll deduction, CSMBS and UCS: free of charge	SSS: 1.5% payroll deduction (CSMBS would be incorporated in the SSS) UCS: free of charge	SSS: 1.5% payroll deduction, UCS: 100 Baht monthly contribution, CSMBS: free of charge	Formal sector employment: compulsory health benefit, Informal sector employment: 2,500 Baht insurance premium voucher	2,500 Baht insurance premium voucher for all Thai citizens
Administration Effectiveness	Low – separated management system	Medium	Low	Open market, private insurance	Open market, private insurance
Equity in health-care features	Not so – SSS receives somewhat the same features as free UCS	Not so – fair, policy-making body may be able to adjust it	Fair	Good	Good

Table 4 A Summary of Thai Universal Health Care Alternatives in Terms of Policy Goals (Cont.)

Goals	Policy Alternatives				
	Current Policy: Continued implementation of the three schemes	**Truly creating a policy-making body with dual sector employment system**	**Required 100 Baht monthly contribution from 30B**	**Privatization with dual sector system: Employee Benefits Health Insurance for formal sector and insurance premium voucher for informal sector**	**Privatization with insurance premium voucher for all citizens**
Equity in government subsidies	Not so – government subsidizes less in SSS	Not so	Fair	Not so – government subsidizes only informal sector employment	Very good
Quality of Care	Low-Medium	Low-Medium	Medium	High	High
Financial Sustainability	Low	Low	Medium	High	Medium - high
Political Feasibility	High – in place	Medium, just small change	Medium – high	Medium - high	Medium - low

Table 4 summaries the major impact of each alternative policy (total five) in terms of policy goals. Continued running of the current three schemes has the lowest rate in almost all policy goals, except in political feasibility, among the five alternative policies. It is obvious that the last two alternative policies, both proposing privatization of the universal health care coverage, look superior to the other three alternative policies. Both the last two alternative policies rate higher than the first three alternative policies on Equity in health-care features, Quality of Care, and Financial Sustainability. However, after further scrutiny of the two privatization policies, the recommendation is that the government should adopt privatization with a dual sector system (tax-free health benefits from their employers for the formal sector and a 2,500 Baht insurance premium voucher for informal sector). In the long run, this marketing-based system will eventually create equity, efficiency, and a financially sustainable universal health care system for Thailand.

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