Chapter 8

Health Security in Thailand

This chapter analyzes the development of health security in Thailand in the past, at present, and in the future as to how it should be implemented. It includes four parts: (1) evolution of health security system in Thailand before 2002, (2) the 2001 transition to universal coverage of health care, (3) development of subsystems to support the universal coverage of health care, (4) achievements of the operation of health security, and (5) the outlook.

1 Evolution of Health Security System in Thailand before 2002

After the establishment of the Ministry of Public Health in 1942, the government specified that, in 1945, the people had to copay for health care provided by state health facilities. Later several health insurance schemes were developed for specific population groups, which can be classified into six major schemes as follows:

1) Medical Service Welfare for the People Project, formerly known as the Medical Services for the Poor Project, started in 1975.
2) Voluntary Health Insurance with Government Subsidies Project for the people in the non-formal employment sector who were ineligible to receive any medical services normally provided by the government for those in the formal sector. It was actually transformed from community health insurance funds of the MoPH that began in 1983.
3) Civil Servants Medical Benefits Scheme for civil servants and state enterprise employees beginning in 1978.
4) Compulsory health insurance schemes required by the government for employees in the private sector, including the Workmen's Compensation Fund (beginning in 1974) covering illnesses from work-related activities and the Social Security Scheme (beginning in 1990).
5) Compulsory Motor Vehicle Accident Victims Protection Project covering illnesses or injuries from traffic accidents beginning in 1993 as required by the 1992 Act.
6) Private voluntary health insurance operated by private health insurance companies, originated from health insurance businesses of transnational companies operating in Thailand before 1910.

1.1 Medical Service Welfare for the People (MSWP) Project

The prime objective of this project was to provide medical services to the poor and underprivileged. Initially, in 1975 the project covered only poor people, but later was extended to cover the elderly in 1989 and children under 12 years of age, the disabled, war veterans, and religious leaders in 1992, and community leaders as well as village health volunteers including their families in 1994. At the beginning stage, free medical service cards were issued to the poor at the discretion of healthcare providers; until 1979, the people's income was used to determine the poverty level when a 3-year card was given only to those who were considered to be poor as determined by subdistrict and district-level officials. This project covered 30% of the population in 2001.

The benefits of the project included outpatient and inpatient medical care except for certain services. In the beginning, the cardholders could obtain services only at MoPH health facilities with health centres saving as the front-line providers. In 1997, the eligible person can receive health services directly at the hospital with health centres as its network members, the reason being every individual should be eligible to see a physician. In the meantime, state-run health facilities under other ministries also joined the scheme under the overall management of the MoPH. In the beginning, the financial management was undertaken at the central level, which allocated the budget to the provincial level for further allocation to health facilities under their respective jurisdiction. Beginning in 1997 there were cooperative efforts in the financial management of the scheme through the national project management committee and provincial committees, according to the Regulations of the Prime Minister's Office on the Management of the Medical Service Welfare Project. Provinces were allotted a capitation budget according to the number of people registered under the project. Around this period, Thailand faced an economic crisis and had to take loans from the World Bank under the Social Investment Project (SIP); and the MoPH requested a loan for medical service fee payments to health facilities in six provinces, according to the capitation rate, on a pilot scale, for outpatients and DRG-weighted global budget for inpatients. This model was later adopted as the universal healthcare scheme.

However, the major problems of the project were the lack of coverage and accuracy in card issuance for the poor. An evaluation of the card issuance process for each round indicated that a lot of poor people did not receive the healthcare cards while a rather large number of card-receivers were not really poor.

1.2 Voluntary Health Insurance with Government Subsidies Project (VHIP)

The MoPH implemented this project (commonly known as voluntary health card project) between 1983 and 2001 in two major phases. In the first ten years (1983-1992), the scheme was operated as community funds aimed at increasing access to essential primary health services by setting low-priced health cards including maternal and child health cards, family medical care cards, and individual medical care cards (later on only family cards were used). It was expanded rapidly during

the first two years but slowed down steadily after that due to MoPH's unclear policy on his matter. During the second half of the scheme (1993-2001), as a result of the project evaluation, a systematic improvement in the scheme operations was undertaken to become a full-scale voluntary health insurance scheme beginning in 1994. Under the new scheme, the national and provincial health insurance funds were established with the government subsidizing half of the health-card price (1,000 baht each); each one-year card was valid for a family of not exceeding five members. In the last phase of the scheme, the government subsidy was increased to two-thirds of the card price (1,500 baht each).

The scheme was popular among the people and expanded widely particularly in rural areas. In 2001, the scheme coverage was 23.4% of Thai population.

The benefits of the scheme were not quite different from those for the MSWP scheme. During the initial stage, which was administered by the community fund, there was a limitation on the number of visits for medical care and a ceiling of coverage; and the cardholder was required to attend the health centre first and, if referred by the health centre, he/she might go to hospital for further medical care. When the full-scale voluntary health insurance scheme was implemented, such limitation and requirements were abolished; and the cardholder could go directly to the district hospital in their area. Moreover, a new card could be obtained from another province in case the person temporarily or permanently migrated during the year.

However, the problem of this scheme was a lack of good risk distribution as it was a voluntary insurance scheme and only one premium rate, resulting in a larger-than-normal proportion of cardholders with health risks and a low rate of cost recovery, particularly in the provinces with low coverage rates in relation to the population.

1.3 Civil Servants Medical Benefits Scheme (CSMBS)

The government and state enterprises have had a medical service welfare system for civil servants and state enterprise employees as well as their spouses, children and parents since 1978. Its aim is the provide welfare to boost morale for state officials and employees using the budgets of the government and state enterprises, covering approximately 8.5% of Thai population in 2001.

The benefits under this scheme are better than those under other schemes in that the eligible person can seek medical treatment at any state-run health facilities and, in case of emergency, at a private hospital (with a limitation on reimbursement) for civil servants. But for state enterprise employees, mostly they are free to choose any hospital as they wish; and their benefits are not much different from other schemes. However, there may be fewer exceptions; for example, they are eligible to the treatment for chronic kidney failure and organ transplantation.

The medical service welfare for civil servants of central and provincial administration agencies is managed by the Comptroller-General's Department, while that for officials of local administration organizations and state enterprises is managed by each particular organization or

enterprise. For outpatients, they have to pay for medical expenses first and get reimbursed later; for an inpatient, with a letter of eligibility certification from his/ her parent agency, the hospital can submit a claim for medical expenses directly to the Comptroller-General's Department. (Since 2005, eligible persons with chronic illness and pensioners have been able to register with a hospital to directly claim medical expenses from the Comptroller-General's Department, without paying for services first, for outpatient care; this mechanism is being extended to other groups of civil servants). Under this scheme, fee-for-services payments are made to the hospital; but for state enterprises, the benefits might vary according to their financial status and mostly have a cap on maximum coverage.

The major problem of this scheme is the rapid increase in the medical expenditure resulting from the fee-for-services payment mechanism.

1.4 Public Sector Compulsory Health Insurance Scheme

In the private employment sector, there are two funds: (1) Workmen's Compensation Fund covering work-related illnesses or injuries of employees with premiums paid only by employers and (2) Social Security Fund (SSF) covering employees' illnesses, disabilities, deaths, and retirements, with premiums jointly paid in equal proportion by the employees, employers, and the government. The SSF's aim is to provide security for employees when they get sick based on the principles of risk sharing and support for each other between the people with better and poorer economic status and between the healthy and the sick. In the initial stage, this scheme covered only employees in business places with 20 employees or more. Later on, it has been extended gradually to cover businesses with 10 employees, 5 employees, and 1 employee, respectively. In 2001, the SSF covered 7.6% of Thai population.

The benefits under this scheme are similar to those under other schemes provided by the government for outpatient/inpatient, maternity, and dental services. The eligible person may choose to register at any public or private hospital under the scheme and may change the hospital registered once a year.

This scheme is managed by the Social Security Office of the Ministry of Labour through the Social Security Commission. The medical service fees are paid to contracted hospitals in different forms, i.e. capitation for general inpatient/outpatient care; additional payments according to types of services, chronic illness and high-cost care; and compensation for childbirth, dental care, and emergency medical care for accident victims outside the contracted hospital.

1.5 Motor Vehicle Accident Victims Protection (VAVP) Act

Health insurance for injuries from traffic accidents is compulsory insurance required of all owners of motor vehicles and motorcycles registered to pay insurance premiums. The scheme aims to protect persons injured from road traffic accidents and provide them with suitable medical services

and also provide compensation for cases with disabilities or deaths. It is a compulsory insurance scheme for all registered vehicle owners and managed by a private company. Its major problem is the duplication of eligibility with other health insurance schemes; and it has complex steps and regulations for reimbursements, resulting in a transfer of payments to other insurance funds or state hospitals.

1.6 Private Voluntary Health Insurance

In Thailand most private health insurance plans are an integral part of life insurance or accident group insurance. The purpose of private health insurance is to cover the risk of medical care payment that may occur in the future. The premiums are usually dependent on the risk level of the individual or group of individuals. The role of private health insurance is rather limited and its market is confined only to groups of people with a rather good economic status who can pay the premiums. In 2001, only 1.2% of Thai population were reported to have private health insurance.

The benefits of private health insurance mostly cover inpatient medical expenses, which are generally higher than outpatient medical expenses, with a cap on protection coverage while income-loss compensation is also paid during illness.

Significant features of different health insurance schemes prior to the launch of the universal healthcare scheme are as shown in Table 8.1.

1.7 Conclusion

Prior to 2002, with a segregated development approach, Thailand had several health insurance schemes with different objectives; the Medical Service Welfare for the People Project focused on providing protection for the poor, the elderly and children. Generally, it was an important social projection scheme, but it could not protect the poor as expected. Moreover, it had inadequate budgetary support to provide suitable medical services. The Civil Servants Medical Benefits Scheme for government officials and state enterprise employees, including their family members, faces a problem of efficiency because hospitals tend to over-provide medical services (beyond the need) under the fee-for-service payment mechanism, resulting in a considerable increase in medical care expenditure each year. As for the Social Security Scheme, a payment system for hospitals has been rather good; it is a capitation payment which should be an option for the long-term reform in Thailand. The Government-subsized Voluntary Health Insurance System was problematic in terms of risk sharing, resulting its financial unsustainability in the long run. Findings from research studies and political will leading to the financing system reform in 2002 will be discussed in section 2.

Table 8.1 Major characteristics of health insurance schemes before 2002

Characteristics	MSWP	VHIP	CSMBS	SSF	VAVP	Private insurance
Type	State welfare	Voluntary insurance with govt. subsidies	Welfare	Compulsory insurance with govt. support	Compulsory for vehicle owners	Private voluntary insurance
Target group	The poor and underprivileged	People living above poverty line with no insurance	Govt officials and state enterprise employees and families	Employees in private sector	All people affected by vehicle accidents	General public
Coverage rate of all Thai population (2001)	30%	23.4%	8.5%	7.6%	All	1.2%
Benefits						
• Outpatient services	State	State(MoPH)	State/private	State/private	State/private	State/private
• Inpatient services	State	State(MoPH)	State/private	State/private	State/private	State/private
• Registration with hospital	Required	Required	Not required	Required	Not required	Not required
• Benefit exceptions	15 cases	15 cases	-	15 cases	-	diseases
• Childbirth	Covered	Covered	Covered	Covered	None	None
• Physical checkups	None	None	Covered	None	None	Maybe
• Services not covered	Special room	Special room	-	Special room	-	-
Financing						
• Sources of funds	Govt budget	Household and 1/2 to 3/4 of govt subsidies	Govt budget	Employees, employers and state in equal proportion	Vehicle owner	Household
• Payments for services	Govt budget	Capitation & performance-based	Fee for service	Capitation & performance-based	Service-based	Service-based
• Copayment	None	None	When attending private hospital	Amount exceeding ceiling, childbirth, emergency	Amount exceeding ceiling	Amount exceeding ceiling
Major problems	Accuracy and coverage of the poor	Lack of good risk sharing	Rapid increase in expenditure	Cover only during employment	Duplication of eligibility and payment	Risk selection