



## 2. Transition in 2001 to Universal Health Care

### 2.1 Processes for Policy Formulation and Drafting National Health Security Bill

#### 1) Policy Formulation Process

The significant change in the Thai Health Service system happened after the Thai Rak Thai Party announced the universal coverage of health care policy, commonly known as “30-baht health care”, in its general election campaign and decided to keep its promise when it won the 6 January 2001 election. Then the universal health care policy became one of the nine urgent policies of the government.

In March 2001, the government held a workshop to develop guidelines for implementation of the universal health care policy, which are in summary as follows:

*“The universal health security policy aims to establish a health insurance scheme for the people by creating a service quality control system which separates service purchasers from service providers (MoPH). The state has the duty to distribute health risks and expenditure, using the government budget. Besides, this scheme has a mechanism for the containment of medical care cost using pre-negotiated, close-ended system of payment to health facilities. There are two funds under the health security scheme: (1) for the employment sector, expanding the social security fund to cover medical service welfare for civil servants and state enterprise employees including their families and (2) for the non-employment sector, using the universal health security scheme. Both funds will provide similar benefits and finally will become a single payment and benefit package system or will be merged as a single fund.”*

The universal health care scheme (30-baht health care) has covered 45.40 million people (73% of Thai population) with a budget from taxpayers’ money of 55,000 million baht each year (2002). During the transition period, the budgetary management was undertaken by the MoPH, allocating the budget for all provinces. At the provincial level, the provincial health office was responsible for managing the fund at the area level under the guidance of the area health board. After the National Health Security Office (NHSO) was established in 2003, the MoPH has gradually phased out its management role. The expansion of the universal health care coverage has been carried out step by step. During the initial stage, it was implemented on a pilot scale in 6 provinces with only state hospitals providing medical services; in the second stage, the scheme was extended to another 15 provinces with some private hospitals participating; in the third stage, the scheme covers the entire country and some (13) districts of Bangkok; and in the fourth stage, it covered all districts of Bangkok and the entire country in April 2002.

The policy was actually implemented, leading to changes, because of three aspects of development: the policy for problem-solving or policy stream, raising of problems or problem stream, and political support or political stream. When all the three aspects of development converged,



a window of opportunity was open. The general election was regarded as a major opening of opportunity that caused the universal health care policy to be adapted on a state policy agenda.

□ Policy stream. A group of technical staff of the MoPH had been working continuously since 1993 to seek ways to solve the problems and push for the adoption of the policy that they desired. They also tried to revise the policy for problem-solving until it was acceptable to all sectors concerned, the public and politicians.

□ Problem stream. The problem related to access to health care was recognized by the public and decision-makers and it had to be resolved. The mechanism that caught the attention of all concerned to the provision of health care in the universal health security system was the decreasing income of the people resulting from the economic crisis, coupled with the presentation of the sufferings in the health system by a nongovernmental organization as well as the network for universal healthcare.

□ Political stream. This is the change in the government and having a political party that was interested in health system reforms and proposed a policy that was in response to the problems and people's needs.

It is noteworthy that the building of knowledge was important in formulating the policy. Besides, the linkage with civil society and other networks created powers for policy adoption, while politicians were the people who opened the window of opportunity. All these factors supported the “triangle moving a mountain” strategy in the public policy movement.

## **2) Legislative Process**

In 1995-1996, the MoPH and the House Commission on Public Health once drafted a universal health insurance bill, but could not get it passed into law.

A new effort was made again after the promulgation of the 1997 Constitution which prescribed that no less than 50,000 eligible voters could jointly proposed a law to the Speaker of the House of Representatives for deliberation. At that time 60,000 people signed the legislation proposal; so a group of academics, NGO representatives and interested members of the public drafted the National Health Security Bill. A statement supporting the universal health care was signed by all NGO representatives in October 2000 (before the January 2001) general election, The Bill was submitted to the House Speaker in 2001.

During that period of time, the political party that adopted the universal health care policy for its election campaign actually expanded the health insurance scheme in April 2001. The party also drafted a National Health Security Bill and then submitted it for the cabinet's approval and later on submitted it to the parliament.

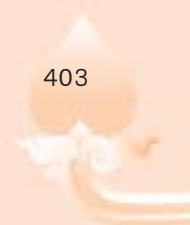
In the meeting of the House of Representatives, there were six bills on universal health care for the House deliberation: one from the cabinet, four from political parties and one from the people (supposed to be submitted directly to the House, but the process of examination of the names of 60,000



eligible voters/signatories could not be completed in time, the House decided to submit it on behalf of the people).

The Bill was reviewed in four sessions of public hearings in the North, Northeast, South and Bangkok; then it was revised and submitted to the Senate. During the Senate's deliberation, there were news coverage, meetings, talks and discussions on the Bill by health professionals, government officials and eligible persons under the Social Security Scheme. They all called for revisions in the Bill as they deemed appropriate. The labour group wanted to delete the provision related to the workmen's compensation and social security funds; representatives of health professionals, despite their support for the Bill, wanted to reduce the Bill's role in controlling their operations and giving some monetary assistance to the health care recipients who were adversely affected by the medical treatment provided by the health facility. Based on the comments from all concerned, the Senate Commission revised some points of the Bill as requested.

Finally, the National Health Security Act was enacted and published in the Government Gazette on 18 November 2002 and coming into force on the next day, 19 November 2002. The main features of the Act are as shown in Table 8.2.



**Table 8.2** Main features of the National Health Security Act, B.E. 2545 (2002)

Feature	National Health Security Act
1. Definition of health services	Services for disease prevention, disease diagnosis, medical treatment, health promotion, and rehabilitation, including Thai traditional and alternative medicine services.
2. Right to receive health services	Every person has the right to receive health services that are of good standard and in an efficient manner as prescribed in this Act.
3. Fixed health service unit	A primary care unit located in residential or working district/subdistrict of the eligible person is the fixed health service unit, except for a good reason, accident or emergency and patient referral.
4. Management of the state health insurance schemes existing before the Act comes into force	Any eligible person under any existing law will have the right to receive health services according to that law. The National Health Security Board shall be prepared and set up a mechanism for the provision of health services according to this Act.
5. National Health Security Board (NHSB)	The Board has 30 members, including the Public Health Minister as chairperson and five representatives of the civic sector as members.
6. National Health Security Office (NHSO)	A state agency and juristic person under the supervision of the Public Health Minister. The NHSB selects for appointment and dismisses the Secretary-General of NHSO.
7. Funding sources of the National Health Security Fund	The funds for service provision come from the annual government budget and other incomes. The NHSB regrets the annual budget from the cabinet as the operating cost of NHSO.
8. Preliminary monetary assistance in case a service recipient is damaged by the medical treatment provided by the service unit	Not exceeding 1% of the budget that will be paid to service units will be withheld for use as preliminary assistance money for the service recipient who is damaged by the medical treatment provided by the service unit.
9. Quality and Standard Control Board	The Board comprises 35 members, including the president elected from among the members and five representatives of the civic sector.
10. Health facilities and standards of medical treatment	<ul style="list-style-type: none"> <li>- Service units and their networks are to be registered.</li> <li>- Criteria are set for payments for health services.</li> </ul>
11. Standard control for health facilities	An investigation committee is established to investigate, make recommendations, and report to the Quality and Standard Control Board.

**Source :** Sirivan Pitayarangarit, Pongpisut Jongudomsuk, Thavorn Sakulpanich and colleagues. The Process for Formulating Universal Coverage of Health Care Policy and the National Health Security Act, 2004.

## 2.2 Major Essence of Reform

### 1) Principles of the Universal Coverage of Health Care

The goal of the universal health care is to guarantee that every citizen will have access to essential health care as fundamental right of the people, and to set up a system for members of society to “share suffering and happiness” due to illness, which will promote fraternity and helpfulness in society.

The three principal targets are: (1) universal coverage, (2) all Thai citizens receive health care according to the standardized benefit package, and (3) there is a master plan as well as coordination mechanism for all agencies on the basis of policy, financial and institutional sustainability.

The design of the universal health care scheme is as follows:

(1) The budget for medical treatment will be from the tax system. Eligible persons will pay 30 baht per visit when receiving health care except for health promotion and disease prevention services. Exemption of the fee is extended to the people who were previously covered under the Medical Welfare for the Poor and Underprivileged Project such as poor people, children, the elderly, monks and veterans.

(2) A primary care unit near people’s residences is the front-line service unit that serves as the main service contractor and the unit for registration of eligible persons.

(3) The financing system is a cost-containment system on a long-term basis with a close-ended and performance-related system of payments to health facilities.

(4) The benefit package is the same as those under other state health insurance schemes.

(5) The quality assurance system is used in monitoring the service quality development programme.

(6) For policy administration, the decentralization of management authority to provincial administration is used, under the responsibility of the area fund management committee.

(7) There is a clear purchaser-provider split in order to make the examination, monitoring and evaluation system more efficient.

### 2) Restructuring of the Health Security System

#### (a) Establishment of the National Health Security Office (NHSO) as the Service Purchaser

The NHSO uses the service purchasing mechanism in efficiently managing the scheme and serves as the representative of consumers in examining service quality and checking the balance of power in the service system, which was previously under the MoPH (which acted as both system monitor and service provider, having no incentive to assess its own service quality as consumers’ representative).

According to the recommendations for the administrative structure reform of the universal health care scheme, there should be a national health security committee charged with the monitoring of policies of all state-run health insurance schemes, i.e. Social Security Fund, Civil Servants Medical Benefits Scheme, and the Universal Coverage of Health Care Scheme. The purpose was to standardize the benefit packages and payment mechanism to health facilities. At the local level, an area health board is used serve as the representative of the three funds in contracting health facilities under the scheme (Figure 8.1). However, during the transition period (2001-2002), there was no royal decree on practical guidelines for other funds and thus the NHSC supervises only the policy implementation of the universal health care scheme.

#### **(b) Establishment of the Medical Injury Compensation System**

This kind of fund is regarded as an innovation aimed at providing compensation to an individual damaged by medical treatment without proving any fault first (pure no-fault system). This is to relieve the suffering of the damaged person. The fund has the following advantages:

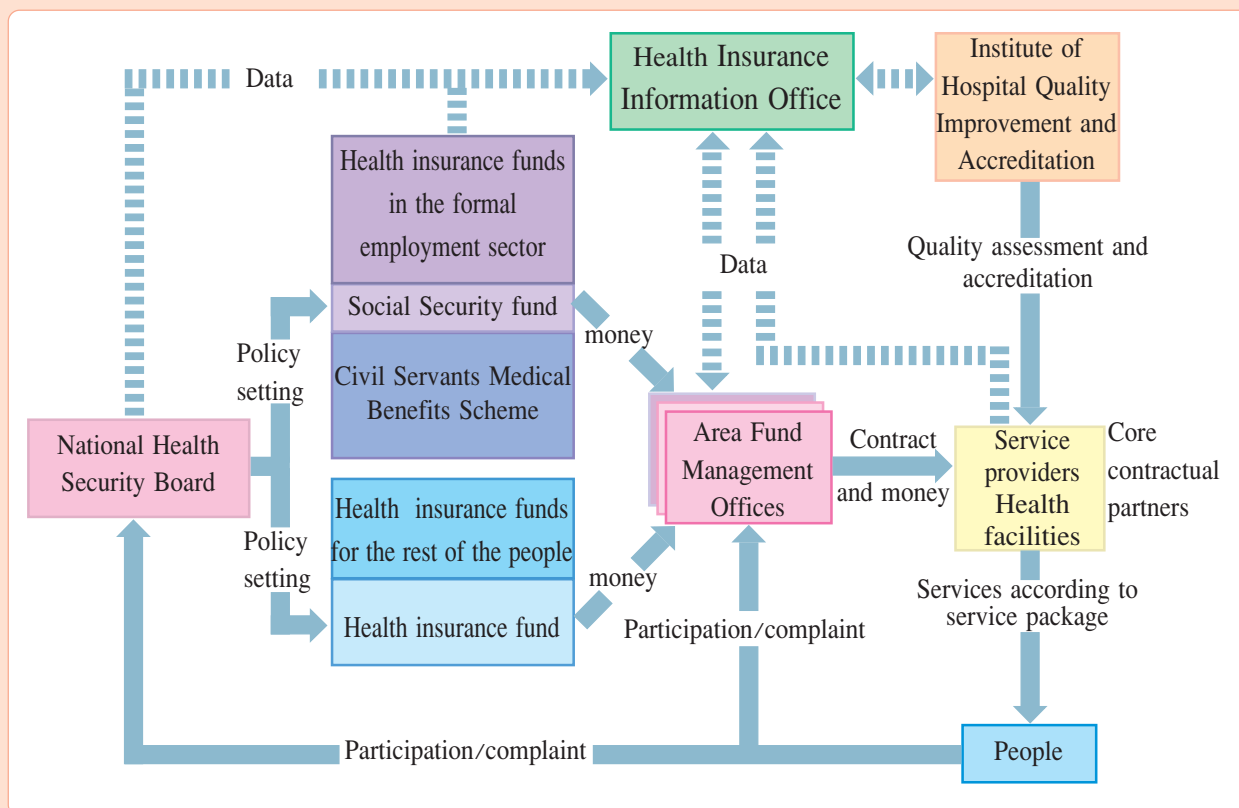
1. Preliminarily providing relief from suffering for damaged persons, without restricting their right to compensation from other system.
2. Promoting the development of medical care quality, making service providers become aware of the damage that may occur the service recipients. The NHSO uses two measures for this purpose: monitoring the quality of health facilities for preventing the damage due to an inevitable cause and having recourse to the wrong-doer or the negligent person.
3. Protecting physicians or service providers from undue litigation, using the mediation and reconciliation principle.
4. Managing the risk sharing effect by using the money earmarked or withheld from the universal health care fund (1% of medical expenditure) so that health service providers used not pay high premiums on insurance from a private firm.

Results of the operations are yet to be seen.





**Figure 8.1** Proposed restructuring of the health insurance system



**Source:** Working Group on Development of Structure of the Universal Coverage of Health Care Scheme, MoPH (2001).



### 2.3 Health Insurance System in Thailand after April 2002

In summary, after the change in cabinet and the implementation of the universal health care scheme, covering eligible persons under the medical service welfare scheme and the health card project and expanded to cover those who had never had any insurance before, the coverage of health insurance has risen to 92.5% of the Thai population, including 74.2% under the universal health care scheme, 6.6% under the civil servants medical benefits scheme, and 11.5% under the social security scheme, while the rest are under small systems such as politicians and Thais residing in other countries. Approximately 4.6 million people or 7.5% of entire population are not registered in any health insurance scheme.

A brief comparison of the three major schemes (see Table 8.3) is as follows:

1) Benefits: There is similarity in the benefit packages under the social security scheme and the universal health care scheme. Basically, the benefits cover inpatient and outpatient services, childbirth service and dental care, with exceptions for 15 specific cases, annual checkups, and special room changes. The universal scheme does not cover kidney dialysis for cases with chronic kidney failure, while the medical service welfare scheme had no exceptions. Disease prevention and health promotion services are included in the benefit package of the universal scheme. All three schemes use the national essential drug list in the benefit packages.

2) Sources of financing and co-payments: The universal health care scheme is financed by the government taxation system and requires that the eligible person pay 30 baht per visit, except for the underprivileged. Similarly, the civil servants medical benefits scheme is financed with tax money, but requires co-payment when attending private hospital. The social security scheme receives funding from three parties: employees, employers and the government; co-payments are required when the medical expenditure exceeds the established ceiling as well as for childbirth or emergency care.

3) Methods of payment to health facilities: The method for the universal coverage scheme is similar to that for the social security scheme, i.e. capitation as well as performance-related payment such as DRG for inpatients. The method used in the civil servants medical benefits scheme is fee for service.

However, there have been efforts to further improve the three schemes so that they have similar features to ensure equitable access to health care, which has to be pursued in the future.





**Table 8.3** Major characteristics of health insurance schemes in Thailand, September 2002

Characteristics	Universal health care	Civil servants medical benefits	Social security
Type	State welfare	Fringe benefit	Social insurance, compulsory
Target group	People outside the civil servants and social security schemes	Civil servants, state enterprise employees, and their families	Employees in the private sector
Population coverage *	74.2%	6.6%	11.5%
<b>Benefits</b>			
• Outpatient services	Public/private	Public/private	Public/private
• Inpatient services	Public/private	Public/private	Public/private
• Registration with hospital	Required	Not required	Required
• Benefit exemptions	15 events	-	15 events
• Childbirth	Covered	Covered	Covered
• Physical checkups	None	Covered	None
• Services not covered	Special room, kidney dialysis	-	Special room
<b>Financing</b>			
• Sources of funds	Government budget	Government budget	Employees, employers and state
• Payment method	Capitation and performance-related	Fee-for-service	Capitation and performance-related
• Co-payment	Fee, 30 baht per visit	When using private hospital	Amount exceeding the ceiling, childbirth and emergency services

\*Note: Total population of 61.2 million, National Health Security Office, September 2002.