

**Universal Health Coverage and Accountability:
A Case study of Thailand¹**
Annex to the IAP reflections report 2021

Background

Since 2002, the population of Thailand has been covered under one of three public health insurance schemes. The first of these is the *Civil Servant Medical Benefits Scheme (CSMBS)* which covers government employees, pensioners, and dependents and is funded by taxes. Established in 1980 and managed by the Comptroller General's department of the Finance Ministry, in 2020 the CSMBS covered 6 million people (9 percent of the population) (Marshall et al., 2021). The second scheme is the *Social Security Scheme (SSS)* which is social health insurance for private sector employees, and is managed by the Social Security Office of the Labour Ministry. Adopted in 1990, social health insurance is funded by contributions from employers, employees, and the government; it covered 11 million people in 2020 (16 percent of the population) (Marshall et al., 2021). The third public health insurance scheme in Thailand—the *Universal Coverage Scheme (UCS)*, also referred to as the 30-Baht Scheme, was established and institutionalized through the National Health Security Act of 2002. The UCS covers the remainder of Thailand's citizens, is tax-based, and is managed by the National Health Security Office (NHSO). In 2020, the UCS covered 51 million people (75 percent of the population) (Marshall et al., 2021). UCS provides members with a comprehensive benefit package including inpatient, outpatient, and emergency care, as well as high-cost care, dental services, health promotion and disease prevention, and essential medicines (Tangcharoensathien et al., 2020).

When UCS was introduced, it was determined that beneficiaries must have Thai nationality. Therefore, stateless people were not covered and had to pay for health services out of pocket. District hospitals along the Thai-Myanmar border began experiencing high levels of debt since they were providing subsidized services to stateless people (Suphanchaimat et al., 2016; Tangcharoensathien et al., 2018). These experiences, combined with advocacy from civil society and the humanitarian sector led to the establishment of a new scheme in 2010 called *Health Insurance for People with Citizenship Problems (HIS-PCP)* (Suphanchaimat et al., 2016; Tangcharoensathien et al., 2018). This scheme, which is envisaged as a temporary financial measure, is managed by the Ministry of Public Health and involves a comprehensive benefit package similar to the UCS. Additionally, a voluntary migrant health insurance scheme was introduced in 2001, funded through premiums paid by migrant workers. By 2016, this scheme covered 34 percent of Thailand's migrants and their dependents (Tangcharoensathien et al., 2018).

Citizen participation in Thailand's UHC schemes

Participatory and responsive governance is an important component of UHC in Thailand, particularly in the UCS scheme which includes legislative provisions that promote accountability to citizens and health-care providers and enable citizens' voices to be heard. The prominence of participatory mechanisms in the UCS is notable given that Thailand's ranking in voice and accountability more generally has been decreasing over the last two decades. According to the World Bank, the voice and accountability indicator—which captures perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media—dropped between 2002 and 2018 in Thailand from the 60th to the 20th percentile (World Bank, 2021; Kantamaturapoj et al, 2020).

Participatory governance is embedded in the UCS because citizens actively participated in the initiation and development of its policy formulation process (whereas that was not the case for the

¹ This case was developed by Global Health Insights based on a narrative literature review with input from IAP.

other two schemes) (Marshall et al., 2021). Despite the existence of the CSMBS and social health insurance for private sector employees, along with efforts to introduce voluntary health insurance for the informal sector and a low-income scheme for the poor, by 2001 thirty percent of the population remained uninsured (Tangcharoensathien et al., 2018). At this time, there was a general election campaign, and UHC became part of the political manifesto (Tangcharoensathien et al., 2020). The *Thai Rak Thai* party formed a coalition government and after their victory, led the pilot implementation of the UCS in six provinces (Tangcharoensathien et al., 2018). In parallel, a legislative process was underway to enact the National Health Security Act of 2002. As part of this process, Thai citizens through the Network of People Organizations drafted a bill on UHC which was endorsed by 50,000 electors and submitted alongside five other draft bills proposed by government and political parties (Kantamaturapoj et al, 2020; Alfers and Lund, 2012). This was the first action to test a constitutional right in which citizens can propose legislation through submitting draft Acts for consideration by legislative bodies (Article 170 of the 1997 Constitution and Article 133 of the 2017 Constitution). After the first reading of the draft bills, five members of the Network of People Organizations were invited to the parliamentary committee which considered the second and third readings, after which key items were negotiated and the final text was endorsed. This final text included key provisions regarding voice and accountability that came originally from the citizen-led draft bill (Kantamaturapoj et al, 2020; Alfers and Lund, 2012). Citizen participation and public discussion on health continued over subsequent years and eventually led to the National Health Act of 2007 which institutionalized multi-stakeholder participation in health policy-making in Thailand through the annual convening of a National Health Assembly (Rajan et al., 2017).

There are multiple legislative provisions in the National Health Security Act 2002 that have promoted multistakeholder participation in the UCS. First are provisions that mandate the National Health Security Office (NHSO) to hold *annual public hearings* for both health care providers and patients. These have been held since 2004, are convened separately for providers and patients, and involve a transparent process in which further actions are identified. These public hearings have led to important changes—for example the removal in 2015 of the two-child limit on the number of birth deliveries eligible in the UCS (Kantamaturapoj et al, 2020). Second are provisions that mandate the NHSO to *register citizens* to health-care provider networks and to re-register them to a different network if they relocate; this registration system is both publicly accessible and updated on a monthly basis (Kantamaturapoj et al, 2020). The third set of notable provisions are those that mandate the NHSO to set up *complaint systems* and for issues to be investigated and resolved. The NHSO since 2002 has run a 24/7 helpline for seeking information and lodging complaints. This system has been adapted over time to ensure that it is responsive and that data is used to improve performance. Similarly, the Social Security Office operates a 24/7 helpline for the social insurance scheme, while the Comptroller General manages a call center for the CSMBS that is only open during office hours (Kantamaturapoj et al, 2020). Fourth are provisions that mandate the NHSO to earmark up to 1 percent of the total annual budget for *no-fault financial assistance* to patients or families that have been affected by “adverse events” (such as death or disability after using health services) (Kantamaturapoj et al, 2020).

These legislative provisions in the UCS represent an essential entry point for participatory and responsive governance but are not on their own sufficient; the implementation capacity of the NHSO has also been essential (Kantamaturapoj et al, 2020). The work of the NHSO is overseen by the multistakeholder National Health Security Board, chaired by the health minister. Of the 30-member board, five members are citizens, selected from civil society constituencies. The board provides annual reports on performance and finances, all of which are publicly available on the organization’s website (Marshall et al., 2021).

Using evidence in budgetary processes

The UCS is financed by general taxation and based on the principle of per-capita budgeting (the per capita budget is the product of the related unit cost of services and quantity of services provided as measured by utilization rates) (Tangcharoensathien et al., 2020). The budgetary process is managed by a multistakeholder subcommittee appointed by the National Health Security Board, a process that limits discretionary decisions by ministries (Tangcharoensathien et al., 2018; Tangcharoensathien et al., 2020).

Budget requests are supported by the evidence-based, policy approach of health technology assessment (HTA) which has become institutionalized and integrated into the policy-making process for the UCS benefit package (as well as other policy-making processes in the health sector, including the development of the National List of Essential Medicines) (Leelahavarong et al., 2019). To address the growing budget requirement of the UCS, the government decided to adopt HTA to ensure accountability to the population for decisions about UHC resource use and coverage. In 2007, as demand for HTA grew, the Health Intervention and Technology Assessment Program (HITAP) was created as part of the International Health Policy Program (IHPP), a semi-autonomous body of the Ministry of Public Health, to conduct HTA and give evidence and recommendations to policy makers. HITAP conducts cost-effectiveness studies and budget impact analysis, develops guidelines, conducts capacity building, and is a formal part of UHC coverage decisions. By 2017, HITAP had conducted over 150 studies, the majority of which have fed into national policy-making processes (Tantivess et al., 2019). To foster participation and engagement of stakeholders in HTA, the Thai HTA process guidelines encourage engagement of stakeholders from across disciplines in selection and prioritization of topics for HTA, and the fine-tuning of policy recommendations (Leelahavarong et al., 2019). This has led to greater legitimacy of the process and acceptance of the findings (Leelahavarong et al., 2019).

Monitoring progress of UHC implementation

Monitoring progress is important for holding government and partners accountable for their commitments to UHC. In Thailand, data is collected and analyzed to monitor UHC population coverage, service coverage (SDG indicator 3.8.1), and financial risk protection (SDG indicator 3.8.2) drawing from four sources: i) national surveys, ii) health facility and administrative data, iii) specific disease registries, and iv) research (Witthayapipopsakul et al., 2019). Factors that have enabled this monitoring include the existence of a supporting infrastructure and information system (including a Civil Registration and Vital Statistics system established in 1956), a policy requirement for routine patient data records, commitment of and collaboration between key responsible organizations, and sustainable in-country capacities such as technical capacities in health information and IT systems (Witthayapipopsakul et al., 2019). Issues that have been identified for improvement in monitoring and evaluation of UHC in Thailand include monitoring in the non-Thai population (migrant workers and stateless persons), tracking access to essential medicines, and maximizing the use of collected data (Witthayapipopsakul et al., 2019).

Positive outcomes from Thailand's UHC system

After years of planning, implementation, and adaptations, these efforts are leading to clear, positive outcomes for the population. The establishment of the UCS, with its comprehensive benefits and free services, has decreased household out-of-pocket payments from 34 to 11 percent of total health expenditure between 2000 and 2018 (World Bank, 2021). UHC has led to increased access to health services for the country's population and evidence from a national household survey suggests low levels of unmet needs for both outpatients and inpatients, comparable to OECD countries (Thammatacharee, 2012; Tangcharoensathien et al., 2018). Research findings suggest that UHC has led to increased hospital admissions and outpatient visits, but no increase in unhealthy behaviors or

reduction of preventive efforts (Ghislandi et al., 2015). Annual check-ups have increased, in particular among women (Ghislandi et al., 2015).

The increased use of health service has been found to benefit the poorest, thus UHC is leaving no one behind. This is due to several factors including extensive coverage of health services including at peripheral levels, well financed and functioning primary health care, and the comprehensive benefit package and free services at point of service (Limwattananon et al., 2012). Increased access to health services due to the UCS has decreased gaps in infant mortality between provinces (Gruber et al., 2014). Additionally, interventions such as antiretroviral therapy (with universal ARV treatment fully implemented in 2004) and renal replacement therapy have decreased adult mortality (Aungkulanon et al., 2012; Tangcharoensathien et al., 2018). Remaining challenges for UHC in Thailand include addressing the needs of an ageing population, primary prevention of non-communicable diseases, preventing road traffic mortality, and coverage of diabetes and tuberculosis control (Tangcharoensathien et al., 2018).

Lessons on Accountability: The Case of UHC in Thailand

1. Achieving progress on accountability requires political commitment at the highest levels—initially part of its political manifesto during the 2001 general election campaign, the government made a commitment to UHC and has taken responsibility for its progress.
2. Multistakeholder participation should start from the beginning of policy initiation and development. From the beginning of the development of the UCS scheme, citizens actively participated in policy formulation by taking advantage of a constitutional right in which citizens can propose legislation. This contributed to the embedding of legislative provisions in the UCS that have promoted people-centred, participatory governance through annual public hearings, registration of citizens in health-care provider networks, establishment and implementation of complaint systems, and provision of no-fault financial assistance for patients or families that have been affected by adverse events.
3. Legislation is important but implementation capacity is equally important. The work of the UCS is overseen by a multistakeholder board, with five members of the thirty-member board selected from civil society constituencies.
4. Data has also been central to decision-making, building on a strong, existing infrastructure and information system (including the Civil Registration and Vital Statistics system that was established in 1956) and adopting the health technology assessment (HTA) approach that has become institutionalized and integrated into the policy-making process for the UCS benefit package.
5. Thailand's experience demonstrates the power of multistakeholder participation in building an efficient, responsive, evidence-based scheme that people can trust, use, and have ownership over and that leaves no one behind in pathways to UHC.

Bibliography

- Alfers L, Lund F. Participatory policy making: lessons from Thailand's universal coverage scheme. WIEGO Policy Brief (social protection) No. 11. Manchester: Women in Informal Employment Globalising and Organizing; 2012. Available from: https://www.wiego.org/sites/default/files/migrated/publications/files/PB11_Alfers_Lund_2012.pdf.
- Aungkulanon, S., McCarron, M., Lertiendumrong, J., Olsen, S. J., & Bundhamcharoen, K. (2012). Infectious disease mortality rates, Thailand, 1958-2009. *Emerging infectious diseases*, 18(11), 1794–1801. <https://doi.org/10.3201/eid1811.120637>
- Ghislandi, S., Manachotphong, W., & Perego, V. M. (2015). The impact of Universal Health Coverage on health care consumption and risky behaviours: evidence from Thailand. *Health economics, policy, and law*, 10(3), 251–266. <https://doi.org/10.1017/S1744133114000334>

- Gruber, J., Hendren, N., & Townsend, R. M. (2014). The Great Equalizer: Health Care Access and Infant Mortality in Thailand. *American economic journal. Applied economics*, 6(1), 91–107. <https://doi.org/10.1257/app.6.1.91>
- Kantamaturapoj, K., Kulthanmanusorn, A., Witthayapipopsakul, W., Viriyathorn, S., Patcharanarumol, W., Kanchanachitra, C., Wibulpolprasert, S., & Tangcharoensathien, V. (2020). Legislating for public accountability in universal health coverage, Thailand. *Bulletin of the World Health Organization*, 98(2), 117–125. <https://doi.org/10.2471/BLT.19.239335>
- Kuhonta E.M. (2017). The Politics of Health Care Reform in Thailand. In: Yi I, ed. Towards universal health care in emerging economies. Social policy in a development context. London: Palgrave Macmillan.
- Leelahavarong, P., Doungthipsirikul, S., Kumluang, S., Poonchai, A., Kittiratchakool, N., Chinnacom, D., Suchonwanich, N., & Tantivess, S. (2019). Health Technology Assessment in Thailand: Institutionalization and Contribution to Healthcare Decision Making: Review of Literature. *International journal of technology assessment in health care*, 35(6), 467–473. <https://doi.org/10.1017/S0266462319000321>
- Limwattananon, S., Tangcharoensathien, V., Tisayaticom, K., Boonyapaisarncharoen, T., & Prakongsai, P. (2012). Why has the Universal Coverage Scheme in Thailand achieved a pro-poor public subsidy for health care?. *BMC public health*, 12 Suppl 1(Suppl 1), S6. <https://doi.org/10.1186/1471-2458-12-S1-S6>
- Marshall, A. I., Kantamaturapoj, K., Kiewnin, K., Chotchoungchatchai, S., Patcharanarumol, W., & Tangcharoensathien, V. (2021). Participatory and responsive governance in universal health coverage: an analysis of legislative provisions in Thailand. *BMJ global health*, 6(2), e004117. <https://doi.org/10.1136/bmjgh-2020-004117>
- Rajan, D., et al., *The triangle that moves the mountain: nine years of Thailand's National Health Assembly (2008-2016)*. 2017, World Health Organization: Geneva.
- Suphanchaimat, R., Kantamaturapoj, K., Pudpong, N., Putthasri, W., & Mills, A. (2016). Health insurance for people with citizenship problems in Thailand: a case study of policy implementation. *Health policy and planning*, 31(2), 229–238. <https://doi.org/10.1093/heapol/czv046>
- Tangcharoensathien, V., Thammatach-Aree, J., Witthayapipopsakul, W., Viriyathorn, S., Kulthanmanusorn, A., & Patcharanarumol, W. (2020). Political economy of Thailand's tax-financed universal coverage scheme. *Bulletin of the World Health Organization*, 98(2), 140–145. <https://doi.org/10.2471/BLT.19.239343>
- Tangcharoensathien, V., Witthayapipopsakul, W., Panichkriangkrai, W., Patcharanarumol, W., & Mills, A. (2018). Health systems development in Thailand: a solid platform for successful implementation of universal health coverage. *Lancet (London, England)*, 391(10126), 1205–1223. [https://doi.org/10.1016/S0140-6736\(18\)30198-3](https://doi.org/10.1016/S0140-6736(18)30198-3)
- Tantivess, S. (2019). Health Technology Assessment in Thailand: Institutionalization and Contribution to Healthcare Decision Making: Review of Literature. *International journal of technology assessment in health care*, 35(6), 467–473. <https://doi.org/10.1017/S0266462319000321>
- Thammatacharee, N., Tisayaticom, K., Suphanchaimat, R., Limwattananon, S., Putthasri, W., Netsaengtip, R., & Tangcharoensathien, V. (2012). Prevalence and profiles of unmet healthcare need in Thailand. *BMC public health*, 12, 923. <https://doi.org/10.1186/1471-2458-12-923>
- Witthayapipopsakul, W., Kulthanmanusorn, A., Vongmongkol, V., Viriyathorn, S., Wanwong, Y., & Tangcharoensathien, V. (2019). Achieving the targets for universal health coverage: how is Thailand monitoring progress?. *WHO South-East Asia journal of public health*, 8(1), 10–17. <https://doi.org/10.4103/2224-3151.255343>
- World Bank. World Development Indicators database. <https://data.worldbank.org> (accessed March 2, 2021).
- World Bank. Worldwide Governance Indicators. <https://info.worldbank.org/governance/wgi/> (accessed March 2, 2021).