International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Thailand

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Extending Social Health Protection in Thailand: Accelerating progress towards Universal Health Coverage

1. Introduction

When it comes to socio-economic progress and poverty reduction, Thailand is widely considered a success story. Despite being classified as a middle-income country with limited fiscal resources, Thailand's economic growth has allowed for a reduced national poverty headcount ratio of 42.3 per cent in 2000 to 9.9 per cent in 2018. From 1960—1996, Thailand's economy grew at an average annual rate of 7.5 per cent, and after the 1997 financial crisis, the annual growth rate was still 5 per cent. Not only has this growth spurred job creation, helping to pull millions of households out of poverty, it has driven the development of Thailand's health system. In 2002, as a result of increased investment in health delivery system infrastructure, financing reforms, health workforce capacity building, health information system development, and a high level of political commitment, Thailand achieved Universal Health Coverage (UHC). As such, the case of Thailand is often-cited as an international good practice in this area.

In Thailand, the right to health care is anchored in the 2007 Constitution, which stipulates that "a person shall enjoy an equal right to receive appropriate and standard public health service".[1] In order to realize this right, three main public health protection schemes are implemented to cover Thailand's population: the government-funded Civil Servant Medical Benefit Scheme (CSMBS) for public employees; the contributory health Social Security Scheme (SSS) for private sector employees; and the most recently implemented Universal Coverage Scheme (UCS), which is a tax-based scheme providing free health care for those not covered by the two other schemes. For migrant workers in Thailand, coverage is provided either through the SSS scheme in the case of regular formal sector migrant workers, or the Migrant Health Insurance Scheme (MHIS) for those working in the informal economy.

In tandem with the development of the social health protection system, health outcomes in Thailand have significantly improved. Specifically, the under 5 mortality rate in Thailand decreased from 37 deaths per 1000 live births in 1990 to

[1] Constitution of Thailand, 2007, article 51, available at: https://www.constituteproject.org/constitution/Thailand_2007.pdf

12.2 deaths per 1000 live births in 2016, and the maternal mortality rate also declined, from 42 deaths per 100,000 live births in 1990 to 20 per 100,000 live births in 2015 (WHO 2018a; 2015). However, challenges remain as the country faces similar issues experienced by health care systems in other countries, including financial sustainability obstacles and growing burdens related to population ageing.

2. Context

Thailand's strong social health protection system is a product of relatively recent history. Before implementing the UCS scheme in 2002, which is widely perceived as having been instrumental to the achievement of UHC, the country had four health protection schemes. These included the two aforementioned health insurance schemes covering formal sector employees: the CSMBS and the SSS, established in 1980 and 1990, respectively. In addition, the 1975 community-based Medical Welfare Scheme (MWS) managed by the Ministry of Public Health (MOPH) was implemented to exempt the poor from user fees at public health facilities and was later extended to cover the elderly, the poor and other vulnerable groups. However, the programme faced issues related to inefficient financial management and complex funding usage rules (Health Security Office 2003)from underfunding and very little political interest (Mongkhonvanit and Hanvoravongchai 2015). In 1991, the MOPH merged fragmented community health insurance schemes into one programme, namely the Voluntary Health Card Scheme (VHCS), with the objective to cover those not eligible for the other programmes. Through the VHCS, each household with up to five people was able to purchase health insurance for 500 Thai baht (THB) per year. However, due to its voluntary nature and lack of incentives (Mongkhonvanit and Hanvoravongchai 2015), and the wide-spread perception that the quality of care was higher for those who paid the full cost upfront (Satidporn 2020), the scheme proved unsuccessful.

Due to underlying operation issues, mainly with the MWS and VHCS, 30 per cent of the Thai population were still uninsured during this period. This accelerated efforts to create a new health financing scheme by integrating the MWS and VHCS schemes to launch UCS. Introduced in April 2001, the UCS scheme was initially piloted in six provinces and rolled-out to the rest of the country (with the exception of Bangkok) within seven months. Through the UCS, supported by strong political commitment, adequate budget allocation, active civil society engagement and technical expertise, Thailand managed to expand its health insurance coverage rapidly, covering 76 per cent of its population (47 million) less than 2 years on from its launch (ILO 2016).

3. Design of the social health protection system

- Financing

Overall, for the past decade, current health expenditure financing resources have remained at around 3.7 per cent of Thailand's GDP, and since the introduction of UCS, out-of-pocket (OOP) payments have drastically decreased from 33.9 per cent to 11 per cent in 2018 (World Bank n.d.) In tandem, government expenditure per capita has steadily increased, rising from US$232 per capita, and reaching US$723 in 2018 (World Bank n.d.).

Thailand's social health protection system is predominantly tax-funded, with the exception of the contributory SSS scheme, which is financed via tripartite financing arrangements, equally shared between employers, employees and the government. The payroll tax contribution to the SSS scheme is set at 1.5 per cent, borne equally by each of the three parties, namely the worker, the employer and the government (WHO 2015). It is the responsibility of the employer to deduct 1.5 per cent of their employee's salary and match the same amount. The government also contributes to the SSS through an annual budget contribution to the Social Security Office (WHO 2015).[2]

The CSMBS on the other hand, is a non-contributory scheme. Since its inception, the scheme has been fully funded by the government budget as a fringe benefit to supplement civil servants' historically low salaries. Despite

[2] WHO data shows that since the scheme was first launched, the salary threshold to calculate contributions has been fixed at THB15,000 per month and has not been increased since 1991 (WHO 2015).

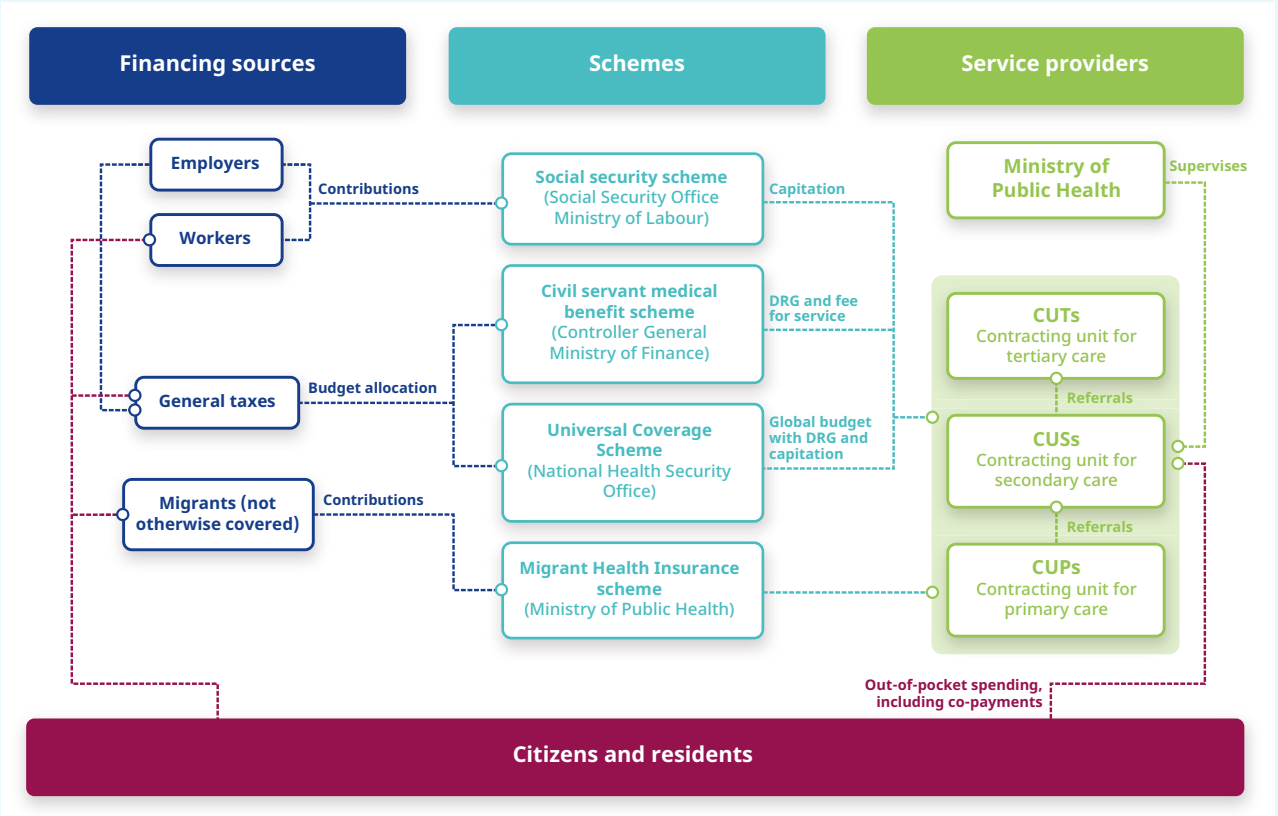
covering a relatively small proportion of the Thai population, the CSMBS is considered the most expensive scheme and its expenditure is rising rapidly, making it four times higher than the other two main schemes (Barber, Lorenzoni, and Ong 2019).

The UCS scheme is tax-financed, characterized by a fixed annual budget, transferred from the government budget to the National Health Security Office (NHSO), based on the number of beneficiaries it covers and the capitation rate per beneficiary (McManus 2012). In addition to rapidly expanding coverage, the creation of UCS led to sweeping reforms of the Thai health financing system. In 2002, the implementation of a purchaser-provider split was introduced through the establishment of the NHSO, which contracts health care providers to provide health services for its beneficiaries. This signalled a move away from the previous model of budget allocation from the central MOPH to health care providers.

Along with the introduction of UCS, Thailand introduced capitation payments, and later on, Diagnostic Related Groups (DRGs), launching another significant reform toward demand-side health care financing and strategic purchasing (Hanvoravongchai 2013).

The MHIS scheme for migrant workers is a contributory scheme and paid out-of-pocket by the worker, with the exception of migrant workers in the fishery sector, where the employer must cover the expenses (IOM 2021). Differential prices apply depending on pre-defined categories of the population. While the standard price of the insurance is a fixed amount (THB3,200 for one year) for adults, the cost of the insurance for children under the age of 7 is lower (THB365). For migrant workers waiting to be covered by the SSS scheme, who are expected to register with MHIS during the three-month waiting period, the cost is THB1,050.

▶ Figure 1. Overview of main financial flows of the social health protection system in Thailand



Source: Authors.

- Governance

The Civil Servant Medical Benefit Scheme (CSMBS)

The CSMBS was launched in 1980 through the Royal Decree on the Disbursement of Medical Benefits for Civil Servants, B.E. 2523, last amended in 2007. Additional legal documents for the scheme include the Royal Decree on Medical Benefits, B.E. 2553 (2010), in accordance with the Act on Stipulation of Payment Rules in line with budget, B.E. 2518 (1975). Since its inception, the scheme has been managed by the Comptroller General's Department at the Ministry of Finance (MOF) and governed by an advisory board of 19 members, including member representatives, chaired by the Permanent Secretary of the MOF (WHO 2015).

The health Social Security Scheme (SSS)

The SSS health scheme was legally established in 1990, pursuant to the Social Security Act, B.E. 2533, which also established the Social Security Fund and the Social Security Office (SSO). The Social Security Act includes two different sections: Section 33 for all private sector employees and regular migrant workers; and Section 39, which relates to individuals who have been previously insured under Section 33, paid contributions for no less than 12 months, ceased being employees, and wish to continue being insured (Schmitt, Sakunphanit, and Prasitsiriphol 2013). The SSO, under the Ministry of Labour (MOL), assures the management of the SSS scheme. Its governance body is a tripartite board, chaired by the Permanent Secretary of the MOL, and composed of 15 members, including government, employee and employer representatives (WHO 2015).

Universal Coverage Scheme (UCS)

The UCS scheme was officially institutionalized through the 2002 National Health Security Act, B.E. 2545, which complements Section 51 of the 2007 Constitution of Thailand. The Act is considered the first Thai law to foster public participation in health policy formulation and agenda setting, providing a platform for stakeholders from all relevant sectors to participate in health promotion and the development of conducive policies and strategies (WHO 2017). To manage the scheme, an autonomous public agency known as the NHSO was created. It is governed by the National Health Board (NHSB), which is composed of 30 members (including civil service representatives) and chaired by the Minister of Public Health. Under its legal provisions, the National Health Security Act [3] defines health services (section 3) and sets out the NHSO's responsibilities, which include registration of both UCS beneficiaries and service providers under the scheme (Section 6); administration of the scheme's fund (sections 26 and 38); and reimbursement of claims in line with NHSB regulations (sections 7 and 8).

Migrant Health Insurance Scheme (MHIS)

The MHIS, which is also referred to as Compulsory Migrant Health Insurance (CMHI) by the MOL, is managed by the Health Insurance Fund for Foreigners and Foreign Workers under the MOPH. The primary legal basis for the scheme is the Cabinet Resolution of 15 January 2013 and a set of announcements by the MOPH, known as the Health Examination and Health Insurance of Foreign Workers (No. 2) B.E. 2562 (2019) (IOM 2021). The governance and guiding documents for the scheme are few and complex, subject at times to disparate understandings between various government bodies.

- Legal Coverage and eligibility

The Civil Servant Medical Benefit Scheme (CSMBS)

The CSMBS is Thailand's largest public employee health scheme, covering civil servants and their dependents (spouses, up to three children under 20 years of age and parents). It also covers government retirees, military personnel and foreign employees whose wages are paid from the Government budget and whose employment contract does not specify an alternative type of medical coverage (Schmitt, Sakunphanit, and Prasitsiriphol 2013). Some types of public employees are not covered by the scheme, including those working for local governments, state enterprise workers, government employees under temporary or fixed term contracts, and government retirees who opted for a pension lump sum payment (Schmitt, Sakunphanit, and Prasitsiriphol 2013). Such groups are covered by separate public health insurance schemes.

The health Social Security Scheme (SSS)

The SSS scheme covers employees from the private sector and documented migrants employed in the formal sector. Currently, dependents are not

[3] National Health Security Act B.E. 2545 (A.D. 2002), available at: http://eng.nhso.go.th/view/1/National_Health_Security_Act_B.E.2545/EN-US

covered under the scheme, with the exception of maternity protection for spouses (WHO 2015). Registration is compulsory for private sector employees and regular migrant workers employed in the formal sector in Thailand.

Universal Coverage Scheme (UCS)

As set out under the provision of the Health Security Act, the UCS was created to cover the remaining Thai population not eligible under the CSMBS or SSS schemes, and exclusively covers Thai Nationals. Section 5 of the Health Insurance Act stipulates that "every person" shall be entitled to health services under this Act, and "person" is to be understood a person of Thai nationality who possesses an ID number (Schmitt, Sakunphanit, and Prasitsiriphol 2013).[4] Beneficiaries of the scheme are identified through the national registry of beneficiaries. This registry was built upon the existing Ministry of Interior Population database and it is shared by the three statutory health protection schemes. As such, the identification of UCS members is made possible by the exclusion of beneficiaries from the two other schemes (ILO 2015).

Migrant Health Insurance Scheme (MHIS)

The MHIS is a voluntary health insurance scheme and covers documented migrants working in the informal economy and their dependents (up to 18 years of age), as well as documented migrant workers working in the formal sector, who are not yet covered by the SSS scheme. As previously noted, since workers eligible under the SSS scheme are not eligible for benefits under the scheme for the first three months of their employment, they are expected to sign up to the MHIS during this period; prior to May 2020, irregular migrant workers could enrol in the scheme, but now only regular migrant workers are eligible (IOM 2021).

There are three main channels for regularized work migration into Thailand: bilateral MoU processes with neighbouring countries (Lao PDR, Cambodia and Myanmar and Viet Nam), the Border Pass employment scheme for seasonal work, and the nationality verification process, undertaken on an ad hoc basis, in Thailand. Migrant workers under any of these categories are eligible to enrol in the MHIS. However, only workers that have achieved regularized status through the national verification process are allowed to register their dependents. Dependents who enter the country alongside MoU and Border Pass migrant workers have irregular status and cannot register with the MHIS (IOM 2021).

Although the MHIS is a voluntary insurance scheme by law, migrant workers are required to purchase it in order to work in Thailand (IOM 2021). In order to be allowed to proceed with a work permit request, the MOL requires all migrant workers to provide a health check-up report and receipt of enrolment in the MHIS beforehand, making the scheme de facto "compulsory" via the work permit process. This has resulted in the adoption of the informal name, "Compulsory Migrant Health Insurance" by the MOL and related agencies.[5]

- Benefits

Despite varying eligibility requirements and governance and financing structures, the three main schemes (CSMBS, SSS and UCS) offer essentially the same range of benefits. Defined negatively, the benefit packages include general practitioner care, primary care and specialist care, including inpatient and outpatient services at public hospitals. A fee-for-service mechanism based on fee schedules is applied for high-cost health services, such as open-heart surgery, coronary bypass or brain surgery, for example (Schmitt, Sakunphanit, and Prasitsiriphol 2013). The benefit packages also cover pharmaceuticals and medicines on the National List of Essential Medicines (NLEM), including antiretroviral therapy for HIV/AIDS. Drugs not included in the NLEM can also be fully reimbursed if a GP considers them a necessity. Dental care, rehabilitation, delivery, ante natal and post-natal care, long term care, medical devices (270 items) and traditional Thai medicine services or other alternative medicine practices are also provided under the schemes. Preventive health care services and clinic-based health promotion activities are not explicitly part of the benefit packages but are organized by the NHSO, the managing agency of the UCS, through its annual budget for members of all three schemes (WHO 2015). These services, which were initially not included in all the schemes, have been extended to the whole Thai population by UCS.

[4] Section 5 of the National Health Security Act states that "a Person has the right to Health care" and in order to register for the scheme you need a Thai ID card. Only Thai nationals are entitled to a 13-digit ID card, and Section 52 of the Thai Constitution states that ''Thai people are entitled to health care".

[5] This information was obtained through informal 2021 interviews undertaken with ILO experts.

There are a range of exclusions, with the following treatments not included in the benefit packages: treatment for psychosis (with the exception of acute attacks); drug addiction treatment; long-term hospitalization (more than 180 days in a year); haemodialysis (except for acute renal failure requiring immediate treatment for no more than 60 days and end-stage of chronic renal failure); cosmetic surgery; experimental treatments; infertility treatments; tissue biopsy for organ transplantation (except for bone marrow and corneal transplantation); non-medically indicated procedures; sex reassignment surgery; reproductive surgery; recovery care; dental surgery services (except for extraction, filling, scaling and dentures at a rate specified by SSO); spectacles; and contact lenses (fully covered by the patient).

Compared to the other schemes, the MHIS benefit package has a slightly less comprehensive range of benefits, and does not include rehabilitation and specialist care.[6] Official MHIS documents include both a positive and negative list. The positive benefits package under the MHIS includes an annual health check-up; general medical treatment (consultation, diagnosis and treatment); maternity care (delivery and neonatal care); rehabilitation care; dental care (tooth extraction, filling and cleaning); medicines listed in the NLEM; access to child health care (comprising vaccinations for children aged 0–15 years old); and emergency medical treatment. Moreover, antiviral and HIV/AIDS medication, as well as communicable disease prevention services are also covered (IOM 2021). High-cost care is also covered, in line with the conditions set by the Migrant and Mother and Child Health Insurance Administrative Board (MMCHAB). There are exclusions to the benefit package, including various types of surgeries (organ transplant, cosmetic and/or sex reassignment surgeries), drug rehabilitation, psychosis treatment and fertility treatments. Moreover, inpatient care for the same condition/disease exceeding 180 days of treatment is no longer covered, unless there are complications and/or medical conditions.

A 2019 qualitative study found that although the benefits packages are virtually the same, the choices are not. For example, although contributory, SSS beneficiaries have fewer choices of artificial/medical devices/rehabilitation services compared to the non-contributory schemes. Disparities among the three health insurance schemes have emerged due to differences in purposes, financial resources and management, and payment mechanisms, which has led to different treatments and reactions among health care units for different patients depending on their health insurance scheme (Suksamai, Dhebpanya, and Sangrugsa 2019).

- Provision of benefits and services

The Civil Servant Medical Benefit Scheme (CSMBS)

CSMBS members can choose any public health provider, with no previous registration required (WHO 2015), and in case of emergencies, beneficiaries can go to any private hospital with the requirement of being transferred as soon as possible (Schmitt, Sakunphanit, and Prasitsiriphol 2013). A minimal co-payment is required. In terms of referrals, there are no primary health care gate keeping mechanisms for the scheme (Tangcharoensathien et al. 2018). For inpatient care, two options are available: patients have the choice to go to any facility and pay for the services upfront and be reimbursed retrospectively or register first with a preferred hospital for the scheme, which reimburses the provider directly. The use of retrospective unlimited fee-for-service with no set fee-schedule for both outpatient and inpatient services (including the reimbursement of bills from up-front payments) has been identified as a key factor contributing to the high cost of the scheme.

In 2007, to respond to the increasing cost of the scheme, the CSMBS management unit introduced DRGs to reimburse inpatient services (including maternity care), using the traditional fee-for-service mechanism or outpatient care (Sakunphanit 2008). The CSMBS uses a fee-for-service payment mechanism based on rates applied by all public hospitals. Up until 2007, CSMBS members had to pay an upfront conventional fee-for-service for outpatient care (including rehabilitation).This was replaced by a direct reimbursement to the health care provider on a monthly basis (WHO 2015).

The health Social Security Scheme (SSS)

Unlike the CSMBS scheme, patients under the SSS scheme have to register with a contracted

[6] The majority of the information in this paragraph is sourced from an unofficial translation of the 2013 MOPH Announcement on Health Check Up and Health Insurance for Migrants, available at: https://www.usp2030.org/gimi/RessourceDownload.action?ressource.ressourceId=45078

public or private provider and are only eligible for free care at their registered hospital. The only exception is emergency care — in such cases, a patient insured under the SSS can choose any hospital, even outside the contracted network. In fact, through an integrated Emergency Medical Services (EMS) policy initiative implemented in 2012, patients covered under any of the three statutory health schemes are able to go to any public or private hospital free of charge for the first 72 hours, in case of emergencies (Suriyawongpaisal et al. 2016).

Health services from any registered provider under the SSS are free of charge, without co-payments for any of the services provided in the benefits packages, with "no deductibles, no maximum ceiling of coverage and no extra-billing allowed by health care providers" (WHO 2015). However, there are some notable exceptions with implicit co-payments, as follows: dental care, which includes a reimbursable expense of THB250 per service, with use limited to twice a year; maternal care via a lump sum payment of THB12.000 to cover antenatal treatment, delivery and postnatal care; and haemodialysis, for which a ceiling is set at THB1500 per session and THB3000 per week. In these three instances, co-payments are implicit if the actual payments go beyond the schedule and covered amount (WHO 2017).

In order to gain access to benefits under the SSS scheme, members must have contributed for a minimum period of three months. Those who have contributed for less time are encouraged to enrol on or purchase other insurance schemes to cover for this three-month period. As previously noted, migrant workers eligible for coverage under the SSS scheme are encouraged to enrol in the MHIS scheme (IOM 2021).

Regarding provider payment mechanisms, inclusive capitation is used for both outpatient and inpatient payments, and includes additional adjusted fees for accidents, emergency and high-cost care, with DRG inpatient payment applied only partially for this particular scheme (WHO 2015).

Universal Coverage Scheme (UCS)

Benefits and primary care services for UCS beneficiaries are provided by locally contracted district units, known as "contracting units for primary care" (CUPs), which are required to set up one primary care unit for every 10,000-15,000 registered beneficiaries (McManus 2012). In urban settings, the UCS scheme also contracts private clinics/hospitals for the provision of ambulatory care. CUPs deliver primary care services and also arrange referrals of patients to secondary and tertiary care services in autonomous hospitals. A strategic objective of the scheme is to foster a culture of proper referrals to hospitals via a more systematic strategy (McManus 2012).

As previously noted, the UCS scheme introduced a major transformation for service delivery through the introduction of a provider-payment split between NHSO as the purchaser, and public and private providers which supply health services to the scheme's beneficiaries . The scheme is characterized by a capitation payment mechanism for outpatient care and a global budget allocation and DRGs for inpatient care (Schmitt, Sakunphanit, and Prasitsiriphol 2013).

When the scheme was first launched, it was accompanied by a "30 Baht for All Diseases Policy", which introduced a flat co-payment per consultation with exemption for specific groups of population, and was later eliminated in November 2006, making health care through the scheme free at the point of use. The co-payment was however reinstated on 1 September, 2012 under the Pheu Thai government, but is only charged to patients who need prescription of medicine. If no medicines or drugs are prescribed, the patient is exempt from the TBH30 co-payment. Emergency care, prevention activities and visits to health facilities below the community hospital level are also exempt from co-payments (PHCPI 2018). Moreover, hospitals and clinics can determine under their own discretion additional co-payment exemptions, for example when patients are unable to pay.[7]

For both public and private hospitals, a single base rate per relative weight is used. Health promotion and prevention for the whole population is paid primarily through capitation in combination with a fee schedule. Expensive treatments such as chemotherapy, antiretroviral treatment and chemotherapy are paid exclusively on a fee schedule (Tangcharoensathien et al. 2018).

Migrant Health Insurance Scheme (MHIS)

[7] Information from 2012 news article (in Thai), available at: https://www.posttoday.com/social/general/164465.

Migrant workers have to register at the public hospital where they had their health check and purchased the health insurance scheme. Once the insurance has been purchased at a specific public hospital, the beneficiary can only access services in that health care facility for the duration of the insurance (1 year) and cannot transfer it to a different facility should they move to a different district (IOM 2021). As well as being limited to accessing medical services at the health facility they initially registered at, members do not have access to private hospitals. However, migrant workers employed in the fishery sector can access health care at registered hospitals in 22 coastal provinces.[8]

Under the conditions set out in the 2013 MOPH announcement on Health Insurance for Migrants, several referral guidelines are outlined. Specifically, insured workers can be referred from their registered hospital to a second hospital for further treatment. In such cases, full reimbursement of the service provided at the referral hospital will be undertaken at the workers' registered hospital, without exceeding the rates set out by the Health Insurance Group (HIG). Moreover, for inpatient care, reimbursement of referral fees are aligned with the rates set out in the Medical Treatment Costs Guidelines, using DRG criteria. In cases of a referral to a health care provider not registered under the MHIS (such as private or university hospitals), reimbursement for both outpatient and inpatient care follows the same principles as at registered hospitals.

Upon registration to the MIHS scheme, a card is delivered to the insured person which is valid for one year. The card, which is individual and does not cover dependents, is mandatory to access health care services through the scheme. In addition to presenting their card, users must pay a small fee [9] for each visit (IOM 2021).

▶ 4. Results

- Coverage

Thailand achieved universal coverage in a very short space of time, demonstrating that UHC is not solely a reality for high-income countries. As of 2020, 71.2 per cent (47.5 million beneficiaries) of the Thai population was covered by the UCS scheme, 18.9 per cent (12.6 million beneficiaries) was insured under the SSS scheme and 7.7 per cent of the population (5.2 million beneficiaries) was covered by the CSMBS (NHSO, 2020). Of all the schemes, CSMBS covers a high percentage of the elderly population, including both Government pensioners and parents of currently employed civil servants (Jindapol et al. 2014). According to the most recent Thai National Health and Welfare Survey results (2017), 99.2 per cent of the population are covered by one of the health insurance schemes, though this figure does not account for MHIS beneficiaries, irregular migrants and beneficiaries of other micro schemes (Tangcharoensathien et al. 2018).

There is currently no detailed information on the exact numbers of migrant workers insured by each scheme (MHIS and SSS), making it impossible to get an accurate picture of population coverage or ascertain the percentage of eligible migrant workers insured. In 2018, Thailand was home to around 4.9 million non-Thai residents, a substantial increase from 3.7 million in 2014, including an estimated 3.9 million documented and undocumented migrant workers from neighbouring countries (UN 2019). Although Thai nationals and migrants who contribute to the social security system have equal rights to social health protection, it is believed that a significant number of undocumented migrant workers are not covered by the MHIS due to problems of affordability and a lack of information and transparency. Health protection for undocumented migrants therefore remains a challenge, as only migrant workers with valid work permits are fully covered. Accordingly, in September 2019, only 823,420 migrant workers and dependents were enrolled in the MHIS scheme, and in August 2020, the number of workers with active MHIS membership dropped to 510,211 (IOM 2021).

Initially upon its launch in 2002, UCS covered all Thai nationals, including those awaiting proof of Thai nationality (PWTN), who hold a 13-digit ID card. However, entitlement for this group was later terminated as a consequence of the legal interpretation of what constitutes a Thai

[8] Information for this and the following paragraph is sourced by authors from an unofficial translation of the 2013 MOPH Announcement on Health Check Up and Health Insurance for Migrants, available at: https://www.usp2030.org/gimi/RessourceDownload.action?ressource.ressourceId=45078

[9] The exact amount of the co-payment could not be determined based on sources available to authors.

National (WHO 2015). Consequently, in addition to the exclusion of undocumented migrant workers, there are coverage gaps among some marginalized groups, including those born in the country that failed to obtain legal registration under Thai law, and stateless persons (Schmitt, Sakunphanit, and Prasitsiriphol 2013).

- Adequacy of benefits/financial protection

Through UCS, financial protection drastically increased, allowing more people, especially marginalized and vulnerable populations, to access health services when needed without hardship. This is reinforced by the relatively minimal co-payments and comprehensive benefits packages offered by all the schemes, despite some significant exclusions. As a result, OOP expenditure rates have reduced dramatically over the past decade, dropping to 11 per cent in 2018 (World Bank n.d.). Results based on data from the NSO's annual national household socioeconomic survey (SES) show a significant drop in household health expenditures from 6 per cent (1996) to 2 per cent (2015) at the 10 per cent threshold, and from 1.8 per cent to 0.4 per cent at the 25 per cent threshold (Tangcharoensathien et al. 2020) Before UHC was achieved, catastrophic health expenditures were much higher in rural settings, where most households and UCS beneficiaries reside, but today, the gap between urban and rural settings is virtually non-existent (Tangcharoensathien et al. 2020). To further enhance financial protection in the context of the COVID-19 pandemic, in 2020, Thailand extended health-related financial protection to foreign residents, providing access to the UCEP (Universal Coverage for Emergency Patients) to allow patients to seek COVID-related treatment free-of-charge at public and private hospitals (ILO 2020).

- Responsiveness to population needs
    - Availability and Accessibility

To enhance accessibility and availability of services in Thailand, geographical barriers have been systematically addressed over the years. Since the 1970s, the Government has continuously invested in the development of health system infrastructure at district level, prioritising rural over urban investment and earmarking funds specifically for rural development. As a consequence, at least one primary health care centre per sub-district (amounting to 9,762) was built and there are community hospitals in over 90 per cent of districts (Fleck 2014). Moreover, to counter the unequal distribution of human resources and medical practitioner shortages in rural areas, financial incentives were implemented and the provision of community health volunteers —a pioneering programme first implemented in the 1960s —has been promoted and extended. Combining enhanced geographical accessibility and financial protection has allowed for a drastic increase in utilization of health services, including an increase in outpatient visits in urban settings from 29.4 per cent to 41.1 per cent between 1977 and 2006. Skilled birth attendance also drastically rose from 66 per cent (1987) to 99 per cent in 2007 (PHCPI 2018).

Thailand's long history of investment in the creation of health care structures placed the country in a good position to build the local health infrastructure needed for UCS. Indeed, the wide geographical coverage of MOPH owned hospitals and health care units is considered a key foundation of UCS, as it enables beneficiaries, including those living in rural areas, to easily access services (McManus 2012). As such, within 10 years of its implementation, UCS drastically improved access to needed health services for its beneficiaries. However, UCS beneficiaries have very limited or no choice of provider since they are automatically assigned to their local district hospital via their registration document (Hanvoravongchai 2013).

As previously noted, recent years have seen a drop in migrants enrolled in MHIS, which may be indicative of access barriers among this group. Notably, among MHIS- insured migrants, MOPH [10] records show that in 2019, only 13 per cent of members, accounting for 109,127 migrant workers, made 293,738 hospital visits (IOM 2021). Potential access barriers identified include a lack of compliance from employers, fragmented coordination and management information systems, lengthy and costly administrative processes, and limited awareness of the scheme. Specifically, the second step of the health insurance registration process for migrants, which involves a compulsory health check-up, has proven a challenge due to a lack of clarity and discrepancies within the policy messages of the MOPH on the validity of health checks from private hospitals.

[10] 2020 data provided by the Division of Health Economics and Health Security.

- Acceptability and Quality

Data suggests a steady increase in the use of outpatient services from the launch of UCS onwards among all health services providers, with a preference for using services at health centre level (41.1 per cent), followed by community hospitals (38.8 per cent) and regional/general hospitals (20.1 per cent) (Prakongsai, Limwattananon, and Tangcharoensathien 2009). However, research shows that the increase in the use of outpatient services at hospital level (community, regional and general) has had a negative impact of the quality of provision, highlighted by an increase in complaints, lawsuits and patient-health provider conflicts at hospitals (Prakongsai, Limwattananon, and Tangcharoensathien 2009).

Furthermore, while Thailand's historical investment in the district health system development in rural areas has allowed for more isolated members of the population to received services, this has meant that health care services are not as well developed in urban areas, where most CSMBS beneficiaries reside (Tangcharoensathien et al. 2018). This, in turn, has contributed to the lack of a gate keeping function for the CSMBS scheme.

In terms of the quality of awareness raising and availability of information on benefits and rights, there is a lack of awareness of rights under the MHIS scheme, specifically (Mon and Xenos 2015). Although some individuals are satisfied with the services provided through the scheme (including the provision of translators in some provinces), there is a consensus on the lack of clear, organized and available information on the scheme, including its benefits and services covered (IOM 2021).

▶ 5. Way Forward

Over the past two decades, Thailand's significant efforts to strengthen its social health protection system have enhanced access to health care services across the country and helped to reduce the financial burden and risks associated with poor health. The country's achievement of UHC is a testament to this. However, with Thailand set to become an aged society by 2025, combined with an increasing prevalence of NCDs and challenges resulting from air-pollution and road accidents, [11] the country is facing an increased burden on health care costs. These challenges threaten the long-term financial sustainability of the UCS scheme. National efforts to further develop the health sector in response to these challenges, including ambitions for budgetary and fiscal reforms, are reflected in broad terms in the 12th National Development Plan (2017–2021). Moving forward, enhancing administrative and management efficiency of the public health service system, and improving its fiscal viability has been identified as a key development pathway for Thailand.[12]

Specifically, further harmonization of the three public insurance schemes would be needed. Thus far, progress in this area has been slow due to limited political support, resistance from CSMBS members for fear of a loss in benefits, and predominantly public hospitals benefiting from excessive CSMBS claims (WHO 2015). Streamlining of operations by further standardizing common features, such as the benefits package, information system and payment method, could promote harmonization and reduce disparities and inequities in benefits and level of expenditure (McManus 2012).

[11] Due to weak enforcement of road and vehicle safety laws, Thailand has the world's second highest death rate in road accidents, at 36.2 deaths per 100 000 people (WHO 2018b).
[12] Thailand 12th National Development Plan (2017-21).

6. Main lessons learned

- Thailand's achievement of UHC provides an internationally recognized example that this milestone is achievable in the face of significant challenges. In particular, Thailand was able to successfully and rapidly extend health protection to the entire Thai population through the UCS scheme in the aftermath of the Asian financial crisis, despite being a middle-income country with limited fiscal resources. Civil society members were crucial for the long-lasting success of the UCS scheme, working tirelessly to convince the public and political figures of the importance of universal coverage Furthermore, health purchasing power shifted and is no longer centralised with the MOPH. Within a year of the launch of UCS, 75 per cent of the Thai population, who were previously uncovered or partially covered benefited from health insurance coverage.

- Achieving UHC in a very short space of time with low levels of spending through the establishment of a predominately tax-financed system, although laudable, has inevitably led to challenges related to sustainability and funding. With an ageing population, as well as a rise in non-communicable and chronic diseases, health care costs are likely to increase. Furthermore, the relatively high cost of the CSMB scheme and the absence of coverage of dependents of the SSS members pose concerns. This translates into heavy reliance on general tax revenues as the main source for UCS and CSMBS, running the risk of incurring shortfalls, especially during cyclical economic downturns (WHO 2015). Key policy actions require a reconsideration of the level and composition of the financing mix necessary to maintain efficiency and equity of the system.

- Thailand has utilised the use of new technologies to promote the rapid expansion of health protection to all Thai citizens. In particular, the use of a unique identification number (UIN) and the Thai civil registration (CR) databases have contributed to the development of the country's health insurance beneficiary registration system, facilitating the rapid enrolment of beneficiaries. The widespread adoption of provider information and communications technology, and the implementation of national information and communications technology infrastructure has supported and enhanced the reimbursement system.

- Despite the laudable efforts made in Thailand to provide coverage to migrant workers, the challenges faced by migrant workers, who have to register for either the SSS or MHIS, highlight the legal complexities inherent in registering and accessing benefits. Specifically, the administrative burden and legal intricacies of the National Verification (NV) process is an obstacle towards legalising the precarious status of undocumented migrant workers, who are not eligible under the main MHIS scheme.

- There is fragmentation and lack of coherence within the various statutory health insurance schemes for migrants. The MHIS is considered the main scheme for informal migrant workers as opposed to the SSS for formal migrant workers. However, the differences in the design of the MHIS scheme, its voluntary basis, and the lack of a legal framework, make it a less attractive option for workers.

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Contact information

International Labour Organization
Social Protection Department
Route des Morillons 4
CH-1211 Geneva 22
Switzerland

ILO Regional Office for Asia and the Pacific
United Nations Building
Rajdamnern Nok Avenue
Bangkok 10200
Thailand

T: +41 22 799 7239
E: socpro@ilo.org
W: www.ilo.org/asia
www.social-protection.org

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