Published in final edited form as:
Australas epidemiol. 2010 December ; 17(3): 24–26.

The first 10 years of the Universal Coverage Scheme in Thailand: review of its impact on health inequalities and lessons learnt for middle-income countries

Vasoontara Yiengprugsawan[1], **Matthew Kelly**[1], **Sam-ang Seubsman**[2], and **Adrian C. Sleigh**[1]

[1]National Centre for Epidemiology and Population Health, The Australian National University, Canberra, Australia [2]School of Human Ecology, Sukhothai Thammathirat Open University, Nonthaburi, Thailand

Abstract

Aims—We aim to assess the impacts of Thailand Universal Coverage Scheme (UCS) of health insurance on health service use and healthcare finance in the past 10 years.

Methods—We review the impacts of the UCS on preventive and health promotion including dental care and reproductive health as well as on vulnerable population subgroups.

Results—Three decades after the implementation of low income health insurance in the 1970s, Thailand finally introduced a UCS in 2001. It has brought under its umbrella the uninsured 30% of the Thai population. Many empirical studies of illness expenditure confirm that the Thai UCS substantially reduced the financial burden of healthcare among the poor. The Thai UCS mechanism boosts use of primary healthcare facilities and has substantially reduced catastrophic medical payments and consequent impoverishment.

Conclusions—The UCS relies on a solid primary healthcare foundation. Continued investment into primary healthcare resources will help to ensure sustainable development of the UCS and reduced health inequity. The UCS development in Thailand can provide some valuable lessons for middle income countries pursuing the goal of equity in health and healthcare.

Background

For the past few decades, many countries have been working toward ‘health for all’ and improving equity in access to healthcare and equitable healthcare financing through conceptualising and implementing universal health coverage.[1, 2] Such is the case for middle-income Thailand with a goal of equity in health and health care being an integral part of its development strategies over many decades. This article provides background and reviews the impacts of the Thai Universal Coverage Scheme (UCS) on health service use, healthcare financing, and vulnerable population subgroups. The evidence from Thailand provides some lessons for other countries particularly those in middle-income settings.

Thailand is a developing country in Southeast Asia which has gone through rapid economic growth (1950-1997), economic crisis (1997-2000) and steady economic recovery (2001 onward). Like many developing countries it faces the accompanying challenge of widening inequality. The UCS was introduced in 2001 following collaboration by many stakeholders,

Corresponding author: Dr. Vasoontara Yiengprugsawan, The Australian National University, Building 62 – National Centre for Epidemiology and Population Health, Acton 2601, Canberra, Australia. Tel: +61 2 6125 2378; Fax: +61 2 6125 0740, vasoontara.yieng@anu.edu.au; vasoontara.yieng@gmail.com.

Europe PMC Funders Author Manuscripts

both within and outside the health system.[3, 4] This was in response to section 52 of the 1997 Constitution which stated that "All Thai people have an equal right to access quality health services", and aimed to provide Thais with health services that were both accessible and equitable. The UCS was an extension of existing public health insurance provisions, which were expanded to cover uninsured individuals. It replaced two previous public insurance schemes: the public-financed free care for the poor (Medical Welfare Scheme) initiated in 1975, and a subsidised public voluntary insurance program (Voluntary Health Card Scheme) that had operated since 1983.

The UCS brought under its umbrella the uninsured 30 percent of the population who fell outside the two previous schemes. After 2001, two types of universal coverage provision emerged: the UCS with fee exemption and the UCS with 30 Baht copayment (30 Baht ~ 0.75 USD). Then, from 2006, the government abolished the copayment. Policymakers use capitation payments for purchasing ambulatory care and Diagnosis Related Groups — a patient classification system for inpatients that has been used as a healthcare finance mechanism and National List of Essential Drug was adopted as the basis of pharmaceutical benefits. UCS policy requires scheme members to be registered at a primary healthcare facility, and except in an emergency to first access the healthcare system where registered. The primary care network, contracted units for primary care, acts as gatekeeper to higher level hospitals.

Impacts of the UCS on health service use and healthcare financing

The UCS consists of three main benefit packages: a curative package covering most common diagnoses and treatments, a high-cost care package, and a preventive package. Overall, the system has been working well and no informal under-the-table payments have emerged.[5] Since the implementation of the UCS, several Thai studies have reported increase overall use of health services.[6-9] After the UCS in 2003, the rate of ambulatory care was 4.93 episodes per capita per year, 20.1% higher than that before UCS.[10] The implementation of the UCS also changed patterns of health services use, particularly for rural people and the urban poor, by placing greater emphasis on primary healthcare.[11]

Other dimensions of inequalities have also been improved including a major reduction of healthcare costs, substantial reduction of catastrophic payments, as well as great reduction of impoverishment due to medical care costs. Benefit incidence analysis has indicated that public subsidies for healthcare benefited the poor more than the rich when compared to the situation before the UCS.[12] Households using inpatient care experienced catastrophic expenditures most often (31.0% in 2000, compared with 15.1% and 14.6% in 2002 and 2004, respectively).[13] Use of certain services not covered by the UCS benefit packages (e.g., cosmetic surgery) or bypassing designated providers (prohibited under the capitation contract model without proper referrals) are the major causes of the small number of Thais still experiencing catastrophic medical expenditure and consequent impoverishment.

Overall we now know that the UCS not only prevented households from incurring liability for catastrophic health payments, but also protected them from becoming impoverished. Estimates revealed that 1.01% of Thai households fell below the Thai poverty line due to out-of-pocket payments for healthcare in 2000 before the UCS; the corresponding proportions after the UCS were 0.62% and 0.49% in 2002 and 2004, respectively.[14]

Impacts of the UCS on population subgroups

Initially antiretroviral treatment for HIV/AIDS and renal dialysis therapy were excluded from the UCS benefits, but due to strong social movements these were included in October 2003 and January 2008, respectively.[15, 16] The UCS preventive package covers

immunizations, annual check-up, dental healthcare,[17] as well as antenatal care and other reproductive health services.[18] In addition, a most important complementary program for the preventive aspect of the UCS was established in 2001—the Thai Health Promotion Foundation. The Foundation is a health promotion funding mechanism that draws upon a 2% surcharge levied on alcohol and tobacco excise tax, approximately USD 50-60 million a year to promote healthy living at school, in workplace and within the community.[19]

The UCS also attempts to reach specific population group targets. For the elderly, the UCS and healthcare delivery appears to provide relatively equitable access to health care, but issues of inadequate hospital access for rural residents due to geographical barriers still persist.[20] Access to inpatient care was inequitable, most likely due to problems of physical access and travel costs for these rural residents. The UCS not only includes Thai citizens, but also covers registered foreign workers via a health insurance program.[21] The results show that the UCS also plays a major role in improving the use of health care for ethnic groups, especially for Thai ethnic minorities. However, a gap still existed in health service use in 2004 among ethnic minorities, migrants and Thais. Better coverage of minorities and foreign workers is still needed.

Lessons learnt and ways forward

The Thai UCS relies on a solid primary healthcare foundation.[22, 23] The necessary infrastructure was largely set in place during the 2-3 decades preceding its implementation, but it is important that these infrastructures are constantly monitored. Lessons learned from other countries include the need for a nationally agreed package of prioritised and phased primary health care that all stakeholders are committed to implementing, management systems at district level and consistent investment in primary healthcare resources.[24] Effective and efficient primary health care can be assisted by community and village health volunteers.[25] Nurses are also key providers of primary care services, particularly in remote areas and play an important role in improving the health and well-being of the Thai community.[26] Primary healthcare resources have also improved in parallel to the UCS. For example, health centre workers now accept information technology freely with widespread use of computerised records and internet reporting and feedback systems.[27] These results are similar in all of the country's geographic regions.

Conclusions

Internationally and in Thailand, many empirical studies of illness expenditure confirm that a UCS system of finance substantially reduces the financial burden of health care among the poor. Because the UCS mechanism focuses on health promotion and disease prevention through community health volunteers, and boosts use of primary healthcare facilities such as health centres and community hospitals, strengthening of these human resources and health facilities is vital to sustainable development of the UCS. As use of health services is determined by their availability in an area, the geographic distribution of health resources among rural areas and among regions will be a vital part of the overall and long term plan to address inequalities in the health system.

Acknowledgments

This study was part of the Thai Health-Risk Transition research program supported by the International Collaborative Research Grants Scheme with joint grants from the Wellcome Trust UK (GR071587MA) and the Australian National Health and Medical Research Council (268055).

References

1. WHO. Health for all by the year 2000. World Health Organization; Geneva: 1978.
2. WHO. The World Health Report 2000 Health systems: improving performance. World Health Organization; Geneva: 2000.
3. Tangcharoensathien, V.; Jongudomsuk, P., editors. From policy to implementation: historical events during 2001-2004 of universal coverage in Thailand. National Health Security Office; Nonthaburi: 2004.
4. Pannarunothai S, Patmasiriwat D, Srithamrongsawat S. Universal health coverage in Thailand: ideas for reform and policy struggling. Health Policy. 2004; 68:17–30. [PubMed: 15033549]
5. Damrongplasit K, Melnick GA. Early results from Thailand's 30 Baht Health Reform: something to smile about. Health Aff (Millwood). 2009; 28:w457–466. [PubMed: 19336469]
6. Coronini-Cronberg S, Laohasiriwong W, Gericke CA. Health care utilisation under the 30-Baht Scheme among the urban poor in Mitrapap slum, Khon Kaen, Thailand: a cross-sectional study. Int J Equity Health. 2007; 6:11. (doi:10.1186/1475-9276-1186-1111). [PubMed: 17883874]
7. Suraratdecha C, Saithanu S, Tangcharoensathien V. Is universal coverage a solution for disparities in health care? Findings from three low-income provinces of Thailand. Health Policy. 2005; 73:272–284. [PubMed: 16039346]
8. Hughes D, Leethongdee S. Universal coverage in the land of smiles: lessons from Thailand's 30 Baht health reforms. Health Aff (Millwood). 2007; 26:999–1008. [PubMed: 17630443]
9. Yiengprugsawan V, Carmichael GA, Lim LL-Y, Seubsman S, Sleigh AC. Explanation of inequality in utilisation of ambulatory care before and after universal health insurance in Thailand. Health Policy Plan. 2010 doi:10.1093/heapol/czq028.
10. Vasavid C, Tangcharoensathien V, Tisayaticom K, Patcharanarumol W, Opanapun N. Health and welfare of Thai population after Universal Care Coverage (UC) - Part I: Illness, utilisation compliance of health care services of UC members. Journal Health Science [in Thai]. 2004; 13:428–439.
11. Yiengprugsawan V, Carmichael GA, Lim LL-Y, Seubsman S, Sleigh AC. Has universal health insurance reduced socioeconomic inequalities in urban and rural health service use in Thailand? Health Place. 2010 doi:10.1016/j.healthplace.2010.06.010.
12. Prakongsai, P.; Palmer, N.; Tangcharoensathien, V. Benefit incidence analysis before and after universal coverage in Thailand. Paper presented at the 69th Health Economists' Study Group; 26-28 July 2006; University of York.
13. Limwattananon S, Tangcharoensathien V, Prakongsai P. Catastrophic and poverty impacts of health payments: results from national household surveys in Thailand. Bull World Health Organ. 2007; 85:600–606. [PubMed: 17768518]
14. Somkotra T, Lagrada LP. Payments for health care and its effect on catastrophe and impoverishment: Experience from the transition to Universal Coverage in Thailand. Soc Sci Med. 2008; 67:2027–2035. [PubMed: 18952336]
15. Teerawattananon Y, Mugford M, Tangcharoensathien V. Economic evaluation of palliative management versus peritoneal dialysis and hemodialysis for end-stage renal disease: evidence for coverage decisions in Thailand. Value Health. 2007; 10:61–72. [PubMed: 17261117]
16. Kitajima T, Kobayashi Y, Chaipah W, Sato H, Toyokawa S, Chadbunchachai W, Thuennadee R. Access to antiretroviral therapy among HIV/AIDS patients in Khon Kaen Province, Thailand. AIDS Care. 2005; 17:359–366. [PubMed: 15832884]
17. Somkotra T, Detsomboonrat P. Is there equity in oral healthcare utilization: experience after achieving Universal Coverage. Community Dent Oral Epidemiol. 2009; 37:85–96. [PubMed: 19191821]
18. Tangcharoensathien V, Tantivess S, Teerawattananon Y, Auamkul N, Jongudoumsuk P. Universal coverage and its impact on reproductive health services in Thailand. Reprod Health Matters. 2002; 10:59–69. [PubMed: 12557643]
19. Buasai S, Kanchanachitra C, Siwaraksa P. The way forward: experiences of health promotion development in Thailand. Promot Educ. 2007; 14:250–253. [PubMed: 18372878]

20. Srithamrongsawat S. Equity in health services utilization among Thai elderly under the universal coverage. Journal Health Science [in Thai]. 2006; 15:685–696.
21. Hu J. The role of health insurance in improving health services use by Thais and ethnic minority migrants. Asia Pac J Public Health. 2010; 22:42–50. [PubMed: 20032034]
22. Wibulpolprasert S, Tangcharoensathien V, Kanchanachitra C. Three decades of primary health care: reviewing the past and defining the future. Bull World Health Organ. 2008; 86:3. [PubMed: 18235878]
23. Towse A, Mills A, Tangcharoensathien V. Learning from Thailand's health reforms. Bmj. 2004; 328:103–105. [PubMed: 14715608]
24. Rohde J, Cousens S, Chopra M, Tangcharoensathien V, Black R, Bhutta ZA, Lawn JE. 30 years after Alma-Ata: has primary health care worked in countries? Lancet. 2008; 372:950–961. [PubMed: 18790318]
25. Kauffman KS, Myers DH. The changing role of village health volunteers in northeast Thailand: an ethnographic field study. Int J Nurs Stud. 1997; 34:249–255. [PubMed: 9306159]
26. Hanucharurnkul S. Nurses in primary care and the nurse practitioner role in Thailand. Contemp Nurse. 2007; 26:83–93. [PubMed: 18041988]
27. Kijsanayotin B, Pannarunothai S, Speedie S. Penetration and adoption of health information technology (IT) in Thailand's community health centers (CHCs): a national survey. Medinfo. 2007; 12:1154–1158.

Europe PMC Funders Author Manuscripts