Thailand Health Care System: An Example of Universal Coverage

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Thailand provides an example of a country reaching universal coverage using a pluralistic approach. Thailand has a long history of multiple and varied insurance schemes, and even today, different schemes target different populations with different funding sources, administration, and benefits. While the Thai system has been able to achieve great strides towards achieving universal coverage, the country aims to continually improve the efficiency and effectiveness of its health care system in several ways.
Can we do that in Lebanon?

Introduction

Thailand has had "a long and successful history of health development," according to the World Health Organization. Life expectancy is seventy years at birth, ninety-eight and ninety-six percent of the population have access to improved drinking water and sanitation, and a system providing universal health care for Thai nationals has been established since 2002. Health and medical care is overseen by the Ministry of Public Health, along with several other non-ministerial government agencies, with total national expenditure on health amounting to 4.3 percent of GDP in 2009. Although HIV/AIDS, tuberculosis, malaria and other infectious diseases remain serious public health issues, non-communicable diseases and injuries have also become important causes of morbidity and mortality.

Health Indices

According to the World Health Organization's Global Health Observatory (data from 2009), life expectancy at birth in Thailand is 66 years for males and 74 for females. Mortality rate is 20.5 per 1,000 adults 15 to 59 years of age, and under-5 mortality rate is 14 per 1,000 live births. Maternal mortality ratio is 48 per 100,000 live births (2008), compared to a regional average of 240, while prevalence of HIV is 13 per 1,000 adults 15-49 years (regional average 3) and prevalence of tuberculosis is 189 per 100,000 populations (regional average 278). Years of life lost distributed by cause was 24% from communicable diseases, 55% from non-communicable diseases, and 22% from injuries (2008).

In 2009, annual spending on health care amounted to 345 U.S. dollars per person in purchasing power parity (PPP). Total expenditures represented about 4.3% of the gross domestic product (GDP); of this amount, 75.8% came from public sources and 24.2% from private sources. Physician density was 2.98 per 10,000 populations in 2004, with 22 hospital beds per 100,000 populations in 2002.

Data for utilization of health services in 2008 include 81% contraceptive prevalence, 80% antenatal care coverage with at least four visits, 99% of births attended by skilled health personnel, 98% measles immunization coverage among one-year-olds, and 82% success in treatment of smear-positive tuberculosis. Improved drinking-water sources was available to 98% of the population, and 96% were using improved sanitation facilities (2008).

Health Care Services

The majority of health care services in Thailand are delivered by the public sector, which includes 1,002 hospitals and 9,765 health stations. Universal health care is provided through three programs: the civil service welfare system for civil servants and their families, Social Security for private employees, and the Universal Coverage scheme theoretically available to all other Thai nationals. Some private hospitals are participants in these programs, though most are financed by patient self-payment and private insurance. According to the World Bank, under Thailand's health schemes, 99.5% of the population has health protection coverage.

The Ministry of Public Health (MOPH) oversees national health policy and also operates most government health facilities. The National Health Security Office (NHSO) allocates funding through the Universal Coverage program. Other health-related government agencies include the Health System Research Institute (HSRI), Thai Health Promotion Foundation ("Thai Health"), National Health Commission Office (NHCO), and the Emergency Medical Institute of Thailand (EMIT). Although there have been national policies for decentralization, there has been resistance in implementing such changes and the MOPH still directly controls most aspects of health care.

Thailand introduced universal coverage reforms in 2001, becoming one of only a handful of lower-middle income countries to do so. Means-tested health care for low income households was replaced by a new and more comprehensive insurance scheme, originally known as the 30 baht project, in line with the small co-payment charged for treatment. People joining the scheme receive a gold card which allows them to access services in their health district, and, if necessary, be referred for specialist treatment elsewhere. The bulk of finance comes from public revenues, with funding allocated to Contracting Units for Primary Care annually on a population basis. According to the WHO, 65% of Thailand's health care expenditure in 2004 came from the government, while 35% was from private sources. Thailand achieved universal coverage with relatively low levels of spending on health but it faces significant challenges: rising costs, inequalities, and duplication of resources.

Although the reforms have received a good deal of criticism, they have proved popular with poorer Thais, especially in rural areas, and survived the change of government after the 2006 military coup. Then Public Health Minister, Mongkol Na Songkhla, abolished the 30 baht co-payment and made the UC scheme free. It is not yet clear whether the scheme will be modified further under the coalition government that came to power in January 2008.

Hospitals

Most hospitals in Thailand are operated by the Ministry of Public Health. Private hospitals are regulated by the Medical Registration Division under the MOPH's Department of Health Service Support following the Sanatorium Act, B.E. 2541. Other government units and public organizations also operate hospitals, including the military, universities, local governments and the Red Cross. As of 2010, there are 1,002 public hospitals and 316 registered private hospitals.

1. Provincial hospitals operated by the MOPH's Office of the Permanent Secretary are classified as follows
2. Regional hospitals are located in province centers, have a capacity of at least 500 beds and have a comprehensive set of specialists on staff.
3. General hospitals are located in province capitals or major districts and have a capacity of 200 to 500 beds.
4. Community hospitals are located in the district level and further classified by size:
   - Large community hospitals have a capacity of 90 to 150 beds.
   - Medium community hospitals have a capacity of 60 beds.
   - Small community hospitals have a capacity of 10 to 30 beds.

While all types of hospitals serve the local population, community hospitals are usually limited to providing primary care, while referring patients in need of more advanced or specialised care to general or regional hospitals.

The term general hospital, when referring to private hospitals, refer to hospitals which provide non-specialised care. Private hospitals with fewer than 30 beds are officially termed health centers. Both are defined as accepting patient admissions.

Public Health Issues

Although infectious diseases, most notably HIV/AIDS and tuberculosis, remain serious public health issues, non-communicable diseases and injuries have also become important causes of morbidity and mortality. Major infectious diseases in Thailand also include bacterial diarrhea, hepatitis, dengue fever, malaria, Japanese encephalitis, rabies, and leptospirosis.

1- HIV/AIDS

Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) is a serious problem in Thailand. The United Nations Programme on HIV/AIDS (UNAIDS) reported in November 2004 that the Thai government had launched a well-funded, politically supported, and pragmatic response to the epidemic. As a result, national adult HIV prevalence has decreased to an estimated 1.5 percent of all persons aged 15 to 49 years (or about 1.8 percent of the total population). It was also reported that 58,000 adults and children had died from AIDS since the first case was reported in 1984. The government has begun to improve its support to persons with HIV/AIDS and has provided funds to HIV/AIDS support groups. Public programs have begun to alter unsafe behavior, but discrimination against those infected continues. The government has funded an antiretroviral drug program and, as of September 2006, more than 80,000 HIV/AIDS patients had received such drugs.

2- Food Safety

Food safety scares, like the rest of developing Asia, are not uncommon to Thailand. Moreover besides the ever common microbial contamination of street side food left out in the hot sun and dusty roads, as well as store food, contamination by banned or toxic pesticides and fake food products is also common. 3-MCPD, a genotoxic and carcinogenic substance, was found in extreme amounts (hundreds to thousands of times limits) in an Asia-wide (ex Japan and Korea) acid-hydrolyzed soy sauce scandal in 2001, including exports to Western nations, melamine in Thai food products along with 2008 Chinese milk scandal, and July 2012 consumer action groups demanding 4 unlisted toxic pesticides found on common vegetables (which are banned in developed countries) be banned. Chemical companies are requesting to add them to the Thai Dangerous Substances Act so they can continue to be used, including on exported mangoes to developed countries which have banned their use.

The Current Health Care Statistics

Since 2002, 80% of Thailand's health care has been provided by the government. The other 10-20% is covered by private health care.

Only 4% of Thailand's GDP goes to health care unlike the United States who spends 16% of its GDP on health care.

In order to receive health care Thai people must be registered. In the villages, by the border, there are 200,000 hill tribe people who are not able to receive health care because they are not registered citizens of Thailand.
Tuition for medical school is the same because the government helps cover the higher costs.

However, because the government helps cover the costs after medical students graduate they must work for the government for 3 years, usually in a rural setting. Salaries are the same as many other professors but they get packages to compensate which include benefits like free health insurance for the private practices, having their children's education paid for, and so forth. To increase their salaries, many doctors open up a private practice at night. However, since this can only be effective in the cities and not the rural areas, making working in the city more desirable, the government offers higher salaries for doctors in rural areas. The typical age of retirement is 60 although professors work until they are 65. From 60+ doctors receive 70-80% of their last earned salary each month until they pass away.

Summary of Reforms

In 2002, the new Thai government passed the National Health Security Act with a great deal of popular support. It has since become one of the most important social tools for health systems reform in Thailand. The new Universal Coverage Scheme (UCS), or "30 Baht Scheme", combined the already existing Medical Welfare Scheme and the Voluntary Health Card Scheme to expand coverage to an additional 18 million people. Through the Universal Coverage Scheme and other, existing schemes, Thailand has expanded coverage to 65 million people, or roughly 98% of the population. The Universal Coverage Scheme enrolls those not covered by either the Civil Servant Medical Benefit Scheme (CSMBS) or the Compulsory Social Security Scheme (SSS)) – about 74% of the population. The table below summarizes the various population groups covered by each of the public insurance schemes in Thailand.
The Universal Coverage Scheme is financed solely from general tax revenue. The Baht 30 copayment was abolished by the next government in November 2006, and the system is now totally free of charge.

Scheme	**Target Population**	**Population Coverage (as of 2007)**
Universal Coverage Scheme (UCS)	Every Thai citizen not covered under the CSMBS or SSS	74.6%
Civil Servant Medical Benefit Scheme (CSMBS)	Government employees or pensioners and their dependents	8.01%
Compulsory Social Security Scheme (SSS)	Private employees or temporary public employees	12.9%
Private health insurance	Individuals and private firms	2.16%
Total		**98%**

The UHC scheme aims to provide universal access to essential health care and reduce catastrophic expenditures from out-of pocket payments by establishing a tax-based financing system and paying providers on a capitation basis. This scheme covers 74.6 percent of the population as of 2007 estimates. The benefits package is a comprehensive package of care, including both curative and preventive care.

Public hospitals are the main providers, covering more than 95 percent of the insured. About 60 private hospitals joined the system and register around 4 percent of the beneficiaries. Private health insurance organizations play no role in this reform, and remain only as a supplemental option for high-income groups.

Since October 2003, the government has also embarked on universal access to antiretroviral drugs (ARVs). Through May 2007, more than 90,000 patients had been registered in the system.