Executive Summary

Background
Thailand has gone through demographic and epidemiological transitions, evolving from high fertility, high mortality to low fertility and low mortality. The below-replacement-level fertility rate and low crude mortality have had profound impacts on health- and social-service development and financing which needed to respond to a rapidly greying society.

The health systems context and achievement
Since 1999, the major causes of death are noncommunicable diseases (NCD); the total disability-adjusted life years (DALY) loss from NCD were 58.5%, 64.6% and 75.0% in 1999, 2004 and 2009, respectively, while communicable diseases contributed to 27.7%, 21.2% and 12.5% in the same years. Despite the reduction in DALY loss from communicable diseases, HIV/AIDS was still an outstanding public health problem until the universal antiretroviral treatment became available in 2004, when mortality from HIV/AIDS was dislodged from the top position. The burden from a few preventable causes, such as traffic injuries, ischaemic heart diseases, diabetes and alcohol dependence/harmful use, are still high and challenging.

Despite high performance of maternal and child health outcomes, adult mortality was not performing well where decline in adult mortality was stagnated. Some remaining challenges are road traffic injuries and excessive use of alcohol despite containment efforts. Despite advancement in two tobacco control acts legislated well before the ratification of the Framework Convention on Tobacco Control (FCTC), reduction in the prevalence of tobacco has dropped significantly but became slower in recent years, for which the increase in retail price should be increased to keep pace with the increase in disposable income.

Despite the high level of contraceptive prevalence and equitable access to reproductive health services, a few challenges remain such as unmet contraceptive needs among unmarried young couples and unprotected
sex among young adolescents, resulting in HIV/AIDS and unplanned pregnancies, especially among teenagers.

The Ministry of Public Health (MOPH) is the national health authority responsible for formulating, implementing, monitoring and evaluation of health policy. Such role has changed as recently several autonomous health agencies were established through legislation, notably the Health Systems Research Institute (1992), the Thai Health Promotion Foundation (2001), the National Health Security Office (2002), the National Health Commission Office (2007), the Healthcare Accreditation Institute (2009). MOPH and these independent agencies form a complex interdependent governing structure where non-state actors and civic groups also play an increasing role. The National Health Commission Office is mandated to convene the annual National Health Assembly (NHA), ensuring participatory engagement by all government and non-state actors in formulating health policy through NHA Resolutions, where a number of resolutions were further endorsed by the Cabinet Resolution, strengthening the resolutions’ legality and enforcement. The advent of National Health Security Office (NHSO) has a major impact in transforming the integrated model where MOPH plays purchaser and service provision role, to NHSO as purchaser and MOPH as a major service provider.

Thailand has a long history of de-concentration of management decision to the Provincial Health Office (PHO) and all public hospitals such as delegating financial power to generate, retain and use revenue according to regulations, subject to regular audits by the Auditor General. The PHO also holds regulatory power, such as licensing and relicensing private pharmacies and clinics, and consumer protection on food, drugs and cosmetics.

The Decentralization Act 1999 requested the MOPH to devolve all public health-care facilities to the local elected government units, health centres to Tambon Administration Organizations, district hospitals to municipalities and provincial hospitals to Provincial Administration Organizations. After a decade, there were only 43 MOPH health centres out of a total of 9768 (0.4%) devolved, as Tambon Administration Organizations’ lack of readiness, capacities and funding did not fulfil the criteria for devolution. A shift in government policy and unwillingness of MOPH to devolve are additional factors. The benefit of devolving the current integrated model of district health system (which contributes to
equitable access and systems efficiency) continues to be questioned due to risks of fragmentation.

Significant progress was made on the national household surveys regularly conducted by National Statistical Office, and its uses for monitoring impact of health policies on households and support the estimation of capitation budget for Universal Coverage Scheme. The adoption of the locally innovated Diagnosis Related Group in paying hospitals for admission services by all three public insurance schemes contributed to significant improvement in inpatient clinical data and development of national inpatient dataset, very useful for monitoring outcome of treatment. Capacity in health technology assessment was gradually developed since 2007 and has contributed to inclusion of proven cost effective new medicines into the National List of Essential Medicines and proven cost effective new interventions to be included into the benefit package of Universal Coverage Scheme, for which two other schemes also refer to.

When Thailand achieved universal health coverage in 2002, public expenditure on health significantly increased from 63% in 2002 to 77% of total health expenditure in 2011. While out-of-pocket expenditure reduced from 27.2% to 12.4% of total health spending. A significant increase in General Government Health Expenditure was noted, from 8% to 11% of General Government Expenditure in 2002–2003 to 11% to 13% in 2006–2011. Curative expenditure dominates total health spending, about 70% of total.

Thailand legislated an earmarked sin tax for health promotion, using 2% additional surcharge on tobacco and alcohol excise tax and managed by ThaiHealth Foundation, an autonomous public agency, for campaigning on various key health risks.

By 2002, the entire population was covered by three public health insurance schemes - civil servants and their dependents by the Civil Servant Medical Benefit Scheme (CSMBS), private sector employees by the Social Health Insurance Scheme (SHI) and the rest of the population by the Universal Coverage Scheme (UCS). This resulted in three main public purchasers where purchaser-provider split has been fully implemented; and supply-side financing through annual budget allocation to health facilities was fully replaced by demand side financing. Thailand applied a mix of provider payment methods, though closed-ended payment plays dominant role, notably capitation for outpatient was
applied by SHI and UCS while fee for service is used by CSMBS outpatient payment. Diagnostic Related Group inpatient payment was widely applied by CSMBS and UCS though some variations in its application, and partially applied by SHI.

As a result of strong political commitment to the health of the population, during the 1980s there was a heavy investment in government health-care delivery systems: health centres, district and provincial hospitals had full geographical coverage in all sub-districts, districts and provinces. Health delivery systems are dominated by the public sector: Public hospitals account for 75% and 79% of total hospitals and beds. Local government almost has no role in primary care and hospital service provision. Most private hospitals are small, with 69% having fewer than 100 beds. Large private hospitals include some hospital chains registered in the stock market, located in Bangkok and offer services to mostly international patients. Private non-profit charity-run hospitals account for a negligible share of beds. The extensive geographical coverage of Ministry of Public Health primary health care (PHC) and public hospital services are the foundation for successful implementation of universal health coverage; especially pro-poor health service utilization and public subsidies.

Thailand is self-reliant in health-care workforce production with high quality standards; the health-care workforce density per 1000 population is slightly above the 2.28 indicative WHO benchmark of doctors, nurses and midwives. To ensure adequate health-care workforce serving rural populations, continued efforts of multiple interventions were applied, such as education strategy by recruiting students from rural background, curriculum reflecting rural health problems, mandatory rural services by all doctors, nurses, pharmacists and dentists graduated since 1972, and financial and non-financial incentives such as social recognition. Task shifting has also been applied throughout, such as nurse practitioners and other specialized nurses, dental health officers and pharmacist assistants. Quality is ensured through national licence examination for all cadres of professionals since 2001, licensing by professional councils, and relicensing for professional nurses every five years, requiring cumulative number of credits of continued nursing education.

As a result of the 2002 public sector reform, the downsizing of the public sector, including health, resulted in the termination of all retirement posts and termination of compulsory services after gradation by nurses and pharmacists (only doctors and dentists maintain), as there were no available posts for their employment. Nurses and pharmacists become
contract workers paid by hospital revenue, not a civil servant. This has had negative ramification on health-care workforce morale in the whole systems. Political pressures exerted by contracted health personnel sometimes have resulted in reactive reforms approved adhoc by the cabinet, such as the approval of new posts.

Strong institutional capacity in strategic purchasing by National Health Security Office resulted in improved equitable access to certain high cost interventions, such as cataract, open-heart surgery, Renal Replacement Therapy, and antiretroviral therapy. Improvement in the quality of hospital care is indicated by increase in the number of hospitals that meet the standard requirement of Hospital Accreditation and a reduction in hospital standardized mortality. The geographical and public–private maldistribution of health-care workforce can be worsened by government policy on promoting Thailand as a regional medical hub and the 2015 emergence of ASEAN Economic Community, which facilitates free flows of people, goods and services across ten ASEAN countries.

Health systems reforms

Several major health reforms introduced in the 2000s were locally initiated and implemented successfully; international development partners have played a limited influence in agenda settings, policy formulation and financing. Each reform included complex policy processes and context specificity, as well as different levels of influence by various state and non-state actors in shaping them.

The legislation of two tobacco laws before the ratification of FCTC, introducing two percent additional surcharge on tobacco and alcohol excise tax and earmarked to health promotion is a “technocrat driven” initiative led by the Permanent Secretary of the Ministry of Finance in close collaboration with a few health and anti-tobacco champions. Thai Health Promotion Fund, financed by an annual outlay of 3 billion Baht (US$ 100 million) was established to support a wide range of activities to promote and protect health of population with favour outcome from external assessments.

Thailand is internationally recognized for its successful implementation of universal health coverage (UHC) in 2002, with a favourable pro-poor outcome. Although the UHC agenda was politically driven, Ministry of Public Health technocrats contributed significantly at the initial phase, to the policy formulation, systems design, monitoring and evaluation,
and fine-tuning of policies; later NHSO took over successful UCS implementations. High level of government support and the extensive geographical coverage of health-care delivery systems, especially at district level, contributed to favourable pro-poor outcomes in terms of health-care utilization, benefit incidence and financial risk protection against catastrophic health-care expenditure and medical impoverishment. The external assessment of the first decade of UHC implementation confirmed these good outcomes.

The advent of National Health Commission Office has a long history of engagement by civil society, until the National Health Act was legislated in 2007. By law, the Office is mandated to convene an annual National Health Assembly, a platform for participatory public policy development engaging state, non-state, political and private sectors on a level ground for evidence based deliberation. Several resolutions endorsed by the National Health Assemblies were endorsed by the Cabinet Resolution. The outcomes of implementation of these Resolutions are mixed, some with good progresses and some without, reflecting different levels of capacity and effectiveness of concerned state actors.

Factors contributing to these locally initiated reforms include a group of champions, mostly MOPH technocrats who are driven by their pro-poor ideology and rural health background, who at the same time also act as “policy entrepreneurs” while working closely with civil society organizations. When windows of opportunity open, these champions liaise with politicians, making political decisions and subsequent some legislations. Also evidence contributes significantly in policy formulation led by Health Systems Research Institutes and other partners although academia and university have limited contribution to health systems reform.

**Health systems performance**

Assessments of the Thailand health systems performance against financial risk protection, responsiveness, health outcomes, and efficiency have found favourable outcomes although a few challenges remain.

Financing health care is dominated by general tax revenue and is progressive with respect to population incomes. Direct payment by households has consistently declined while the Government significantly increased spending from tax revenues on public insurance schemes, especially after the Universal Coverage Scheme (UCS) for the majority of
the population in 2001–2002. Achievement in financial risk protection is evident by a noticeable reduction in the number of non-poor households being impoverished by health payment.

Use of the UCS entitlement when using health services has gradually increased and is higher for inpatient than outpatient care. Net public budget subsidy to outpatient and inpatient services for the poorest UCS members was relatively higher than for the richest members. This pro-poor subsidy was driven by service utilization disproportionately concentrated among the economically worse-off, contributed by easy access to district health system contractor network.

Thailand has performed better in terms of maternal and child health as compared with other low- and middle-income countries. Despite good health at low cost, adult mortality rates are not lower than in neighbouring countries, and are actually higher than countries in Central America. Mortality amenable to health care, such as breast and cervical cancers were not adequately abated during the time of economic growth. In addition, hospital admissions with the conditions that could be managed as ambulatory patients have an increasing trend.

Harmonization of the three public insurance schemes has shown slow progress due to a lack of political will and resistance from the CSMBS members and mainly public hospitals who benefit from excessive CSMBS outpatient claims. The National Health Security Act in 2002 for the UCS set a better governance structure where all relevant stakeholders, especially civil society representatives fully engage in the governing board. By comparison, the Social Security Board of the Social Security Scheme is equally represented by employers, employees and the government. The CSMBS can learn from these two schemes on how to improve its governance structure, leading to improved performance in strategic purchasing.

**The remaining challenges.** A few remaining challenges are worthy of further research and policy attention. In recognition of the demographic and epidemiological transitions, health and social welfare systems should prepare for a long-term care policies, in particular adapting the source of financing and modality of care, (including training of and support to home care), as well as the development of effective interface mechanisms between families and community care and health and other social services.
While rural health services are well established and have shown a significant contribution to UHC goals of equitable access and financial risk protection, by comparison urban health systems are dominated by hospital oriented care, private clinics and hospitals, and lack of effective PHC systems catering chronic NCD. This is compounded by a generally weak role of the Municipality Health system. There is a large room for strengthening urban PHC systems. The feasibility of contracting to qualified private clinics beyond curative to prevention and health promotion services is one approach to such improvements.

Heavy reliance on general tax as a main source of financing health services for UCS and CSMBS, as well as the mandatory one third contribution to SHI by the government, runs the risk of incurring shortfalls especially during the cyclical economic crunch. The UCS budget was affected in Fiscal Year 2015, when the capitation budget was frozen at zero nominal growth, the same figure of Fiscal Year 2014. This has resulted in a reduction in real terms, especially given protection of salaries that have a six percent annual adjustment; overall there has been a net contraction of non-salary operating budget. Key policy choices include devising new sources of funding or reduction of nonessential benefit package such as outpatient care, while safeguarding continuity of treatment of chronic conditions and admission services.

Historically the MOPH was the sole agency responsible for policy formulation, regulation, human resource production (through its own nurse colleges and its affiliate with University for additional production of physicians) service provision, implementation of health programmes and monitoring and evaluation. The MOPH has its bureaucratic structures from central to the most peripheral sub-district health centre. Since the 1990s a few public autonomous agencies have emerged and are assuming a role in health systems governance, such as Health Systems Research Institute and Thai Health Promotion Foundation. In particular the role of National Health Security Office has separated two functions of the MOPH: the MOPH maintains the service provision, and as supply-side financing was curtailed the NHSO assumed management of the health service budget. There has been an unresolved institutional conflicts between the two; however, effective governance mechanisms for collaboration continue to be developed in response to the distinctions between roles of provider and purchaser.
The contributions of the National Health Assembly challenge the traditional public dominance and at times monopoly in policy formulation, not only health but other government sectors, such as Ministry of Commerce on free trade agreement, Ministry of Environment on health impact assessment, Ministry of Industry on total ban of chrysotile asbestos, Ministries of Social Development and Human Security and Education on teen pregnancies. Both public and non-state actors are learning during the last decade on how to adapt into this new environment of participatory public policy formulation. There is a need to document lessons both positive and negative on the function of national health assembly. The National Health Assembly is a practical platform for realizing Health In All Policies.

**Lessons learnt.** One of the key success factors of health reforms in Thailand is the capacity to generate knowledge supporting policy formulation; equally important is the implementation capacity and government effectiveness. This capacity was systematically built when the Health Systems Research Institute was established in 1992. A critical mass was built up with the close collaboration with external academic and research agencies such as London School of Hygiene and Tropical Medicine, Prince Leopold Institute of Tropical Medicine, Antwerp, Belgium and others. This critical mass was consolidated with the emergence of the International Health Policy Program and the Health Intervention and Technology Assessment Program under the Bureau of Policy and Strategy of the MOPH, and the Health Insurance System Research Office under the HSRI. These partners have worked productively in both knowledge generation and knowledge translation and influencing policies.

Another key success factor is the links between policy entrepreneurs and civil society, which are essential to the success of both upstream and downstream policy development. “The triangle that moves the mountain” proposed by Professor Wasi (2000) describes the three synergistic and interlinked powers: wisdom and evidence generated by the researcher constituencies, civil society movement and public support, and finally involvement of the politicians who make the political decisions. Policy entrepreneurs have played bridging role among the three forces to get the desirable decision. A degree of autonomy and independent accountability framework from the MOPH are important for researcher constituencies.