Political economy of Thailand's tax-financed universal coverage scheme

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(Submitted: 15 June 2019 – Revised version received: 14 October 2019 – Accepted: 18 October 2019 – Published online: 18 November 2019)

Abstract

Problem The challenge of implementing contributory health insurance among populations in the informal sector was a barrier to achieve universal health coverage (UHC) in Thailand.

Approach UHC was a political manifesto of the 2001 election campaign. A contributory system was not a feasible option to honour the political commitment. Given Thailand’s fiscal capacity and the moderate amount of additional resources required, the government legislated to use general taxation as the sole source of financing for the universal coverage scheme.

Local setting Before 2001, four public health insurance schemes covered only 70% (44.5 million) of the 63.5 million population. The health ministry received the budget and provided medical welfare services for low-income households and publicly subsidized voluntary insurance for the informal sector. The budgets for supply-side financing of these schemes were based on historical figures which were inadequate to respond to health needs. The finance ministry used its discretionary power in budget allocation decisions.

Relevant changes Tax became the sole source of financing the universal coverage scheme. Transparency, multistakeholder engagement and use of evidence informed budgetary negotiations. Adequate funding for UHC was achieved, providing access to services and financial protection for vulnerable populations. Out-of-pocket expenditure, medical impoverishment and catastrophic health spending among households decreased between 2000 and 2015.

Lessons learnt Domestic government health expenditure, strong political commitment and historical precedence of the tax-financed medical welfare scheme were key to achieving UHC in Thailand. Using evidence secures adequate resources, promotes transparency and limits discretionary decision-making in budget allocation.
Introduction
Though there are several approaches to financing universal health coverage (UHC), tax-based schemes have been advocated by the World Health Organization and international development partners. Taxation is a progressive method of raising government funds for health (richer people pay more than poorer people) and has lower administrative costs and is more feasible than contributory health insurance schemes. The challenge of enforcing mandatory insurance premiums for health care among populations in the informal sector is a major barrier to achieving UHC.

Increasing domestic tax revenue is especially important for achieving UHC in countries with low tax bases. For each 100 United States dollars (US$) per capita annual increase in tax revenue results in a US$ 9.86 increase (95% confidence interval, CI: 3.92–15.8) in government spending on health.

Here we report how historical precedence and the political situation in Thailand paved the way for taxation as the sole source of financing for the universal coverage scheme.

Local setting
Thailand’s medical welfare scheme for low-income households was launched in 1975 and later extended to cover elderly people, children younger than 12 years and disabled people. The voluntary health card scheme, launched in 1984 for non-poor households in the informal sector, was financed by premium contributions. Aiming to increase coverage, in 1994 the government began subsidizing 50% of the premiums. In 1980, the government legislated regulation on the civil servant medical benefit scheme as a non-contributory tax-funded scheme to cover government officers, pensioners and their dependents. Social health insurance, legislated in 1990 for private sector employees, was financed through payroll tax with equal contributions from employers, employees and the government. Financing social health insurance was categorized as public financing.

There were three budgetary challenges to these schemes. First, budget allocation to the medical welfare scheme and voluntary health insurance was based on historical figures with minimal annual increases. The per capita budget support to the medical welfare scheme increased from 225 Thai baht (THB) in 1995 to 273 THB in 2001 (the conversion rate was US$ 1 at 30.3 THB in 2019). Subsidies to voluntary health insurance were 500 THB per household of four members, equivalent to 125 THB per capita. The budget was inadequate and did not reflect the total cost of health care provision, leaving the shortfalls to be borne by
out-of-pocket payments from the members. In 2000, out-of-pocket payments were 34.2% (US$ 21.2) of the current health expenditure of US$ 62 per capita. The incidence of medical impoverishment was 2.0% (0.32 million out of 16.1 million households) and of catastrophic health spending (> 10% of total household expenditure) was 5.7% (0.92 million households; Fig. 1).

Second, the finance ministry was responsible for allocating health service budgets to health ministry-owned facilities at sub-district, district and provincial levels. The allocation applied incremental increases, and was often decided by the discretionary powers of the finance ministry, particularly on the capital budget. The finance ministry was responsible for reviewing all competing budget proposals against government priorities and submitting budget ceilings for the prime minister’s approval. The finance ministry was therefore able to influence final decisions on the ministerial budget ceiling.8

Third, these multiple budget flows to health facilities confused accountability among the health facilities (the recipients of funds), the four health insurance funds, the health ministry and the citizens (the taxpayers).

**Approaches**

UHC was a part of the political manifesto of the *Thai Rak Thai* party, who were able to form a coalition government in 2001.9 Prior to the election, discussions within the party were in favour of collecting 100 THB monthly premiums from the uninsured. However, for several reasons, the proposal was withdrawn a few weeks before the election.10

First, a financial analysis showed that combining all existing budget streams (health ministry annual budget, medical welfare scheme and voluntary health insurance scheme) would require a moderate additional budget to implement a non-contributory scheme and this amount was within the prime minister’s power to mobilize.11 Second, the voluntary health insurance scheme had adverse selection of members, because healthy people did not join and the high proportion of sick members undermined the financial viability of the scheme.6 Third, collecting and enforcing premium payments among those working in the informal sector with erratic and seasonal incomes was politically and technically difficult. Failure of people to contribute would interrupt their membership and hinder access to care.

Opposition parties in parliament raised concerns that tax revenues for health should not benefit richer people who were able to pay their own medical bills. Civil society organizations rejected this argument by highlighting that an entitlement to public health
services, even for the rich, was enshrined by Article 52 of the 1997 Thai Constitution. However, some university academics preferred premium contributions, arguing that a tax-financed scheme might be jeopardized by changing government policies and funding interruptions. These criticisms did not change the government’s decision to use taxation, an outcome which could be explained by stakeholder theory. In this case, the Thai Rak Thai party qualified as the dominant stakeholder. The party had constitutional legitimacy because UHC endorses the right to health for everyone. The party also had both legislative power through a majority in parliament and executive power to mobilize additional budgets. The policy on UHC was socially acceptable and a matter of urgency as a political promise to implement within a year. With the combination of power, legitimacy and urgency, the party became the definitive stakeholder and was in position to win over opponent stakeholders. Ultimately, the universal coverage scheme was designed to be financed wholly by general taxation and this was legislated into Article 39(1) of the 2002 National Health Security Act.

An advantage was that health-care providers, one of the key stakeholders, did not oppose the reform. The overall budget for the universal coverage scheme increased substantially from the 273 and 125 THB per capita (total population for medical welfare: 18.4 million) and voluntary health insurance scheme (total population: 14.9 million) in 2001 to 1202 THB per capita universal coverage scheme member in 2002.

In 2001, the budget allocation to the health ministry for publicly-financed health services was 26.5 billion THB. The total resources required for a universal coverage scheme was estimated based on 1202 THB\(^1\) \(14\) per capita multiplied by 47 million universal coverage scheme members, equivalent to 56.5 billion THB. The additional budget, 30 billion THB (a funding gap of between 56.5 and 26.5 billion THB), was within the capacity of the prime minister to mobilize. To prevent double funding to public health facilities, the supply-side budget was terminated and included in annual budgets of the universal coverage scheme.

The government has adopted the principle of per capita budgeting for the scheme. The annual per capita budget was the product of the related unit cost of services and quantity of services provided as measured by utilization rates. The total budget requested to the government, through the finance ministry, was the product of per capita budget and the total number of universal coverage scheme members. Budgetary process, based on objective evidence, was managed by a multistakeholder subcommittee which prevented the use of discretionary power by the finance ministry.
Relevant changes

All Thai citizens were entitled to one of three non-competing public insurance schemes. The newly implemented universal coverage scheme covered the population who were not beneficiaries of the existing schemes. Individuals’ enrolment into health insurance schemes were automatically switched based on the changes in their eligibility status such as age and employment. For example, children of civil servant medical benefit scheme members would be entitled to the universal coverage scheme as soon as they turned 20 years old; universal coverage scheme members who became employed by the private sector would be automatically enrolled into payroll-tax financed social health insurance.

The universal coverage scheme offered a comprehensive benefit package inclusive of outpatient, inpatient and emergency care, high-cost care, dental services, health promotion and disease prevention, and all medicines in the national list of essential medicines. Closed-end provider payments were adopted, notably capitation and diagnostic-related groups, and these methods improved efficiency and contained costs. A primary-care gate-keeping system was also adopted. Copayments of US$ 1 per visit or per admission (later copayment was ended in 2008) boosted financial protection. Out-of-pocket payments of health expenditure decreased to 11.3% (US$ 25.2) of the current per capita health expenditure (US$ 221.9) in 2016. By 2015, the incidence of household’s medical impoverishment had fallen to 0.3% (71,524 of 21.3 million households) when the national poverty line was applied and the incidence of catastrophic health spending also decreased to 2.0% (427,808 of 21.3 million households; Fig. 1).

In addition, the universal coverage scheme had reduced the infant mortality gaps between poorer and richer provinces between 2000 and 2002 because of increased access to health care among the poor.

Thailand’s UHC index in 2015 was 75 (on a scale of 0–100) with a low level of unmet health care needs, a steady decline in all-cause mortality between 2001–2014, and reduced inequality of adult mortality across geographical areas. Engagement by multistakeholders in the subcommittee promotes transparency of the budgetary process.

Table 1 compares relevant changes before and after the introduction of the scheme.

Lesson learnt

Domestic government health expenditure was key towards achieving UHC in Thailand due to the large population working in the informal sector. Political commitment and historical
precedence of tax-financed medical welfare scheme were also important, however. A comprehensive benefit package with nominal copayments can significantly reduce out-of-pocket expenditure and improve financial protection. The participatory use of evidence in budgetary processes limits discretionary decisions by ministries and promotes transparency and accountability. Finally, sustained political commitment and civil society engagement are key contributing factors (Box 1). The Thai universal coverage scheme has survived two decades through rival governments and a climate of political conflict. A network of bureaucrats who mobilized resources in the bureaucracy, political parties, civil society and international organizations helped institutionalize the UHC in the face of broader professional dissent and political conflicts.¹⁷

Acknowledgements
We thank Dr Sanguan Nittayaramphong, all frontline health workers and hospital referral backups and policy-makers in the Ministry of Health and National Health Security Office staff.

Funding:
Funding support was provided by Thailand Science Research and Innovation (TSRI) to the International Health Policy Program (IHPP) under the Senior Research Scholar on Health Policy and System Research [contract no. RTA628000].

Competing interests:
None declared.

References


Box 1. Summary of main lessons learnt

• Domestic government health expenditure, political commitment and a tax-financed insurance scheme which promotes greater equity were essential to achieving universal health coverage in Thailand.

• A shift from supply-side to demand-side budgeting and the use of evidence secures adequate resources, promotes transparency, limits discretionary budget allocation and improves accountability to citizens.

• A comprehensive benefit package can reduce out-of-pocket expenditure and improve financial protection for the population.
<table>
<thead>
<tr>
<th>Relevant changes</th>
<th>Before universal coverage scheme in 2001</th>
<th>After universal coverage scheme in 2016</th>
</tr>
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<tbody>
<tr>
<td>Population coverage</td>
<td>Only 70% (44.5 out of 63.5 million) of the Thai population were covered by many fragmented health schemes</td>
<td>More than 99% (68.2 out of 68.9 million) of the Thai population were covered by the three main public health insurance schemes. The new scheme covers the majority, about 51.7 million (75%) of the population</td>
</tr>
</tbody>
</table>
| Budgetary process                                                              | • Parallel funding, with annual supply-side budget allocation and funding for the medical welfare and voluntary insurance schemes  
• Historical incremental budget increases  
• Full cost of services for the two schemes was not reflected in government budgets  
• Budget allocation was at the discretion of the finance ministry | • Full cost subsidies to a comprehensive package  
• Evidence-based budget estimates are based on service utilization rates and unit costs  
• Multistakeholder financing subcommittee ensures transparency and limited room for discretion by the finance ministry |
| Governance and relationships between providers and funding agencies             | In a public integrated model whereby the health ministry played both financing- and service-provision roles for the medical welfare and voluntary insurance schemes | Splitting the role of purchaser and provider, the health ministry maintains a service-provision role, National Health Security Office, which manages the new scheme, is responsible for strategic purchasing function |
| Financial protection                                                            | Current health expenditure, THB millions  
801 690.44  
54 977.39 (33.9)  
88 987.64 (11.1)  
88 987.64 (55.0) | 161 752.41  
2 737 009.17  
62 144.05 (11.3)  
416 025.39 (15.2)  
416 025.39 (76.0) | 547 735.15  
2 737 009.17  
62 144.05 (11.3)  
416 025.39 (15.2)  
416 025.39 (76.0) |
| THB: Thai baht.                                                                 | Note: the conversion rate in 2019 was 1 United States dollars at 30.3 THB- |
| Source: Financial protection data are from the National Health Account of Thailand, 2019. | 19 |
Fig. 1. **Incidence of catastrophic health expenditure and household impoverishment, Thailand, 1990–2015**

<table>
<thead>
<tr>
<th>Year</th>
<th>Impoverishment</th>
<th>Catastrophic</th>
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<tbody>
<tr>
<td>1990</td>
<td>7.1</td>
<td>6.8</td>
</tr>
<tr>
<td>1992</td>
<td>6.8</td>
<td>6.8</td>
</tr>
<tr>
<td>1994</td>
<td>6.0</td>
<td>5.3</td>
</tr>
<tr>
<td>1996</td>
<td>5.7</td>
<td>4.1</td>
</tr>
<tr>
<td>1998</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>2000</td>
<td>3.2</td>
<td>3.9</td>
</tr>
<tr>
<td>2002</td>
<td>3.1</td>
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</tr>
<tr>
<td>2004</td>
<td>2.9</td>
<td>2.2</td>
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<tr>
<td>2006</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>2008</td>
<td>2.0</td>
<td>1.7</td>
</tr>
<tr>
<td>2010</td>
<td>1.0</td>
<td>1.3</td>
</tr>
<tr>
<td>2012</td>
<td>0.9</td>
<td>1.1</td>
</tr>
<tr>
<td>2014</td>
<td>0.8</td>
<td>0.9</td>
</tr>
<tr>
<td>2016</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>2018</td>
<td>0.6</td>
<td>0.7</td>
</tr>
<tr>
<td>2020</td>
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<td>0.6</td>
</tr>
<tr>
<td>2022</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>2024</td>
<td>0.3</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Source: Authors’ analysis using socioeconomic surveys conducted by Thailand’s National Statistical Office, 1990–2015. Data used for the calculation of catastrophic health expenditure and household impoverishment are available in the authors’ data repository.