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A Case Study on Thailand's Social Protection and Universal Health Coverage

Prapaporn Tivayanond Mongkhonvanit and Piya Hanvoravongchai

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UNRISD, Palais des Nations
1211 Geneva 10, Switzerland

Tel: +41 (0)22 9173020
Fax: +41 (0)22 9170650
info@unrisd.org
www.unrisd.org

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Acronyms

AIDS	acquired immunodeficiency syndrome
CSMBS	Civil Servant Medical Benefit Scheme
CUP	Contracting Unit for Primary Care
DRG	diagnosis-related group
GDP	gross domestic product
HISRO	Health Insurance System Research Office
HIV	human immunodeficiency virus
ID	identity
MOPH	Ministry of Public Health
MWS	Medical Welfare Scheme
NHSB	National Health Security Board
NHSO	National Health Security Office
P&P	prevention and health promotion
PSSOP	Public Sector System of Provision
SSS	Social Security Scheme
UCS	Universal Coverage Scheme
UHC	universal health coverage
VHCS	Voluntary Health Card Scheme

Summary

This paper examines the impact of universal health security in Thailand and probes the impacts of the 30 Baht health policy objectives, poverty and inequality. The paper begins with an understanding of health policy as couched in the broader perspective of social protection. An understanding of social protection systems and health policy frameworks requires an awareness of institutional development specific to the national context. Here, research on government processes in allocating funds and their planning contributes to an expansive understanding of the comprehensive outcomes linked to the health policy frameworks.

In order to analyse the policy process and identify key drivers for the universalization of health care in the country, the paper focuses on both direct and indirect impacts on the programme objectives as well as the structure of policy making. By assessing the direct and indirect impacts of the 30 Baht health policy, the paper draws out the trend of social security extension and examines the policy and institutional linkages between health care and other policies of the country.

The paper is divided into five parts. The first part provides an overview of the conceptual thinking of "comprehensive outcomes" and social protection categories. The second part of the research focuses on social protection and health-care access in Thailand. Health financing reform and the path toward universal health coverage (UHC) in the country are addressed in depth in part three. The fourth part describes the comprehensive outcomes of the UHC movement by delineating between the direct and indirect impacts. And finally, the fifth part advances the discussion and conclusion of the research.

Prapaporn Tivayanond Mongkhonvanit is Lecturer at the Faculty of Social Administration, and Director, Social Policy and Development at the Thammasat University in Thailand.

Piya Hanvoravongchai is Lecturer at the Department of Preventive and Social Medicine, Faculty of Medicine at Chulalongkorn University in Thailand.

1. Introduction to Comprehensive Outcome Framework and Social Protection

Thailand is a country situated in Southeast Asia. Provision of its health scheme dates back to 1975. Over only 30 years, the country has attempted to provide universal coverage of health protection—a much shorter time than taken by other countries. Preceding UHC, there were various protection schemes that targeted different population groups. During the first year after its inception in 2001, the Universal Coverage Scheme (UCS) covered 47 million people—75 per cent of the population. The remaining 25 per cent belonged to other schemes such as the Civil Servant Medical Benefit Scheme (CSBMS) and private sector employees who belonged to the country's Social Security Scheme (SSS).

This paper attempts to probe some of the lingering questions surrounding the nature of UHC. It looks at both intended and unintended outcomes in order to uncover a wide spectrum of analysis. The paper also considers how the extension of social security includes or excludes various stakeholder groups in the process toward achieving the SSS in question. Primarily, how do these processes affect stakeholder groups?

The next section begins with a conceptual approach that offers a guideline to analysing the specific 30 Baht health policy in Thailand.

Comprehensive outcomes framework—Process, institutions and actors

Health policy needs to be seen in relation to other social policies because a wide spectrum of factors affect health and vice versa. Some of these factors include income levels, employment levels and access to and the level of education. A comprehensive outcome approach offers an expansive yet intuitive lens in understanding the impacts of universalism.

A comprehensive outcome, referred to by Sen (2009),[1] describes a state of affairs that can be rich, and incorporate processes of choice and not only a narrowly defined ultimate result.[2] According to the "comprehensive approach", the content of outcomes can also be seen as including all the agency information that may be relevant and all the personal and impersonal relations that may be seen as important for resolving the problem at hand.

Sen pointed out that we care not just *that* we achieve what we want, but also *how* we achieve what we want. Comprehensive outcomes matter as much as culmination outcomes by considering the process taken to arrive at culmination outcomes, for example, regardless of what is expected from an intended agency or a range of valuable "functionings". Thus, a concentration on achieved results of culmination outcomes would consider the ultimate effect of policy on welfare, however, reflection of comprehensive outcomes would consider if the policy has been developed and implemented in a fair manner. The outcome of "fairly developed and implemented" is a comprehensive outcome, incorporating a deontological element within a consequentialist framework. Hence, the approach focuses on the deontological emphasis of actions (actions' adherence to normative rules), the functionings or the relations between outcomes, and institutional complementarity.

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1 See also Sen (1997).

2 This is also reflected in "culmination outcomes" that is detached from processes, agencies and relations.

This paper delineates comprehensive outcomes, while focusing on the relations between outcomes (for example, the generation of both intended and unintended outcomes) and the institutional complementarities that may exist. For instance, in Thailand, there is a conscription system that is embedded in the societal, economic and political fabric. This system is an important institution in expanding the human resources available for the health system when it is combined as a compulsory rule and education system for rural doctors (both drivers and outcomes of health system development). The stance of comprehensive outcome evaluates the development of Thai health insurance with an attention to such kinds of outcomes that have been produced in the process of development of the Thai health insurance system. For instance, if there is an institution or system to mobilize doctors who were dispatched to rural areas and consequently increase the capacity of medical care in rural areas under the 30 Baht health policy, this is also considered an outcome. This system plays a significant role in enhancing the accessibility of the rural residents to medical doctors since it could mobilize and dispatch medical doctors to rural areas, and consequently contribute to increasing the capacity of the medical care system in rural areas under the 30 Baht health policy. The stance of comprehensive outcome focuses on this kind of interdependence of policies and institutional complementarity created in the process of development of the Thai health insurance system.

Social protection categories

Comprehensive social protection can address health risks. Social protection is the set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation. The policies and programmes that comprise social protection often serve multiple (and often simultaneous) roles and functions. Social protection protects people from risks, hardship and insecurities related to poverty and vulnerable conditions, prevents people from falling into poverty, boosts people out of poverty and contributes to socioeconomic security and overall well-being if it becomes a sustained and systemic policy. Components of social protection include labour market interventions, social insurance, social welfare and safety nets.

This study distinguishes between two main aspects of social protection:

- *reactive* social protection that is put in place to cope with a major shock or vulnerability (for example, in response to a health scare or injuries);
- *proactive* social protection that aims to invest in people's social security and their ability to manage risks, enabling them to plan and be more productive in their livelihood.

When health protection is "reactionary", it is put in place out of a sense of urgency to cope with a major generalized shock or vulnerability, for example, to respond to a disease. Such an emergency reaction lacks time for thinking and planning. A more "proactive" approach, which aims to invest in people's social security and their ability to manage risks, enables people to plan and be more productive in their livelihood. It is under this proactive approach that health protection can become a central element to reducing risks.

Different social protection programmes have different types of impact on citizens' health. Devereux and Sabates-Wheeler (2004) proposed a typology to distinguish between interventions (table 1).

Table 1: Types of social protection programmes

Reactive	*Protective programmes* that offer relief to those with low levels of adaptive capacity through humanitarian support in emergencies, and targeted cash transfer schemes.
Proactive	*Preventive programmes* to prevent damaging coping strategies, particularly before a shock to avert deprivation or to mitigate the impact of an adverse shock. Examples include health and unemployment insurance and non-contributory pension schemes. *Promotive programmes* to enhance resilience through assets, human capital and income earning capacity of the poor with skills training and active labour market programmes. *Transformative interventions*[3] to address underlying causes of power imbalances that create or sustain economic inequality and social exclusion, aimed to transform social relations. Measures include legal and judicial reform, budgetary analysis and reform, the legislative process, policy review and monitoring, and social and behavioural/attitudinal change. Here, Mkandawire's (2004) concept of "transformative social policy" seems to be a more elaborated concept, which highlights the synergies between the economic, political and social determinants, and the developmental role of social policy in shaping non-state actors and markets in social provisioning.

The distinctiveness of Thailand's health system within social policy or social protection is further described under the framework of Fine and Leopold's (1993) Public Sector System of Provision (PSSOP) by examining the chain of provision from production, distribution and consumption at the empirical level. In Thailand, consumption of health care has shifted from a "passive process", where a limited pool of citizens *reacted* to health risks, to a gradual "active process", whereby a wider range of citizens can prevent their own health risks as well as respond to them with treatments. The transition is linked to how consumption of health care is connected to the changing pattern of production and distribution of the health-care system. Access to early intervention and preventative support, which were not previously financially accessible, is key to this change.

When considering the distributional outcomes under the modes of financing, it is evident that the PSSOP of the 30 Baht health policy expanded coverage of health insurance. While the public structure of provision, which is heavily reliant on government revenue, is subject to decreasing private health-care spending, tension across service providers persists, for example, in the quality of medicine. Consumers are aware of the lower quality band of medicine used under the 30 Baht health policy due to the constrained public budget. Those who can afford private health care would, therefore, opt to pay for their own health care.

While the state's role in health provision under the 30 Baht health policy concerns distributive and social justice outcomes, the norms of consumption specific to UHC show increasing representation of women, children and the elderly. However, discrepancy in provision persists as access in rural areas falls short of urban and central areas, given the number of available hospitals and health-care workers. Also, the proportion of migrant workers who moved from rural areas to the central city of Bangkok maintain their 30 Baht eligibility registered in rural areas. For this reason, it is

[3] See Davies et al. (2013). Transformative social protection is grounded in social justice and seeks to address underlying causes of vulnerability beyond the provision of short-term relief from poverty or management of risk. For example, social protection can assist in transforming social conditions by establishing certain rules, policies, laws and norms such as minimum standard of working conditions, access to microfinance (particularly for children), minimum wages and inclusive policies. Most recent discussions on social protection examine the interface between social protection, minimum income and basic health insurance, emphasizing the provision of a core set of basic social services, a discussion associated with the social protection floor (ILO 2011). The transformative dimension suggests that there are structural barriers to livelihood security and there is a need to address the root causes of people's vulnerability.

estimated that 72 per cent of these workers employed in Bangkok bought their own medicine because their 30 Baht eligibility was recorded in another town.[4] In 2012, the National Health Security Office (NHSO) allowed workers to move their 30 Baht eligibility more frequently, from two times to four times per year, so that they can use health-care services closer to where they were working. However, many members are still unaware of this and the process may still be cumbersome for some (ASTV Manager Online 2012).

Analysis of Thailand's health care via the PSSOP approach needs to be understood within the historical evolution of the infrastructure and the institutions involved. In Thailand, changes in social policy direction can be traced to the 1997 Asian financial crisis. The next section brings these changes into perspective and anchors assessment of Thailand's 30 Baht health policy in the broader development of the country's social policy.

2. Social Protection and Health-Care Access in Thailand

Historical development of social protection in Thailand

Prior to the 1997 financial crisis, Thailand demonstrated a case of a residual developmental welfare state[5] in which income protection was not provided to the informal sector and assistance benefits were offered at a rather low level. Since the crisis, social protection in Thailand has evolved from its subordination to economic development to a broader support for local development and increasing inclusiveness of the informal sector. The financial crisis proved instrumental to the formation of Thailand's current structure (Tivayanond 2011).

Before the financial crisis, the Thai developmental state was characterized by export-led economic growth. Like many other Asian countries, this economic growth in terms of aggregate gross domestic product (GDP) was the fundamental goal, which preceded social development.[6] The precedence of export-oriented economic development meant that social protection covered mainly civil servants and the formal sector workers, mainly large companies. These social protection schemes included the Civil Servant Pension Scheme, Social Security Fund and Provident Fund that were offered by the public sector and large-scale corporations (Pongsapich 1999). Meanwhile, there was an absence of social protection for those informally employed who largely relied on the family and community network (Parnwell 2002). As soon as the financial crisis hit Thailand in 1997, the harsh reality of loss of income and unemployment for workers in the rural economy made the impact of the absence of social protection heavier (table 2).

[4] *Daily News*. 9 January 2013. www.dailynews.co.th/Content/politics/50057/นายกฯวอนอสม.ชวนคนกรุงใช้+30+บาท, accessed on 7 May 2013.

[5] Residual developmental welfare provision means minimal and/or temporary state assistance, requiring evidence of need, and available after all other avenues of help have been exhausted (www.socialpolicy.ca/cush/m3/m3-t7.stm).

[6] Chang 2003; Kwon 2005; Wood and Gough 2006.

Table 2: Social protection schemes

Coverage	Before the 1997 crisis	Since 1997 Asian financial crisis	Since 2008 global economic crisis
Formal sector: private and government sectors[7]	Provident Fund Civil Servants Pension Scheme Social Security Fund	Social protection as found before the 1997 crisis	Social protection as found after the 1997 crisis
Informal sector and non-government sector	Social Security Act 1990 Benefits covering sickness, disability, death, childbirth, old age and child welfare. (Unemployment benefit was drafted in the Social Security Act, but it was not provided.) Labour Protection Act 1998 Workmen's Compensation Fund[8] Severance Pay[9] Provident Fund[10] Employee Welfare Fund[11]	Additional schemes: Dual track policies: One Tambon One Production (OTOP) Village and Urban Revolving Fund[12] Three-year debt moratorium Small and Medium Enterprise Bank 30 Baht health policy	Additional schemes: Universal tax-financed 500 baht ($18) as income security for elderly over age 60. Revision of Social Security Act Article 40 of voluntary package covering sickness, invalidity, death and old age pension (lump sum amount).[13] National Savings Fund for Thais aged 15–60. Members have to contribute monthly. Depending on the amount contributed (ceiling of 600 baht or $18) and age, members will benefit from a contribution from the government.

Source: Authors' analysis from documentary data and interviews.

Following the financial crisis, changes slowly emerged in the forms of normative and institutional shifts. The government seized new grounds of introducing the dual track policies. The impact of the financial crisis was so grave it prompted the necessity of change and the need for both social protection and economic development, consisting of the Village and Urban Revolving Fund, the One Tambon One Product scheme, and the 30 Baht health policy (Office of Small and Medium Enterprises Promotion 2007). These new policies aimed to address the problems of capital accumulation and economic downturn within the country. At the same time, the dual track policies (Brown 2003)

[7] Government programmes include protection for employees of government and government enterprises. Social security was provided for employees in the private sector, but managed by a government agency. Contributions to the Social Security Fund come from employees, employers and the government. Civil servants and employees of government enterprises were eligible for benefits in terms of pensions and health care for self and family members Pensions for civil servants are for life, while compensation for employees of government enterprises vary from agency to agency. (Government of Thailand. 1999. Department of Labour Protection and Welfare, Bangkok).

[8] Employers contribute to the fund to provide compensation for employees in case of sickness, disability or death caused by injury at the workplace. (Government of Thailand. 1999. Department of Labour Protection and Welfare, Bangkok.)

[9] Severance pay is provided to employees upon termination of employment. (Government of Thailand. 1999. Department of Labour Protection and Welfare, Bangkok.)

[10] The fund includes contributions by both employers and employees as a protection in case of retirement, death, termination of employment, or termination of membership of the fund. The Provident Fund Act 1987 states that the Provident Fund is voluntary and not required of all firms. (Government of Thailand. 1999. Department of Labour Protection and Welfare, Bangkok.)

[11] The Employee Welfare Fund was established to provide welfare for workers terminated from employment because of death or other reasons. Both employers and employees are required to make contributions to the fund. (Government of Thailand. 1999. Department of Labour Protection and Welfare, Bangkok.)

[12] The loan portfolio totaled $4.9 billion in 2011 with a network of nearly 8,000 village banks. Villagers are eligible to take out loans limited to 20,000 baht ($656) without collateral. The scheme has drawbacks, including strict regulations and licensing requirements. (T.F.J. 2013)

[13] Only 1.68 per cent of the informal worker sector is covered so far. (*Global Extension of Social Security*. www.social-protection.org/gimi/gess/ShowCountryProfile.do.)

were also intended to raise the level of productivity within the local economy. In the case of the 30 Baht health policy, health coverage for those belonging to the informal sector was a primary concern for attribution because if people had better health behaviour, this correlated to lower workplace absenteeism and higher productivity.

Along with this adjustment, reactive response to the policies that were biased toward economic growth-centred development suggested that the Thai government had to adjust the way it sought economic development. When the government included goals of social protection and local economic development on top of previous goals of export-led growth, this increased the legitimacy/popularity of the government. As a result, the government maintained economic competitiveness by supporting local economies that were designated as a locus for complementarity between social protection and economic development.

The government's policy to create complementarity was to strike a balance between social protection in addressing economic, social and environmental risks. Its approach is not protection of specific economic needs, but instead of various needs in different dimensions. This involves not only access to social protection, but also how social protection addresses the structural causes of vulnerability, rather than only responding to symptoms. In the context of ongoing financial crises and environmental shocks such as the 2011 floods, social protection needs to ensure that all people are better protected and become more resilient to uncertainties.

Access to health services in Thailand (General historical thinking)

Rights and citizenship concept

The concept of social citizenship (Dwyer 2010) offers an interesting point in the balance between rights and responsibility under the provision of health-care protection in Thailand. Social citizenship provides a benchmark to assess the status of individuals and groups in relation to access to agreed welfare rights and resources available to those who are regarded as citizens of a specific community.

Discussion on conditionality and exclusion relates to how rights are viewed in individualistic terms. When public welfare is regarded as a contract between individual citizens and the state, individuals who recognize contributions to nation states' collective welfare arrangements have a right to demand state provisions in return. This endorsement of conditionality and exclusion, with emphasis on responsibilities rather than rights, critically redefines the social elements of citizenship. The contested and ambiguous nature of "responsibility" remains problematic in perspective to citizenship. This is witnessed in the case of the poor claiming benefits when they are not prepared to work.

Issues of rights and responsibilities in the configuration of citizenship, and its implication on social inclusion and exclusion are complex in the Thai context because of the informal nature of the labour market. These informal workers do not contribute to wider welfare needs through taxes. However, they also experienced less social security, as discussed below. For these workers to be deserving of social security, the threshold is not couched in the conventional thinking of tax payment, but instead through their employment in the local market and their participation in the country's economy as a whole.

The type of social citizenship promoted by the Thai government is based on both conditional contracts and universal entitlement.[14] The approach reflects key recognition of social obligations along with individual rights. To illustrate the point, the Government of Thailand runs a variety of social protection programmes—many with wide coverage—including the 30 Baht health policy. The government further promotes universal education coverage with free education from pre-primary time, school meals and nutrition initiatives, and child allowance programmes. It also runs a series of community-based social development programmes, including the One Million Baht Village and Urban Revolving Fund that provides loans for community projects and individual families. Villagers receive loans with attendant responsibilities to use the loans in productive ways. However, it has been documented that villagers misused their loans to fund personal extravanganzas instead of efforts leading to crop yields (Kinnan 2009).

Under the country's health scheme, the balance between rights and responsibility is much needed so that health-care users in Thailand do not take the benefits received for granted. A sense of responsibility to themselves and the wider society would allow citizens to access health care in ways that would also allow them to protect against illnesses. From this perspective, the Thai state will have to effectively manage shared risks and benefits in its distribution of welfare provision.

Different policy options before UCS

In the transition toward the 30 Baht health policy, several policy options were considered, including:

- incremental addition of new schemes to the existing system;
- single-payer system;
- dual health insurance system for the formal and informal sectors.

The policies for the first option have been implemented over the years with the introduction of several health schemes to different target groups. The incremental addition of new targeted schemes was met with little resistance since there was no explicit tradeoff in providing a new scheme that targets a different group. Also, in terms of financing, the expansion of an existing system was estimated to incur an additional 120,000 million baht—much less than the introduction of UHC, which cost 202,000 million baht. However, this method of expansion of coverage increased the degree of fragmentation and the level of benefits or outcomes among health-care recipients of different security coverage. The targeted schemes also involved inclusion error where the non-poor receive the benefits. The effectiveness of targeting was also questionable. One study in an urban community showed that a significant proportion of the scheme members were not poor and many poor families were not covered (Pannarunothai and Mills 1997).

The second option required that the entire population belongs to a unified single system of health insurance (Tanmunthong 2010). Funding from taxes was suggested as a method to finance the insurance. The second option faced strong resistance from the

[14] The right to access health care was addressed in the 1997 and 2007 Thai Constitutions. The 2007 Constitution describes the rights of citizens to public health services and welfare as follows: "A person shall enjoy an equal right to receive standard public health services, and the indigent shall have the right to receive free medical treatment from State infirmaries. The public health service by the State shall be provided thoroughly and efficiently".

private sector since it meant ending other health-care provisions. One objection was the perception that the centralized system had the risk of poor quality of care from the lack of competition among health funds.

The third option involved two forms of funding—one from the "formal sector fund" and the other from the "informal sector fund". The approach offered distinct differentiation between the two large targeted groups, which by default may induce bias in budget and benefits.

Inequality among beneficiary target groups was a concern. Also, the gap in the uninsured population emerged as a political issue and became the driving force behind UHC (Evans et al. 2012). After 27 years of population targeting and expanding financial risk protection schemes to poor and vulnerable populations, the scheme reached universal coverage and Thailand implemented UHC in 2002. The scheme provides health-care coverage to all Thai citizens who are not covered by other public health protection schemes. The 30 Baht health policy, a prime component of the political platform for the government at the time it was launched, provided universal access to care in public facilities for a cost of 30 baht ($0.34)[15] per visit.

3. Health Financing Reform toward UHC

Health financing development in Thailand (prior to universal coverage)

Even before the introduction of the 30 Baht health policy (subsequently changed to Universal Health Coverage Policy), many health insurance and assistance programmes and schemes have been implemented since 1975, although with mixed results (Pramualratana and Wibulpolprasert 2002). The first major health welfare programme was implemented in 1975 to cover the poor. The Medical Welfare Scheme (MWS) was established by the Ministry of Public Health (MOPH) to exempt the poor from user fees at government health facilities with funding from the government budget. The programme subsequently expanded to cover the elderly, children and other socially deprived groups. Although helpful for these underprivileged groups, the programme suffered from ineffective targeting. The programme was also seriously underfunded given the limited political interest in supporting these population groups. It provided very low compensation to the providers in exchange for user fee exemption, making it unattractive for public hospitals to provide services to these groups. In addition to the MWS, there were other health insurance and government welfare schemes for formal sector employees. The Civil Servant Medical Benefit Scheme (CSMBS) was established in 1980 to cover civil servants, public employees and their families. The SSS for private employees was first introduced in 1990.

Efforts to expand coverage to informal sector families were tried with community financing schemes in 1983. Government subsidies were provided to incentivize enrolment in the schemes. These community health insurance schemes were later nationalized into the Voluntary Health Card Scheme (VHCS) and operated by the MOPH in 1991. Health card buyers paid 500 baht for the coverage of a family of up to five persons and the government contributed another 500 baht into the common fund.

[15] All references to $ are to United States (US) dollars.

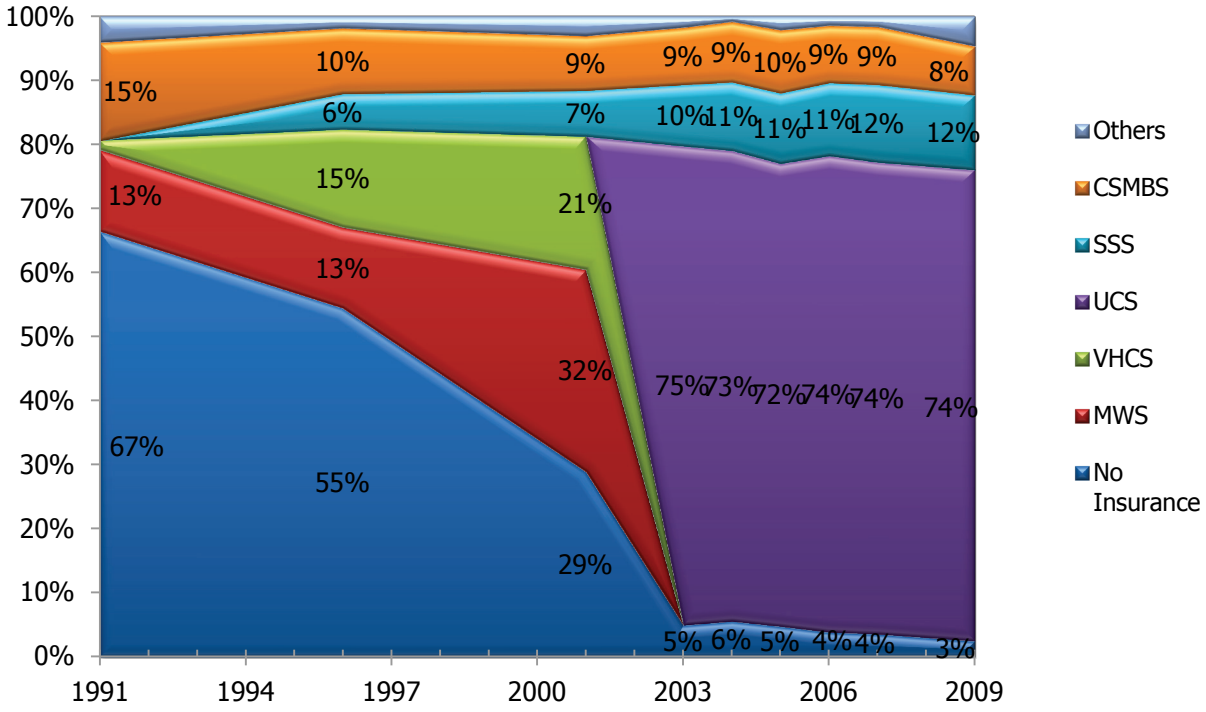
However, the programme was not successful due to the problem of adverse selection that derived from its voluntary nature.

Since the early 1990s, there have been regular debates and discussions about how to improve efficiency in the health system and expand health-care coverage to the informal sector to achieve UHC (Hanvoravongchai 2013). It was clear to policy makers and technocrats that relying on the VHCS or existing schemes (CSMBS, SSS or MWS) to expand their coverage to the uninsured population would not be successful. With a large proportion of the informal sector, it would not be easy to rely on health insurance coverage expansion by the SSS. At the same time, the CSMBS was aimed at a specific population (civil servants) that would be incompatible with the informal sector and it suffered from cost escalation and inefficiency (Sriratanabun 2002). The chosen approach, therefore, was to end the MWS and the VHCS, and to create a new financing scheme for the non-CSMBS and non-SSS population, which was the UCS in 2002. UCS offers a relatively comprehensive package of health-care coverage of outpatient care, inpatient care and operations, with very low co-payment and no premium payments. UCS was initially called the 30 Baht (about 1 United States dollar) health policy to reflect the co-payment level that was required to be paid out of pocket by the UCS members at every health-care visit. The programme was piloted in six provinces in April 2001, and subsequently expanded to 15 provinces two months later before being implemented in all provinces in April the following year. The pattern of health insurance expansion from 1991 to 2009 in Thailand is shown in figure 1.

Economic crises in 1997 led to a key health management and financing study supported by the Asian Development Bank that proposed a series of reform activities, including health insurance expansion for universal coverage (Donaldson et al. 1999).

Another precursor to the development of UCS was the World Bank Social Investment Project that was implemented in Thailand from 1998 to 2001 (Hughes and Leethongdee 2007). The project was piloted in six provinces to test a payment reform from input-based financing (an historical budgeting system based on hospital size and number of staff) to demand-based financing (budget based on population size). The 30 Baht health policy also expanded such reform to demand-side health-care financing and strategic purchasing of health services nationwide, with closed-end payment mechanisms. Instead of providing budgetary funding to public sector health-care providers based on its size, staff number and historical performance as usually done previously, the 30 Baht health policy introduced a capitation payment (cost per beneficiary) that pays providers based on the number of people under their responsibility, called the Contracting Unit for Primary Care (CUP). More details about UCS establishment, health insurance coverage expansion and the accompanying reform are provided in the next section.

Figure 1: Health insurance coverage by insurance scheme, 1991–2009



Source: HISRO. 2012. *Thailand's Universal Coverage Scheme: Achievements and Challenges*. Health Insurance Systems Research Office, Nonthaburi.

UCS reform and implementation

Following the 30 Baht health policy implementation, UCS was officially and institutionally established when the National Health Security Act was promulgated (Government Gazette 2002). According to the National Health Security Act, "the Thai population shall be entitled to a health service with such standards and efficiency as prescribed in this Act". A new, independent organization, the NHSO, was created to serve as a state (autonomous) agency under the authority of the National Health Security Board (NHSB). According to the law, the board is authorized to prescribe the "types and limits of Health service for [UCS] beneficiaries". The NHSB also appoints the NHSO secretary-general, who is in charge of NHSO operations. Under the law, the NHSO is responsible for the registration of beneficiaries and service providers, and administers the fund and pays the claims according to the regulations set out by the NHSB.

Thai nationals who are not already covered by the CSMBS or SSS are eligible for UCS. UCS enrolment is automatic, although registration is required. People living in Bangkok can register at any district office, and people living outside of Bangkok can register at health centres, public hospitals or provincial health offices. Initially, the NHSO relied on a national campaign and community leaders to increase the registration of beneficiaries. Now, with the use of a civil registration system, the house registration system and the national identification number, UCS works with the SSS and CSMBS to identify beneficiaries of the CSMBS and SSS so that the remaining people are eligible UCS beneficiaries.

The UCS benefits package is comprehensive and includes inpatient and outpatient care, prevention, promotion and rehabilitation. Dental care, maternity care and delivery, home health care and prescription drugs are also included. The benefits package

generally describes the categories that will be covered. However, the package contains a positive list that specifies precise health conditions or clinical procedures that will be covered and a negative list that identifies health conditions or clinical interventions that will be excluded. For example, infertility and cosmetic treatment are not covered. For medicines and therapeutics, the benefits package also refers to the National Essential Drug List, which classifies medicines and therapeutics into categories based on effectiveness and cost-effectiveness characteristics. Since 2010, with an effort to contain costs and more evidence based on its decisions, new technologies or medicines are required to prove their cost effectiveness and budgetary impacts before being considered by the UCS Benefit Package Committee (Jongudomsuk et al. 2012).

Even though the benefits package is rather comprehensive, UCS beneficiaries are restricted to using health-care services only from a specific health-care provider network. UCS members are required to register with a specific CUP, which can be a private or public health-care provider under UCS. They must have a primary care visit at the registered provider or in the contractor's network. This "gate-keeping" mechanism allows the members to use health-care services with very minimal or no co-payment. If the member uses health-care providers outside the network, then they are not covered and must pay out of pocket themselves. This gatekeeping is, however, exempted in case of emergencies, when the patients can use any provider without payment. Recently, UCS allowed members to change their provider up to four times per year (previously only once or twice per year) to allow more choices and competition across providers, but in most areas outside major cities there is only a single provider network (public hospital under the MOPH) so the competition is limited in real practice.

In addition to health insurance coverage expansion from UCS as shown in figure 1, UCS also includes major health financing reform in the Thai health-care system (HISRO 2012). A major difference between the previous financing system and the current system, especially in the public sector, is the introduction of a *purchaser and provider split* and *strategic purchasing*. Instead of the previous model of budget allocation from the central MOPH to public health-care providers based on facility size, staff numbers and performance history, UCS uses the NHSO as its purchaser, which contracts with health-care providers, both public and private, to provide health services for its beneficiaries. The emergence of UCS and the accompanying major financial reform in the health system, especially the purchaser–provider split in 2002, meant a major shift in health financing authority from the MOPH to the NHSO. Many MOPH administrators perceived the change as UCS undermining the role of the MOPH as the steward of the health system (Treerat and Ngamarunchote 2012).

The NHSO receives a UCS budget from the government based on the number of beneficiaries it covers and the capitation rate approved by the government. Each year, the NHSO estimates the total cost of health-care provision based on its costing studies and the number of beneficiaries it will cover. The capitation rate is then submitted for approval by the government Cabinet. The total budget based on the capitation rate is then submitted together with NHSO operating costs as part of the government budget to be approved by the Parliament. Since its inception in 2002, the Parliament has never revised the capitation rate approved by the Cabinet. However, the Cabinet could change the capitation figure requested by the NHSB, as happened in 2011, if the approved budget per capita is lower than the proposed capitation rate. The trend of the UCS per capita budget from its initial launch to 2012 is provided in table 3.

Table 3: Trend in the UCS budget per capita, 2002–2012

Year	UCS budget per capita		
	Baht	United States dollars	Baht (2007 price)
2002	1,201	27.9	1,407
2003	1,201	28.9	1,381
2004	1,308	32.5	1,464
2005	1,396	34.7	1,495
2006	1,718	45.3	1,757
2007	1,983	57.4	1,983
2008	2,194	65.8	2,082
2009	2,298	66.9	2,199
2010	2,497	78.7	2,312
2011	2,693	88.3	2,405
2012	2,895	93.1	2,508

Source: NHSO 2012.

Purchaser and provider split

In the past, the MOPH was both the budget holder and provider. However, after UCS, the MOPH and its network of hospitals and health-care providers became the main contractors of the NHSO. The contractors can have subcontractors, such as private clinics or health centres, to provide primary care and preventive and promotive health services. There are over 10,000 health centres under the MOPH that joined the contracting networks of MOPH hospitals. For private and other public providers, an individual contracting process is required.

The NHSO regional office has the authority to contract with non-MOPH providers in their regions. There are certain standards that must be followed to be an eligible contractor, including the requirement of a nominal financial deposit. There are more than 70 other public hospitals that are NHSO contractors. The NHSO also has contracts with private hospitals, but the number of private hospital contractors continuously declined—from 71 in 2004 to 44 in 2011 (NHSO 2012) or less than 15 per cent of all private hospitals in the country. Relatively low capitation and case-based payments are cited as the reasons for private hospital withdrawal from UCS. A limited beneficiary base to adequately pool health-care risks is another alleged reason, since UCS members were enrolled first with MOPH providers. In addition to hospital contracts, the NHSO also contracts directly with private clinics in Bangkok for primary care.

Strategic purchasing

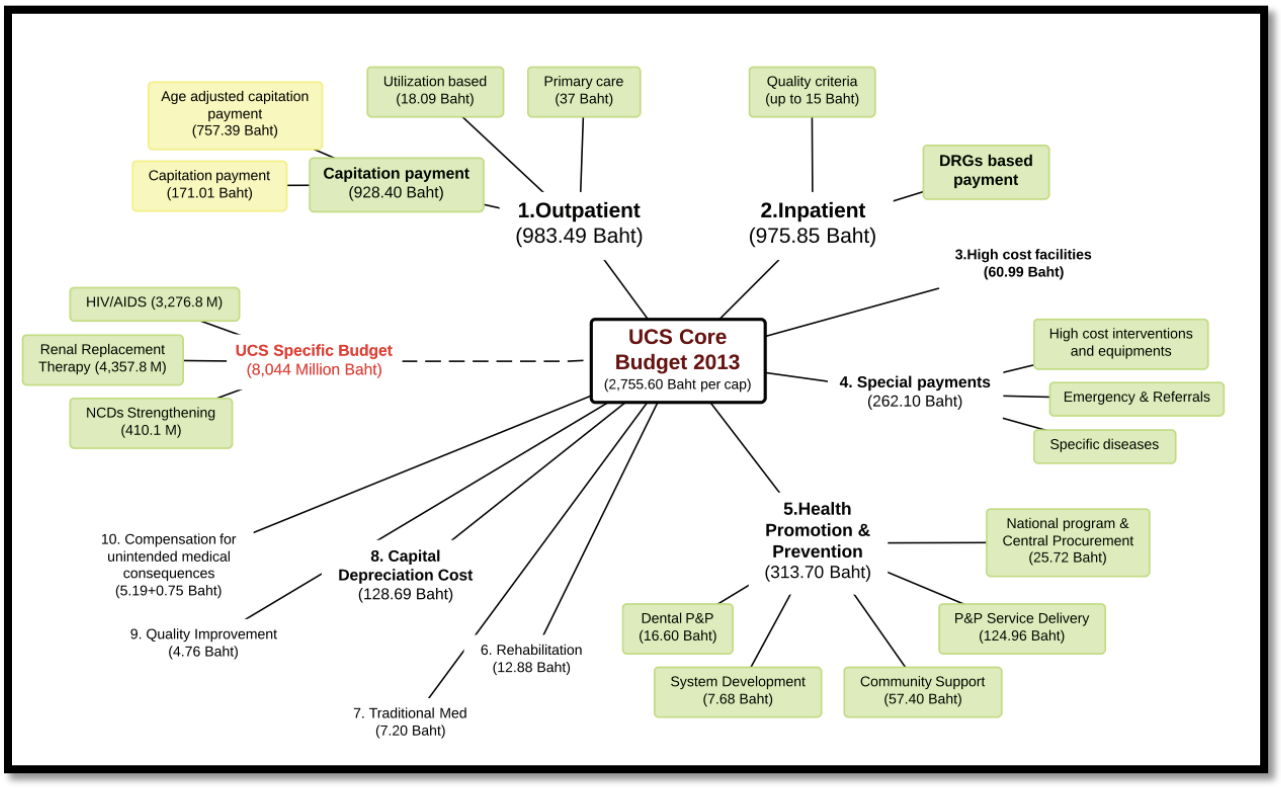
Under UCS, the NHSO channels the funds to the contracted providers using several active purchasing mechanisms, with capitation and diagnosis-related groups (DRGs) the main payment methods. Payment for outpatient services is allocated based on the number of beneficiaries registered with a provider network or CUP. The capitation rate is adjusted by age composition, and the money is channelled directly to CUP at the beginning of each budget year. For MOPH facilities, the amount transferred may be deducted for specific expenses, such as staff salary, at the central or provincial level depending on prior agreement between the NHSO and MOPH. Payment for inpatient services was allocated using case-based payment (following DRGs) under a global

budget ceiling cap. This means that the payment rate per DRG relative weight varies according to the total number of total DRG relative weights within each period.

Initially, UCS charged the non-poor a 30-baht copayment and exempted former participants in the MWS (poor and special groups) from this copayment. However, in 2006, the NHSB, under the then-minister of public health, decided to exempt both groups from copayment. The policy was reverted again in September 2012, and use of the scheme's nickname, the 30 Baht health policy, was encouraged when the government from the political group that initially launched UCS returned to power.

In addition to outpatient and inpatient payments, which consume most of the UCS budget, the NHSO also employs additional funding mechanisms for disease prevention and health promotion (P&P) activities, emergency services, rehabilitation services, specific high-cost clinical conditions, priority services and clinical areas that are still considered underdelivered. High-cost cases such as heart attack, stroke, hemophilia or selected diseases that require specific instruments are paid for by using a pre-assigned fee schedule. Fee schedule payments are also used for priority services to increase access to services such as cataract surgery or kidney stone treatment. UCS gives special incentive payments to encourage early detection and care of diabetes and hypertension patients. The Antiretroviral Treatment Fund and Renal Replacement Therapy Fund are special funds under UCS that were created to cover medical care for HIV/AIDS patients and renal replacement therapy for end-stage renal disease patients. These funds pay providers based on predefined fee schedules for specialized care. They also provide a capital depreciation replacement budget to support the providers. The payment mechanisms and the proposed budget for each payment item for 2013 is summarized in figure 2.

Figure 2: Payment mechanisms and budget for different benefit type under UCS



NCDs = non-communicable diseases. **Note:** Data from NHSO. NHSO administration costs are not included. **Source:** Authors' analysis.

The use of different payment methods for various interventions was designed to introduce different incentives to providers. By paying capitation and DRG-based payments under a global budget, the system incentivizes hospitals and health-care providers to be efficient and cost conscious. At the same time, the system tries to avoid negatively affecting quality of care due to the undertreatment of patients as a result of the cost-containment effect of the two payment mechanisms. It does so by introducing additional payments for specific high-cost diseases or procedures. The NHSO also provides additional financial incentives for in-time reporting of utilization data and other desired provider behaviours such as quality improvement.

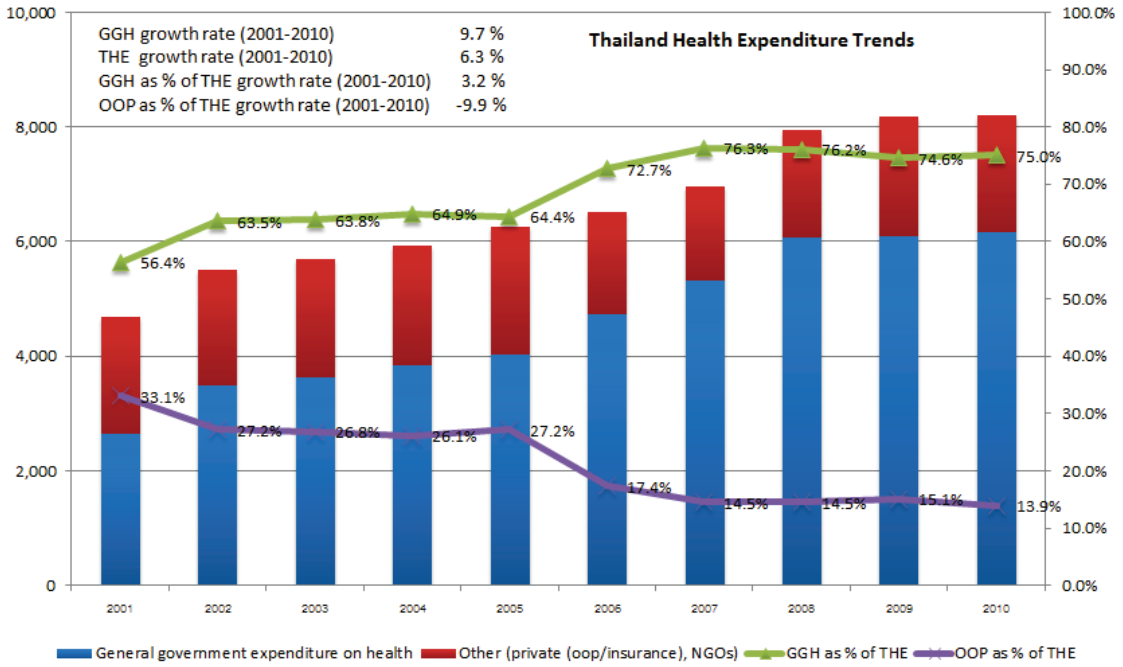
Health financing situation after UCS

In 2011, the total expenditure for UCS was 89,836 million baht (NHSO 2012). About 36 per cent of the budget was used for outpatient services, 42 per cent for inpatient services, 10 per cent for P&P activities and 6 per cent for capital depreciation replacement. The Antiretroviral Treatment Fund received less than 3 per cent, as did renal replacement therapy. The remaining payment channels accounted for less than 1 per cent each.

The UCS implementation changed the landscape of health-care financing in the country. Public sector financing for health, mainly from government revenues, became the most important funding source for health care in the country. The amount of public health spending increased continuously and the share of private financing in total health spending declined (figure 3 and figure 4). Out-of-pocket health spending was less than 15 per cent of total health spending in 2010, while government expenditure on health grew on average at almost 10 per cent annually to account for about three-quarters of total health spending (figure 3). Health financing from UCS increased from about 15 per cent in 2003 to 22 per cent of total health spending in 2010 (figure 4). Nevertheless, the proportion of GDP spent on health did not increase much, still at around 4 per cent (figure 5).

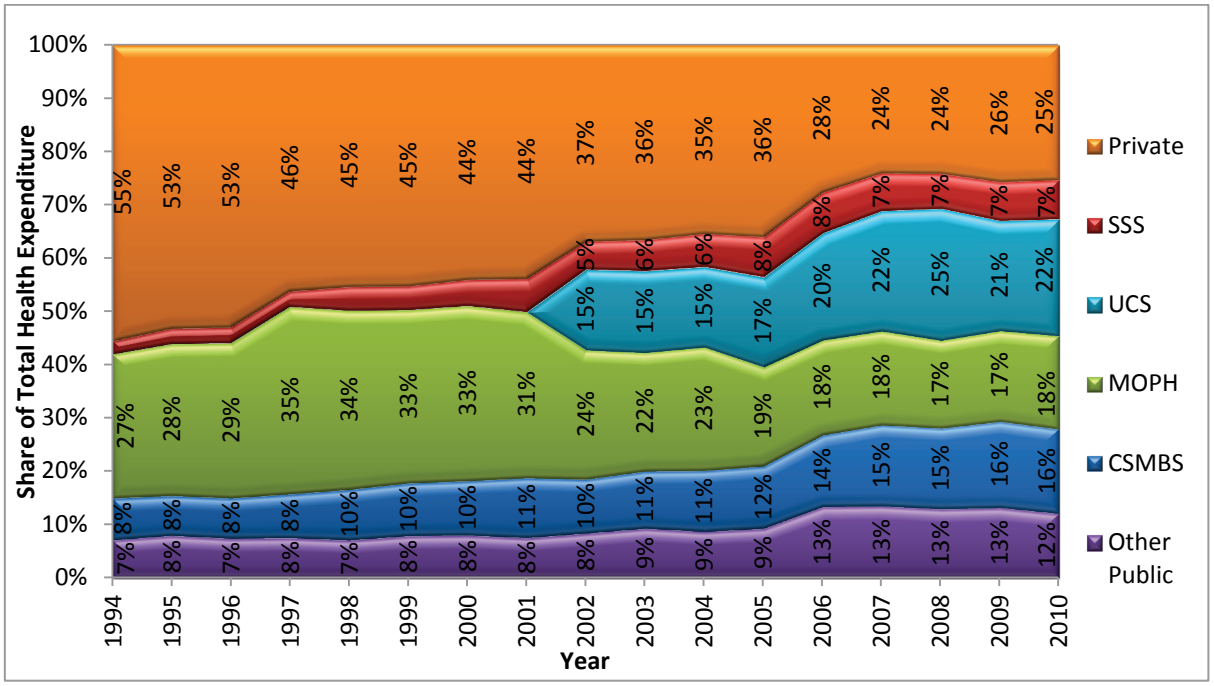
In summary, the introduction of UCS helped expand coverage of health insurance to almost all the Thai population. It also lowered private health-care spending. The health financing reform accompanying the establishment of UCS also created significant impacts on the health-care financing functions and health system arrangements (further discussed in section 4).

Figure 3: General government expenditure on health and total health expenditure in Thailand



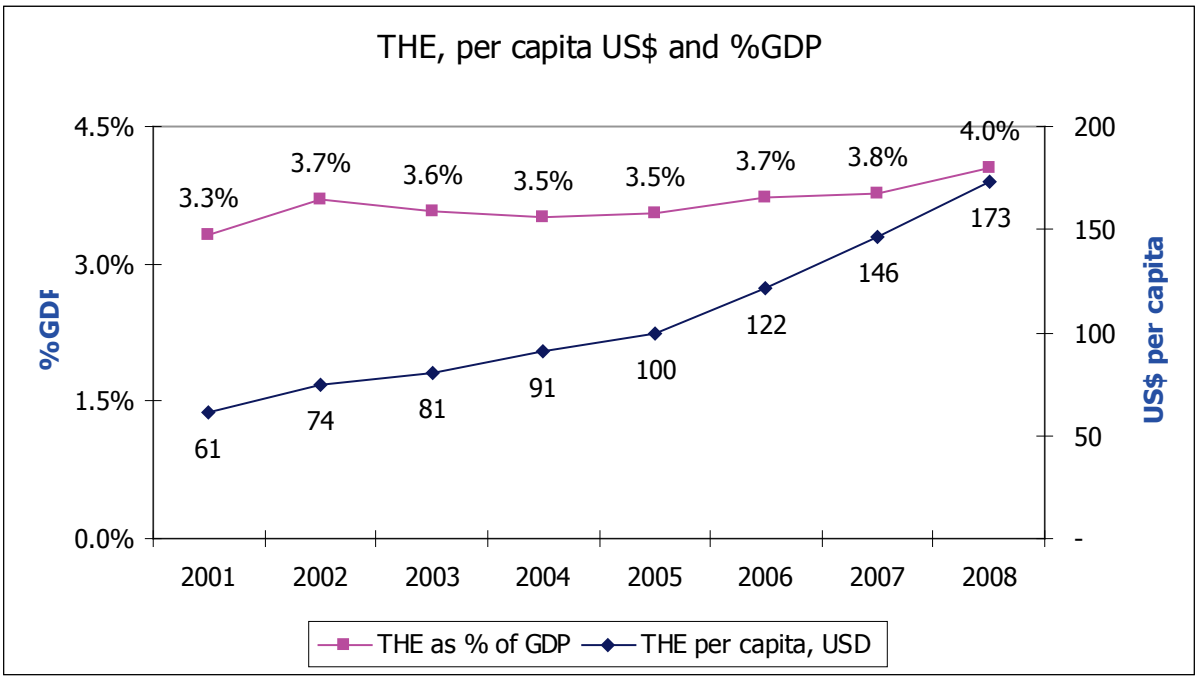
GGH = general government expenditure on health. OOP = out-of-pocket. THE = total health expenditure. NGOs = non-governmental organizations.
Note: GGH and Other are shown in 2005 constant United States dollars. Annualized growth rates calculated using the least squares growth rate method.
Source: Hanvoravongchai, P. 2013. Health financing reform in Thailand : Toward Universal Coverage under Fiscal Constraints. World Bank, Washington DC, pp.1–36 (using data from the World Health Organization Global Health Expenditure database).

Figure 4: Share of health financing from variety of public and private sources, 1994–2010



Source: Thailand NHA 2011 Working Group 2013.

Figure 5: Total health expenditure per capita (United States dollars) and a percentage of GDP



THE = total health expenditure. US$ = United States dollars.**Source:** HISRO 2012.

4. Comprehensive Outcomes of the UHC Movement

To assess the comprehensive outcomes of the UHC movement in Thailand, it is necessary to look at the intended impacts of UCS implementation on health-care access, utilization and financial protection against excessive health-care payments. The broader effect on health outcomes of the population beyond health care also should be evaluated. The UHC movement has direct and indirect impacts on other health financing schemes and health system functions beyond UCS as it influenced the institutional, process and outcomes of a broader range of social protection movement in the country. The next section describes the results of our review of the outcomes of UHC in Thailand from its implementation in 2002 to the time of writing in 2013.

Direct outcomes of UCS implementation

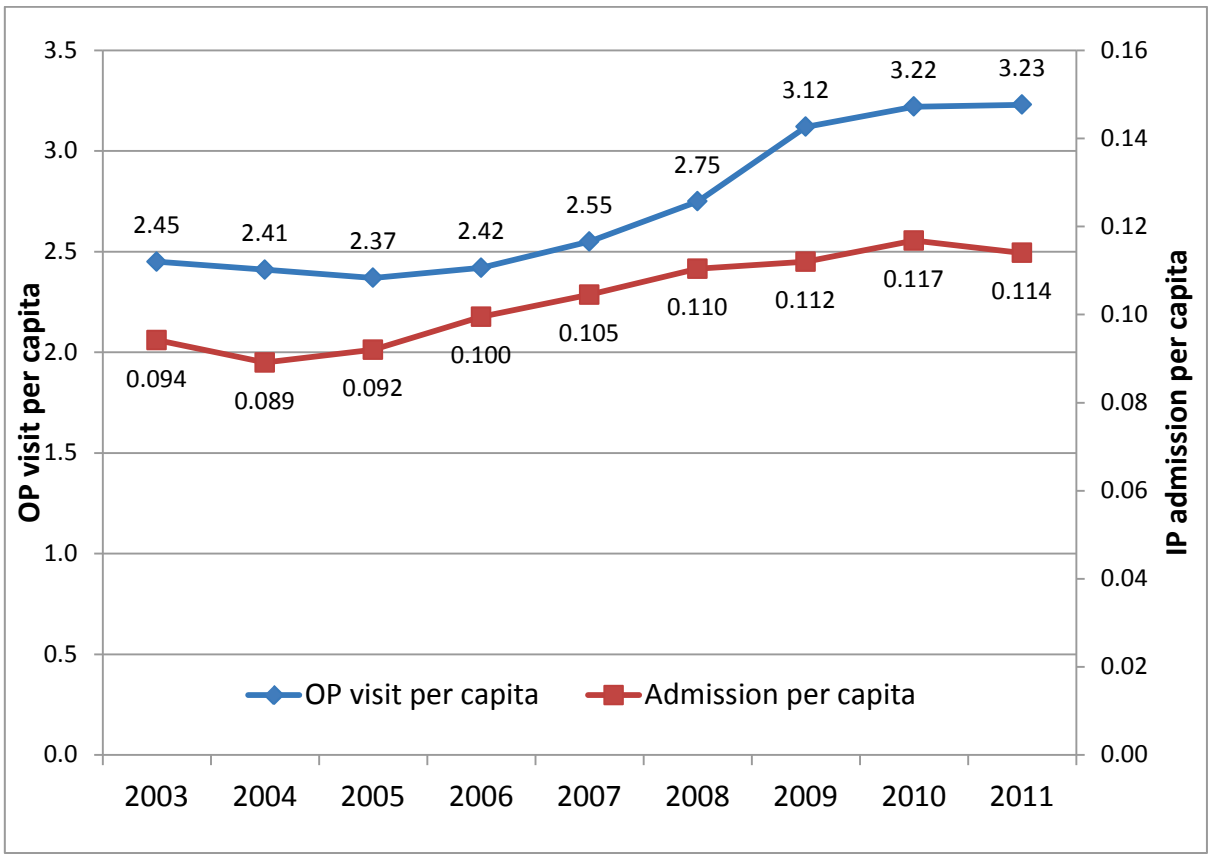
The implementation of UCS to expand health insurance coverage was a major step in Thailand's social protection movement. Until today, a number of studies have been conducted to evaluate the outcomes of UCS implementation in the dimensions of health-care access and health-care utilization, protection against excessive out-of-pocket health-care payments and improving population health outcomes, which are the main objectives of UCS.

UCS outcome on health-care access and health-care utilization

Based on an evaluation of UCS in 2011 by a group of independent international experts (HISRO 2012), the introduction and implementation of UCS has improved health-care utilization as shown by the statistics. Although overall outpatient and inpatient services among UCS members, in particular outpatient service, did not increase much at the beginning of the programme (NHSO 2012), the utilization rate rose steadily after implementation with outpatient visits per person increasing from 2.45 to 3.23, and

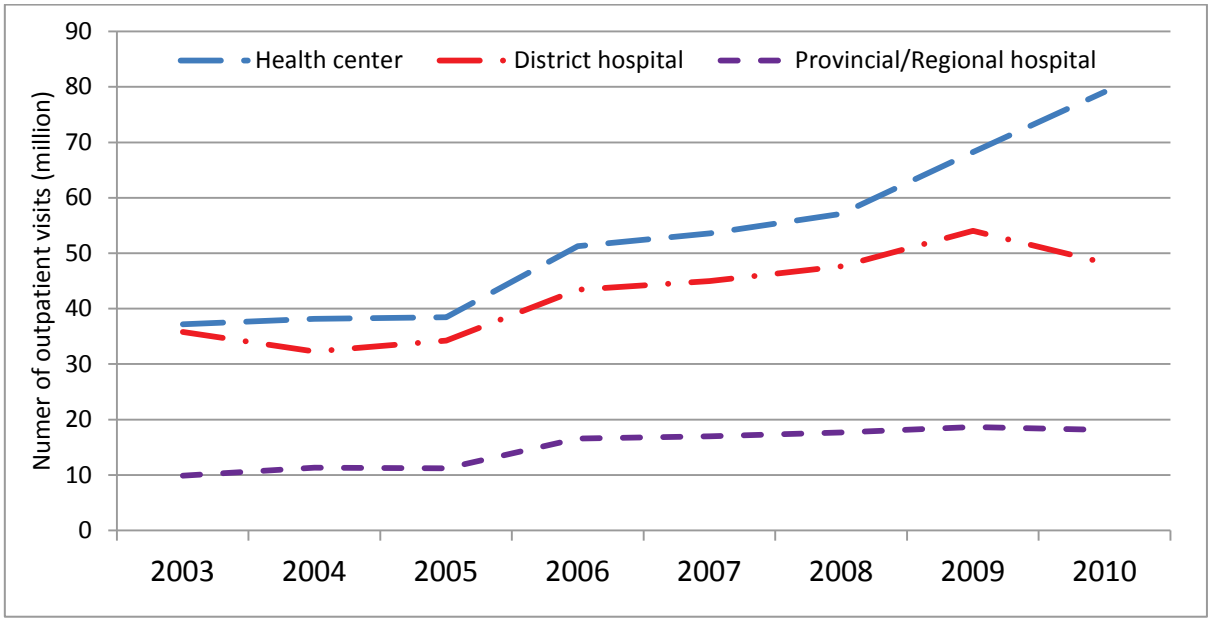
inpatient admissions per person increasing from 0.094 to 0.114 (figure 6). One major contributor is the expansion of outpatient service provision at health centres and district hospitals where the total number of outpatient visits showed an increasing trend from 2005 onwards (figure 7). A recent study to evaluate the impact of UCS on health-care utilization and access using a quasi-experimental method found that UCS reduced the probability of foregoing formal health care when ill by 11 per cent and increased the opportunity of inpatient admissions by 18 per cent, with the greatest effect of outpatient care access on the poor and rural population (Limwattananon et al. 2013).

Figure 6: Changes in health-care utilization rate among UCS members, 2003–2010



OP = outpatient. IP = inpatient. **Source:** NHSO 2012.

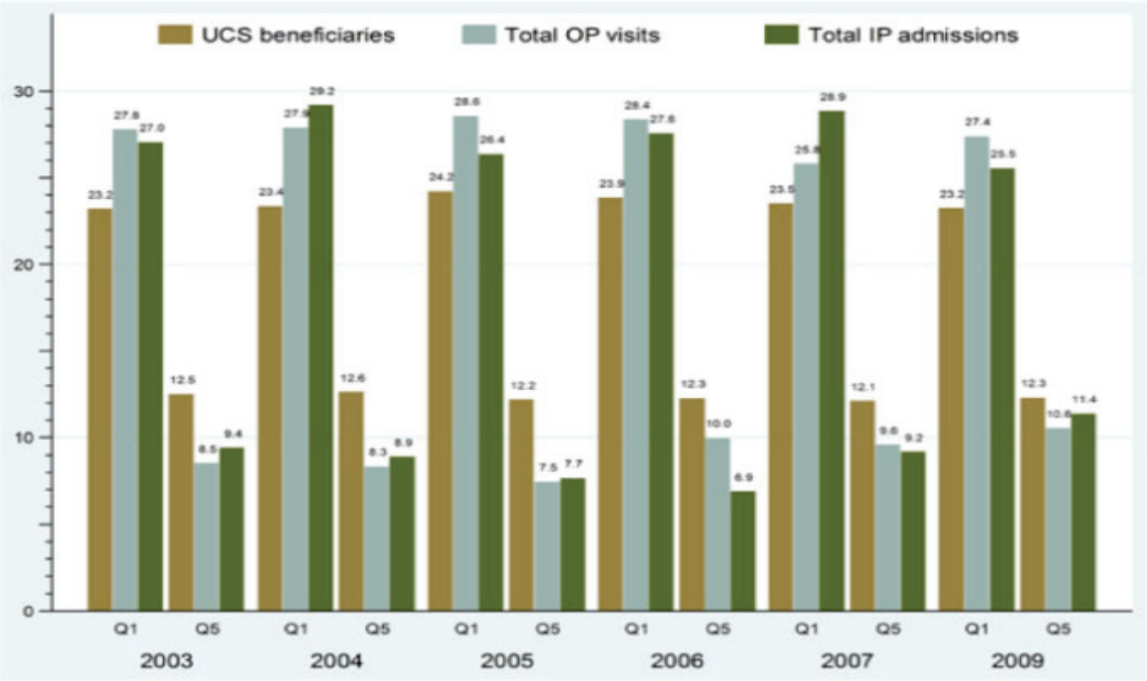
Figure 7: Trends of total number of outpatient visits at different levels of health-care providers under the MOPH, 2003–2010



Source: Data from MOPH Bureau of Health Policy and Planning as presented in NHSO 2012.

Limwattananon et al. (2012) studied the difference in the outpatient and inpatient utilization rates between the poorest and richest quintiles and found significantly higher use by the poorest group. As shown in figure 8, the poorest group's shares of outpatient and inpatient utilization in total utilization are higher than the proportion of UCS members in the poorest group, reflecting higher use. Nevertheless, the analysis did not control for the probability of illness that is generally higher in the poorer populations.

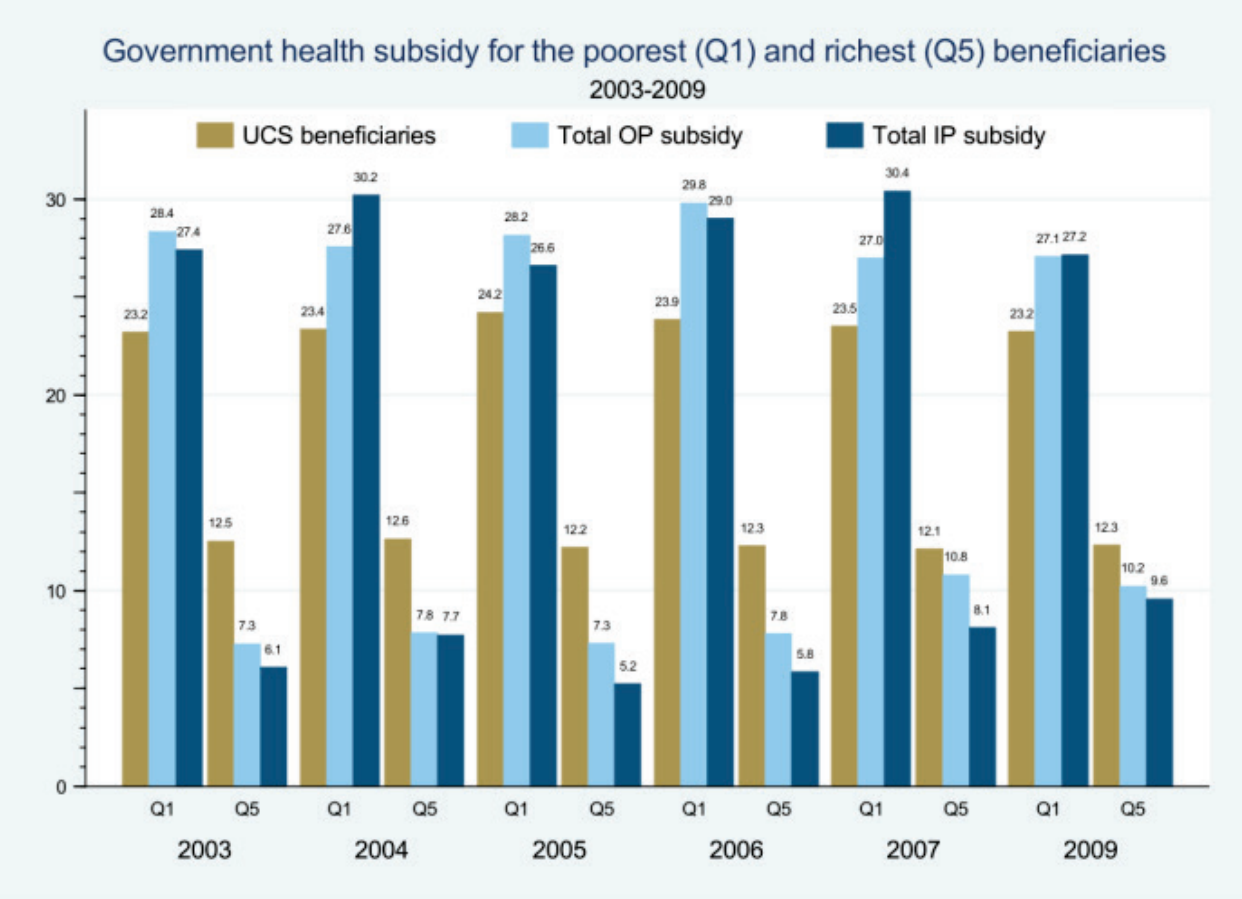
Figure 8: Proportion of UCS members and their outpatient and inpatient utilization rates comparing between richest (Q5) and poorest quintiles (Q1), 2003–2009



OP = outpatient. IP = inpatient. ***Source:*** Limwattananon, S. et al. 2012.

One criticism from UCS skeptics about UCS in comparison to previous health welfare programmes for the poor concerned its plausible shift in subsidy to the better off given that all population groups are covered by the scheme instead of targeting the underprivileged. On the contrary, a benefit incidence analysis of government subsidies to UCS by Limwattananon et al. (2012) found that a greater proportion of the subsidies went to the poorest group than the richest. The availability of an extensive network of public health-care providers at the district level and little or no copayment are considered major contributors toward pro–poor subsidies of UCS even without targeting. The relatively long queue at public facilities may be another factor, since richer populations who can afford to pay out of pocket privately can choose private clinics or private hospitals with shorter waiting times when ill. This indirect pro–poor effect, however, may pose longer-term problems to UCS because it may lack broad national support, especially if it is perceived as a low-income programme with poor-quality care (figure 9).

Figure 9: Proportion of UCS members and the UCS benefit incidence analysis of government subsidy comparing between richest (Q5) and poorest quintiles (Q1), 2003–2009



OP = outpatient. IP = inpatient. **Source:** Limwattananon, S. et al. 2012.

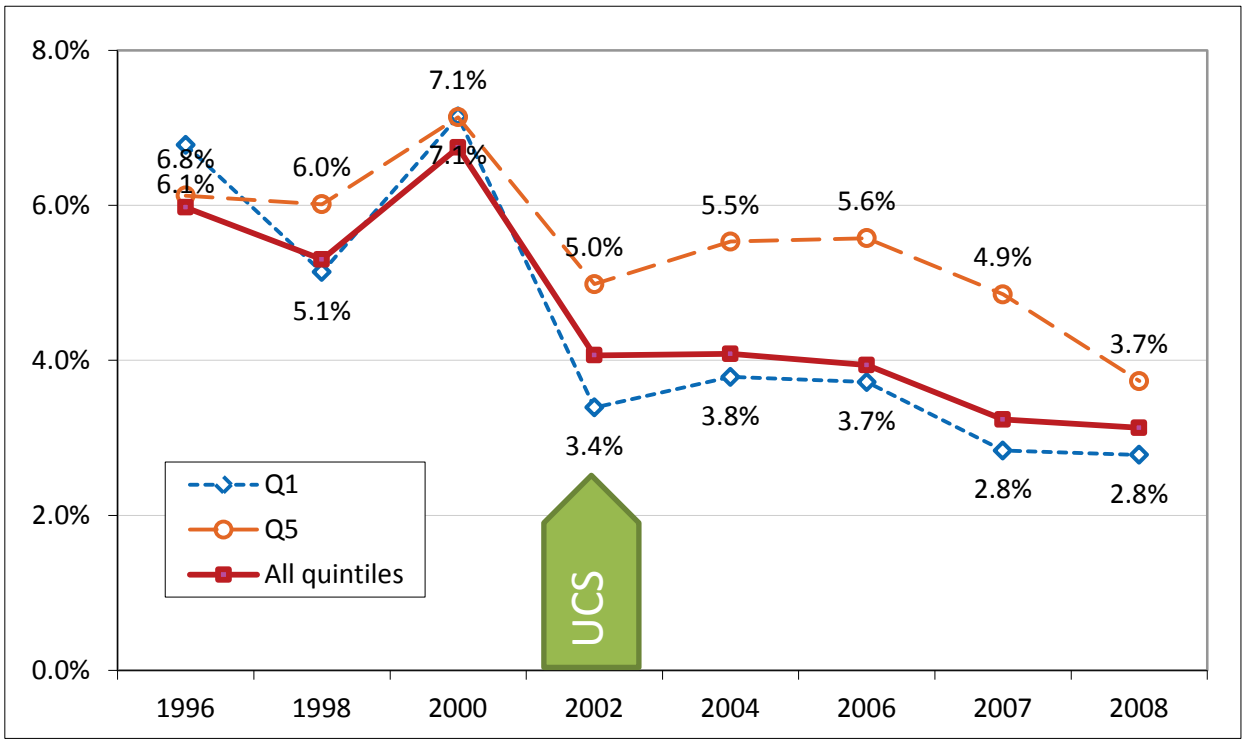
UCS outcome on the protection against health spending shocks

In addition to reducing financial barriers to access to health care, another main purpose of health insurance is to help protect individuals and households from the financial shocks due to health-care payments when obtaining health-care services. Two widely used measures in the assessment of financial protection from health-care payments are

the proportion of households with catastrophic health spending[16] and the proportion of households who become poor because of health-care payments.

A number of studies found that the incidence of catastrophic health spending from health payments decreased after the introduction of UCS.[17] As shown in figure 10, after UCS in 2002, the proportion of households with catastrophic health spending (defined using a 10 per cent threshold level) declined compared with the period before UCS, that is, from 6 per cent in 1996 to 3 per cent in 2008. The reduction occurred in almost all economic groups with a higher reduction among the UCS members in the poorest quintile group, from 6.8 per cent to 2.8 per cent, while the members in the richest group also dropped from 6.1 per cent to 3.7 per cent.

Figure 10: Proportion of households with catastrophic health spending by quintiles, 1996–2008



Note: Household catastrophic health spending is defined as the level of health spending higher than 10 per cent of total household consumption. Q1 is the poorest quintile.
Source: Modified from: HISRO 2012 *Thailand's Universal Coverage Scheme: Achievements and Challenges*. Health Insurance Systems Research Office, Nonthaburi.

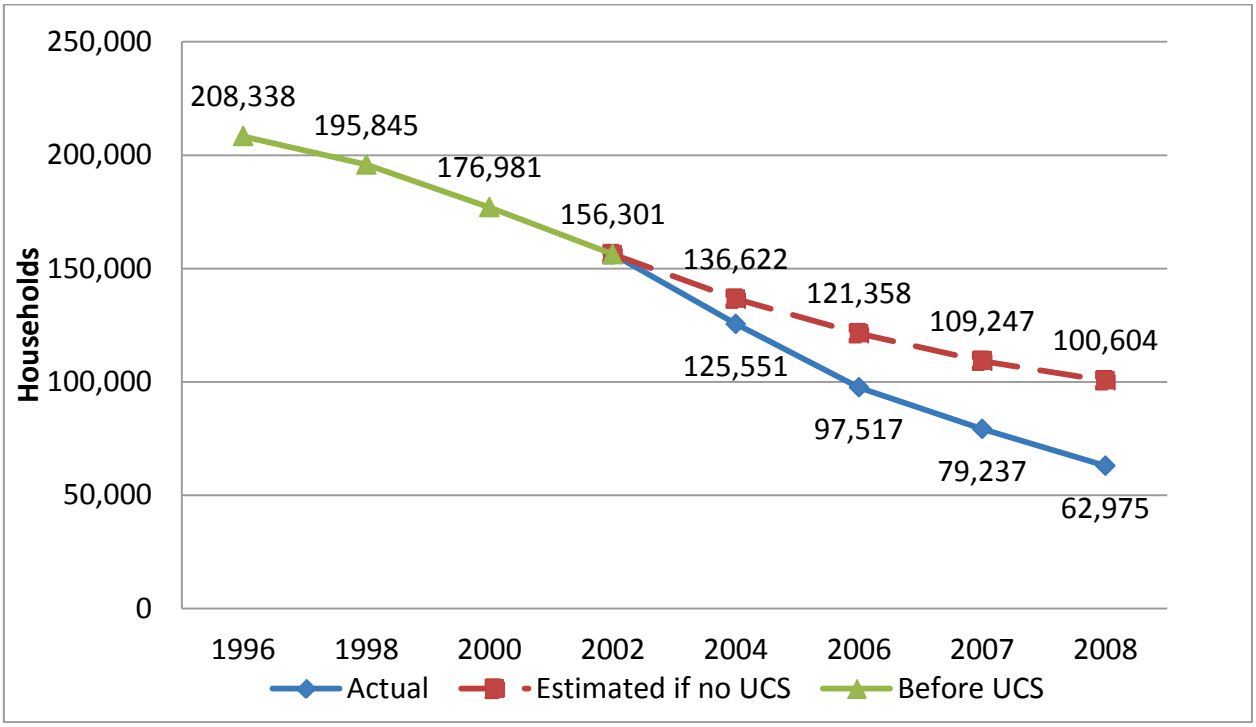
Limwattananon et al. (2007) found that the majority of households who became impoverished from health spending, defined as the household consumption level, moved from above the poverty line to below the poverty line after out-of-pocket health-care payments, was highest among households whose family members required inpatient services. However, the proportion of households facing impoverishment decreased in 2002 and 2004 when compared to the proportion prior to UCS in 2000. An analysis presented by HISRO in 2012 estimated that from 2003 to 2008 more than 100,000

[16] Catastrophic health expenditure is usually defined as having out-of-pocket payment for health exceeding a threshold level (for example, 10 per cent) as a proportion of household income (usually measured using total consumption expenditure). Household impoverishment from health spending is defined as households whose income (consumption expenditure) level declines below the poverty level because of health spending.

[17] Somkotra and Lagrada 2009; Limwattananon et al. 2007; HISRO 2012.

households were prevented from impoverishment due to out-of-pocket health-care spending (HISRO 2012) (figure 11).

Figure 11: Estimated number of households impoverished from health-care payments and the estimated trend if there were no UCS



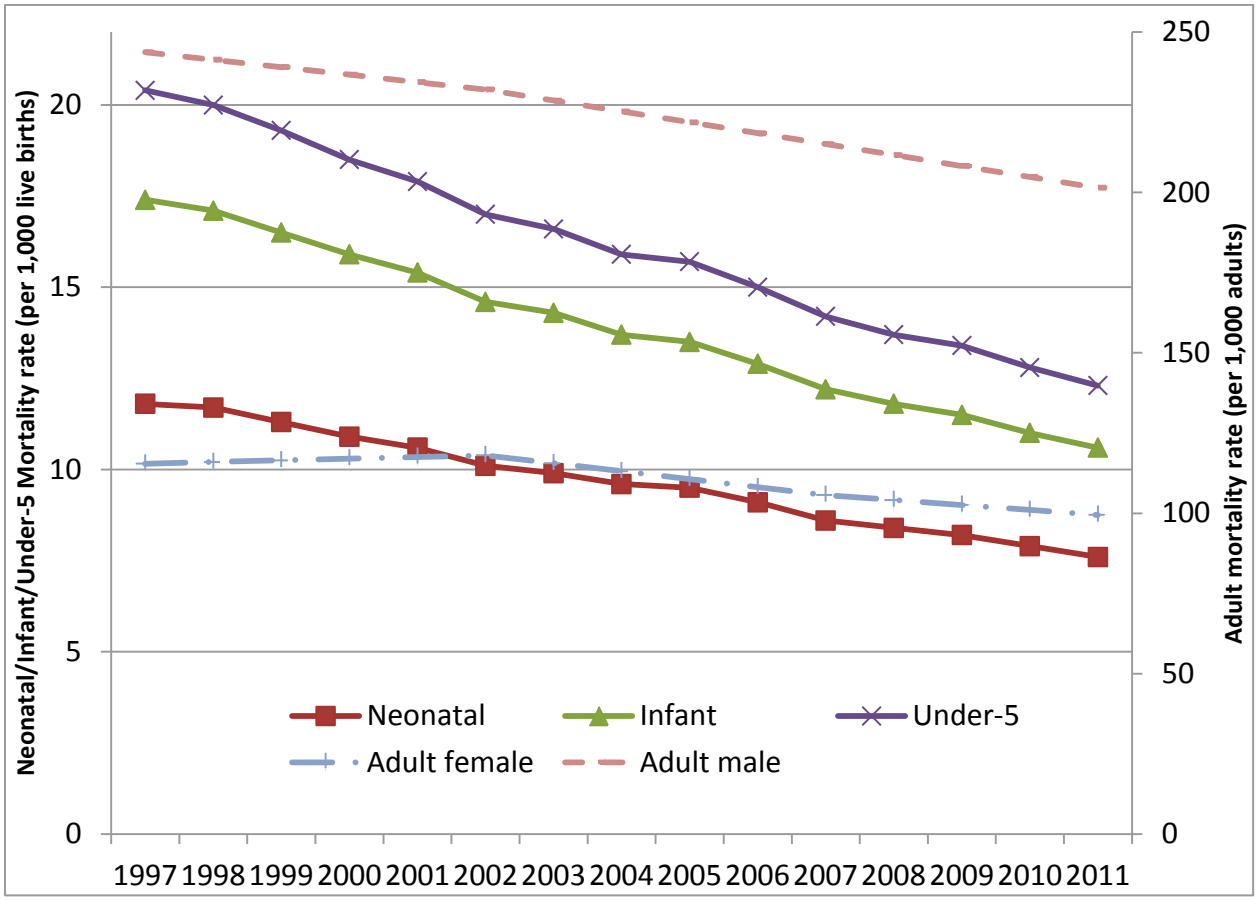
Source: Modified from HISRO 2012.

UCS outcome on population health

The goal of the health system is not only limited to increasing access to health care or financial protection from excessive health spending, but also to include the improvement of the population health status as measured in a number of outcome indicators. Unfortunately, the NHSO did not regularly evaluate the change in health outcome of its members so it is not possible to assess the impact of UCS on population health.

One way to assess the health outcome impact of UCS is to look at key health outcome statistics such as child and adult mortality. Data from the World Development Indicators (figure 12) showed a continuously declining trend of neonatal, infant, child and adult mortality after the introduction of UCS. However, it would be difficult to solely attribute these changes to the impact of UCS given its declining trend prior to UCS and the potential effect of many contextual factors. Nevertheless, recent evidence from a team of United States economists using a quasi-experimental analytical approach showed that the introduction of UCS has increased health-care utilization, especially among the previously uninsured. It also created a significant reduction in their infant mortality, after controlling for other factors (Gruber et al. 2014).

Figure 12: Trend of adult and child mortality rate in Thailand, 1997–2011



Source: World Bank 2013.

Indirect effects of UCS implementation

In addition to direct outcomes on health insurance expansion on health-care access and financial protection against catastrophic payments, there are other indirect outcomes of UCS beyond these goals. These indirect effects can be aimed at the health sector as well as beyond it, as described below.

A shift in paradigm thinking about health care as a basic right

One of the major paradigm shifts as a result of the UHC movement in Thailand is the change in public thinking about access to health care. Prior to the establishment of the NHSO and UCS, health care was mainly an individual or family responsibility unless they were covered by health insurance provided through their employment (CSMBS or SSS) or they purchased private health insurance. The government provided support to the poor and other disabled or underprivileged groups through the MWS that exempted them from user fees at publicly owned health facilities only. People viewed government-provided health care as public welfare or charity and had no voice over the quality of services they received. Approximately one-third of the population did not have any coverage as most of them worked in the agricultural or informal sector or were self-employed. The MWS was underfunded and their targeting mechanism was not effective. One study found that most of the MWS beneficiaries were not poor and a significant proportion of the poor did not enrol (Pannarunotai and Mills 1997).

The introduction of UCS changed the perception of the public toward health care as a citizens' right. Everyone has the right to quality health care and the public felt ownership of the programme and are more likely to express their opinions over how

health care should be provided.[18] Many civic groups to support UHC, and in particular UCS, were formed and they have been very vocal in the health policy directions of UCS (HISRO 2012). Publicly provided health care is no longer a social assistance programme operated and controlled by the government, but one component of a publicly financed health-care scheme to ensure the right to health care for everyone.

Under the universal mandate for health-care coverage, UCS had to identify the underprivileged and vulnerable populations who may not easily have proper identification of their citizenship as many of them are nomads or hill-tribe populations living close to border areas. Many of them do not have a birth certificate or national identification card and do not have access to government services. With some pressure from health-care providers at border areas, the NHSB agreed to ensure health insurance coverage for these Thai populations so the hospitals that provide care to these populations can be compensated for the services provided. Even after UHC among Thais, in recent years there were ongoing movements to develop health insurance coverage to non-Thai migrant workers, many of them from neighbouring countries, to improve their access and reduce the uncompensated care burden of the hospitals (Chalermpol and Apipornchaisakul 2012).

The shift toward the right-to-health paradigm does not happen without concerns or criticisms. There are concerns from some population groups about the imbalance between civil responsibility and welfare dependency from having free health-care programmes (Na Ranong and Nna Ranong 2002), who argued that the interest in self-care and living with healthy behaviour could be jeopardized and the costs to the society in the long run would be unaffordable. So far, there have been no studies to demonstrate such negative implications. However, members of other contributory health insurance schemes such as the SSS also requested lower or no contributions given that UCS beneficiaries do not need to pay premiums or contributions. More discussion about this is provided in the section on indirect effect of UCS on social security expansion below.

More emphasis on system accountability

The change from a welfare approach to a rights-based approach means that the health-care system needs to be more responsive to the needs of the population. At the same time, the NHSO and public health providers need to be more accountable to the public. The demand-side financing approach requires hospitals and health-care providers to be more user oriented in their operations given that their funding is more dependent upon the users and patients. This is a major change from the system prior to UCS when the top-down approach in financing and authorization led to more interest in serving the central bureaucratic interests rather than population demands.

A number of systems and programmes have been implemented to monitor and improve public accountability of the NHSO (and UCS) and health-care providers. For example, there are five representatives from civil societies on the NHSB.[19] The NHSO also has

[18] See, for example, one decade of civil participation and ownership of national health security system, a declaration and policy proposal in the occasion of a decade of Universal Health Coverage by civil society groups. (www.prachatai.com/journal/2012/10/43383) (in Thai).

[19] According to the National Health Security Act, five members of the NHSB are self-elected from representatives of non-governmental non-profit organizations working in the following areas: (i) child and youth affairs; (ii) womens' affairs; (iii) elderly affairs; (iv) disabled or mental health-related affairs; (v) HIV/AIDS or chronic disease conditions; (vi) labour-related affairs; (vii) slum affairs; (viii) agricultural affairs; and (ix) minority affairs.

an external monitoring system to evaluate its performance every year in relation to a number of key performance indicators (KPIs). The results are then reported to the NHSB for system improvement (NHSO 2012).

UCS also contains a system to allow for complaints and appeals from its members or contractors. A telephone hotline was set up with the number 1,330 for questions and complaints from the public. In 2011, there were over half a million calls of which only about 1 per cent were complaints. The NHSB has a committee on investigation that is required by law to handle issues or complaints related to inappropriate service fees charged by health-care providers, inconvenience in access to care and substandard or unsatisfied service. The majority of the complaints in 2011 were because of not receiving care according to eligible benefits (1,696 cases), service inconvenience (972 cases), service charges (965 cases) and substandard service (753 cases). The NHSO policy is expected to address all complaints within one month, and in 2011 about 94 per cent of the complaints were resolved within the specified period (NHSO 2012).

Another safeguard system for health-care users integrated into the National Health Security Act is a no-fault compensation policy for health care-related injuries and deaths. This provision aims at reducing the trend of medical litigation that had been increasing in Thailand over the last decade. According to Section 41 of the National Health Security Act, injuries due to health-care services provided under UCS will be compensated. Those affected by health care-related injuries or deaths may submit a request for no-fault compensation, which will be considered by a provincial-level committee. Once approved, compensation will be provided to the patient or relatives. If the patient appeals the decision by the provincial-level committee, it is sent to the Health Service Standard and Quality Control Board for consideration.

UCS also indirectly supports the introduction and implementation of the hospital accreditation system. In the beginning, UCS provided financial incentives to health-care providers who had been accredited or had been working on quality improvement under this voluntary hospital accreditation system. Lately, UCS provided funding to the Health Care Accreditation Institute (a public organization) to provide support and capacity building as well as assessment of hospitals on their quality improvement performance. The proportion of hospitals under contract with the UCS that have been fully accredited (third level) increased from 6 per cent in 2003 to 43 per cent in 2013, with almost all of the remaining hospitals passing the first or second level of accreditation.

Decentralized financial management and outcome-based payment

As described earlier, the emergence of UCS was accompanied by a major financial reform in the Thai health system. The purchaser–provider split and strategic purchasing of health-care services were key components of the health sector reform in 2002. The financial system in the public health-care sector shifted from an inputs-based financing to a more decentralized financial management system based on outcome-based payments. The financial authority previously controlled by the MOPH was transferred to the NHSO. Hospitals that are UCS contracting partners receive funding based on the number of registered members and clinical care episodes provided. They can then use the revenues from UCS for hospital operations and maintenance.

The increase in financial autonomy of the public hospitals under the UCS payment system relative to the previous government budgetary system allows many health-care providers to better respond to the demand for health care of their population. Some

hospitals, with more funding under the new payment system, are enabled to improve their health-care infrastructure to expand health-care service. This would not have been easily done in the previous top-down budgetary system where the process requires many steps of approval. Most public hospitals with staff shortages due to a zero-growth policy in the public sector (an ongoing civil servant system policy since 2006) can hire more staff as hospital employees to ease the workloads. The adjustment in the health-care staff in the public sector is discussed further below.

New culture and mechanisms to promote the use of evidence for health policy decisions

UCS establishment and the new financial management system after health-care reform also requires good intelligence for policy decision making in many areas. At the start of UCS, it was necessary to know how many people were still not covered by any major health insurance. To carry out strategic purchasing, UCS requires an extensive information system for beneficiary registration, benefits decision, health-care process and output monitoring and evaluation, and health-care payments. The NHSO relies on several existing and specifically established organizations and internal information management to fulfil its information needs. They also contributed significantly to the evidence generation and the development of a better information system in the health sector. Two specific areas are discussed here: health information and research system development and health technology assessment.

Health information and research system development

The need to expand coverage to the population not already covered by other schemes led the NHSO to work with the Bureau of Registration Administration and the Department of Provincial Administration to improve the Ministry of Interior vital registration system and birth registry to better capture the Thai population. All Thai citizens are required to have an identity (ID) card with a unique ID number, which is also used for their house registration. This national identification number system was developed in 1984 prior to the existence of UCS, but it was never used fully for health insurance or a social protection purpose. For UCS member registration, the NHSO works with the Department of Provincial Administration to use the demographic information provided in this vital registration database. UCS also adopted the national ID card as its membership card, so all individual-level information is linked to the unique ID numbers.

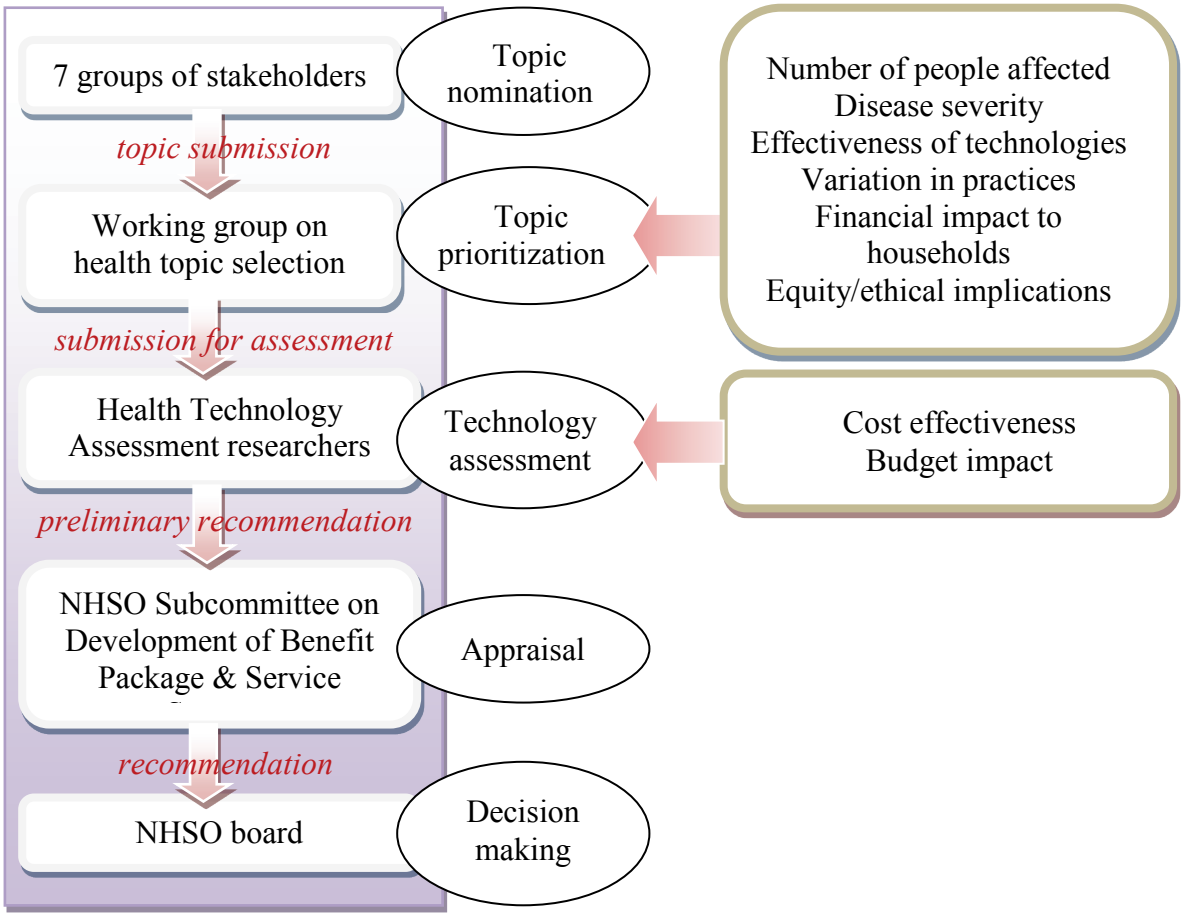
In addition to routine information system development, the NHSO also supports and collaborates with the Health Insurance System Research Office (HISRO), an independent, nonprofit research agency created after UCS to conduct research and development on health financing and health service system development. There were additional ad hoc studies on health outcomes and other aspects of health system performance supported by HISRO using funding from the NHSO. For the research community, there is an agreement between the NHSO and HISRO to use individual utilization statistics for research on health services. To protect patient privacy, a protocol to make the data and other utilization information available for researchers is being developed.

Health technology assessment for UCS benefits decisions

Even though the UCS scheme is relatively comprehensive, it does not cover services for all the available technologies and medicines. The NHSO frequently receives more requests to include new health technologies, medical interventions or medicines or

biologicals in the benefits package. In this regard, the NHSB Committee on Benefits Package is in charge of revising the benefits package and making recommendations to the NHSB on the adoption of new drugs and technologies. Prior to 2010, there were no systematic and transparent mechanisms to make such decisions (Jongudomsuk et al. 2012). A guideline was, therefore, developed and the committee regularly requests the Health Intervention and Technology Assessment Program and the International Health Policy Program, two technical agencies working on health technology assessment and health system evaluation under the MOPH, to supply evidence such as the effectiveness and cost effectiveness of various health interventions that will be considered for benefits package expansion. In addition, financial feasibility, budgetary impact and ethical considerations are among the important criteria in the decision process (figure 13). Overall, UCS contributed significantly to strengthening the health technology assessment capacity in response to its demand for evidence for benefits package decisions.

Figure 13: Schematic diagram of the benefits package decision process since 2010



Source: Modified from: Teerawattananon 2012.

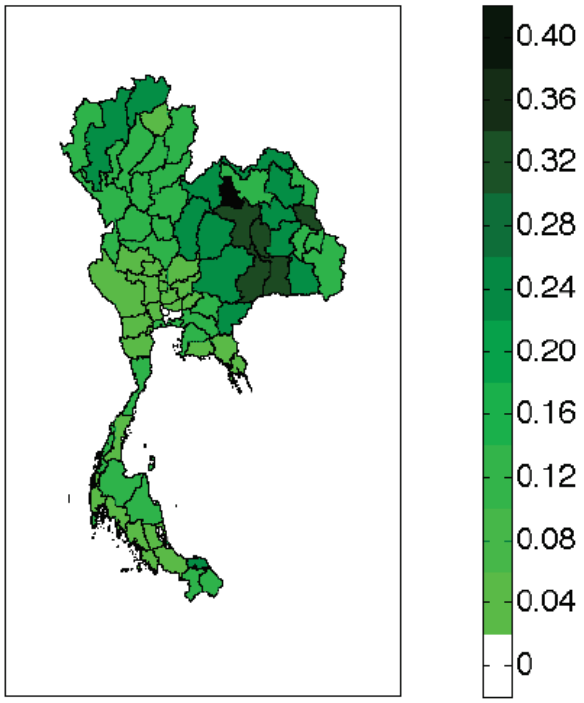
Better distribution of the health workforce for more equitable health system

The health workforce is one of the key components of any health system. With rapid expansion of coverage and increase in health-care utilization, the initial phase of UCS saw higher staff workloads that demanded rapid adjustment from the health-care providers to satisfy the increase in health service needs. This exacerbates the challenges in the Thailand health workforce system that had long suffered shortages and distribution problems of its skilled workforce before the introduction of UCS.

With the change in payment mechanism toward more strategic purchasing, it was expected that demand-side financing would help improve the situation of the health workforce, especially in the rural and deprived areas. By initially including salary as a part of the capitation rate in 2002, health-care providers in rural areas with larger populations and health-care needs, therefore, would have received higher total budgets to increase the number of staff. However, due to the rigidity in the civil service system and its zero-growth policy, the number of health personnel posts in the public sector was heavily controlled, making it difficult to increase staff positions in those areas.

Nevertheless, it was found that the increase in financial autonomy at the hospital level from the UCS payment system relative to formal government budgetary system allowed many health-care providers to better respond to the increase in health-care utilization in terms of health workforce productivity. Many public hospitals were able to provide additional compensation for higher workloads of their staff. In the areas where there was a staff shortage, temporary hospital staff were hired using hospitals' revenue from UCS, a response to mitigate the impacts of the government policy on "zero growth" in civil servant positions. It was found that the proportion of a temporary health professional workforce to civil servant health professional workforce is much higher in the provinces in the northeast region where health professional densities were much lower than in other regions (figure 14). This may imply a response by health-care providers to health-care demand that helped improve health workforce distribution in the country.

Figure 14: Proportion of temporary health professional staff to civil servant, 2009

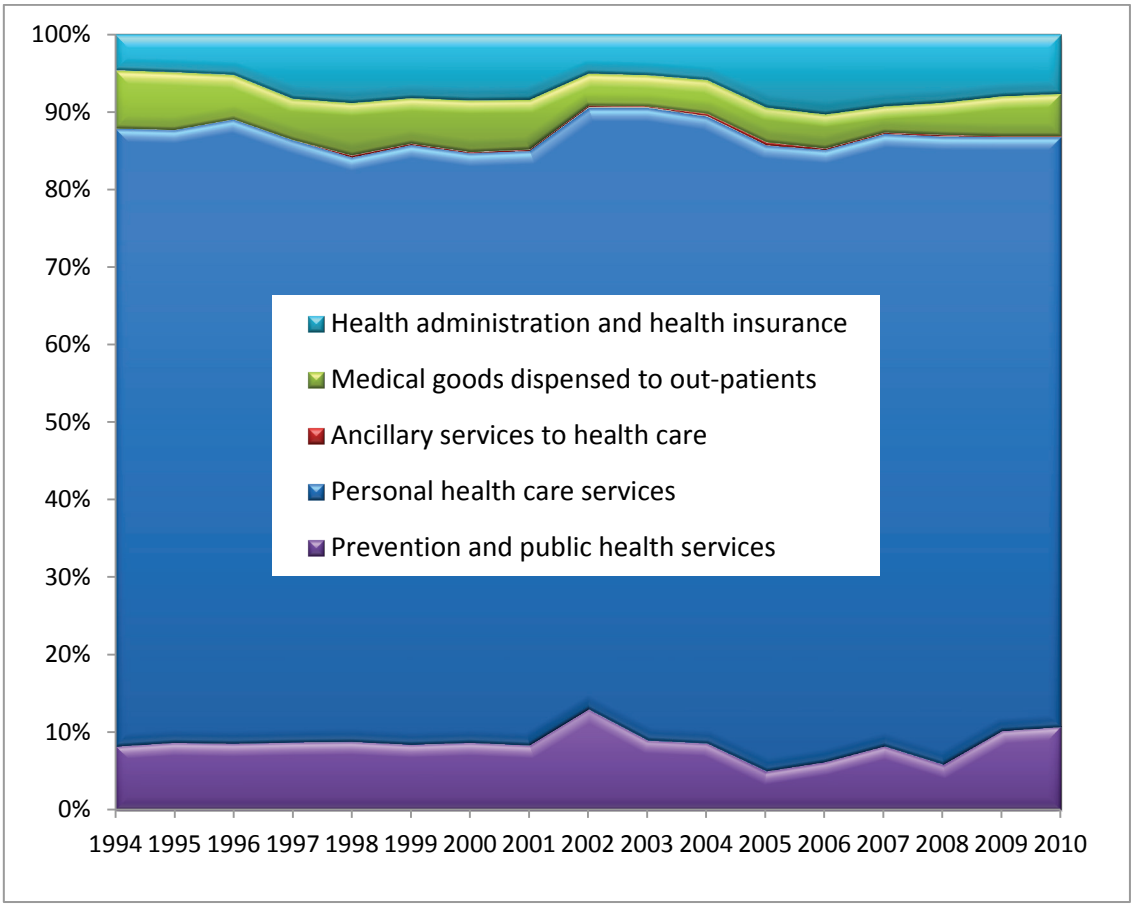


Source: Hanvoravongchai 2013. (using data from the MOPH and the Office of the Civil Service Commission).

Lower share of investment in health promotion and prevention

UCS not only covers medical care, it also designates part of the capitation budget for health promotion and prevention. A number of programmes have been implemented, including a special fund to provide incentives for diabetes and hypertension screening and care. It also gives financial incentives to providers if they complete prenatal care services to pregnant women according to protocols. The NHSO works with local governments to set up subdistrict health funds composed of two sources of funding from UCS and the local government, which are used to support locally driven public health activities or programmes in the subdistrict (Srithamrongsawat et al. 2010.). Despite such investment, the overall impact on prevention and promotion was not satisfactory. Overall funding for public health and disease prevention as a share of total health spending in the country initially declined after the introduction of UCS (figure 15). The UCS focus on curative care means there is less investment in public health functions, especially in the areas that do not receive UCS special payments, and hence lower interest from local health-care managers and staff (Srithamrongsawat et al. 2010). Only recently, the emphasis on health promotion and public health received more attention as shown in the greater proportion of public health spending from 2009 to 2010 (figure 15).

Figure 15: Proportion of total current expenditure on health spent on various health service categories, 1994–2010



Source: Compiled from: NHA Working Group. 2013. *National Health Account data for 2004–2010*.

Impacts on other health financing and slow expansion of social security coverage

The approach of strategic purchasing adopted by the NHSO and the knowledge and know-how generated for its implementation indirectly influenced other major health

insurance schemes to be more active in their purchasing. For example, the SSS considered and implemented a DRG-based payment system for inpatients in 2012 after the successful experience of UCS (SSO 2011).

In regard to the benefits package, UCS also indirectly guided the decisions of other health insurance schemes through its own policy. For example, the UCS decision to cover renal replacement therapy and antiretroviral treatment also influenced the SSS to expand its benefits package for their beneficiaries.

However, UCS may also have a negative influence on social security coverage. Prior to the establishment UCS, medical benefits under social security were continuously expanding to cover more employees from formal sector large firms (20 or more employees) and smaller firms (10 or more employees), with the aim to expand social security to everyone. However, with the introduction of UCS and its free care offered without a need to pay contributions such as with the SSS, the incentives for individuals to enrol in the SSS became much weaker given the relatively few additional benefits in exchange for contribution payments. The proportion of the population with SSS coverage, therefore, remains at about 11–12 per cent of the population even though the SSS tried to expand to cover all firms regardless of the size (see coverage trend in figure 1). The effort to try to expand SSS coverage to spouses and children of the existing members was not popular among the employers or the employees given that these family members could already receive health benefits from UCS. By contrast, some groups of SSS members, such as university employees, request the government to consider allowing them to opt out of the SSS in order to join UCS instead. Lower coverage of the SSS may not be different for health benefit protection, but it does mean a lower proportion of population covered by other forms of social protection such as old-age pension payments.

5. Conclusion

Comprehensive outcomes of Thailand's public sector system of provision for health care

This paper examines the 30 Baht health policy in Thailand in order to analyse the policy process and identify key drivers for the universalization of health care in the country. It reviews the trends of social security extension and examines the policy and institutional linkages between health care, economic policies and general social protection of the country. The paper focuses on both the direct and indirect impacts on the programme objectives and the structure of policy making. Under the PSSOP framework, the paper argues that UCS has had both intended and unintended impacts. Here, the introduction processes of UCS also affected other PSSOPs.

Increased health-care utilization among the previously uninsured is one of the dominant intended outcomes of UHC. As follows, UCS prompts the need for coordination between government units, namely the MOPH and NHSO, in order to extend the coverage. The shift in the health financing authority from the MOPH as the budget holder and providers to the NHSO has made MOPH administrators feeling undermined as the stewards of the health-care system.

In addition, the Thai experience of UHC resulted in relatively lower financial allocation in health promotion and prevention as funding went into medical care in the financing

system (in terms of budget proportion, the declining percentage is shown in figure 15). The central role given to curative care means that there are fewer projects for preventing infection transmission or in understanding the risk of infection and control. Allocation of the fiscal budget also diminishes in terms of health promotion, leaving a smaller budget for other government units working in this area. Efforts for prevention and raising awareness can be found, for example, the Thai Health Promotion Fund, which is an independent state agency funded by the surcharge tax of tobacco and alcohol excise taxes.

Under the politically driven process, the tendency to build health-care infrastructure has been evident since 1975 when the MWS was first introduced to exempt the poor from user fees at government health facilities. Additional health schemes for civil servants and the VHCS also paved the way for UCS in Thailand. In addition, investment in health infrastructure continued during and after the Asian financial crisis of 1997. Amidst political changes in the country, UCS was introduced in 2002 by the Thaksin Shinawatra government.

At the participatory process level, the convergence of political commitment and civil society mobilization paved the way for UCS in 2001. Civil society had a vital role in setting the agenda and participating in the legislative processes. In October 2000, a group of Thai non-governmental organizations led by Senator Jon Ungphakorn supported UHC and drafted a National Health Security Bill.[20] This initiated the process of convincing people that UHC was financially and programmatically feasible.

At the institutional level, the rollout of UHC influenced slow expansion of health insurance under other schemes such as the national SSS, given that attention to health welfare is encapsulated under the 30 Baht health policy. Before UHC, it was intended that social services provision, including the health system, should be under the national SSS. While progress in health care is seen as more evident under the 30 Baht health policy rather than under the country's SSS, the benefits of health-care coverage curbs other benefits that should be covered under the national SSS. For example, with provision of USC there is less necessity for the SSS to include good health-care coverage. Even those who are entitled to health insurance under the SSS have opted to access the 30 Baht health policy instead. This means less attention and, therefore, less improvement in government action programmes that are intended to promote the welfare of the population through assistance measures or other social protection, suggesting institutional disjoint.

Also, at the institutional level, health-care quality improvement through the hospital accreditation system entails increased accountability of the system. Public interests matter because subsequent allocated funding depends on the number of users and patients. Formation of an external monitoring system of the civil society representatives helps push the NHSB toward system improvement. Responsiveness toward needed health care has improved.

UCS has led to an improved database for the informal sector. Since UCS requires added input of those who are not covered by major health insurance, it prompts an information system for beneficiary registration and output monitoring and evaluation. In addition, knowledge of health-care processes and the informal sector becomes more integrated. The need for the NHSO to work with the Bureau of Registration Administration and the

[20] Assessment of Thailand's Universal Coverage Scheme (Synthesis Report).

Department of Provincial Administration suggests increasing the scope for cross-policy learning and capacity development among government units. This opportunity allows for upgraded knowledge and skills and awareness of gaps as well as best practices across units.

At the consumption level, the 30 Baht UHC has expanded its coverage from those insured by civil servant insurance schemes and big corporations to those previously without insurance schemes, mainly informal sector workers. UHC now includes informal sector workers and provides protection to those who were previously uninsured. They now have better access and financial protection from health-care payments. Universal provision suggests a certain number of rights of health care for these groups. Before this universal provision, health protection was a privilege for those who could access health provisions. Ultimately, UCS changed the thinking about health-care provision by the government from a social assistance to a right.

Meanwhile, unintended consequences of UCS reflected the unequal access of health-care provision for migrant workers. So far, the demands of health service providers in the government and the private sector who serve migrant workers and illegal immigrants have grown in order to cope with increasing numbers of migrant workers.[21] The risk of the spread of communicable diseases means that hospitals have had to provide migrant workers with medical treatment despite no provision of health welfare for them. Meanwhile, many health facilities face financial crises as they must treat migrant workers who do not have a work permit and who do not contribute financially to the Thai health system. Health services for these people become a burden and require adjustment. The need for the Thai government to adapt to this requirement parallels the growth of the Thai economy, which is largely supported by the work of migrant workers. According to the International Labour Organization, migrant workers contribute 7–10 per cent of the value to Thailand's industrial sector, 4–5 per cent to the agricultural sector and an overall 6.2 per cent of the country's GDP.[22] In 2012, an estimated 520,000 migrant workers bought an exclusive type of health insurance offered only to migrants, which is rather low considering that there is an estimated 2.4 million non-Thai migrants living in the country.[23] Limited knowledge about this type of health insurance prevents migrant workers from buying health insurance. Thus, the government still must consider how to expand social protection coverage and address the salient risks of illnesses of migrant workers, which may not have been a pertinent issue until now. The need to extend the thinking of health-care coverage not just for Thais, but also for non-Thais indicates an expanded awareness of social risk protection.

Table 4 summarizes the earlier discussion of intended and unintended outcomes of Thailand's UCS health protection.

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21 Many migrant workers in Thailand come from Cambodia, the Lao People's Democratic Republic and Myanmar. There are an estimated four million legal and illegal migrant workers in Thailand. (National Health Commission Office of Thailand. http://en.nationalhealth.or.th/node/294.)

22 National Health Commission Office of Thailand. http://en.nationalhealth.or.th/node/294.

23 National Economic and Social Development Board (NESDB). Social Development Report in Q3 of the Year 2012. NESDB, Bangkok. http://social.nesdb.go.th/social/Portals/0/Documents/Microsoft%20Word%20-%20Press%20release_Q3%202012%20Thai%20and%20Eng%20%28final%29_163.pdf, accessed November 2014.

Table 4: Summary of intended and unintended outcomes of UCS and UHC

	Comprehensive outcome dimensions		
	Process	**Institutions**	**Actors**
Intended	new financial management system—outcome-based payments	NHSO and related organizations	rights of the people to health care
		claims processing unit	uninsured get better access and financial protection from health-care payments
Unintended	slow expansion of social security coverage	health technology assessment institutions and evidence gathering system for policy decision making	migrants insurance and care
	improved management and benefit of the SSS		non-citizen Thais, informal sector
	lower relative investment in health promotion and prevention	health-care quality through hospital accreditation system	

Source: Authors' analysis.

Assessing outcomes based on SP categories

The final discussion on the social protection typology highlights major obstacles and constraints of the Thai context in provision of UHC. The implementation of Thailand's health schemes falls mainly into the protective coping strategies category. In the protective mode, the health scheme aims at protecting marginalized groups or individuals such as children, the elderly and informal workers.

By contrast, even though the preventative mode directly seeks to reduce the vulnerability of individuals or groups to specific shocks and hazards through, for instance, reduction in catastrophic health spending, there still remains less sense of preparedness. For, example, the 30 baht payment is still used in a reactive manner for illnesses and injuries.

The promotive mode of health protection can be considered at two levels: individual and state. At the individual level, Thai citizens have a better opportunity to deflect risks relating to health. With improved health care, citizens have an increasing resilience and protection against illnesses. There are also increasing resources available at hospitals, not only to deal with symptomatic cures, but also to provide advice in preventing diseases and promoting well-being. At this point, deflection of health risks also depends on how the individual approaches and makes use of doctors and medical resources. While better quality care is available for Thai citizens under the 30 Baht health policy, there are still instances where health-care protection remains in the reactive mode, and people usually do not plan how to respond to vulnerability. Instead, they use the 30 Baht health policy out of a sense of urgency.

At the state level, there are increasing aggregate opportunities of productivity. As citizens experience better health, they are able to contribute more to the country's economy. This increase in productivity means that the spillover effect of improved health care is functional to the country's development, whereas the promotive element seems to be more prevalent at the state level.

As for the last category, the link to the transformative element is merely incidental, and not a central rationale. For the transformative mode to be actualized, access and opportunities are needed for minorities in society to improve their social relations and be in a better position to secure health care for themselves. So far, there is no explicit policy that addresses the comprehensive range of migrant workers, but only a health security fund for foreign workers with work permits.

References

ASTV Manager Online. 13 August 2012. *Minister of Health Announces Four Hospital Changes per Year from September 1st*. www.manager.co.th/daily/ViewNews.aspx?NewsID=9550000099523, accessed November 2014.

Brown, A. 2003. *Labour, Politics, and the State in Industrializing Thailand*. Routledge Curzon, London.

Chalermpol, Chamchan and Kanya Apipornchaisakul. 2012. *A Situation Analysis on Health System Strengthening for Migrants in Thailand*, 1st edition. Institute for Population and Social Research, Mahidol University, Nakhon Pathom.

Chang, H.J. 2003. *Globalization, Economic Development and the Role of the State*. Zed Books, London

Davies, M. et al. 2013. "Promoting resilient livelihoods through adaptive social protection: Lessons from 124 programmes in South Asia." *Development Policy Review*, Vol. 31, No. 1, pp. 27–58.

Devereux, S. and R. Sabates-Wheeler. 2004. *Transformative Social Protection*. IDS Working Paper 232. Institute of Development Studies (IDS), Brighton.

Donaldson, D., S. Pannarunothai and V. Tangcharoensathien. 1999. *Health Financing in Thailand*. Technical Report. Management Sciences for Health, Boston.

Dwyer, P. 2010. *Understanding Social Citizenship: Themes and Perspectives for Policy and Practice*. Policy Press, Bristol.

Evans, T.G. et al. 2012. *Thailand's Universal Coverage Scheme: Achievements and Challenges, an Independent Assessment of the First 10 Years (Synthesis Report)*. Health Insurance System Research Office, Bangkok.

Fine, B. and E. Leopold. 1993. *The World of Consumption*. Routledge, London.

Government Gazette. "National Health Security Act B.E. 2545 (A.D. 2002)." 18 November 2002.

Gruber, Jonathan, Nathaniel Hendren and Robert M. Townsend. 2014. "The great equalizer: Health care access and infant mortality in Thailand." *American Economic Journal: Applied Economics*, Vol. 6, No. 1, 91–107.

Hanvoravongchai, P. 2013. *Health Financing Reform in Thailand: Toward Universal Coverage Under Fiscal Constraints*. World Bank, Washington DC, pp.1–36.

HISRO (Health Insurance System Research Office). 2012. *Thailand's Universal Coverage Scheme: Achievements and Challenges*. Health Insurance Systems Research Office, Nonthaburi.

Hughes, D. and S. Leethongdee. 2007. "Universal coverage in the land of smiles: Lessons from Thailand's 30 Baht health reforms." *Health Aff (Millwood)*, Vol. 26, No. 4, July–August, pp. 999–1008.

ILO (International Labour Office). 2011. *Social Protection Floor for a Fair and Inclusive Globalization*. Report of the Social Protection Floor Advisory Group, Chair Michelle Bachelet. International Labour Organization, Geneva

Jongudomsuk, P. et al. 2012. "Evidence-based health financing reform in Thailand." In D. Coady, B. Clements and S. Gupta (eds.), *The Economics of Public Health Care Reform in Advanced and Emerging Economies*. International Monetary Fund, Washington DC, pp. 307–326.

Kinnan, C. 2009. *Distinguishing Barriers to Insurance in Thai Villages*. MIT, Cambridge.

Kwon, H. J. 2005. *Transforming the Developmental Welfare State in East Asia*. Social Policy and Development Programme, Paper No. 22. UNRISD, Geneva

Limwattananon, S., Viroj Tangcharoensathien and Phusit Prakongsaib. 2007. "Catastrophic and poverty impacts of health payments: Results from national household surveys in Thailand". *Bulletin of the World Health Organization*, Vol. 85, No. 8, pp. 600–606.;

Limwattananon, S., Viroj Tangcharoensathien, Kanjana Tisayaticom, Tawekiat Boonyapaisarncharoen and Phusit Prakongsai. 2012. "Why has the Universal Coverage Scheme in Thailand achieved a pro-poor public subsidy for health care?" *BMC Public Health*, Vol. 12, Suppl. 1.

Limwattananon, S., Sven Neelsen, Owen O'Donnell, Phusit Prakongsai, Viroj Tangcharoensathien and Eddy Van Doorslaer. 2013. *Universal Coverage on a Budget: Impacts on Health Care Utilization and Out-of-Pocket Expenditures in Thailand*. CESifo Working Paper No. 4262, May. http://ssrn.com/abstract=2277437.

Mkandawire, T. 2004. "Social policy in a development context: Introduction." In T. Mkandawire (ed.), *Social Policy in a Development Context*. Palgrave Macmillan, Basingstoke.

Na Ranong, V. and A. Na Ranong. 2002. *From Social Assistance for the Poor to Universal Health Coverage: Debates between Two Underlying Principles for 30 Baht Policy*. Health Systems Research Institute, Nonthaburi.

NESDB (National Economic and Social Development Board). Social Development Report in Q3 of the Year 2012. NESDB, Bangkok. http://social.nesdb.go.th/social/Portals/0/Documents/Microsoft%20Word%20-%20Press%20release_Q3%202012%20Thai%20and%20Eng%20%28final%29_163.pdf, accessed November 2014.

NHSO (National Health Security Office). 2012. *National Health Security Office Annual Report 2011*. National Health Security Office, Bangkok,

Office of Small and Medium Enterprises Promotion. 2007. *OTOP Policy and Implementation in 2007*. OSMEP, Bangkok.

Pannarunothai, S. and A. Mills. 1997. "The poor pay more: Health-related inequality in Thailand." *Social Science and Medicine*, Vol. 44, No. 12, pp. 1781–1790.

Parnwell, M. 2002. "Coping with crisis and migration reversal in Thailand." In P. P. Masina (ed.), *Rethinking Development in East Asia: From Illusory Miracle to Economic Crisis Studies in Asian Topics Series No. 29*. NIAS and Curzon Press, Copenhagen, pp. 261–282.

Pongsapich, A. 1999. *Politics of Civil Society*. Southeast Asian Affairs, Institute of Southeast Asian Studies, Singapore, pp. 325–335.

Pramualratana, P. and S. Wibulpolprasert (eds). 2002. *Health Insurance Systems in Thailand*. Health Systems Research Institute, Nonthaburi.

Samrit Srithamrongsawat, Wichai Aekplakorn, Pongpisut Jongudomsuk, Jadej Thammatach-aree, Walaiporn Patcharanarumol, Winai Swasdiworn and Viroj Tangcharoensathien. 2010. *Funding Health Promotion and Prevention—the Thai Experience*. World Health Report Background Paper No. 45. World Health Organization, Geneva. www.who.int/healthsystems/topics/financing/healthreport/ThailandNo45FINAL.pdf.

Sen, A. 2009. *The Idea of Justice*. Harvard University Press, Cambridge.

Sen, A. 1997. "Maximization and the act of choice." *Econometrica,* Vol. 65, No. 4, July, pp. 745–779.

Somkotra, T. and L. P. Lagrada. 2009. "Which households are at risk of catastrophic health spending: Experience in Thailand after universal coverage. *Health affairs*, Vol. 28, No. 3, pp. w467–478.;

Sriratanabun, J. 2002. "Civil servant medical benefit scheme: Unregulated fee-for-service and cost escalation." In P. Pramualratana and S. Wibulpolprasert (eds.), *Health Insurance Systems in Thailand*. Health Systems Research Institute, Nonthaburi.

SSO. 2011. "SSO regulations on health care provider payments." *Government Gazette*, Vol. 128, No. 60, May, pp. 10–12 (in Thai).

T.F.J. 2013. "The biggest microlender of them all." *The Economist*, January. www.economist.com/blogs/schumpeter/2013/01/microfinance-thailand.

Tanmunthong, S. (สุนทร ตันมันทอง) 2010. The 30 Baht Health Scheme (2002–009) Faculty of Economics, Thammasat University. (โครงการหลักประกันสุขภาพถวนหน้า 30 บาทรักษาทุกโรค พ.ศ. 2545—2552 เอกสารวิชาการหมายเลข 806 กุมภาพันธ์ 2553 คณะเศรษฐศาสตร์มหาวิทยาลัยธรรมศาสตร์ โครงการเมธีวิจัยอาวุโส สกว. สำนักงานกองทุนสนับสนุนการวิจัย) (in Thai).

Teerawattananon, Y. 2012. *How HTA Inform Coverage Decisions in Thailand*. Presentation at the Prince Mahidol Award Conference, January www.pmaconference.mahidol.ac.th/index.php?option=com_docman&task=doc_details&gid=639.

Thailand NHA 2011 Working Group 2013. *National Health Accounts of Thailand 2011*. Ministry of Public Health, Nonthaburi.

Tivayanond, P. 2011. *Developmental Welfare in Thailand after the 1997 Asian Financial Crisis*. DPhil thesis. Department of Social Policy and Intervention, University of Oxford, Oxford.

Treerat, N. and B. Ngamarunchote. 2012. *Politics and Power Balance in the Universal Health Security System*. Health Systems Research Institute, Nonthaburi (in Thai).

Wood, G. and I. Gough. 2006. "A comparative welfare regime approach to global social policy." *World Development*, Vol. 34, No. 10, pp. 1696–1712.

World Bank. 2013. *World Development Indicators 2013*. World Bank, Washington DC.