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## The social security scheme in Thailand: what lessons can be drawn?

Viroj Tangcharoensathien \*, Anuwat Supachutikul, Jongkol Lertiendumrong

*Health Systems Research Institute, 5th Floor, Mental Health Department Bldg., Ministry of Public Health, Tiwanon Road, Nonthaburi 11000, Thailand*

### Abstract

The Social Security Scheme was launched in 1990, covering formal sector private employees for non-work related sickness, maternity and invalidity including cash benefits and funeral grants. The scheme is financed by tripartite contributions from government, employers and employees, each of 1.5% of payroll (total of 4.5%). The scheme decided to pay health care providers, whether public or private, on a flat rate capitation basis to cover both ambulatory and inpatient care. Registration of the insured with a contractor hospital was a necessary consequence of the chosen capitation payment system. The aim of this paper is to review the operation of the scheme, and to explore the implications of capitation payment and registration for utilisation levels and provider behaviour. A key weakness of the scheme's design is suggested to be the initial decision to give employers not employees the responsibility for choosing the registered hospitals. This was done for administrative reasons, but it contributed to low levels of use of the contractor hospitals. In addition, low levels of use were also probably the result of the potential for cream skinning, cost shifting from inpatient to ambulatory care and under-provision of patient care, though since monitoring mechanisms by the Social Security Office were weak, these effects are difficult to detect conclusively. Mechanisms to improve utilisation levels were gradually introduced, such as employee choice of registered hospitals and the formation of sub-contractor networks to improve access to care. A beneficial effect of the capitation payment system was that the Social Security Fund generated substantial reserves and expenditures on sickness benefits were well stabilised. The paper ends by recommending that future policy amendments should be guided by research and empirical findings and that tougher monitoring and enforcement of quality of care standards are required. © 1999 Elsevier Science Ltd. All rights reserved.

*Keywords:* Capitation payment; Utilisation pattern; Cost containment; Provider behaviour; Thailand

### Introduction

In Thailand, there are four categories of publicly organised health insurance and medical welfare systems covering 31.4 million people, 56% of the Thai population (Tangcharoensathien and Supachutikul, 1993a).

The first category, the public assistance scheme financed by general tax revenues, covers 27% of the population consisting of low income households, the

elderly (over 60 years) and primary school children. A means test based on income is used to allocate free health cards to poor households. Card holders are entitled to free care at designated outlets, mainly Ministry of Public Health (MOPH) subdistrict health centres manned by paramedics or district hospitals. Access to higher levels of care requires a referral letter.

The second category includes the scheme for government officials (Civil Servant Medical Benefit Scheme, CSMBS) which is financed by general tax revenue and provides generous benefits to civil servants themselves, their parents, spouses and up to three children under 18 years old. This is seen as a fringe benefit for the

\* Corresponding author. Tel.: +66-2-951-1286/94; fax: +66-2-951-1295; e-mail: viroj@hsrint.hsri.or.th