

Competing interests: JS chaired the working group preparing guidelines on injectable opiate maintenance treatment for the National Treatment Agency and Department of Health (2002/3) and has recently been awarded a research grant for randomised trial of injectable versus oral opiate maintenance treatment

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Learning from Thailand's health reforms

Adrian Towse, Anne Mills, Viroj Tangcharoensathien

Providing all of Thailand's population with subsidised health care required radical changes in the health system

Thailand took a "big bang" approach to introducing universal access to subsidised health care. In 2001, after years of debate¹⁻³ and slow progress,^{4,5} it extended coverage to 18.5 million people who were previously uninsured (out of a population of 62 million). This move was combined with a radical shift in funding away from major urban hospitals in order to build up primary care. Such an approach has merits but also risks. We discuss the implementation and some of the problems.

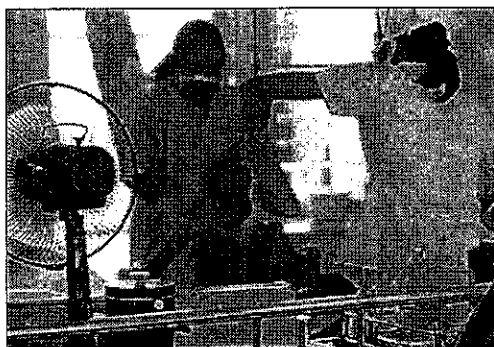
Formulating the change

Prime Minister Shinawatra obtained a landslide victory for his Thai-Rak-Thai (Thais love Thais) Party in 2001 on a platform including the "30 baht treat all" scheme for universal access to subsidised health care. Under the scheme, people pay 30 baht (£0.50, €0.7, \$0.86) for each visit or admission.

Thailand previously had four public risk protection schemes (box 1) with widely differing benefits and contribution levels. These schemes protected a total 43.5 million people, leaving 18.5 million paying fees for care from public or private providers.

The initial plan was to merge resources from the four schemes into one universal coverage scheme to remove overlaps in coverage and improve equity. This met resistance from government departments running the other schemes and from civil servants and trades unionists benefiting from the two employment based schemes. The government therefore decided to fund the 30 baht scheme by pooling the Ministry of Public Health budgets for public hospitals, other health facilities, and the low income and voluntary health card schemes and providing some additional money. This could be done without legislation, enabling progress to be made while legislation was prepared and debated.

The National Health Security Act was passed by parliament in November 2002, creating new institutions to regulate the quality and financial elements of the scheme. It preserves all benefit entitlements for members of the civil service and social security schemes but places management of their financing



The Hai healthcare system is dominated by hospitals

with the National Health Security Office, which runs the 30 baht scheme. The act allows for the civil service and social security schemes to be merged into a single universal coverage scheme by decree should that become politically acceptable in the future.

Factors required for implementation

In low and middle income countries, government capacity is often a key constraint on the design and implementation of policy change.^{6,7} In Thailand, previous experience and investment in health care was essential for implementation of the universal coverage scheme.

Over several decades, comprehensive healthcare coverage had been achieved through developing infrastructure in rural areas, where two thirds of Thailand's

Office of Health Economics, London SW1A 2DY

Adrian Towse
director

London School of Hygiene and Tropical Medicine, London WC1E 7HT

Anne Mills
professor

International Health Policy Programme, Thailand, Bangkok

Viroj Tangcharoensathien
researcher

Correspondence to: A Towse atowse@ohe.org

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Box 1: Public risk protection schemes

Civil servants medical benefit scheme—introduced in the 1960s for civil servants and their dependants

Low income card scheme—introduced in the 1970s; providing free care to low income families and individuals, elderly people, children under 12 years, and people with disabilities

Voluntary health card scheme—predominantly rural; introduced in the 1980s and funded through equal matching of household and Ministry of Public Health payments

Social security scheme—introduced in the 1990s; it protects workers only and is mandatory for all private firms with more than one employee

P+ Tables showing the costs of health care are on bmj.com