# Situational Analysis of the Health Insurance Market and Related Educational Needs in the Era of Health Care Reform in Thailand

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**Abstract**

The purposes of this study were to explore the situation of health insurance in Thailand, to compare public and private perspectives and to identify related educational needs. Between March and April of 1998, the study employed in-depth interviews of 12 public and private major stakeholders of the health insurance systems, including policy makers, providers and insurers. Additional inputs were gathered in a brainstorming session with 41 participants from organizations with important roles in regulating, monitoring, paying, or providing health care services, as well as research and education.

The findings indicated the health insurance market was expanding. But there was no national policy on health insurance. Insurance-related law was outdated. Public and private schemes overlapped, and were generally characterized by inadequate risk diversification, over-utilization of services, lack of effective cost containment, inconsistent service quality, and poor understanding of health insurance principles. There were needs for more education and training in various aspects of health services management and health-insurance related functions.

Consequently, continuing education and training related to health insurance services for policy makers, system administrators, managers, providers and insurers are strongly recommended during the health-care reform process.

**Key word :** Health Insurance, Health Care Reform, Education, Thailand

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The health care system in Thailand has been changing very rapidly in the last decade. It is in transition, both in the way health services are delivered and the mean they are financed. Although the public has always been a major health care provider for the population, the role of the private sector-- primarily for-profit-- is increasingly important. The proportion of private hospital beds to total beds grew from 7.4 per cent in 1973 to 23.1 per cent in 1995[1]. However, more than one-fourth of the 60-million Thais are uninsured, not being covered by any public and private health insurance schemes[2]. Private health insurance also exists, but the market is relatively small being estimated around 8 per cent of the population[3]. The number has increased from the estimated 1.6 per cent in 1992 [4].

Health insurance schemes in this country-- such as the Health Card project, the Social Security Scheme (SSS), the Civil Servants Medical Benefit Scheme (CSMBS) and the public assistance for the indigent-- vary in terms of choice of providers, type of services, benefit coverage, as well as inclusive and exclusive conditions. The modes of service delivery depend upon the financing systems. The methods of provider payment depend upon the philosophy and objectives of each scheme and the management system of its responsible agency. Some major interesting features and differences among schemes are summarized in Table 1.

A health insurance study published in 1996 suggested a number of problems in controlling costs, service utilization, equity and quality of services under different insurance schemes[4]. Cost containment is a major challenge for CSMBS and the Health Card project. The health care expenditure under CSMBS has increased 3 folds within 6 years, from 4,316 million in 1990 to 13,587 million in 1996. Problems of CSMBS also include longer average length of stay than comparable others, cost shifting and fraud[5]. The government expenditure on CSMBS was seven times that of the Low Income scheme.

Financial instability due to growing health care cost is also present in the Health Card project. While the income per card is 1,000 baht (500 from a purchaser and 500 from the government subsidization), the average expenditure per card reached 1,893 baht in 1997. The project suffers selection bias and high hospitalization rates[6]. Currently, there are attempts to reform the Health Card and CSMBS schemes in order to contain cost.

In contrast, under-utilization was prevalent in the early years of SSS. It was attributed to inaccessibility, bureaucratic administration, and inadequate information for SSS beneficiaries[7]. However, the utilization rates have jumped dramatically in recent years. Out-patient visits increased from 0.33 visit per person per year in 1991 to 1.23 visits per person per year in 1995[8,9]. It is believed that better accessibility, awareness among the beneficiaries of their rights and employees' freedom to choose main contractors contributed to the trend. The number of main contractors and network providers in the scheme keeps expanding-- particularly private ones-- although there have been complaints of inadequate capitation payments from the private contractors[10]. The amounts paid to main contractors were increased from 700 baht per person per year (pppy) in 1991 to 800 baht pppy in 1995, and to 900-1000 baht in early 1998-- or about a 50 per cent rise from the 1991 figure.

Service quality of public and private hospitals varied[4]. For public hospitals, major consumer complaints concerned slow services, long queues, poor personnel manners, unsanitary toilets and inadequate information for patients. High price was also a major complaint for private hospitals. Nevertheless, patients were generally more satisfied with private hospitals than public ones[11,12]. In addition, patient satisfaction was, on average, lower among main contractors under the SSS than other hospitals[12]. The finding might relate to the capitation mode of provider payment, poor hospital financial status prior to becoming a main contractor, and different competitive strategies between main-contractor and non-main-contractor hospitals[10].

Problems also exist in the private health insurance sector. Information imbalance between the insured and the insurer, high administrative cost relative to benefits for the insured, lack of power to control costs under the fee-for-service payment system and adverse selection were sited as its weaknesses[4].

Alteration in the way the country finances its health care system have impacts on all of its

**Table 1. Health insurance and welfare schemes in Thailand.**

| Major health insurance schemes | Responsible agencies | Coverage (million)[1] | Financing | Provider payment | Primary mode of service delivery | Interesting characteristics |
|---|---|---|---|---|---|---|
| Health welfare for general population | | 20.3 | | | | |
| Low income | MOPH | 11.7 | Gen. Tax | Global budget | Public only | * Most needy |
| The elderly | MOPH | 3.5 | Gen. Tax | Global budget | Public only | covered; unfair |
| Primary school children | M Ed | 5.1 | Gen. Tax | Capitation | Public only | budget allocation |
| Health welfare for state employees | | 6.4 | | | | * Consuming |
| Civil Servant Medical Benefit | M Fin | 5.6 | Gen. Tax | FFS | Public (Private) | resources seven |
| Public enterprises | Employer | 0.8 | Enterprise Revenue | FFS | Public / Private | times of the low-income scheme |
| Compulsory health insurance | | 5.2 | | | | * Contributions |
| Social Security Scheme | SSO | 5.2[2] | Payroll tax, employer, gen. tax | Capitation (+ fee schedules) | Public / Private | related to income * Using contracted |
| Workmen compensation fund | SSO | 1.8 | Employer only | FFS | Public / Private | providers |
| Voluntary health insurance | | 13.0 | | | | |
| Health Card project | MOPH | 8.1[3] | Gen. Tax | Capitation + workload | Public | * Community rating; adverse selection |
| Private health insurance | Insurance companies | 4.9[4] | Premium | FFS | Private (Public) | * Experience rating; high admin. Cost |

Source: Modified from Supachutikul (1996)

Note: (1) the numbers are based on Tangcharoensathien and Supachutikul (1993) except for (2) 1995 Annual report of the Social Security Office, (3) Srithamrongsawat (1998), and (4) Surasiengsung (1998); The total population of Thailand is about 60 million (1997).

Abbreviations: MOPH = Ministry of Public Health; M Ed = Ministry of Education; M Fin = Ministry of Finance; SSO = Social Security Office; Gen. Tax = General taxation; FFS = Fee-for-service

components. Thailand needs to prepare for change. Human resources development for all parties involved in the process-- policy makers, insurers and providers, public and private-- may be one of the key success factors. This study, therefore, aimed to explore problems related to health insurance in the present health care system, to compare the perspectives of the public health sector with those of the private one, and, where possible, to identify any educational needs among health care providers, health insurers and others who may have concern.

## METHOD

The study used in-depth interviews. In order to ensure the quality of information, two teams of interviewers were arranged to question the total of twelve people whom the investigators believed were experts in the field. They were selected to be representatives of major stakeholders in financing and providing health care services in Thailand. The interviewees from the public sector included a provincial health director of the Ministry of Public Health from the northern part of the country, a hospital director of a public community hospital in a vicinity province of Bangkok, and four high-level executives from two major governmental agencies responsible for public health insurance schemes, including the Health Insurance Office of the Ministry of Public Health (the health card scheme and the public assistance scheme for the indigent) and the Social Security Office of the Ministry of Labor and Social Welfare (the social security scheme and the workmen compensation fund). They had experience working in their positions for 2 to 10 years, in addition to insurance knowledge from formal education and training both domestically and/or abroad.

The interviewees from the private sector were three private-hospital directors and three executives from three market-leading commercial insurers. The three hospitals were all for-profit. One of them is in Samutprakarn province, and is a main contractor under the SSS. The other two hospitals were system hospitals located in different areas of Bangkok--the capital city of Thailand. Both used to be main contractors in the SSS, but they withdrew a few years after participation in the scheme. Two out of the three selected insurance companies in the study sell health and life insurance, while the other one sells only health insurance. They currently account for more than 80 per cent share in the private health insurance market[3].

The interviews applied similar semi-structured questionnaires with open-ended questions asking for their opinion on the current situation and problems of health insurance in Thailand. Where applicable, specific dimensions of health insurance problems were briefly probed, including how health insurance worked in general, culture and behavior of consumers, patient rights, law and medical ethics, management of a health insurance program, sale, premium, compensation payments, standards and quality of services, provision of medical care, and an impact on medical technology. Finally, they were asked to state knowledge and skills required for managing health insurance-related services as health care providers, as well as insurers. The responses could reflect their own needs for additional training, or what they saw as necessary for others who work in this area. The survey period was between March and April of 1998.

Preliminary findings were presented in a brainstorming session organized at the Faculty of Medicine, Chulalongkorn University in Bangkok for comments and suggestions, particularly on educational needs. Criteria for inviting participants were that their organizations took part and played important roles in either regulating, monitoring, paying, or providing health care services, as well as doing research and offering educational programs related to health care and insurance. There were 11 executives from the Ministry of Commerce, which oversees private insurance, and all public third-party payers--including the Ministry of Public Health, the Ministry of Finance, and the Social Security Office. Other participants included eight managers and advisors from private insurers, 13 public and private hospital administrators and nine academicians.

## RESULTS

Table 2 displays a summary of the general situational assessment of the health insurance market in Thailand made by the interviewees. Public and private perspectives shared many similar concerns while there were some differences in emphasis. Both sides indicated that, despite outdated insurance-related laws, the health insurance

**Table 2. Summary of major points made by the interviewees from the public and the private sectors on general issues of health insurance (HI).**

| | Public-sector perspectives | Private-sector perspectives |
|---|---|---|
| General situation | 1. HI sector is growing slowly, but has not achieved objectives.<br>2. Those who buys HI tend to be sick, leading to high cost.<br>3. Private HI generate bad attitude and lower confidence of general population to join public schemes. | 1. Market is small but growing, becoming more and more important to private hospitals.<br>2. There is over-utilization of health services, leading to high cost.<br>3. Provider networks are expanding, similar to PPOs in the U.S. |
| Cultural, social economic, and political influence | 1. Attitude of people towards health insurance is improved. | 1. People with HI have high expectation but do not understand the principle of HI, whereas they do not study the policies clearly and are misled by insurance sale representatives. |
| Difference between urban and rural areas | 1. Rural people have fewer options than urban ones.<br>2. Rural people buy more health cards than urban ones. The health card project has been expanding.<br>3. There are differences in quality of services between the areas. | 1. Private insurance customers tend to be urban.<br>2. Expectations of urban and rural people differ, but the difference is diminishing, particularly between those in urban and suburban communities. |
| Human rights and patients rights | 1. Human rights and patient rights are defined based on law; there should be a legislation so that people have more security. | 1. There is no specific law to support patient rights and regulate the use of information in medical records. |
| Roles of mass media/ promotional activities | 1. The role of mass media should involve more to allow criticism for improvement. More information related to health insurance should be released to the public. | 1. Mass media tends to have negative impacts on health insurance market, contributing to people's having higher expectations than their insurance policies actually offer. |

market in Thailand was growing and in the reforming process. The market-- especially in the private sector-- was still rather small. Both voluntary public and private schemes were generally characterized by inadequate risk diversification and over-utilization of services. They were attributed to voluntary nature of most of the insurance schemes, lack of effective cost containment mechanism, and high expectation on health services contributed. The insured rarely read insurance policies they had and did not understand the principle of health insurance. Some thought they could get any services any time they wanted for free since they had already paid for them. The interviewees also mentioned some differences between urban and rural areas in terms of choices of providers, preferred insurance schemes and quality of care.

Major concerns over managing health insurance related services are summarized in Table 3. A number of interviewees indicated that insurance schemes overlapped one another. There was a need for a national policy on health insurance to create unity and guidelines to solve conflicts between insurers. Current laws need revision to enable development of the insurance market. Several responsible government agencies were referred to as having personnel who lacked adequate knowledge and understanding of health insurance. At the same time, there were a number of innovations, such as managed care plans, introduced into the market without adequate information and legal support. The private sector had concerns on the behavior of insurance sale agents who lacked correct understanding of health insurance principles and concentrate their efforts on selling products to the vulnerable to maximize commissions. Premiums have rapidly increased due to high utilization rates.

In addition, there seemed to be a lot of claim frauds and abuse in both public and private insurance schemes. They were more prevalent among private hospitals. The result was unrealistically high health care expenses. Cooperation among patients, insurance sale agents and physicians was blamed as the enabling factor of frauds and abuse. As an example raised by a few interviewees, there were some physicians who thought that insurance companies were rich and could pay for everything.

**Table 3. Summary of major comments made by the interviewed public and private insurers and providers on health insurance (HI).**

| | Public sector perspective | Private sector perspective |
|---|---|---|
| Comments from third party payers /insurers | 1. Overlapping schemes; no unity and no uniform national policy on HI<br>2. Lack of basic knowledge of HI by administrative personnel<br>3. Several management problems in the Health Card scheme of the Ministry of Public Health<br>4. High number of claims in the Workmen Compensation Fund; Possibility of abuse and fraud | 1. No specific law and regulation for proper management of cases with duplicating insurance policies; no law to support growth of HI<br>2. Inadequate and outdated fundamental data and information to accommodate growth of managed care<br>3. No universal standards to justify hospital charges<br>4. High administrative cost (*10% excluding commission)<br>5. Governmental agencies do not have enough expertise in HI<br>6. Lack of understanding in HI among insurance sale agents<br>7. High insurance premium; potentially unrealistic calculation; inadequate number of actuaries<br>8. Too high service utilization rates, resulting in high health care expenditure; possible frauds and abuses |
| Comments from providers | 5. Current emphasis on coverage and efficiency over equity; individual focus; lacking holistic approach to care<br>6. Upward trends for quality problems, unnecessary services and delay in service delivery<br>7. High doctor fee in the private sector; no standardized fee schedule | 9. Need for quality standards, good quality management, utilization management and risk management systems among hospitals<br>10. Lack of HI knowledge among physicians<br>11. Inadequate choices and return in the HI market<br>12. Outdated and poorly implemented insurance law in health care<br>13. Need for more rationalized use of technology, resource allocation and better referral systems |

**Table 4. Summary of topics of interest and comments for educational programs related to health insurance.**

| | Public-sector perspectives | Private-sector perspectives |
|---|---|---|
| Health insurance administrators | 1. Planning<br>2. Financial management / accounting<br>3. Productivity improvement<br>4. Health economics<br>5. Marketing<br>6. Service ethics and health insurance related law<br>7. Portfolio management<br>8. Concepts and principles of health insurance<br>9. Pricing and reference price setting<br>10. Actuary<br>11. Information technology | 1. Marketing<br>2. Basic knowledge of health insurance<br>3. Insurance medicine<br>4. Roles of physicians in health insurance<br>5. Actuary<br>6. Anti-selection<br>7. Basic managed care techniques and utilization review<br>8. Hospital contracting and provider profiling<br>9. Hospital data and coding systems |
| Health care providers | 1. Financial management / accounting<br>2. General management<br>3. Health economics<br>4. Concepts and principles of health insurance<br>5. Marketing and service psychology<br>6. Network building and supporting | 1. Overview of health insurance in Thailand and abroad<br>2. Medical audit<br>3. Utilization management<br>4. Quality management<br>5. Risk management<br>6. Cost containment<br>7. Customer satisfaction<br>8. Management without financial loss |
| General comments | 1. Organize training programs in levels: the executive level, the general level, the provincial level, and the research / speaker level<br>2. Form network of researchers | 1. Have the Ministry of Public Health as an advisor for development of training programs<br>2. Concepts of health promotion and disease prevention |

There is also a need for better service standards, quality management programs, risk management and utilization management systems, despite some quality movements-- such as the audit system of the Social Security Office in private contractor hospitals under the scheme and the initiation of the hospital accreditation process in 1997. Comments among private providers indicated that public hospitals were unpopular among privately insured patients since they were inconvenient. Services were slow. Moreover, pharmaceutical expenses were relatively high.

Table 4 summarizes topics for continuing education raised by the survey interviewees and participants in the brainstorming session organized in Bangkok. In order to prepare public and private health personnel for expansion of public health insurance schemes and changes in the private health insurance market, there were clearly needs for more education and training in general management, financial management, health economics, health services management, laws and ethics, and a number of health insurance related concepts-- including principles of health insurance and managed care. There was also a comment that health personnel and health-related business should have adequate knowledge of health promotion and disease prevention in order to achieve health for all while containing costs.

## DISCUSSION

The study can point out a number of trends and problems, as well as needs for education and training for skills related to various aspects of the health insurance in Thailand. They could be grouped into four levels-- policy, system, organizational and individual levels. At the policy level, despite expansion of the health insurance market, there is no uniform national policy or public consensus on how health insurance should be provided to the population. It results in no clear direction for development. A national health insurance law is very much needed.

The system-level problems include overlapping of multiple insurance schemes. Current insurance laws and regulations might be outdated, and can hardly accommodate rapid development of the market. Significant differences among insurance schemes in how they were organized, provided coverage and reimbursed providers were

mentioned. Moreover, risk diversification in voluntary schemes was poor. Poor coordination among governmental agencies responsible for various health insurance schemes was evident. Unnecessary service utilization seems to contribute, more or less, to the increasing cost of care. The actual figure is yet to be determined. Public information related to health insurance was poor. These factors may contribute to inefficiency and inequity in the market. No study has been conducted to estimate the potential loss.

At the organizational level, insurers and hospitals lack quality and update of information to manage their services effectively. Administrative costs seemed to be high. Public and private hospitals require new management approaches to cope effectively with the expanding third-party payer market and other changes in the health care market, including quality management, risk management and utilization management.

Finally, there are problems at the individual level. They were attributed partly to lack of knowledge on the principle of health insurance. Opportunistic behavior of patients, physicians and insurance agents were not uncommon. The knowledge problem was also found in governmental agencies overseeing health insurance schemes, including the Ministry of Public Health, the Ministry of Finance and the Ministry of Commerce. There is a need for more in-depth studies to assess the extent of how fraud and abuse occur in different insurance schemes.

Overall, concerns from some previous studies cited earlier are still evident in this study (4). Educational needs in health insurance related services are clearly prevalent. One might draw such conclusions directly from what have been raised from the interviews, and indirectly from the problems and trends of the market. At least four target groups can be identified: insurers, providers (hospitals and physicians), insurance representatives and consumers. Obviously, insurers and providers indicate different needs, while there is not much difference between the public and private sectors. There are some common topics, including principle of insurance, marketing, cost and utilization management. The need for some management-related subjects, such as financial management and accounting, are more prevalent in the public sectors.

The health care system in Thailand is under the reform process. Although there are many issues in the health care system of the country that need to be addressed, we see the human resources as one of the key success factors in dealing with the changing system. We strongly recommend continuing education and training related to health insurance services for health personnel at all levels-- including policy makers, system administrators, managers, as well as providers and insurers-- so that they have the right concepts to enable successful health care reform. At the beginning, although the primary target might be the public sector in our opinion, a common program with participants from both the public and private sectors offers certain advantages as they may be able to exchange ideas, experiences, and perspectives. This might lead to better understanding of each other and future collaboration between them.

Despite our interviews with selected public and private key players in the health care system of the country, we recognize limitations of the study due to the small number of interviewes. It is at the exploratory stage. More research in this area is required since human resources development is undeniably one of many important components of any reform process. We hope that our work can be the first step towards a more comprehensive and systematic assessment of dynamics and need for education and training within the health care system of Thailand, and be a case study for other developing countries in preparing for the nation's health care reform activities as they are currently implemented and will be proposed in the near future.

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# การประเมินสถานการณ์ตลาดการประกันสุขภาพและความต้องการด้านการฝึกอบรมที่เกี่ยวข้องในยุคของการปฏิรูประบบบริการสาธารณสุขในประเทศไทย

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การศึกษาครั้งนี้มีจุดประสงค์เพื่อประเมินสถานการณ์เกี่ยวกับการประกันสุขภาพในประเทศไทย เปรียบเทียบมุมมองระหว่างภาครัฐ ภาคเอกชน และค้นหาความต้องการด้านการศึกษาอบรมที่เกี่ยวข้องกับการประกันสุขภาพ โดยการสัมภาษณ์เชิงลึกผู้ที่มีส่วนได้ส่วนเสียที่สำคัญในระบบประกันสุขภาพ ได้แก่ ผู้บริหารระดับนโยบาย ผู้ให้บริการ และองค์กรที่รับประกัน ทั้งภาครัฐและภาคเอกชน ในระหว่างเดือนมีนาคมถึงเมษายน พ.ศ. 2541 และโดยจัดการประชุมระดมสมองขึ้นมีผู้เข้าร่วมประชุม 41 ท่านจากองค์กรที่มีบทบาทที่สำคัญทั้งภาครัฐและเอกชน ในด้านการควบคุม การกำกับ การคลัง และการให้บริการด้านการดูแลสุขภาพ รวมทั้งด้านการวิจัยและการศึกษา

ผลการศึกษาพบว่า ตลาดของการประกันสุขภาพกำลังขยายตัว อย่างไรก็ตามยังไม่มีนโยบายในระดับชาติเกี่ยวกับเรื่องการประกันสุขภาพ กฎหมายที่เกี่ยวข้องกับการประกันล้าสมัย มีความซ้ำซ้อนกันระหว่างระบบการประกันสุขภาพของภาครัฐ และระบบของภาคเอกชน และมักมีปัญหาในด้านการกระจายความเสี่ยงไม่ดี มีการใช้บริการที่มากเกินสมควร ไม่มีการควบคุมต้นทุนที่มีประสิทธิผล คุณภาพของบริการไม่สม่ำเสมอ บุคลากรที่เกี่ยวข้องมักมีความเข้าใจที่ไม่ถูกต้องเกี่ยวกับหลักการของการประกันสุขภาพ และพบว่ามีความต้องการด้านการศึกษาและอบรมในด้านต่างๆที่เกี่ยวข้องกับการจัดการบริการทางสุขภาพและบริการที่เกี่ยวเนื่องกับการประกันสุขภาพ

ข้อมูลที่ได้จากการศึกษาในครั้งนี้ชี้ให้เห็นว่าการศึกษาและอบรมต่อเนื่องในเรื่องบริการที่เกี่ยวเนื่องกับการประกันสุขภาพสำหรับผู้บริหารระดับนโยบาย ผู้บริหารระบบประกัน ผู้จัดการ ผู้ให้บริการ และผู้รับประกัน น่าจะเป็นสิ่งจำเป็นสำหรับกระบวนการปฏิรูประบบบริการสาธารณสุข

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