Financing universal health coverage in Thailand: Achievements and key challenges

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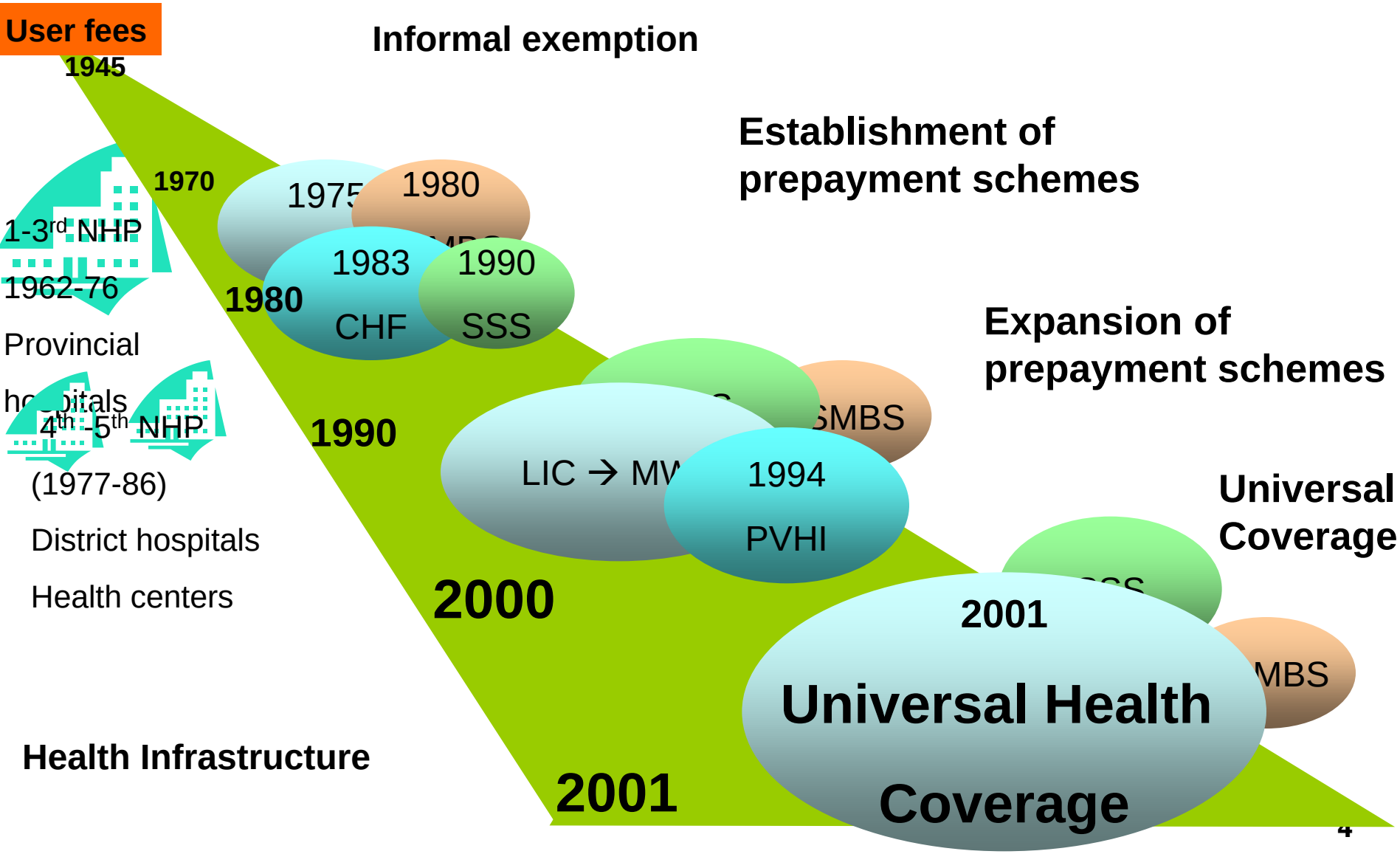
Outline

- The road to UHC in Thailand
  - From user fees to universal coverage
  - Key problems driving financing reform
  - Key factors in making reform happen
- Assessing implementation
  - Sources of financing,
  - Purchasing services,
- Outcomes
  - Trends in out-of-pocket payments,
  - Financial risk protection and health impoverishment,
  - Access to care,
- Summary and conclusions

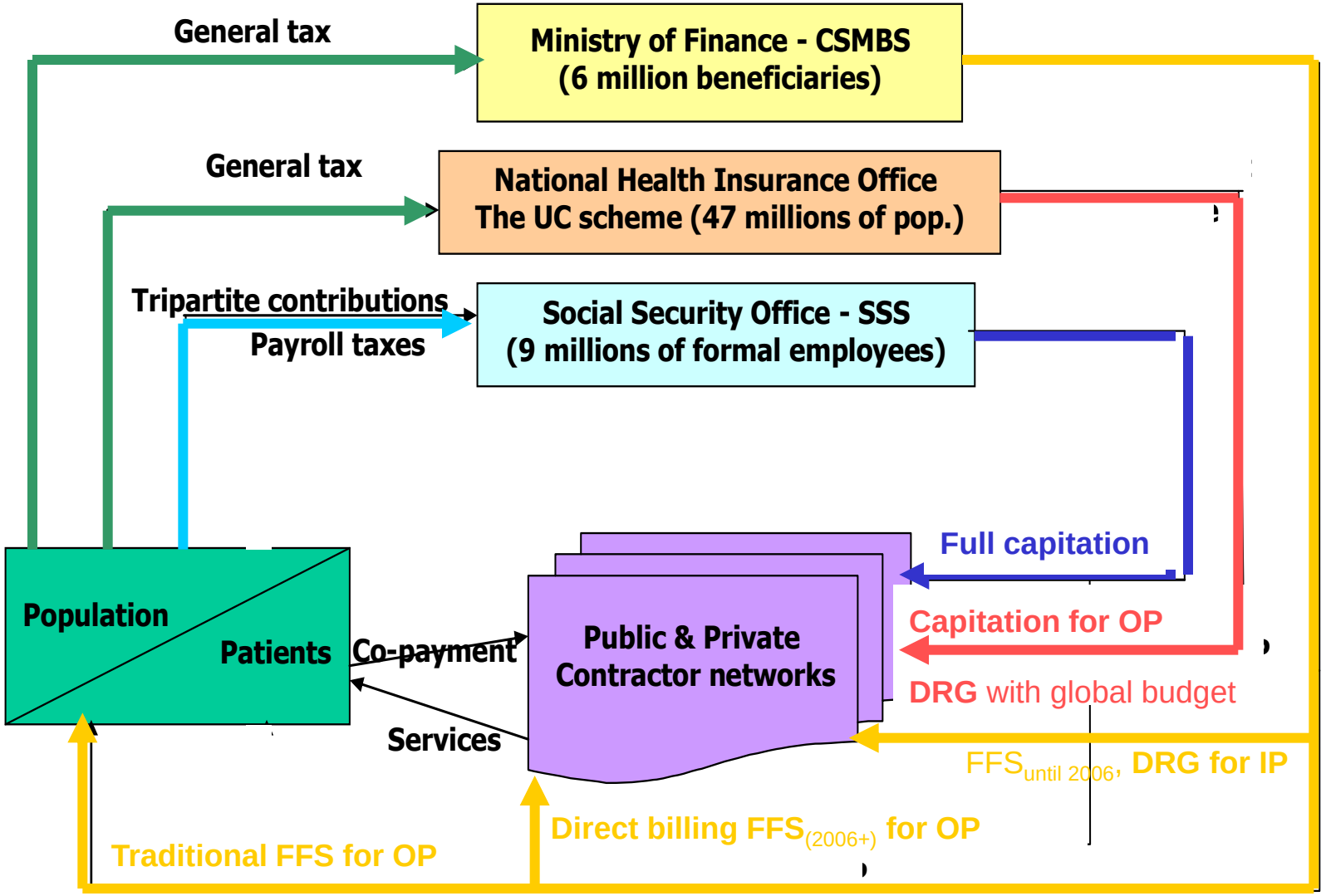
Background

- Population - 68 million
- Life expectancy at birth - 71 years
- GNI/cap - $7,640
- Health Expend/cap - $350
- Physicians/cap – 4/10,000
- Birth rate – 14/1,000
- Death rate – 9/1,000

Thailand: historical development



Health financing arrangements and three public health insurance schemes in Thailand after achieving UHC in 2002



Source: Tangcharoensathien et al. (2010)

Civil Servant Medical Benefit Scheme (CSMBS)

Nature	Fringe benefits, tax-based system
Financing model	Public reimbursement model
Beneficiaries	Government workers, pensioners and their dependents (5.4 million)
Benefit package	Comprehensive package including OP, IP, and private ward in public hospitals
Service providers	Free choice of public facilities Access to private hospitals only in case of emergency
Payment method	Retrospective fee-for-services

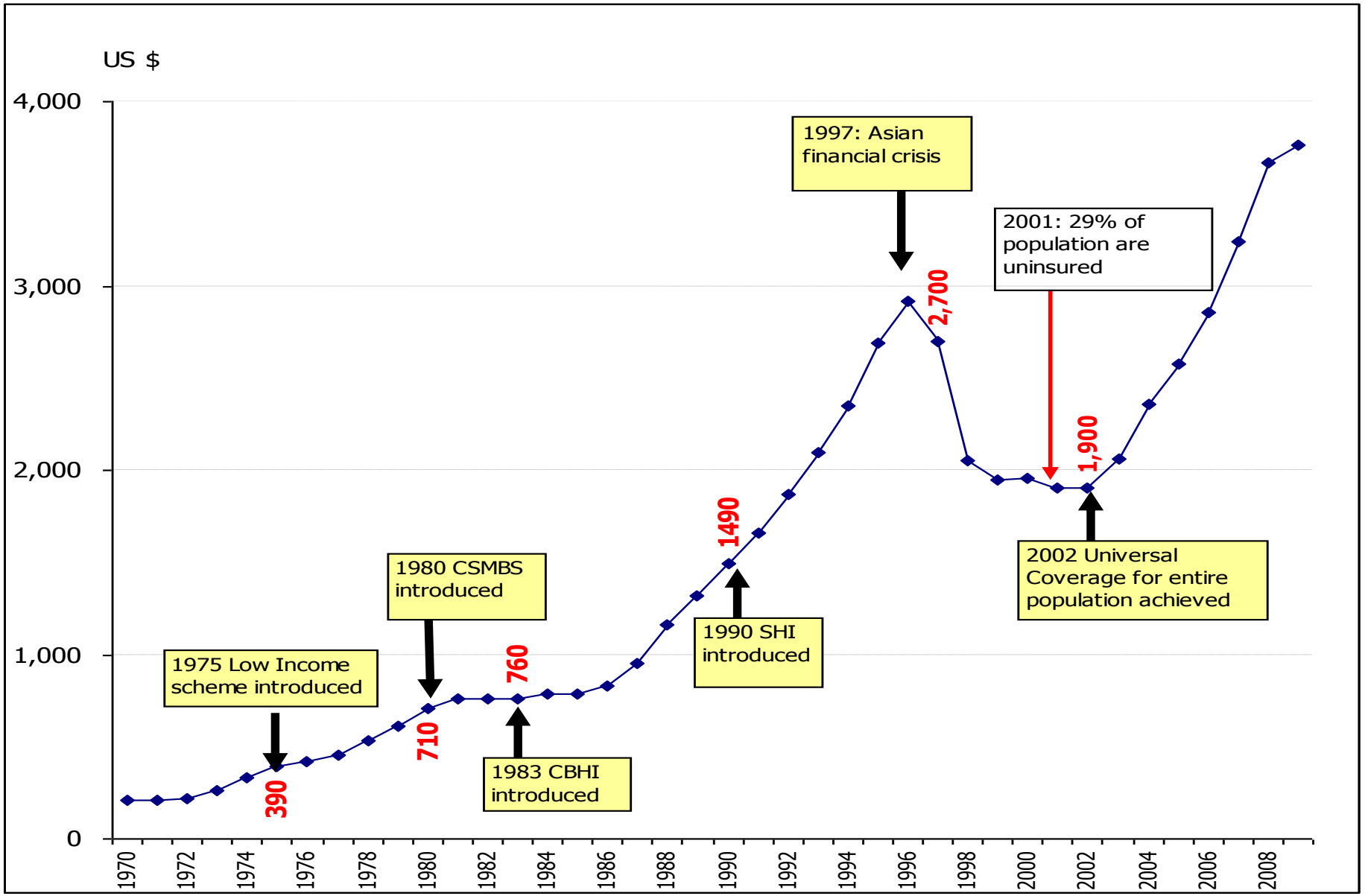
Social Security Scheme (SSS)

Nature	Social health insurance, compulsory contributions from employer, employee, and the government
Financing model	Public contracted model with both public and private hospitals
Beneficiaries	Private employees (8.47 million)
Benefit package	Comprehensive package including OP, IP, maternal care, dental care
Service providers	Contracted public and private hospitals with 100-bed or above
Payment method	Inclusive capitation Additional payments for utilization rate, chronic conditions, fee schedule for high cost services, and fixed amount for AE, dental care, maternity

Universal Coverage Scheme (UCS)

Nature	Entitlement, tax-based system
Financing model	Public contracted model, capitation 2,497 THB in 2010
Beneficiaries	Thai citizens uncovered by SSS and CSMBS (47 million)
Benefit package	Comprehensive package including prevention and promotion services (PP) and accredited alternative medicines with an exclusion list of some services
Service providers	Contracted public and private hospitals and requiring all hospital to establish one primary care unit (PCU) for every 10,000-15,000 registered population
Payment method	OP,PP - Capitation IP - DRG weighted global budget A/E and HC OP – point system, AE/HC IP –DRG weighted global budget

GNI per capita, US$ on a road towards UHC, 1970-2009



What were the main problems driving the demand for financing reform?

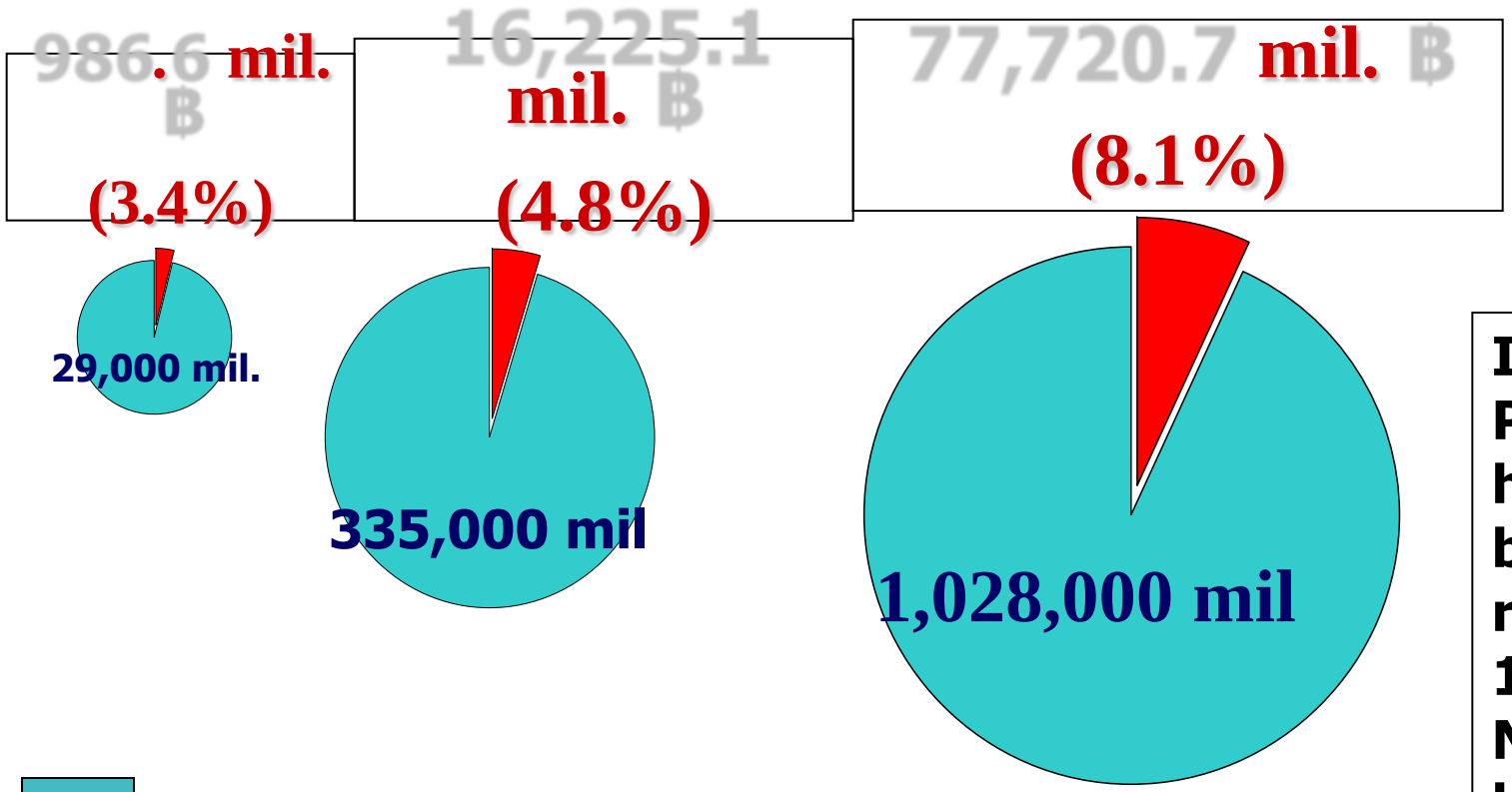
- Inequities
  - Majority of population – mostly poor and informal sector workers – without insurance
  - Very low coverage of insurance amongst lower socio-economic groups
  - Out-of-pocket payments for medical care as a % of household income – highest amongst the poor
  - Allocation of public resources in existing insurance schemes skewed to hospitals in urban areas with very high rates of cost inflation

The Road towards Universal Coverage Key facilitating factors:

- Political commitment:
  - 1997 Constitution – equal access to health care a right
  - 8th Ntl Socio-Eco Development Plan (1997-2001) - "Access to healthcare services for all"
  - Election 2001 - TRT party campaign slogan "30 baht treat all diseases"; UC became one of 9 priorities
- Civil society mobilization:
  - NGO network submits draft bill on UC to parliament with >50,000 signatures
- Technical know-how:
  - MoPH leaders forms working committee to study feasibilty of UHC

Assessing Implementation:
key financing functions

The increasing health budget



In 2011, Public health budget rose to 13% of National budget

National budget

Public health budget

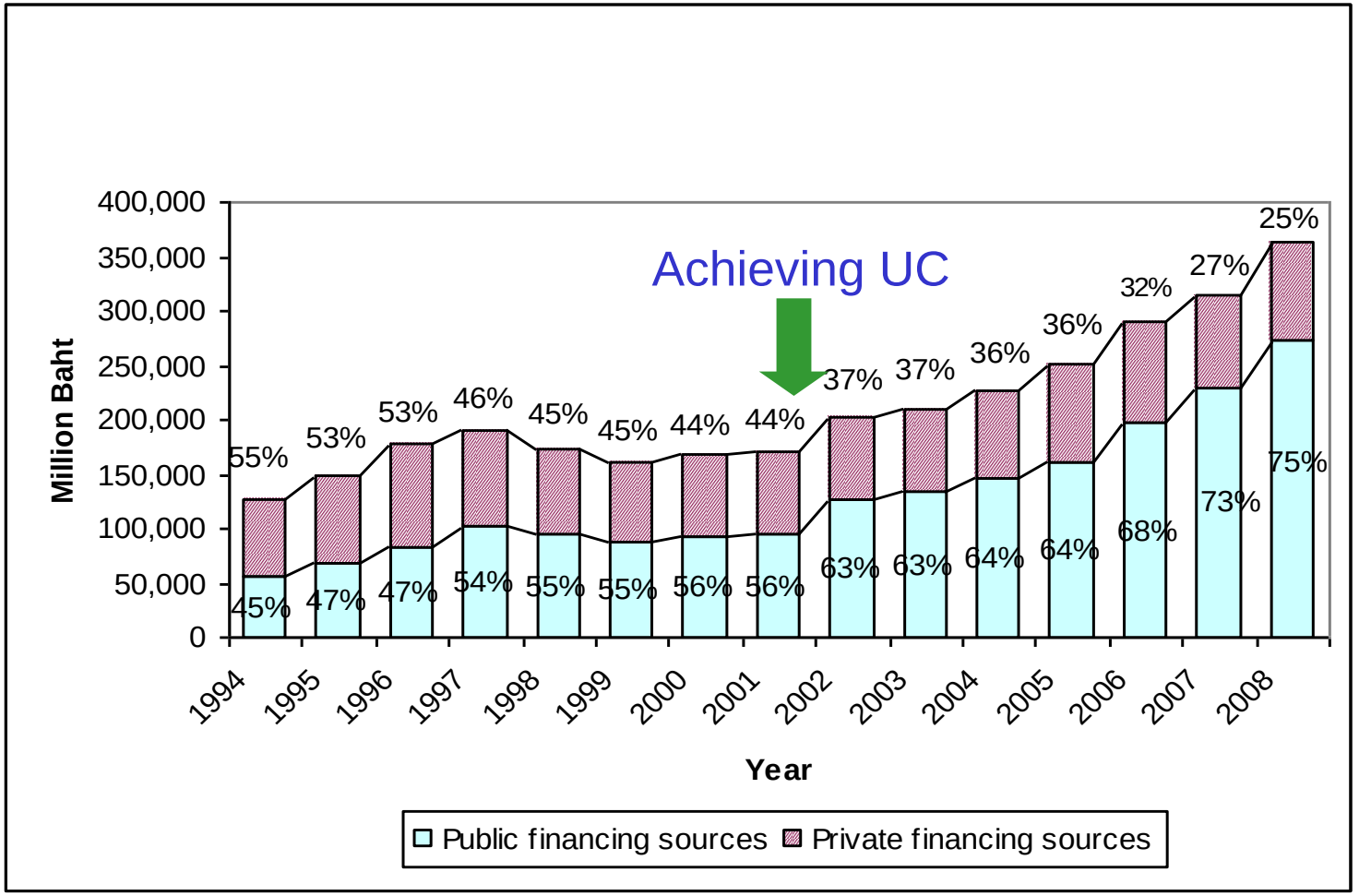
Sources of Health Care Finance Over Time

Share of health care finance (%)

	2000	2002	2004	2006
Out of pocket payments	33.7	27.9	26.4	23.2
Direct tax	18.0	18.8	20.8	24.5
Indirect tax	33.4	38.2	37.1	35.2
Premium Insurance	9.6	9.2	8.9	9.2
SHI contribution	5.3	5.9	6.8	7.9
Total	100.0	100.0	100.0	100.0

Source: Analysis from various years of the HH Socio-economic surveys (SES) conducted by NSO-Thailand

Increasing share of public financing sources in Thailand after achieving universal coverage

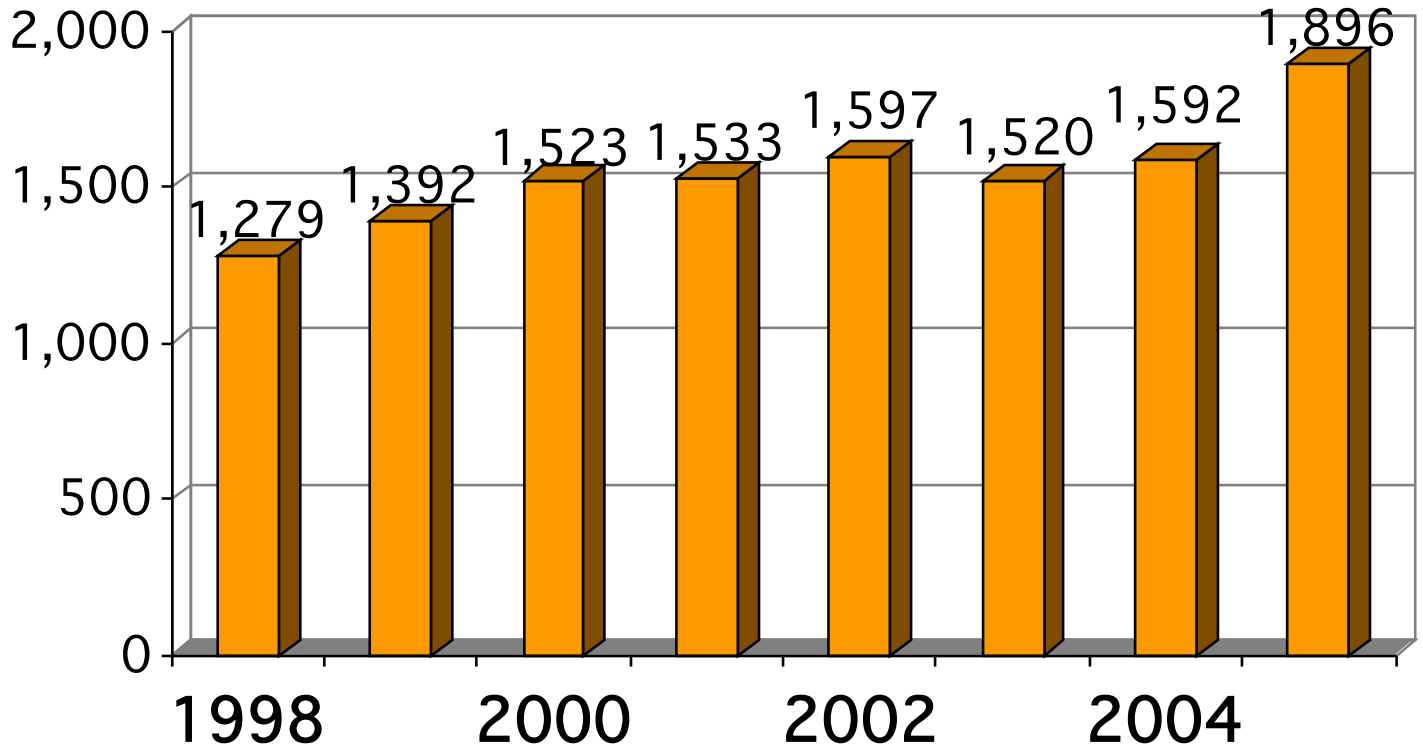


Total health expenditure during 2003-2008 ranged from

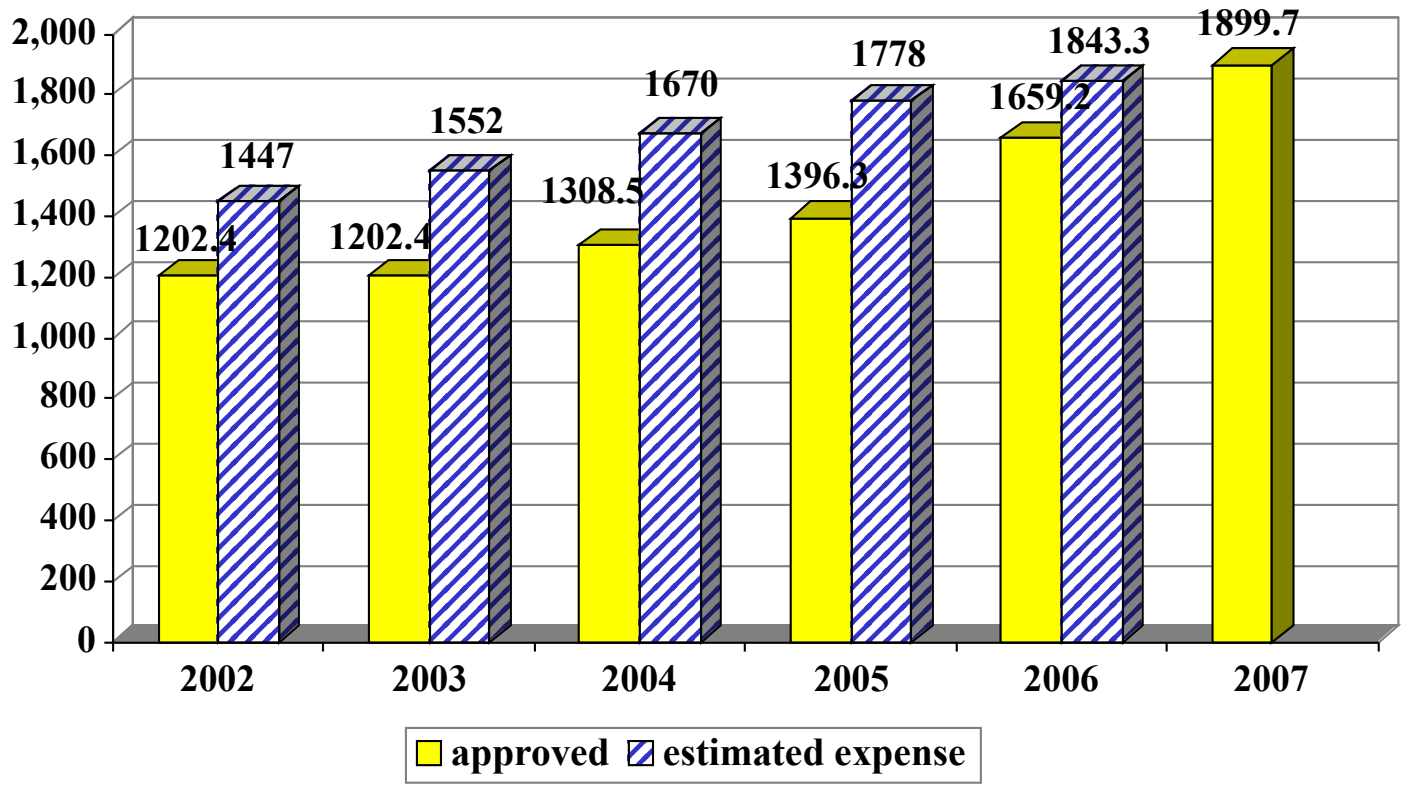
3.49 to 4.0% of GDP, THE per capita in 2008 = 171 USD

Capitation payment for UC beneficiary in 2010 = 80 USD per capita

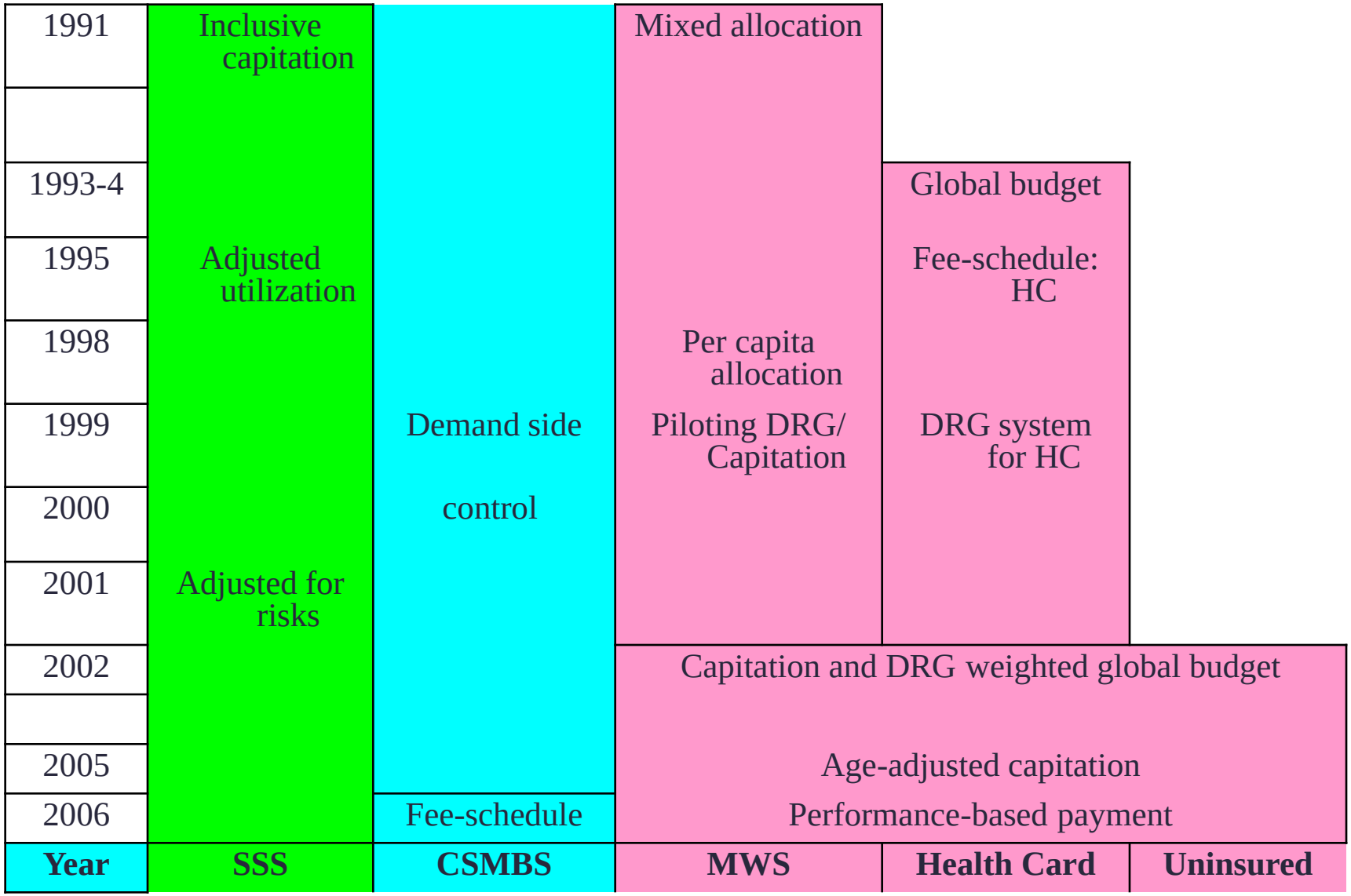
SSS: Per capita expenditures 1998-2005



UCS: approved capitation budget and estimated expenses 2002 - 2006



Historical development: payment methods

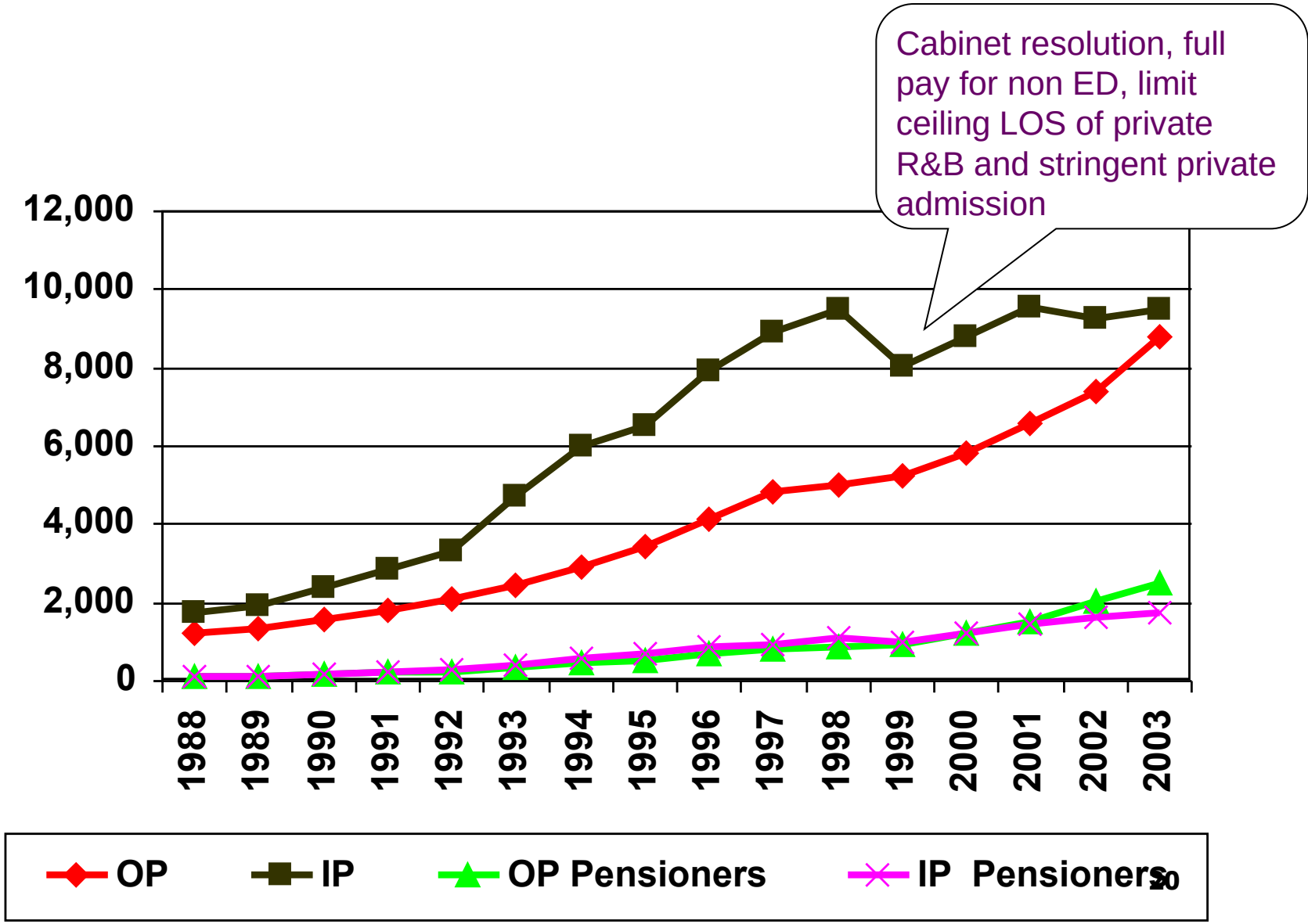


Payment & provider behavior

	Prevent health problem	Deliver services	Responsive ness	Contain costs
Line item budget	+/ -	- -	+ /-	+ + +
Global budget	+ +	- -	+ /-	+ + +
Capitation	+ + +	- -	+ +	+ + +
DRGs	+ /-	+ +	+ +	+ +
FFS	+ /-	+ + +	+ + +	- - -

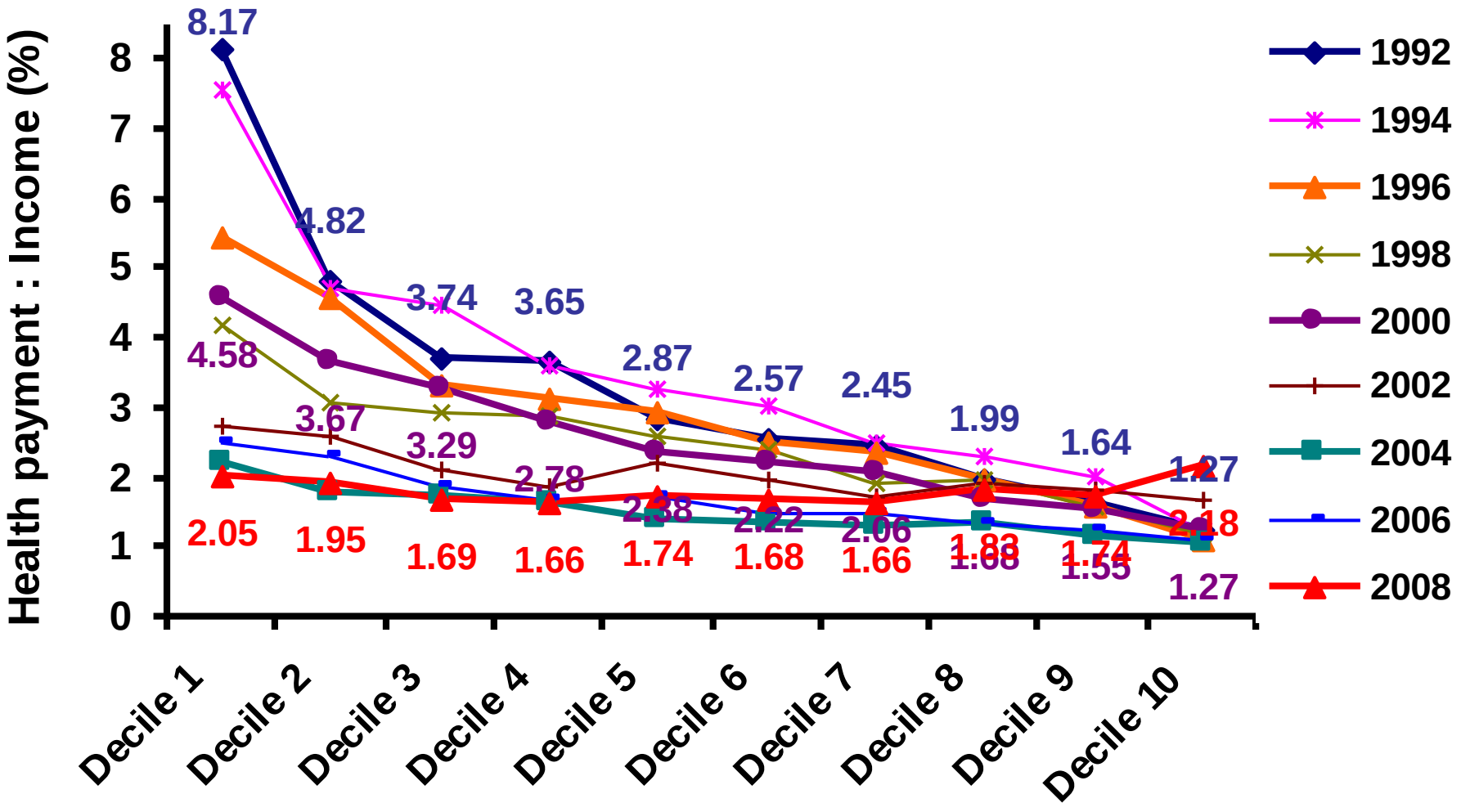
Source: WHR 2000

FFS: CSMBS experiences



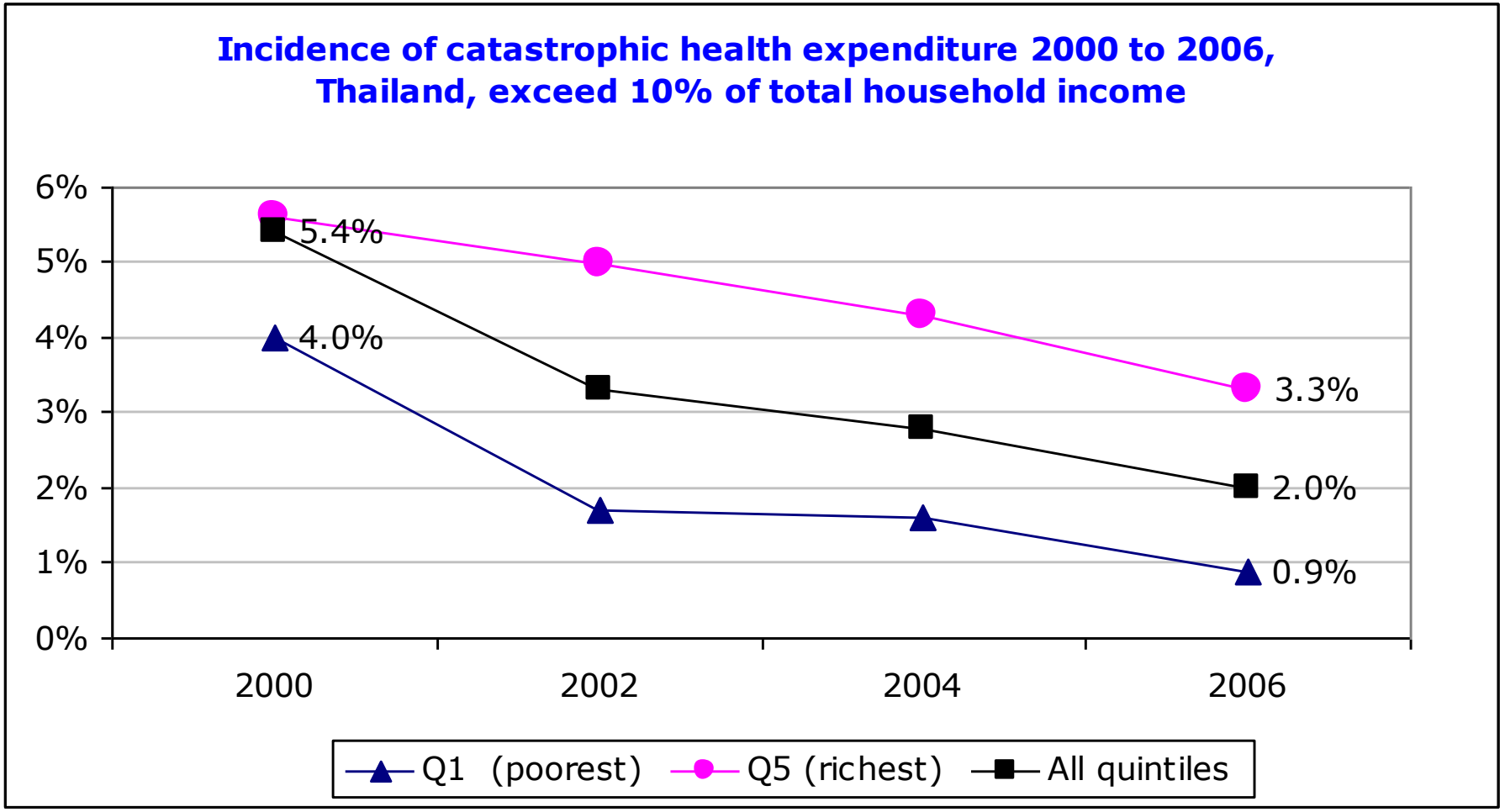
Evidence on outcome:
before and after achieving UHC

Financial risk protection 1:
Household OOP as % household income, 1992-2008



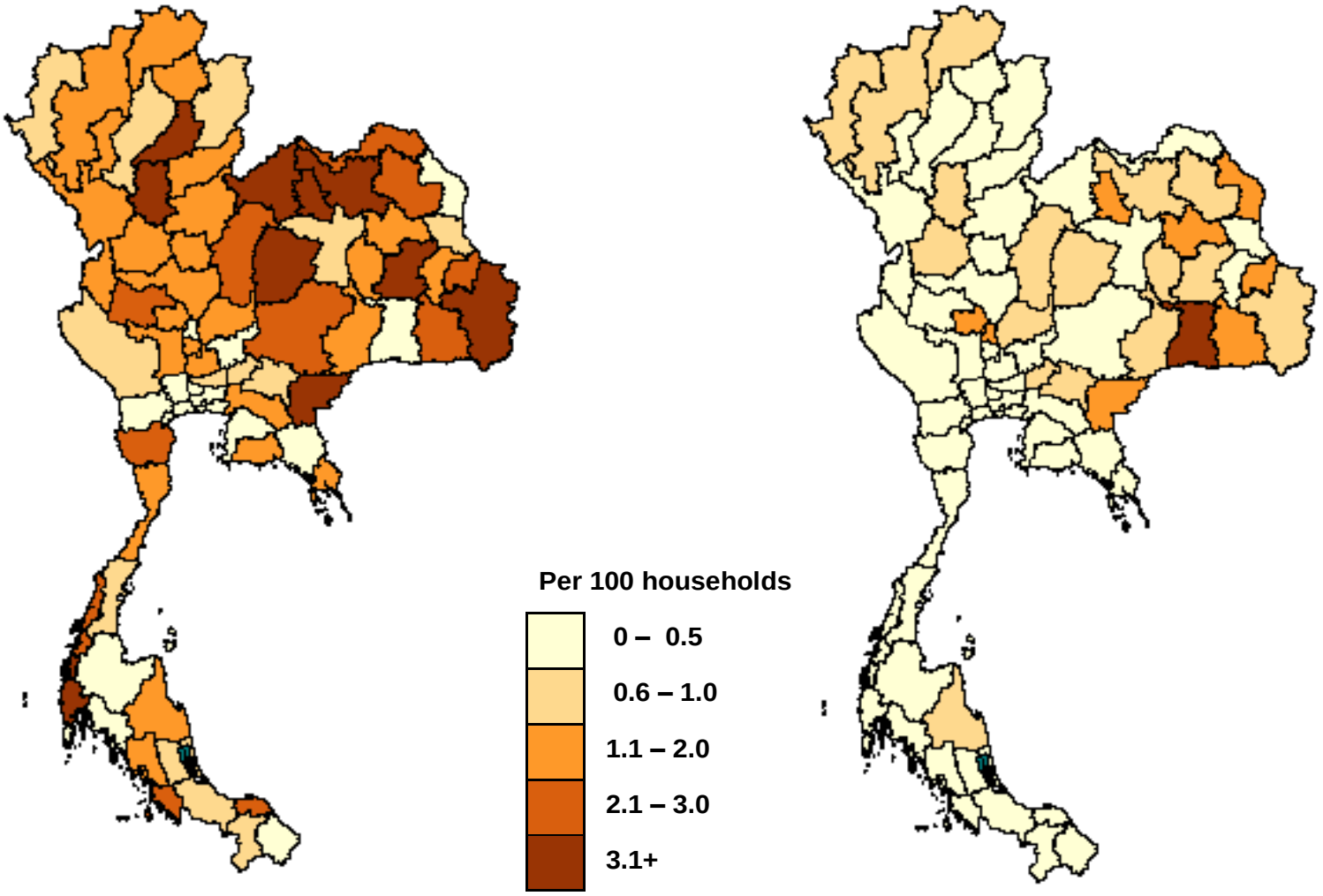
Source: Analysis from household socio-economic surveys (SES) in various years 1992-2008, NSO

Financial risk protection 2:
Incidence of catastrophic health expenditure 2000-2006

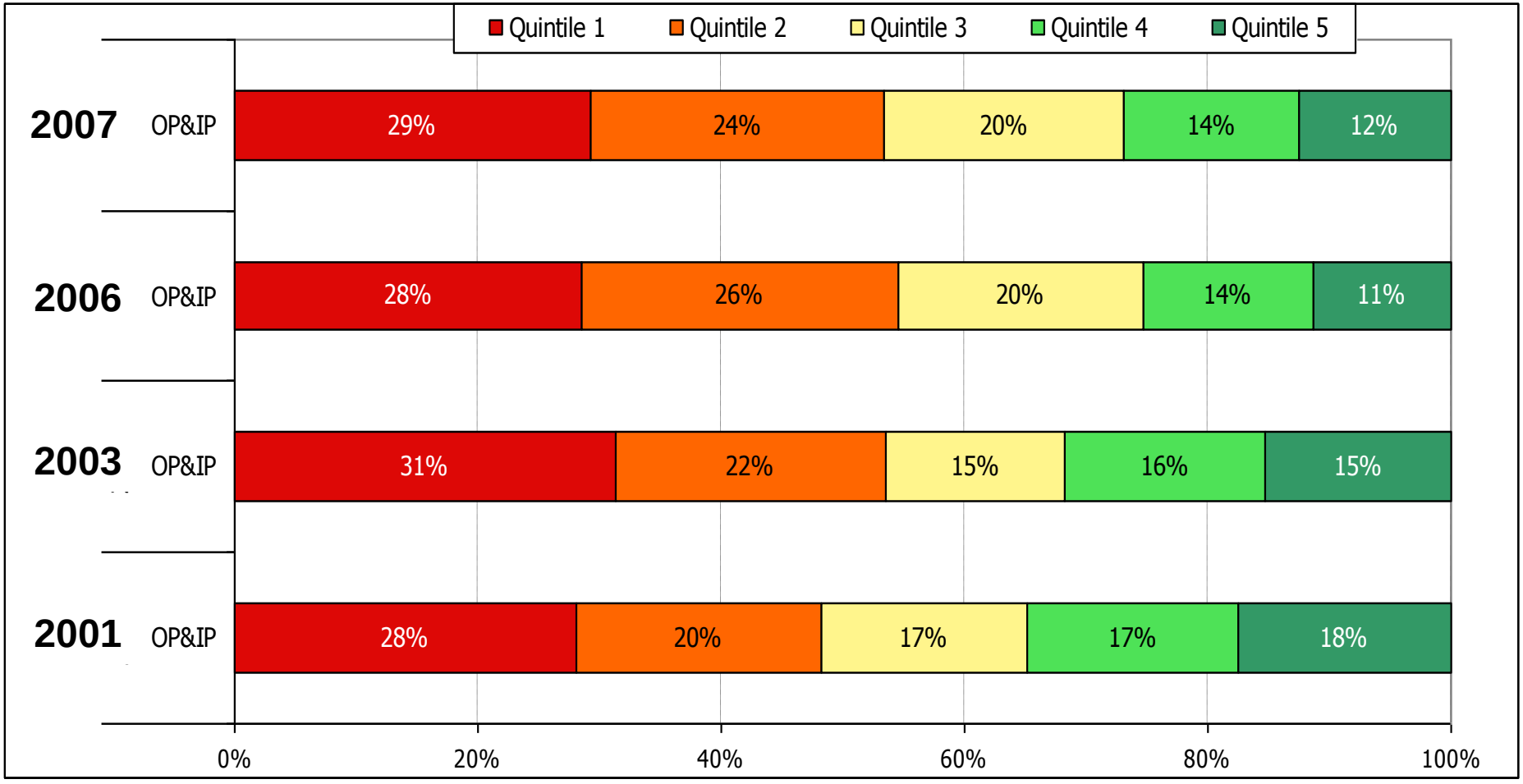


Source: Analysis from NSO SES 2000-2006

Significant reduction in health impoverishment 1996-2008



Profiles of government subsidies for health: (Benefit Incidence Analysis 2001-2007)



Trends in Equity of Utilization of Health Facilities: 2001-2007
(based on analysis of concentration indices)

- Out Patient Utilization
  - Health Centres – remain strongly pro-poor
  - District Hospitals – remain strongly pro-poor
  - Regional Hospitals – increasingly pro-rich
  - Private Hospital – increasingly pro-rich

- In Patient utilization
  - District Hospitals – remain strongly pro-poor
  - Provincial/Regional Hospitals – increasingly pro-poor
  - Private Hospitals – increasingly pro-rich

Summary: achievements

- Financing sources
  - General tax and SHI contributions constituting 2/3rd THE - are very "progressive" or pro-poor.
  - Marked decline in out-of-pocket expenditure to 18% of THE with elimination of rich-poor gap of OOP
- Financial risk protection
  - Very low level of catastrophic health spending and impoverishment
- Public subsidies of health facilities
  - Pro-poor subsidies of out patient and in patient
- Utilization of health facilities
  - Pro-poor utilization of publicly financed out/in patient facilities
  - Pro-rich utilization of privately financed out/in patient facilities

Contributing Factors to Effective Implementation

- Systems design for equity and efficiency
  - Prakongsai et al, the equity impact of the universal coverage policy: lessons from Thailand, in Chernichovsky and Hanson (eds), Innovations in health system finance in developing and transitional economies 2009.
- Supply side capacity to deliver services
  - Extensive geographical coverage of functioning primary health care and district health systems
  - Long-standing policy on government bonding of rural services by doctor, nurse, pharmacist and dentist new graduates
  - Availability of quality private services for which rich either covered by private insurance or OOP, can opt out
- Adequate funding
  - Continued political commitment despite changing political party
  - UC budget was estimated by actual utilization X actual unit costs projected for that year
- Financial access is determined by
  - Comprehensive service package
  - Zero copayment at registered provider network

Contributing Factors to Effective Implementation

- Strong institutional capacities
  - Information systems
    - Burden of Disease, National Health Accounts, National Drug Account, National AIDS Spending Account, national household datasets for routine equity monitoring
  - Health technology assessment
    - HITAP institutional relation with UK NICE
  - Key platforms for evidence informed decision
    - National Essential Drug List sub-committee
    - Benefit package sub-committee
      - mandatory budget impact assessment for new drugs/interventions

Key challenges of UHC in Thailand

- Data from National Health Accounts (NHA) indicate the majority of health finance was spent on curative care, and low investment in health promotion and disease prevention - only 5% of total health expenditure in 2009,

- Though nationwide coverage of good quality health infrastructure and primary care, inequitable distribution of human resources for health especially medical doctors and nurses is the key challenge in equitable access to MCH care,

- Double burden of disease (BOD) from communicable and chronic non-communicable diseases,

- Aging society and increasing demand for health care,

- Advance in expensive medical technologies including medicines.

Conclusions

- Health systems in Thailand
  - equitable and responsive
    - Full geographic coverage, well staffed and funded PHC
    - capacity to absorb rapid increase in utilization
  - translation and implementation capacity
    - translate policy into real actions,
    - M&E and feedback loops for fine-tuning policies
  - strong leadership with continuity,
    - Not only political but financial commitment
    - Capable technocrats
    - Active civil society
  - long term investment in institutional capacity strengthening in health policy and systems research,
    - Evidence generation,
    - Effective mechanisms for evidence informed policy decisions

Acknowledgements

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