Achievements and challenges in financing UHC in Thailand

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Outline of presentation

- Health financing arrangements of universal health coverage (UHC) in Thailand
- Achievements after achieving UHC
  - Equity improvements
  - Financial risk protection
  - Poverty reduction
- Key challenges in financing UHC in Thailand
- Conclusions
**Historical development of the Thai health system:**

**Infrastructure development + financial protection extension**

- **1945** User fees
- **1970** 1-3rd NHP
  - Provinces hospitals
- **1980** 4th-5th NHP
  - (1977-86)
  - District hospitals
  - Health centers

**Infrastructural development**

- **1975** LIC
- **1980** CSMBS
- **1983** CBHI
- **1990** SSS
- **1994** LIC → MWS
- **1994** Pub VHI
- **2000** LIC → MWS
- **2002** Universal Coverage

**Expansion consolidation of prepayment schemes**

- **1975** LIC
- **1980** CSMBS
- **1983** CBHI
- **1990** SSS
- **1994** LIC → MWS
- **1994** Pub VHI
- **2000** LIC → MWS
- **2002** Universal Coverage

**Universal Coverage**

- **2002** full achieve

**Health Infrastructure extension—wide geographical coverage**

**Establishment of prepayment schemes**

- **1975** LIC
- **1980** CSMBS
- **1983** CBHI
- **1990** SSS
- **1994** LIC → MWS
- **1994** Pub VHI
- **2000** LIC → MWS
- **2002** Universal Coverage

**Informal user fee exemption**

- **1945** User fees
How health care providers are paid by insurance?

Financing sources and payment methods for CSMBS, UCS, and SSS

- **General tax**
- **Tripartite contributions**
- **Payroll taxes**

**Ministry of Finance - CSMBS**
(6 million beneficiaries)

**National Health Insurance Office**
The UC scheme (47 millions of pop.)

**Social Security Office - SSS**
(9 millions of formal employees)

**Population**

**Patients**

**Services**

**Public & Private Contractor networks**

**Co-payment**

**Traditional FFS for OP**

**Capitation for OP**

**Direct billing FFS\(^{(2006+)}\) for OP**

**Full capitation**

**Capitation for OP**

**DRG under global budget**

**FFS\(_{\text{until 2006}}\) for OP**

**DRG for IP**

Source: Tangcharoensathien et al. (2010)
Increased access to and utilization of health services with very low unmet needs

Prevalence of unmet need

<table>
<thead>
<tr>
<th></th>
<th>OP</th>
<th>IP</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average</td>
<td>1.44%</td>
<td>0.4%</td>
</tr>
<tr>
<td>CSMBS</td>
<td>0.8%</td>
<td>0.26%</td>
</tr>
<tr>
<td>SSS</td>
<td>0.98%</td>
<td>0.2%</td>
</tr>
<tr>
<td>UCS</td>
<td>1.61%</td>
<td>0.45%</td>
</tr>
</tbody>
</table>

Source: NSO 2009 Panel SES, application of OECD unmet need definitions
More pro-poor health care system and distribution of government subsidies for health after achieving UHC in 2002

Distribution of government subsidies for health: BIA from 2001 to 2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Quintile 1</th>
<th>Quintile 2</th>
<th>Quintile 3</th>
<th>Quintile 4</th>
<th>Quintile 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>11%</td>
<td>48%</td>
<td>55%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>2007</td>
<td>24%</td>
<td>34%</td>
<td>21%</td>
<td>24%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Quintile 1: 20% poorest
Quintile 2: Quintile 2
Quintile 3: Quintile 3
Quintile 4: Quintile 4
Quintile 5: 20% richest
Incidence of catastrophic health spending
OOP > 10% total consumption expenditure

Source: Analysis of Socio-economic Survey (SES)
Protection against health impoverishment

Number of households prevented from medical impoverishment

- Before UCS
  - 142.27
  - 131.27
  - 123.97
  - 120.05

- UHC achieved
  - 112.63

- If without UCS
  - 123.24
  - 118.11
  - 115.82
  - 116.41

- After UCS
  - 77.23
  - 69.69
  - 58.76
  - 49.00
  - 39.75

Number of Households (in 1,000)
Sub-national health impoverishment 1996 to 2008
Increased hospital accreditation status in 2005-2011

Sources: Healthcare Accreditation Institute (Public Organization), 2011.

adapted by Bureau of Service Quality Development, NHSO.
Injection or infusion rate of thrombolytic agent in ST-elevation MI (%)

Case Fatality rate ST-elevation MI (%)


Source : IP individual record 2005-2011, NHSO
How health equity and efficiency were achieved?

**Equity Goals**
1. Equity in financial contribution
2. Minimum catastrophic health expenditure
3. Minimum level of impoverishment
4. Equity in use of services
5. Equity in government subsidies

**Efficiency Goals**
1. Long term financial sustainability
2. Technical efficiency, rational use of services at primary health care

In-feasible for informal sector (equally 25% belong to Q1 and Q2) to adopt contributory scheme

Tax financed scheme, adequate financing of primary healthcare

Provider payment method: capitation contract model and global budget + DRG

Functioning primary health care at district level, wide geographical coverage of services, referral back up to tertiary care where needed, close-to-client services with minimum traveling cost
Remaining key challenges in financing UCH in Thailand
Inequitable government subsidies among three public health insurance schemes

- Harmonization of benefit package and provider payment methods among three schemes is urgently needed,
- Ensuring equal distribution/access of services across regions
- Ensuring good quality of health services
Inequity in quality of care and health service provision: Percentage of caesarian section to total deliveries by health insurance schemes

Use of expensive procedures
Variations across 3 public insurance schemes

Cesarean section

Laparoscopic cholecystectomy

Source: Limwattananon et al. (2009)
Use of expensive OP medicines
Variations across 3 public insurance schemes

Source: Limwattananon et al. (2009)
Evidence:

- In 2010, 62.196 billion THB total expenditure for 5 million CSMBS beneficiaries, US$ 416 per capita is 5.2 times that of UC member capitation US$ 80.
- CSMBS: OP applies fee for service direct disbursement to providers, DRG replaces FFS for IP since 2006, help stabilize expenditure.
Mismatch between increasing burden of disease from NCD and low investment in HP and disease prevention.

DALYs attributable to risk factors

DALY lost from Risk factors, Thailand 1999 and 2004

Health administration and health insurance 8.5%
Prevention and public health services 4.8%
Medical goods 4.3%
Ancillary services 0.4%
Services of curative & rehabilitative care 78.1%

Gross capital formation 3.9%
## HIV/AIDS Financing
(Source: UNGASS Reports 2008 & 2010)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
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<tbody>
<tr>
<td><strong>Total Expenditure:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total AIDS expenditure, million Baht</td>
<td>6,728</td>
<td>6,928</td>
<td>7,208</td>
</tr>
<tr>
<td>↑2.97%</td>
<td></td>
<td>↑4.01%</td>
<td></td>
</tr>
<tr>
<td>Total Health Expenditure, million Baht</td>
<td>248,852</td>
<td>363,771</td>
<td>383,051</td>
</tr>
<tr>
<td><strong>Total AIDS expenditure, as</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>per capita population, Baht</td>
<td>105</td>
<td>110</td>
<td>114</td>
</tr>
<tr>
<td>per capita PLWHA, Baht</td>
<td>11,600</td>
<td>14,275</td>
<td>14,417</td>
</tr>
<tr>
<td>% GDP</td>
<td>0.08%</td>
<td>0.08%</td>
<td>0.08%</td>
</tr>
<tr>
<td>% THE</td>
<td>2.7%</td>
<td>1.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Sources of Fund:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Domestic, % of Total AIDS</td>
<td>83</td>
<td>85</td>
<td>93</td>
</tr>
<tr>
<td>International, % Total AIDS</td>
<td>17</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td><strong>Types of Expenditure:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment, % Total AIDS</td>
<td>71.8</td>
<td>65.8</td>
<td>76.1</td>
</tr>
<tr>
<td>Prevention, % Total AIDS</td>
<td>14.1</td>
<td>21.7</td>
<td>13.7</td>
</tr>
</tbody>
</table>
Household expenditure: tobacco, alcohol and health
Median household expenditure (Baht per month), 2002-2006

Sources: Analyses from the 2002, 2004, and 2006 SES
Inequity in geographical distribution of Health workforce in 2007

Physicians
- 800-3,305
- 3,306-6,274
- 6,245-9,272
- 9,243-12,300

Dentists
- 5,500-15,143
- 15,144-25,767
- 25,768-36,390
- 36,391-47,011

Nurses
- 280 - 652
- 653 - 904
- 905 - 1,156
- 1,157 – 1,408
### Economic loss of 12 priorities BOD in Thailand for prioritization of health investment in the 10th NHDP

<table>
<thead>
<tr>
<th></th>
<th>DALY loss (1)</th>
<th>Curative expenditure (2)</th>
<th>Productivity loss due to premature death (3)</th>
<th>Productivity loss due to absenteeism (4)</th>
<th>Total (2+3+4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HIV/AIDS</td>
<td>19%</td>
<td>17%</td>
<td>35%</td>
<td>6%</td>
</tr>
<tr>
<td>2</td>
<td>Traffic accidents</td>
<td>15%</td>
<td>31%</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>3</td>
<td>CVD</td>
<td>13%</td>
<td>7%</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>4</td>
<td>DM</td>
<td>9%</td>
<td>18%</td>
<td>4%</td>
<td>32%</td>
</tr>
<tr>
<td>5</td>
<td>Liver cancer</td>
<td>8%</td>
<td>1%</td>
<td>10%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Total top 12 disease burden</td>
<td>4,780,000 yr</td>
<td>61,936 million Baht</td>
<td>208,287 million Baht</td>
<td>11,273 million Baht</td>
</tr>
<tr>
<td></td>
<td>Percent by row</td>
<td></td>
<td>22%</td>
<td>74%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**% of Thai GDP in 2005**

|      | 4.0% |

**Note:**

1. Little success in controlling and preventing road traffic injuries, increasing incidence and prevalence of MDR- and XDR-TB,
2. Revitalizing HIV control and prevention in the light of universal ART.
3. Controlling the incidence and prevalence of ESRD patients who require renal replacement therapy (hemodialysis, PD, and KT)
Conclusions
Effective implementation: enabling factors

- System design focusing on equity and efficiency
- Strengthening supply side capacity to deliver services
  - Extensive geographical coverage of functioning primary health care, and district health systems → need strong PHC and health infrastructure and health workforce,
  - Long-standing policy on government bonding of new graduates health workforce for rural services since 1972.
- Strong leadership with sustained commitment
  - Continued political support despite changes in governments,
  - Capable technocrats,
  - Active civil society,
- Strong institutional capacity
  - Long term investment in health information system,
  - Health technology assessment (HTA),
  - Health system and policy research,
  - Good collaboration among researchers, reformists, and advocacy,
  - Key platform for evidence to inform policy making decisions.
Key stakeholders and participatory processes in topic selection for economic evaluation of UC benefit package

**Focus group discussion**
- Policy maker
- Medical specialists
- Academic group
- Civil Society
- General population
- Patients
- Industry

**Topic selection meeting**
- Academic
- Medical specialists
- Civil Society
- Patients

**Research working groups**
- Evidence on cost effectiveness,
- Budget impact analysis,
- Systems readiness to implement,
- Equity and ethical considerations

**UC Benefit Package Subcommittee**
Acknowledgement

- Ministry of Public Health (MOPH) of Thailand
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- Health Systems Research Institute (HSRI)
- Health Information System Development Office (HISO)
- Thai Health Promotion Foundation (THPF)
- National Health Security Office (NHSO)
- WHO long-term fellowship program of WHO-SEA region