Financial Protection from the Universal Health Care Coverage in Thailand: The Evidence

Supon Limwattananon

International Health Policy Program (IHPP), THAILAND

Delivering Effective Health Care for All

Monday 29th March, 2010

DFID Department for International Development

COMDIS CREHS TARGETS

Outline

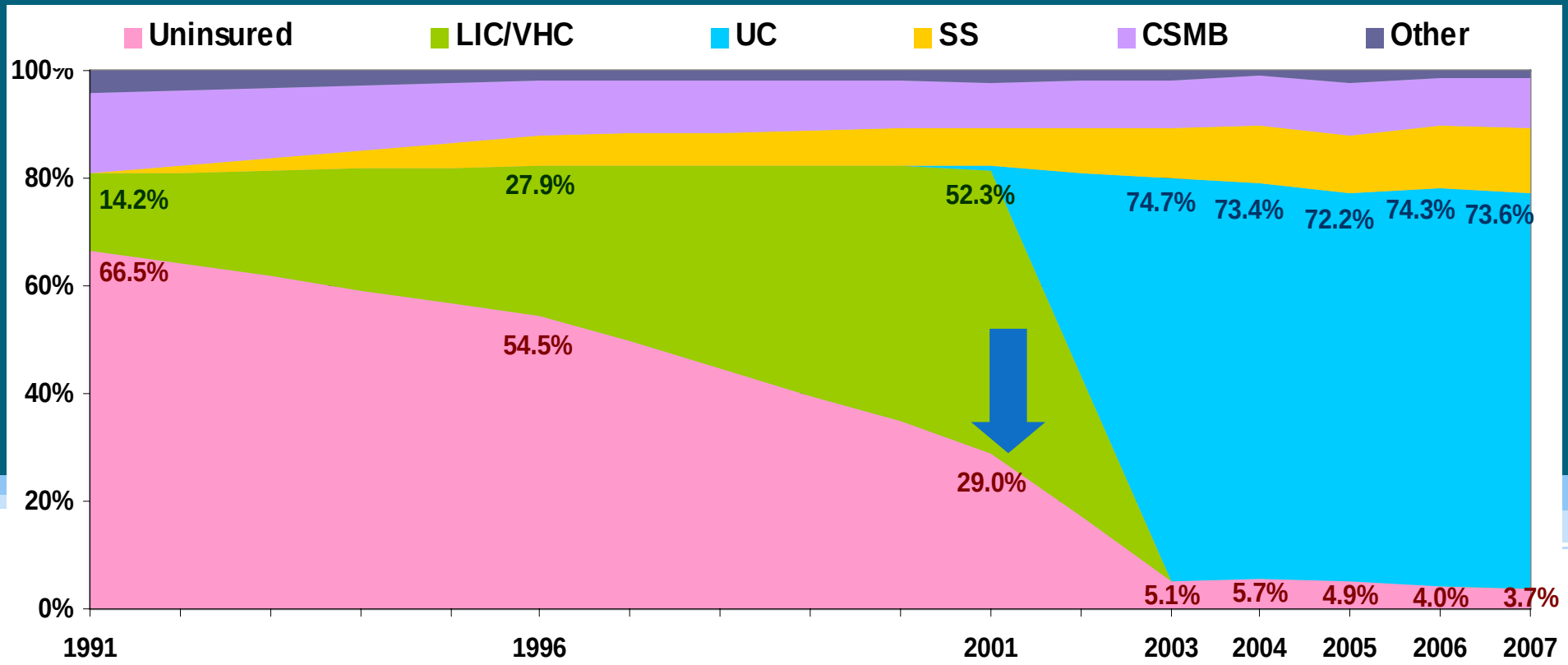
1. Trends in *population coverage* by health insurance
2. Poverty impact of health payment before and after UC
3. *Who pay* for health care during UC?
4. *Who benefit* from health care use during UC?
5. *Why* is that so?

   The long (3-decade) march of health infrastructure development and financing innovation

1. What do we mean by the universal coverage?

Population coverage by health insurance

before and after the 2001 UC reform



LIC: **Low-Income Card Scheme** → Tax-funded, public welfare program (*defunct*)

VHC: **Voluntary Health Card Scheme** → Subsidized, voluntary, community-based health insurance (*defunct*)

UC: **Universal Coverage Scheme** → Tax-funded, entitlement scheme for the *rest of all* Thai population

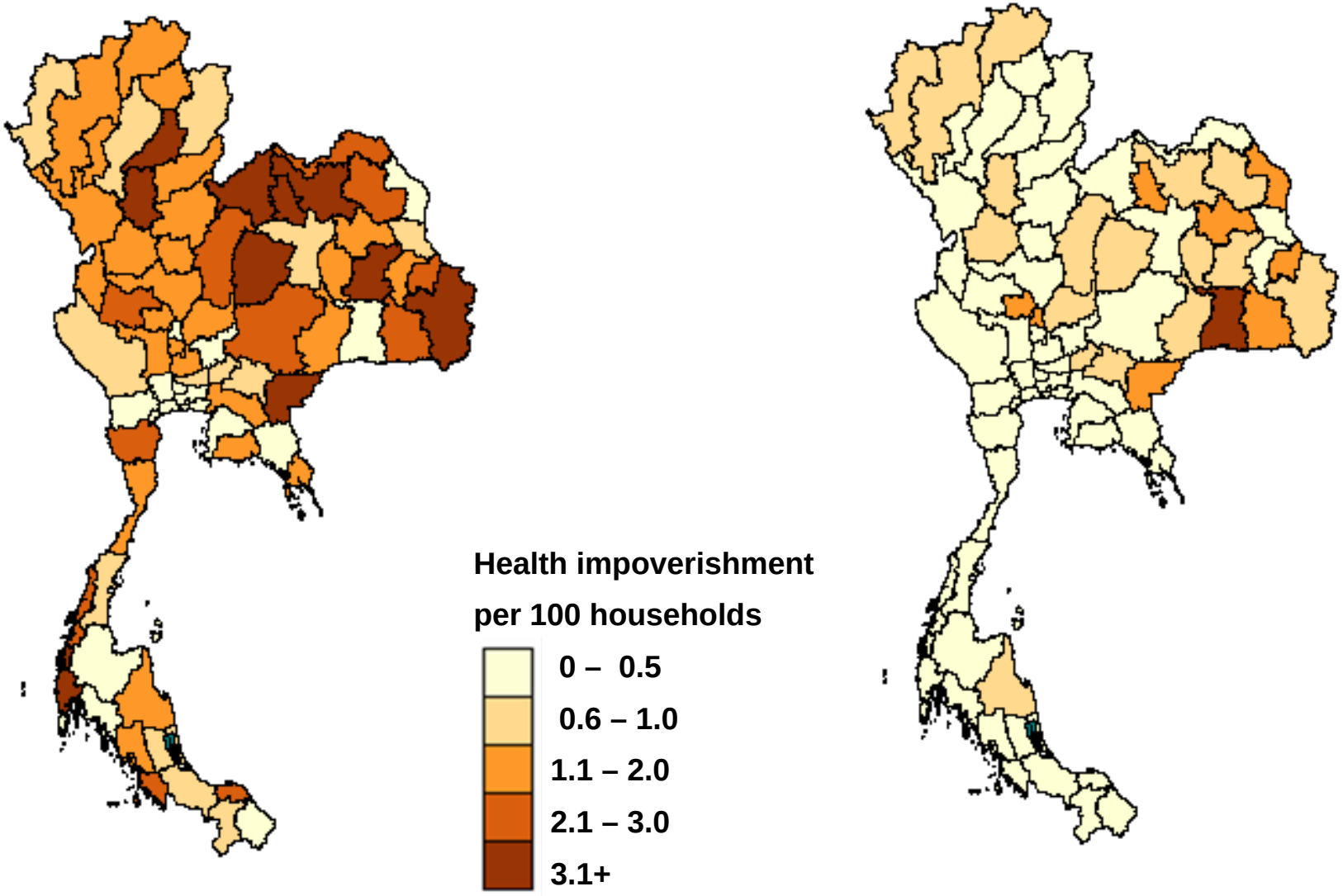
SS: **Social Security Scheme** → Compulsory, contributory, social health insurance (SHI) for *formal private* employees

CSMB: Civil Servant Medical Benefit Scheme → Tax-funded, fringe benefit for *government* employees/pensioners, dependants

Source: Analysis of Health and Welfare Surveys (HWS, various years)

2. Impoverishment by health payment before and after UC

Household impoverishment from health



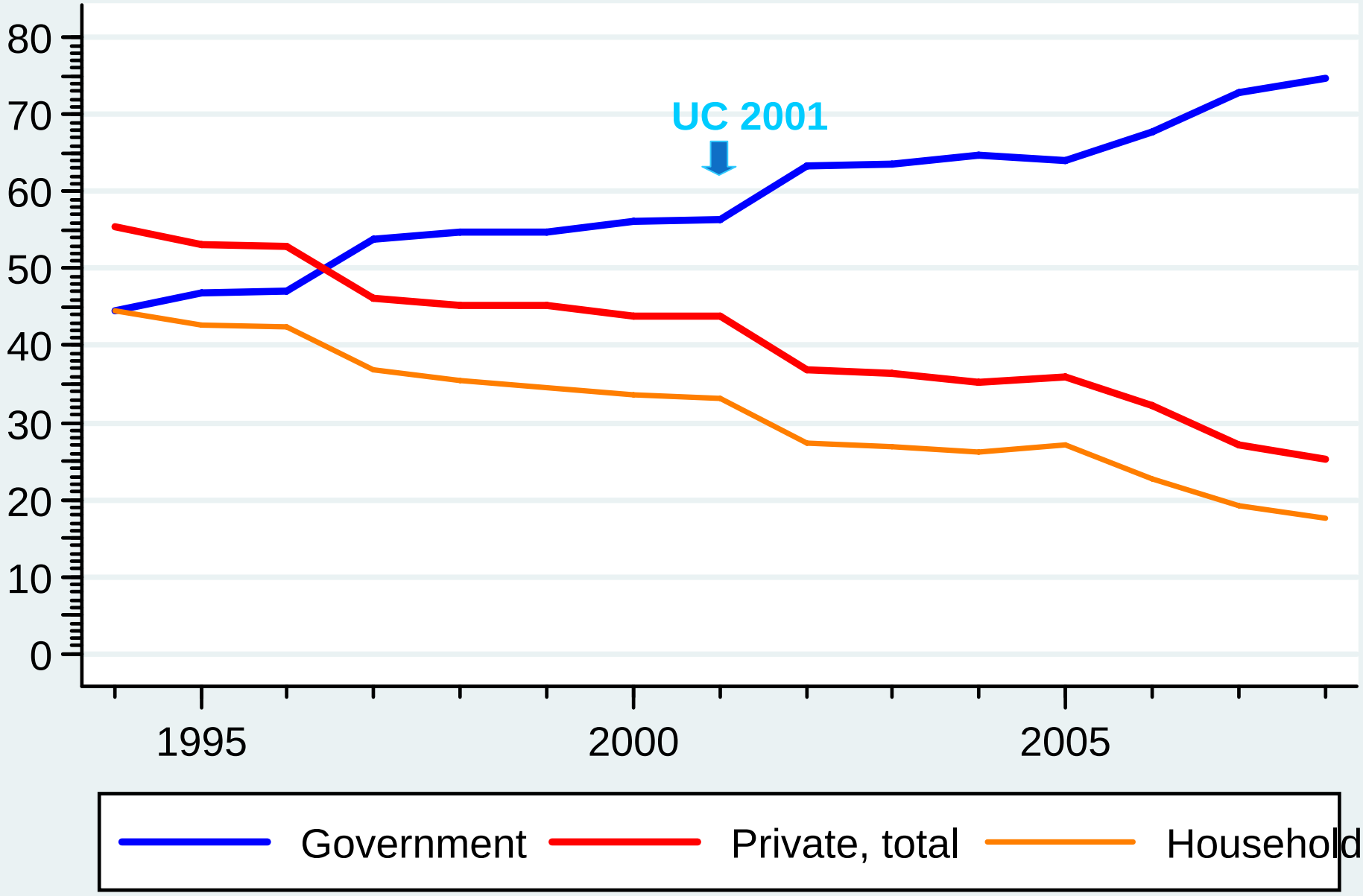
1996 (Pre-UC)

2008 (Post-UC)

Source: Analysis of Socio-Economic Surveys (SES, various years)

3. *Progressive* tax-based health financing of UC

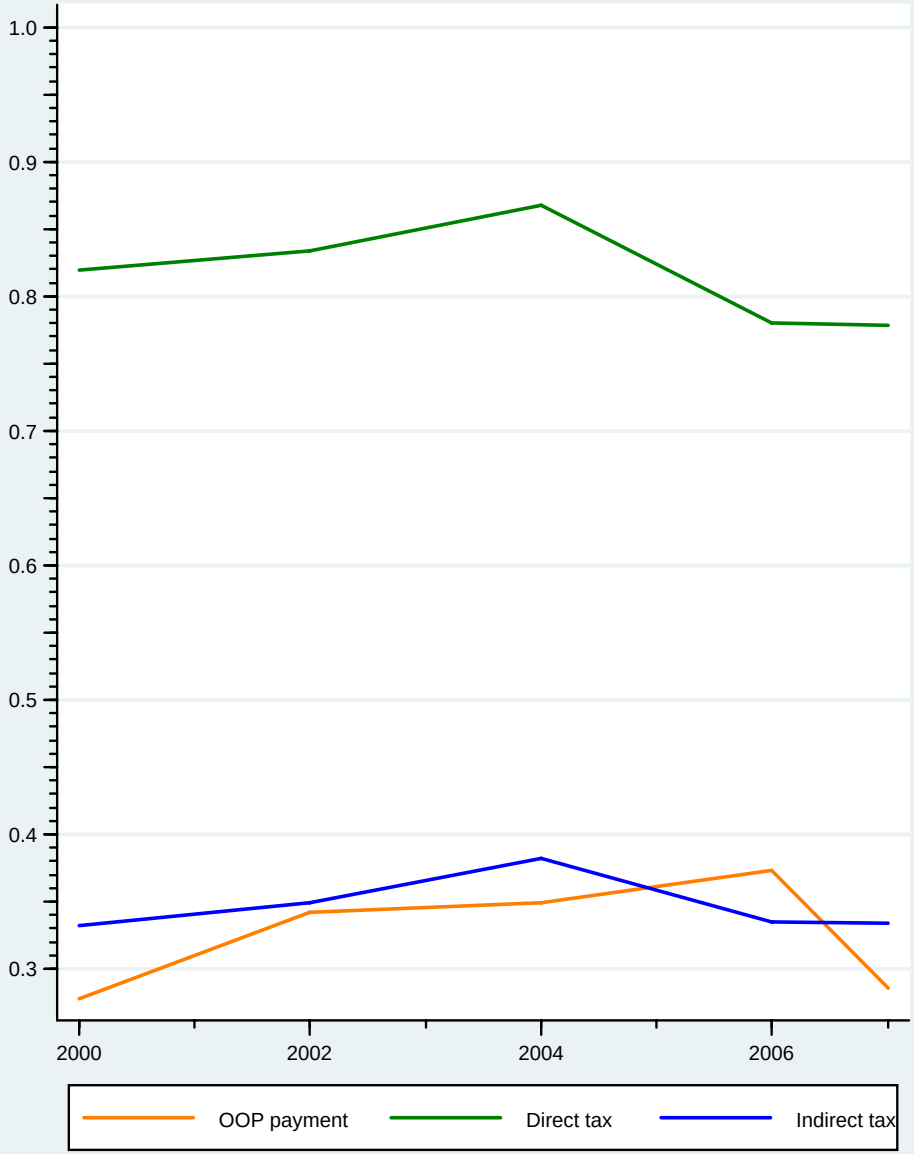
Health expenditure share (%)



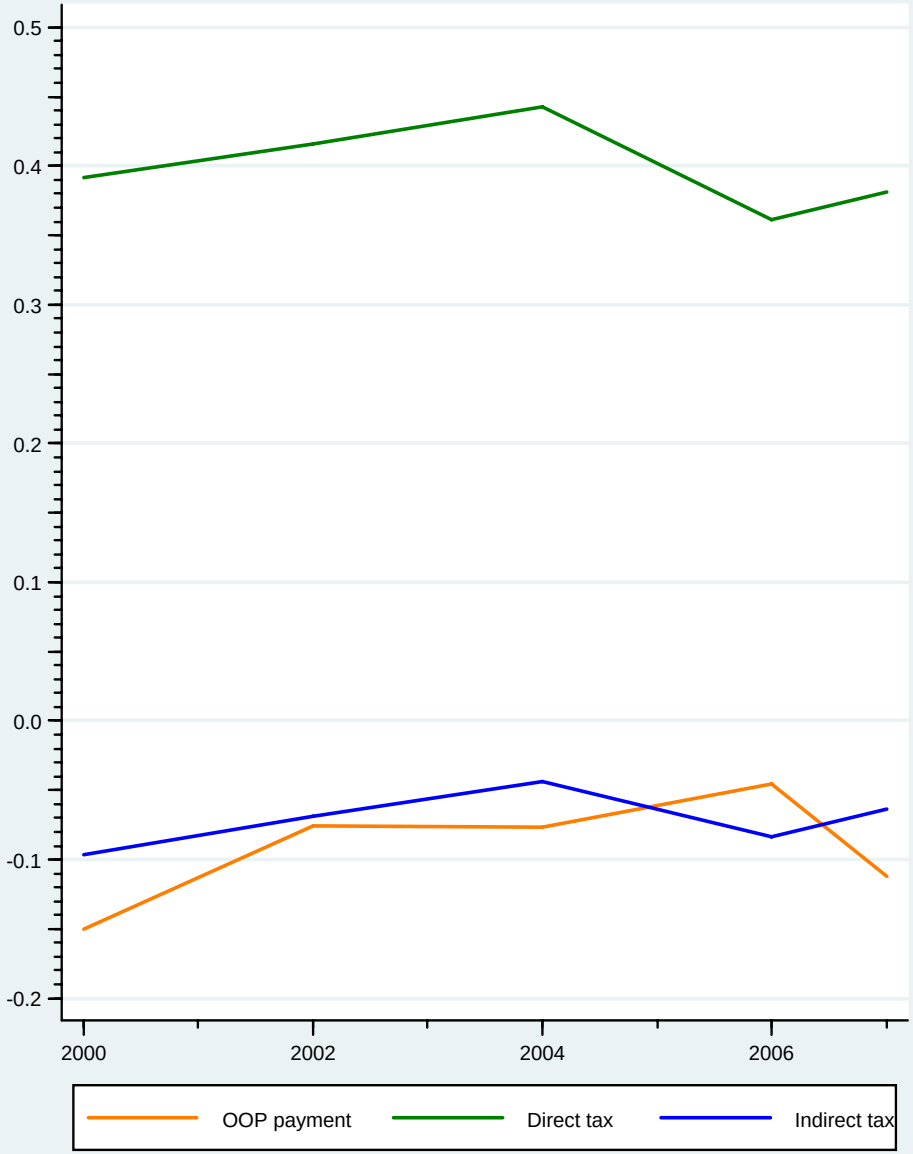
Source: National Health Accounts

Progressivity in health financing -Thailand

Concentration Index



Kakwani Index

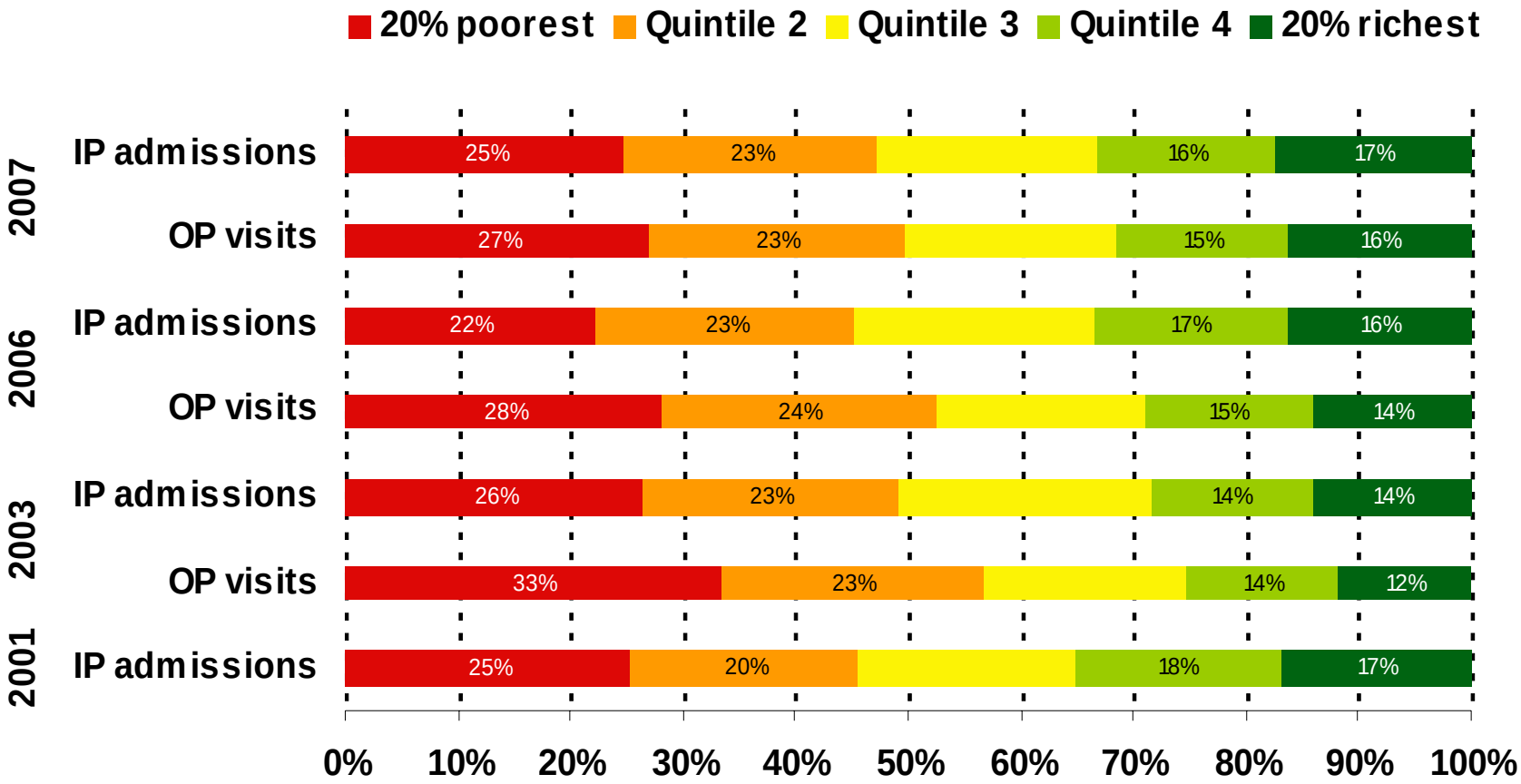


Source: CREHS year-2 Report

4. *Pro-poor* utilization and *pro-poor* public subsidy of district health services during UC

Utilization shares (%) by income quintile

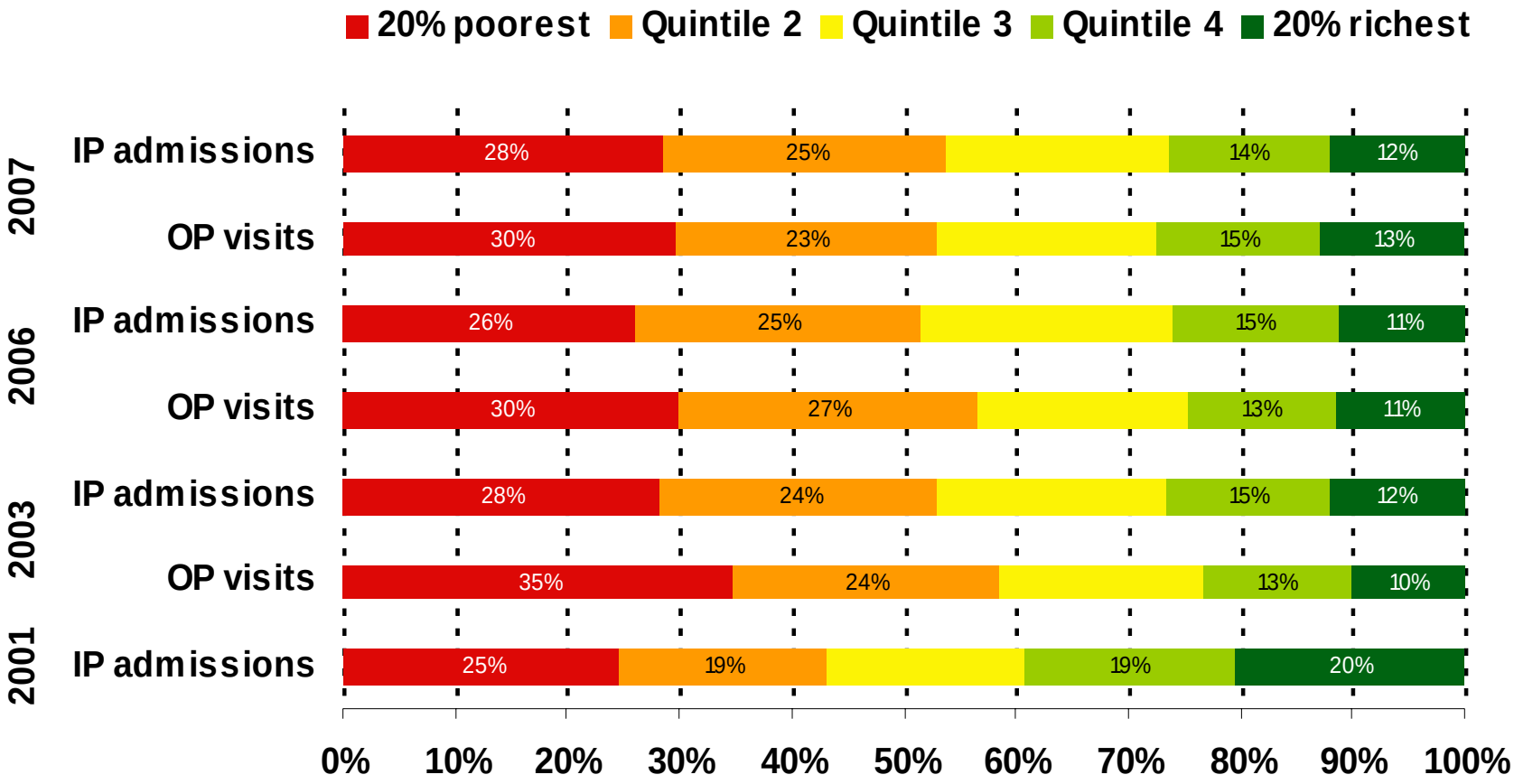
Ambulatory visits and hospital admissions, 2001-2007



Source: CREHS year-2 Report

Public subsidy shares (%) by income quintile

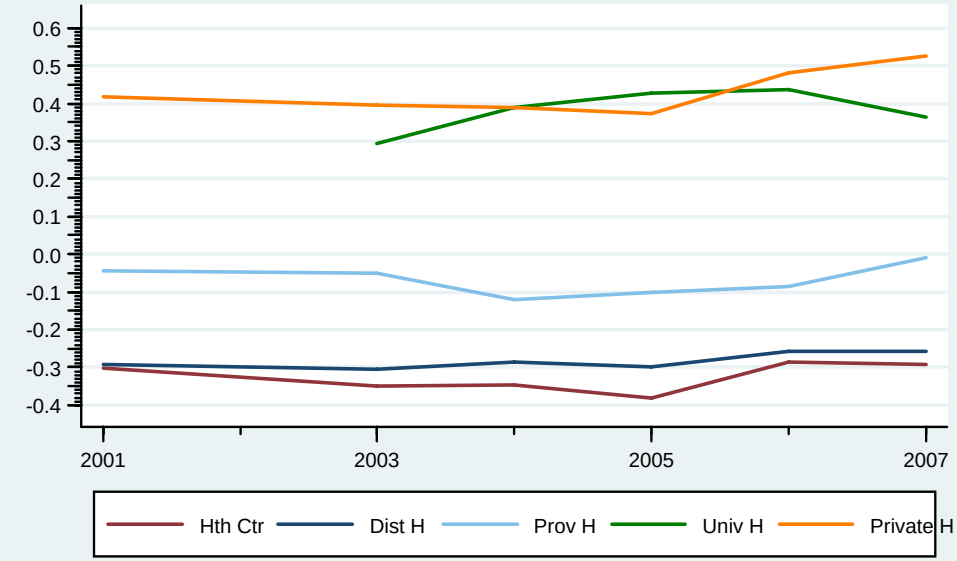
Ambulatory visits and hospital admissions, 2001-2007



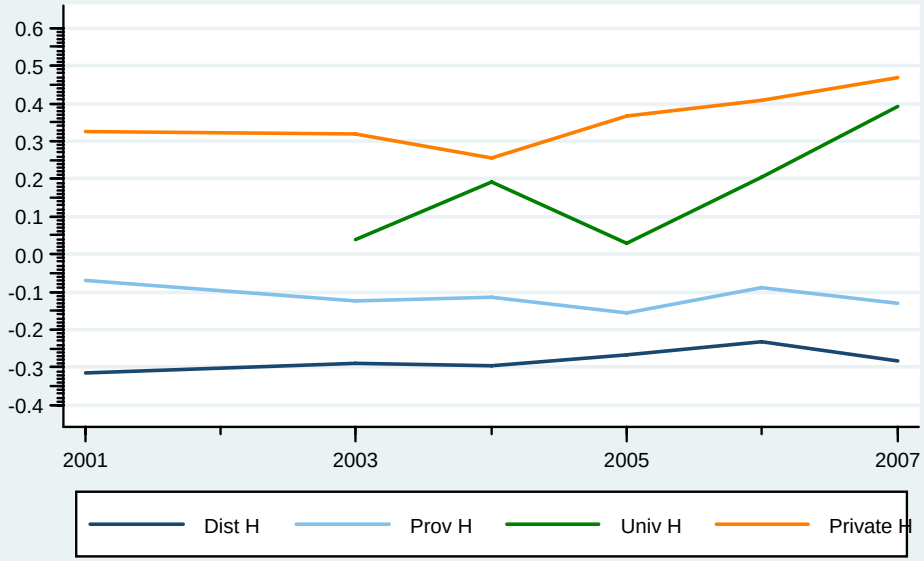
Source: CREHS year-2 Report

Concentration Index: Health use and public subsidy -Thailand

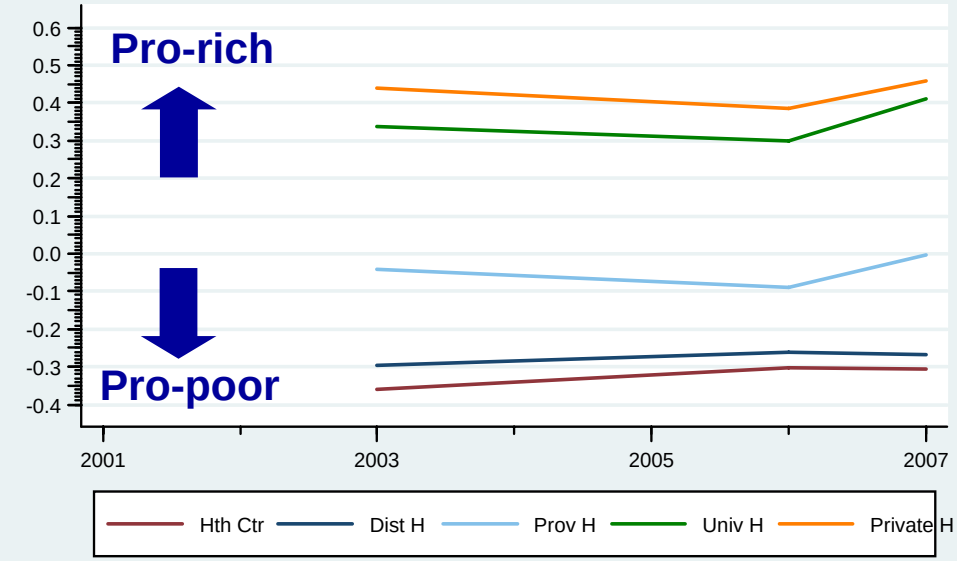
Ambulatory visits



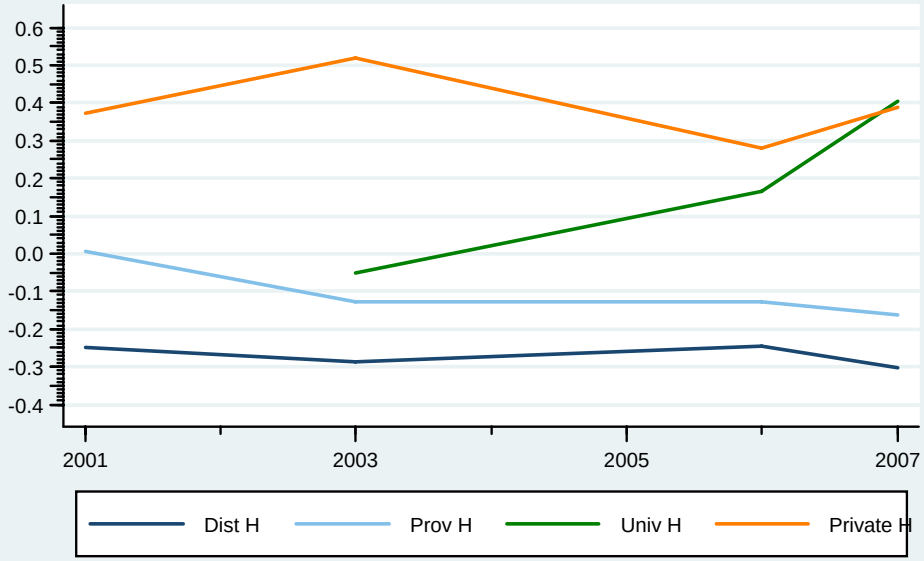
Hospital admissions



Ambulatory subsidy



Hospitalization subsidy



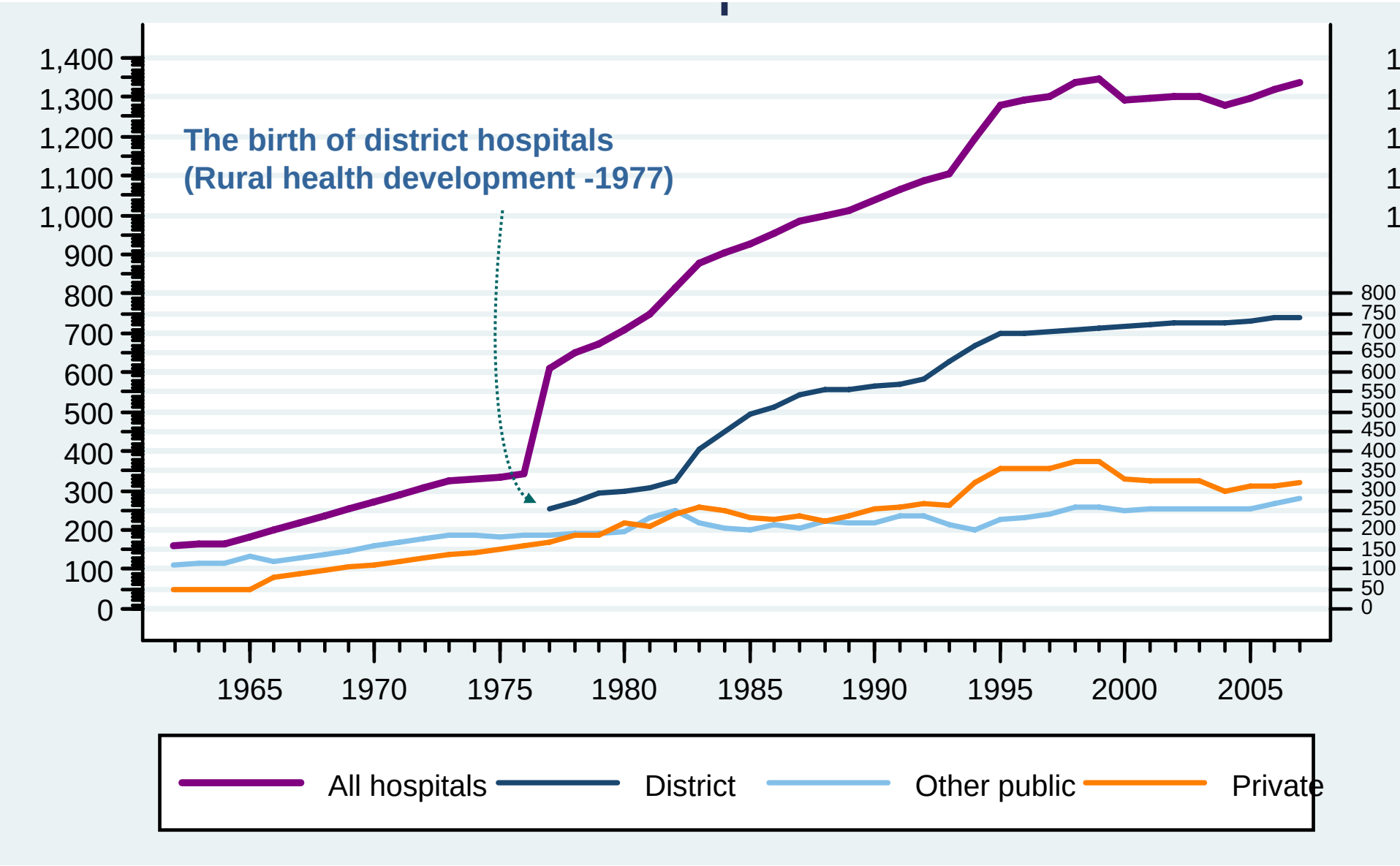
Source: CREHS year-2 Report

5. The message to go!

Health infrastructure and human resources are

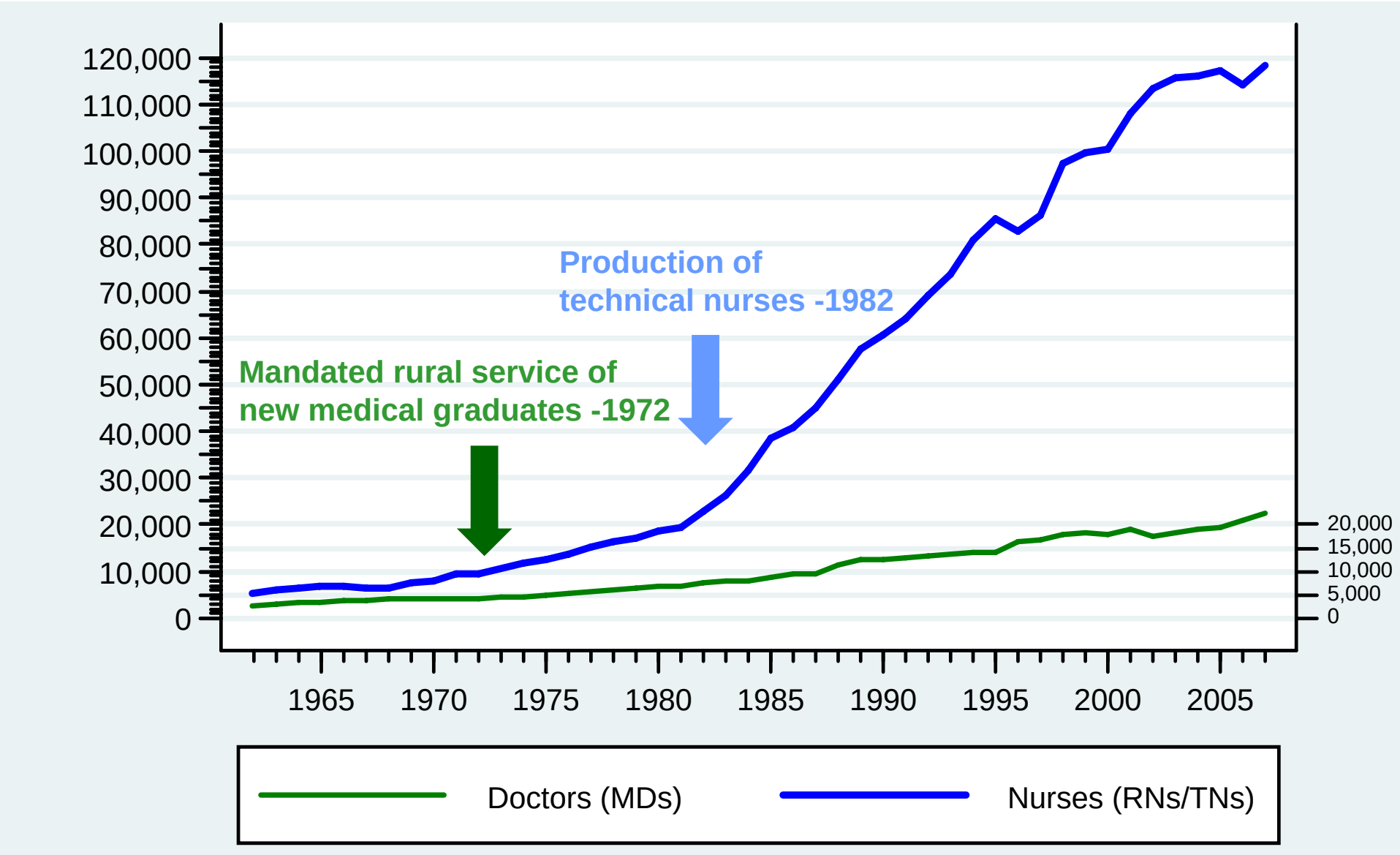
the prerequisite of the demand-side financial risk protection introduced by UC

Trends in expansion of hospitals



Source: MOPH BPS Health Resource Surveys

Trends in expansion of health workers



Source: MOPH BPS Health Resource Surveys

UC: the long march

15 **provincial hospitals**
300+ **health centers**
MOPH established **1942**

1st-3rd NHP (1962-76)
Mandatory rural services for new MDs and nurses
100% provincial hospitals

4th -5th NHP (1977-86)
Expansion of district hospitals and health centers

1. Infrastructure development

1970

Formal and informal user fee exemption

LIC 1975

CSMB 1980

1980

CHF 1983

SS 1991

1990

SS+ 1994

VHC 1994

LIC+ 1996

2. Innovative financing

Prospective payment system (PPS)
- Capitation for SS (OP-IP)
- Diagnostic-related groups (DRG) for LIC/VHC (IP)

2000

SS+ 2002

UC 2001

PPS expansion
- Capitation for UC (OP)
- DRG for UC (IP)
- DRG for CSMB (IP)
- Direct billing for CSMB (OP)

Source: Adapted from Srithamrongsawat