Delivering Effective Health Care for All
Monday 29th March, 2010
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

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

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
2. Impoverishment by health payment before and after UC
Household impoverishment from health

1996 (Pre-UC) 2008 (Post-UC)

Health impoverishment per 100 households

0 – 0.5
0.6 – 1.0
1.1 – 2.0
2.1 – 3.0
3.1+

Source: Analysis of Socio-Economic Surveys (SES, various years)
3. Progressive tax-based health financing of UC
Health expenditure share (%)

- Government
- Private, total
- Household

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.
The birth of district hospitals (Rural health development -1977)

Source: MOPH BPS Health Resource Surveys
Trends in expansion of health workers

Source: MOPH BPS Health Resource Surveys

Production of technical nurses - 1982
Mandated rural service of new medical graduates - 1972
UC: the long march

1. Infrastructure development

- 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

2. Innovative financing

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

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

Formal and informal user fee exemption

Source: Adapted from Srithamrongsawat