Integrating Financing Schemes to Achieve Universal Coverage in Thailand: Analysis of the Equity Achievements

Phusit Prakongsai
Supon Limwattananon
Viroj Tangcharoensathien
International Health Policy Program (IHPP)
Presentation to the 7th World Congress of Health Economics
Beijing International Convention Centre, Beijing, China
13 July 2009
Background

- By 2002, Thailand achieved universal coverage (UC) by introducing a tax-funded health insurance scheme, the UC scheme, to approximately 47 million (~75%) of the population who were neither beneficiaries of SHI or Civil Servant Medical Benefit Scheme,

- Health care financing strategies of the UC policy:
  - removal of financial barriers to health services;
  - shift of the main source of HCF from OOP to general tax;
  - changing provider payment from historical allocations to close-ended payments;
  - promoting the use of primary care by contracting a PCU as the main contractor and gatekeeper.

- Benefit package of the UC scheme is quite comprehensive comprising OP, hospitalization, health promotion and disease prevention, most expensive health services, dental care, medicines and operations.
Evolution of achieving universal coverage in Thailand: Infrastructure development + financial protection extension

- **1945**: Informal user fee exemption
- **1970**: 1-3rd NHP Provincial hospitals
- **1980**: Establishment of prepayment schemes
  - 1975 LIC
  - 1980 CSMBS
  - 1983 CBHI
  - 1990 SSS
- **1990**: Expansion consolidation of prepayment schemes
  - LIC → MWS
  - SSS
  - CSMBS
- **2000**: Universal Coverage
  - 1994 Pub VHI
- **2002**: Universal Coverage
  - 2002 full achieve

Health Infrastructure extension--wide geographical coverage

1962-76 4th - 5th NHP (1977-86) District hospitals Health centers
Health care finance and service provision of Thailand after achieving universal coverage (UC)

- **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)
- **Voluntary private insurance**

**Tripartite contributions**
- Payroll taxes
- Risk related contributions

**Population**
- Patients

**Public & Private Contractor networks**
- Co-payment
- Services

**Fee for services**
- Fee for services - OP

**Standard Benefit package**
- Capitation
- Capitation & global budget with DRG for IP
Scheme beneficiaries by income quintiles, 2004

<table>
<thead>
<tr>
<th>Income Quintile</th>
<th>CSMBS</th>
<th>SSS</th>
<th>UC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (poorest)</td>
<td>11%</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Q2</td>
<td>26%</td>
<td>31%</td>
<td>23%</td>
</tr>
<tr>
<td>Q3</td>
<td>4%</td>
<td>5%</td>
<td>25%</td>
</tr>
<tr>
<td>Q4</td>
<td>52%</td>
<td>49%</td>
<td>25%</td>
</tr>
<tr>
<td>Q5 (the richest)</td>
<td>7%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Total health expenditure during 2003-2005 ranged from 3.49 to 3.55% of GDP, THE per capita approx 100 USD
Household OOP for health, % income 1992-2004

[Graph showing household OOP for health as a percentage of income from 1992 to 2004 for different income deciles.]
The distribution of ambulatory service use among different income quintiles in 2001 and 2003, by types of health facilities

<table>
<thead>
<tr>
<th>Income quintiles</th>
<th>2001</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>0.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Q2</td>
<td>0.4</td>
<td>0.6</td>
</tr>
<tr>
<td>Q3</td>
<td>0.7</td>
<td>0.6</td>
</tr>
<tr>
<td>Q4</td>
<td>0.4</td>
<td>0.7</td>
</tr>
<tr>
<td>Q5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Equity in utilization: Concentration Index of OP service by type of health facilities: 2001 to 2005

Note: CI range from -1 to +1. Minus 1 (plus 1) means in favour of the poor (rich), or the poor (rich) disproportionately use more services than the rich (poor).
Equity in utilization: Concentration Index of hospitalization by type of health facilities: 2001 to 2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Community hospitals</th>
<th>Provincial and regional hospitals</th>
<th>Private hospitals</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>-0.316</td>
<td>-0.069</td>
<td>0.32</td>
<td>-0.079</td>
</tr>
<tr>
<td>2003</td>
<td>-0.293</td>
<td>-0.138</td>
<td>0.309</td>
<td>-0.121</td>
</tr>
<tr>
<td>2004</td>
<td>-0.294</td>
<td>-0.114</td>
<td>0.254</td>
<td>-0.127</td>
</tr>
<tr>
<td>2005</td>
<td>-0.266</td>
<td>-0.156</td>
<td>0.366</td>
<td>-0.114</td>
</tr>
</tbody>
</table>
Equity in budget subsidies: BIA, 2001 and 2003

A comparison of percent distribution of net government health subsidies among different income quintiles in 2001 and 2003

Note:
- Overall net government health subsidies in 2001 were approximately 58,733 million Baht, and in 2003 were 80,678 million Baht (in 2001-value)
- The concentration index of government health subsidies in 2001 was -0.044 and in 2003 was -0.123
The incidence of catastrophic health payments from 2000 to 2007

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (poorest)</td>
<td>4.0%</td>
<td>1.7%</td>
<td>1.6%</td>
<td>0.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Q5 (richest)</td>
<td>5.6%</td>
<td>5.0%</td>
<td>4.3%</td>
<td>3.3%</td>
<td>2.8%</td>
</tr>
<tr>
<td>All quintiles</td>
<td>5.4%</td>
<td>3.3%</td>
<td>2.8%</td>
<td>2.0%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

Note: Catastrophic health expenditure refers to household out-of-pocket payments for health exceed 10% of household consumption expenditure.
Kakwani indexes of different health care finance from 2000 to 2006
(Kakwani = Conc. Index – Gini)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Pocket</td>
<td>-0.1502</td>
<td>-0.0755</td>
<td>-0.0764</td>
<td>-0.0450</td>
</tr>
<tr>
<td>Direct tax</td>
<td>0.3913</td>
<td>0.4159</td>
<td>0.4424</td>
<td>0.3617</td>
</tr>
<tr>
<td>Indirect tax</td>
<td>-0.0964</td>
<td>-0.0691</td>
<td>-0.0435</td>
<td>-0.0831</td>
</tr>
<tr>
<td>Premium Insurance</td>
<td>-0.3623</td>
<td>-0.3906</td>
<td>-0.3233</td>
<td>na</td>
</tr>
<tr>
<td>Social health Insurance</td>
<td>0.1650</td>
<td>0.1121</td>
<td>0.1046</td>
<td>na</td>
</tr>
<tr>
<td>Contribution</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>-0.0491</td>
</tr>
<tr>
<td>Premium Insurance+SHI</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>-0.0491</td>
</tr>
</tbody>
</table>
Discussion

• Health financing reform strategies of the UC policy improved equity in health care use (both ambulatory and hospitalization) and financial risk protection.

• Health care use of government health facilities was pro-poor before UC, and was getting better after UC implementation.

• Health services at primary and secondary care levels were more pro-poor than tertiary care and private facilities.

• Out-of-pocket payments for health tended to be less regressive after the UC policy was implemented.
  – The Kakwani indexes of OOPs significantly decreased from -0.1502 in 2000 (prior to UC) to -0.0450 in 2006.
How 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**

Breadth and depth coverage, comprehensive benefit package, free at point of services
Concluding remarks 1/2

- Enabling factors for achieving UC
  - Strong political supports
  - Health systems capacity and its resilience to rapid nation-wide program scale-up in 6 months
  - Lessons from predecessors
    - SHI capitation contract model
    - CSMBS “no go” fee for service, due to cost escalation and inefficiencies
    - Voluntary Health Card Scheme – adverse selection and non-viable financially
  - Linking evidence to policy decision
    - Integral relationship among researchers – reformists – politicians
  - Pragmatism
    - Limited chance to achieve UC by contributory scheme, especially among informal sector, not feasible for contribution collection and enforcement

- Learning from SHI, UC takes further advanced steps,
  - Well thought systems design towards efficiency, cost containment, ensure referral, advocates of primary care contractor
Concluding remarks 2/2

- UC Schemes covers the poor, half belongs to Q1 and Q2
  - However, the Scheme faced chronic under-funding, capitation was below than the proposed figures based on cost and utilization
  - Significant increase in utilization more on OP than IP
  - In view of under-funding and increased utilization → danger of poor quality of services and serious hospital financial constraints

- Empirical evidence indicates
  - Pro-poor budget subsidy, DHS is a major hub of fostering the pro-poor nature of financing healthcare
    - Policy msg. → invest more in DHS
  - (further) reduction in the incidence of catastrophic illnesses
  - (further) reduction of impoverishment from medical bills
Key challenges of the Thai health care system

- Long-term sustainability of health care finance for the UC scheme and overall health care finance,
- An increasing disease burden from chronic NCD and the situation of aging society,
- Inefficiency and inequitable access to good quality of health services among beneficiaries of different health insurance schemes,
- Low level of health care finance for health promotion and disease prevention,
- Poor governance of health systems in Thailand,
- The unknown impact of economic crisis on health of the Thai population,
- The pandemic of new emerging infectious disease and unsuccessful control of tuberculosis and HIV/AIDS,
- Mal-distribution and internal brain drain of human resources for health.
Thank you for your attention