International Health Policy Program - Thailand

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

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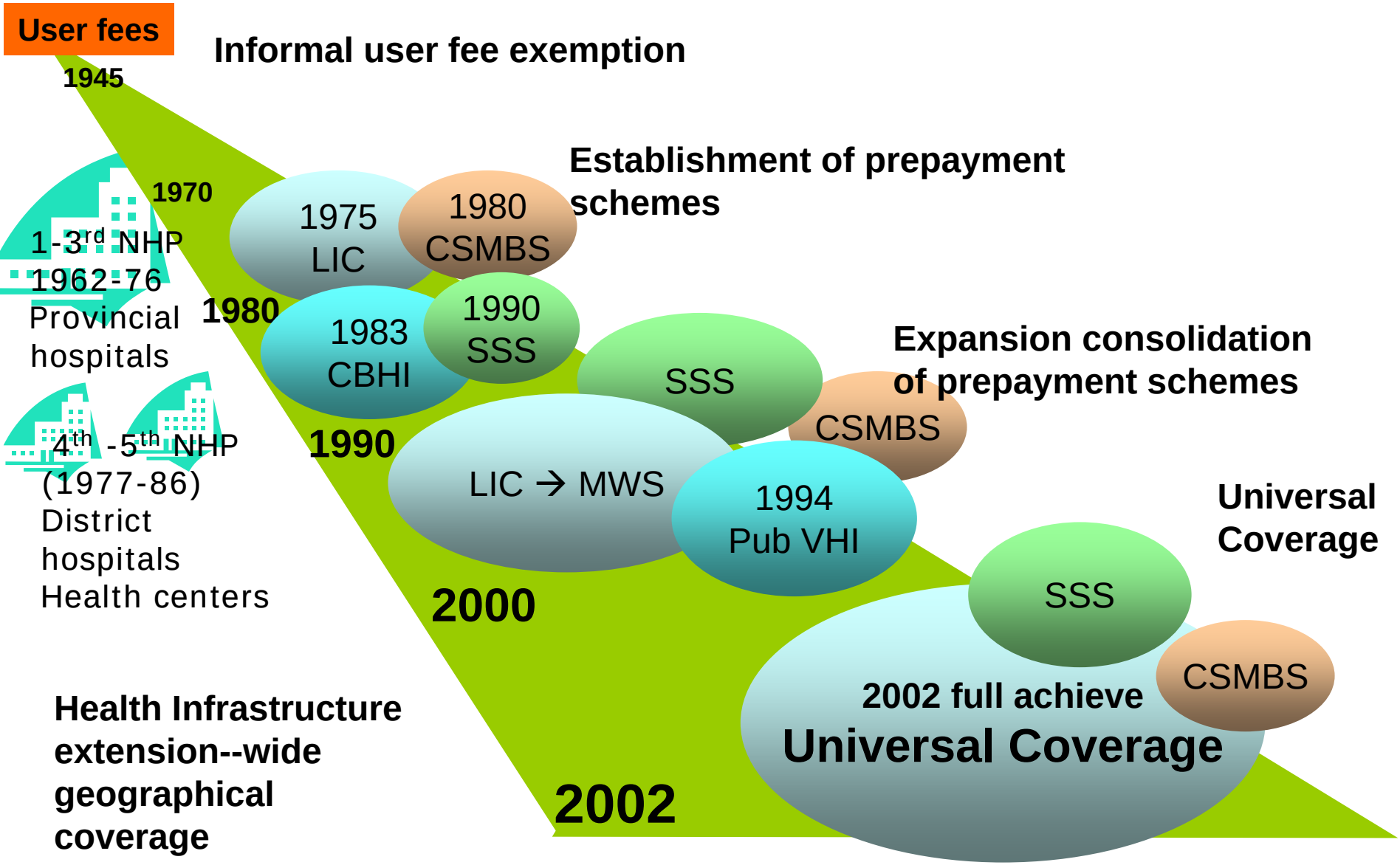
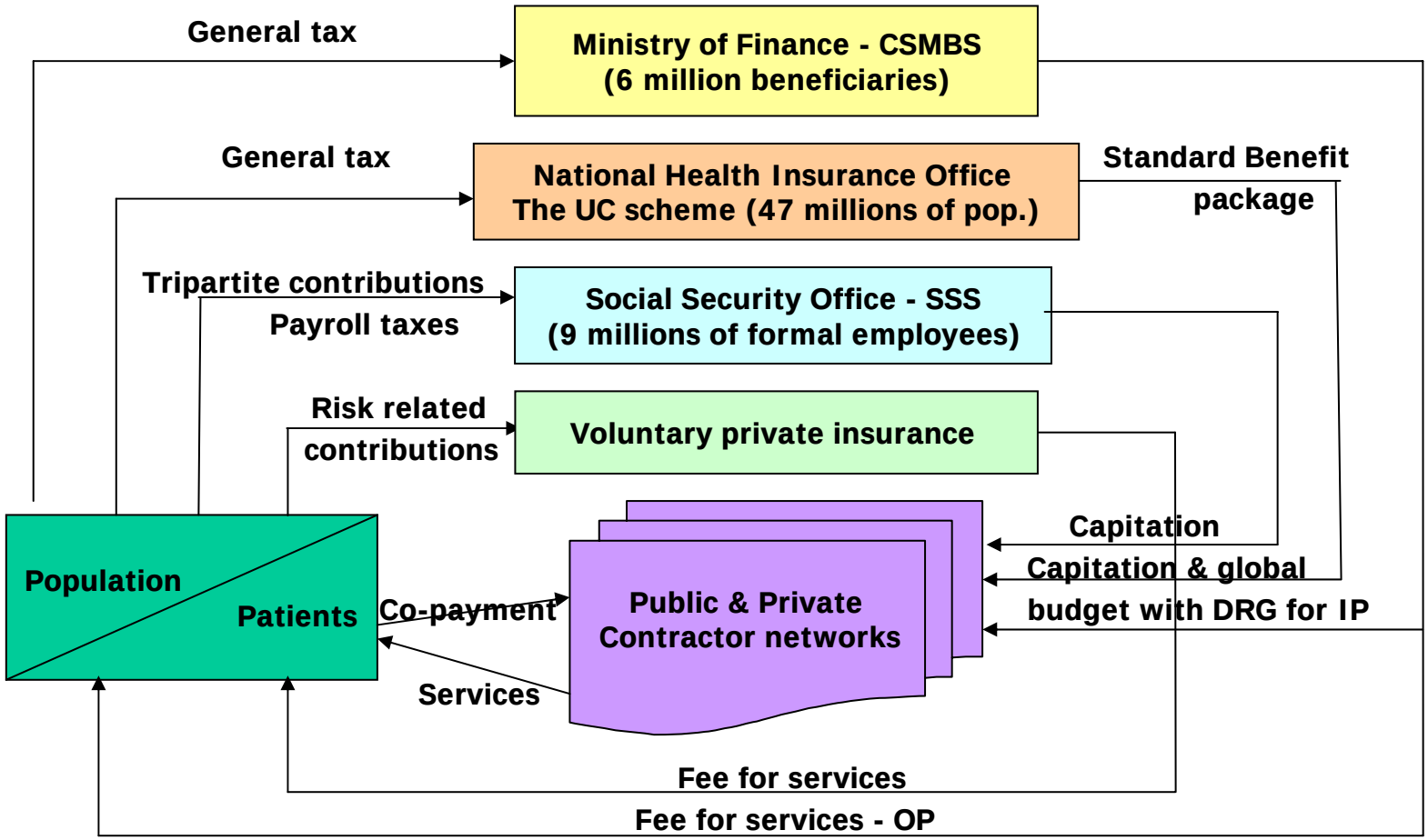
# Background

- 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.

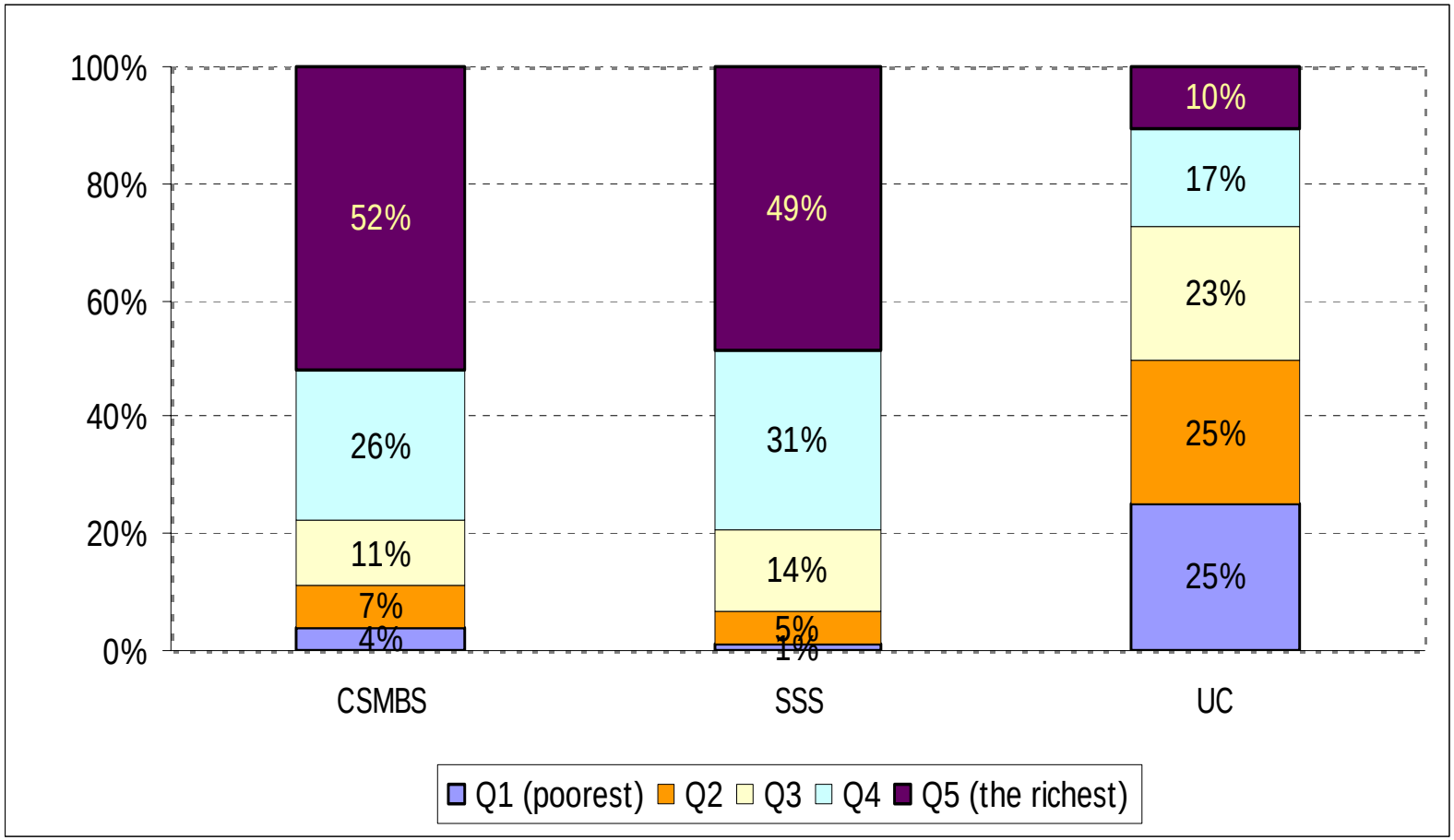
# Evolution of achieving universal coverage in Thailand: Infrastructure development + financial protection extension



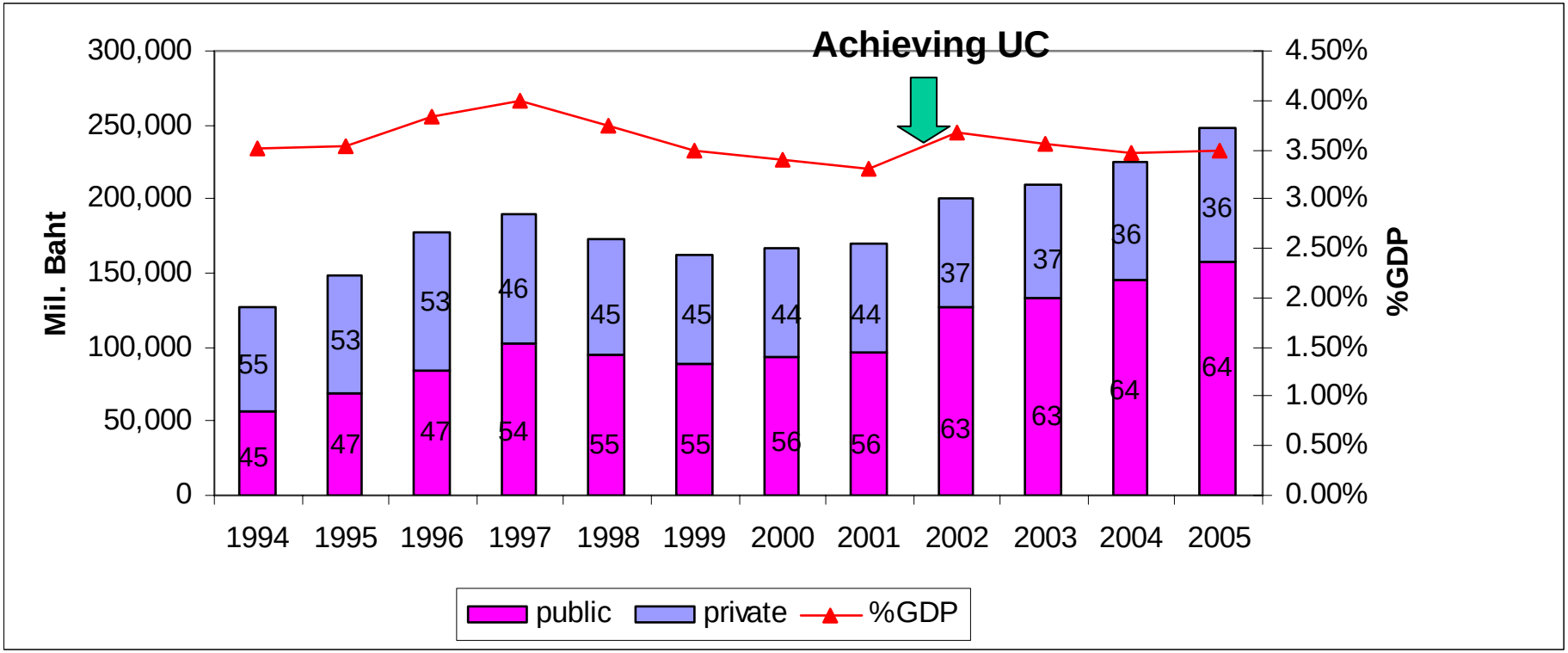
# Health care finance and service provision of Thailand after achieving universal coverage (UC)



# Scheme beneficiaries by income quintiles, 2004

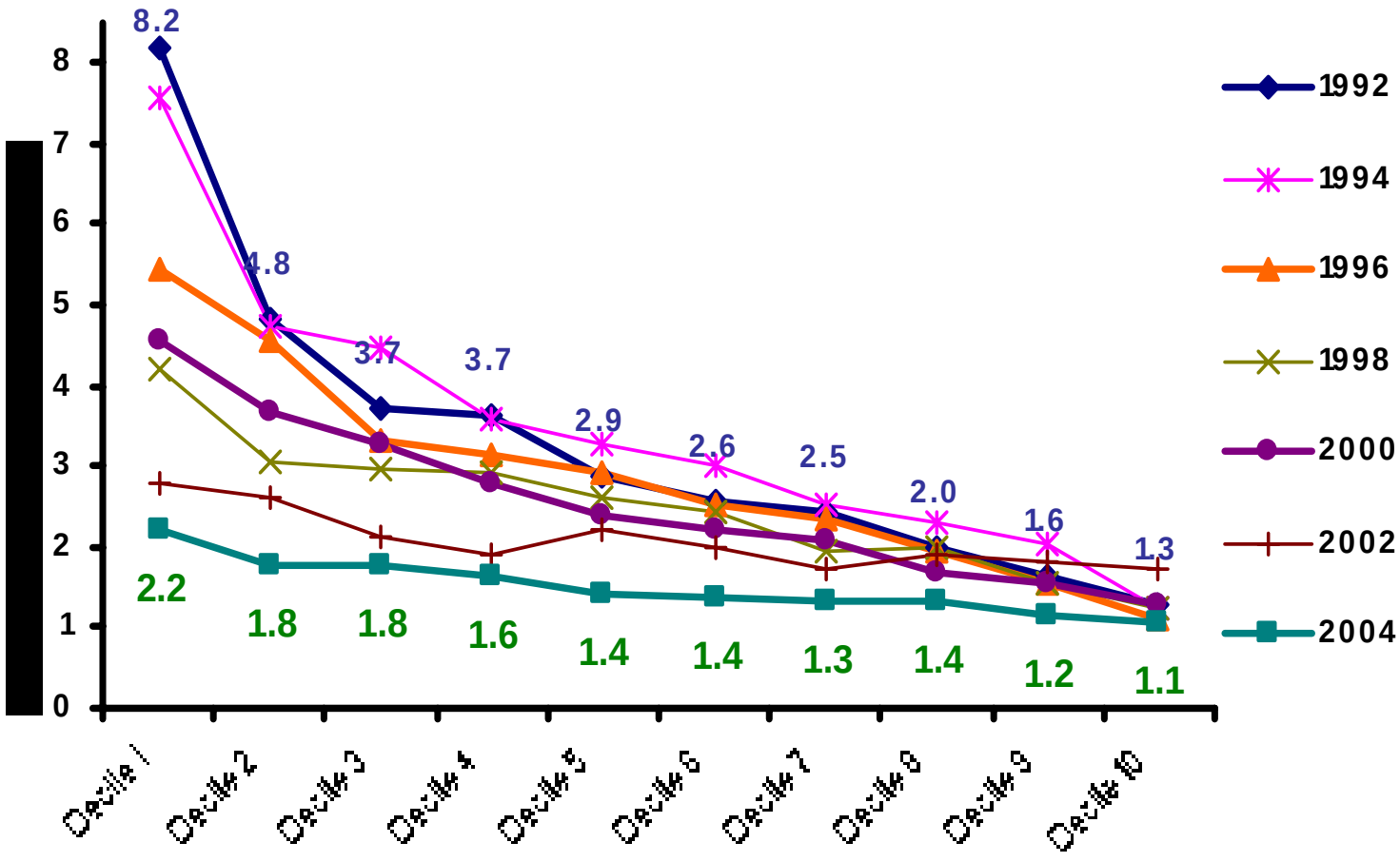


# Total health expenditure 1994-2005

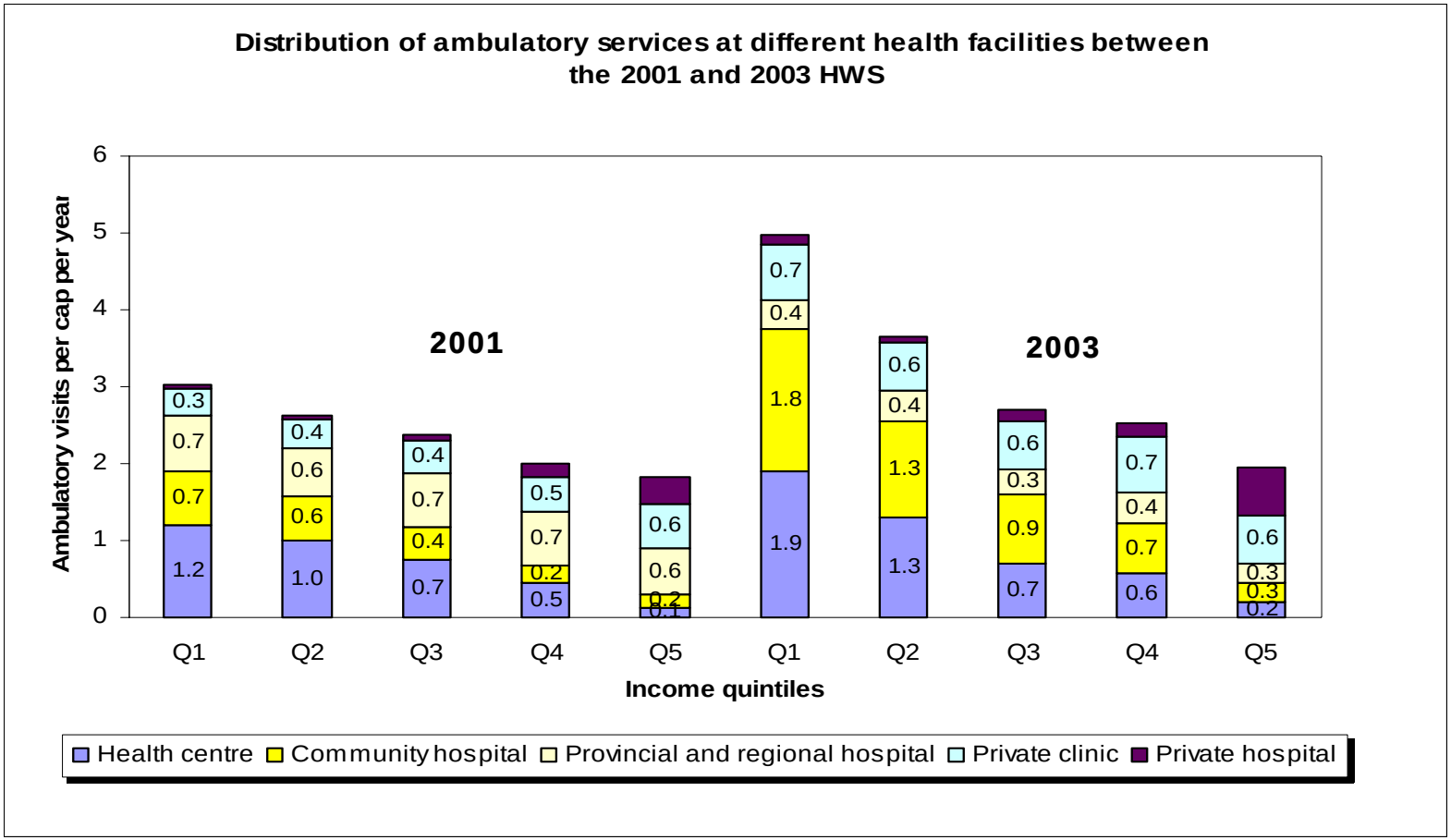



Total health expenditure during 2003-2005 ranged from 3.49 to 3.55% of GDP, THE per capita approx 100 USD

# Household OOP for health, % income 1992-2004



# The distribution of ambulatory service use among different income quintiles in 2001 and 2003, by types of health facilities




## Concentration index

| Type of health facilities | 2001 | 2003 |
|---|---|---|
| Health centers | - 0.2944 | - 0.3650 |
| Community hospitals | - 0.2698 | - 0.3200 |
| Provincial and regional hospitals | - 0.0366 | - 0.0802 |
| Private hospitals | 0.4313 | 0.3484 |

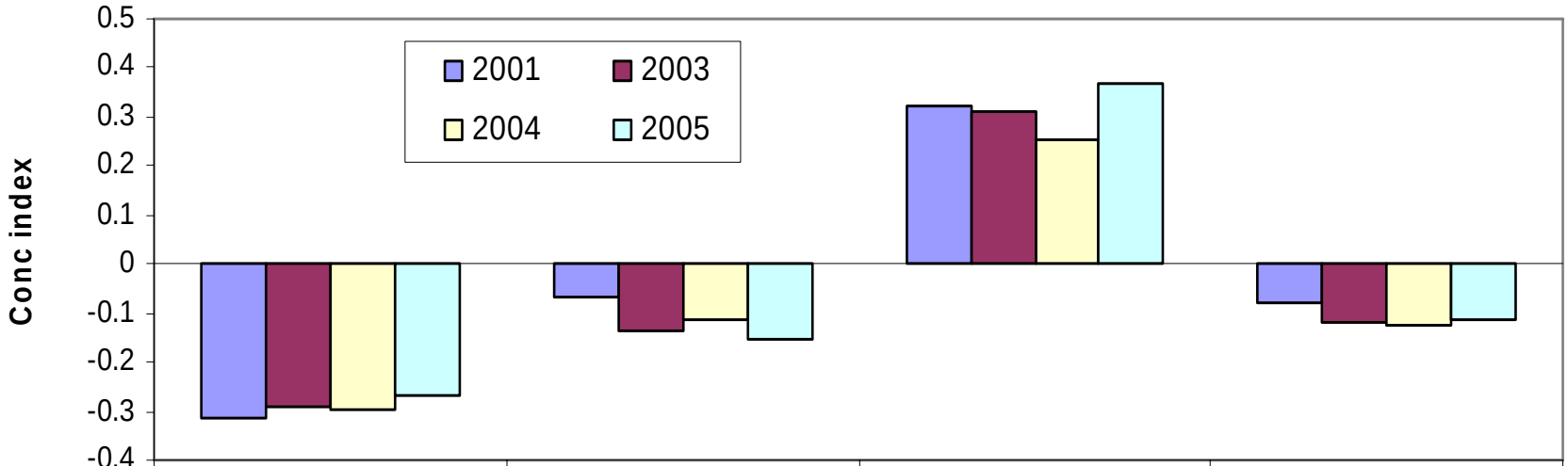
Source: Prakongsai P (2008). The Impact of the Universal Coverage Policy on Equity of the Thai Health Care system.

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


| | Health centre | Community hosp | Provincial hosp | Private hosp | Overall |
|---|---|---|---|---|---|
| 2001 | -0.294 | -0.271 | -0.037 | 0.431 | -0.090 |
| 2003 | -0.365 | -0.315 | -0.080 | 0.348 | -0.139 |
| 2004 | -0.345 | -0.285 | -0.119 | 0.389 | -0.163 |
| 2005 | -0.380 | -0.300 | -0.100 | 0.372 | -0.177 |

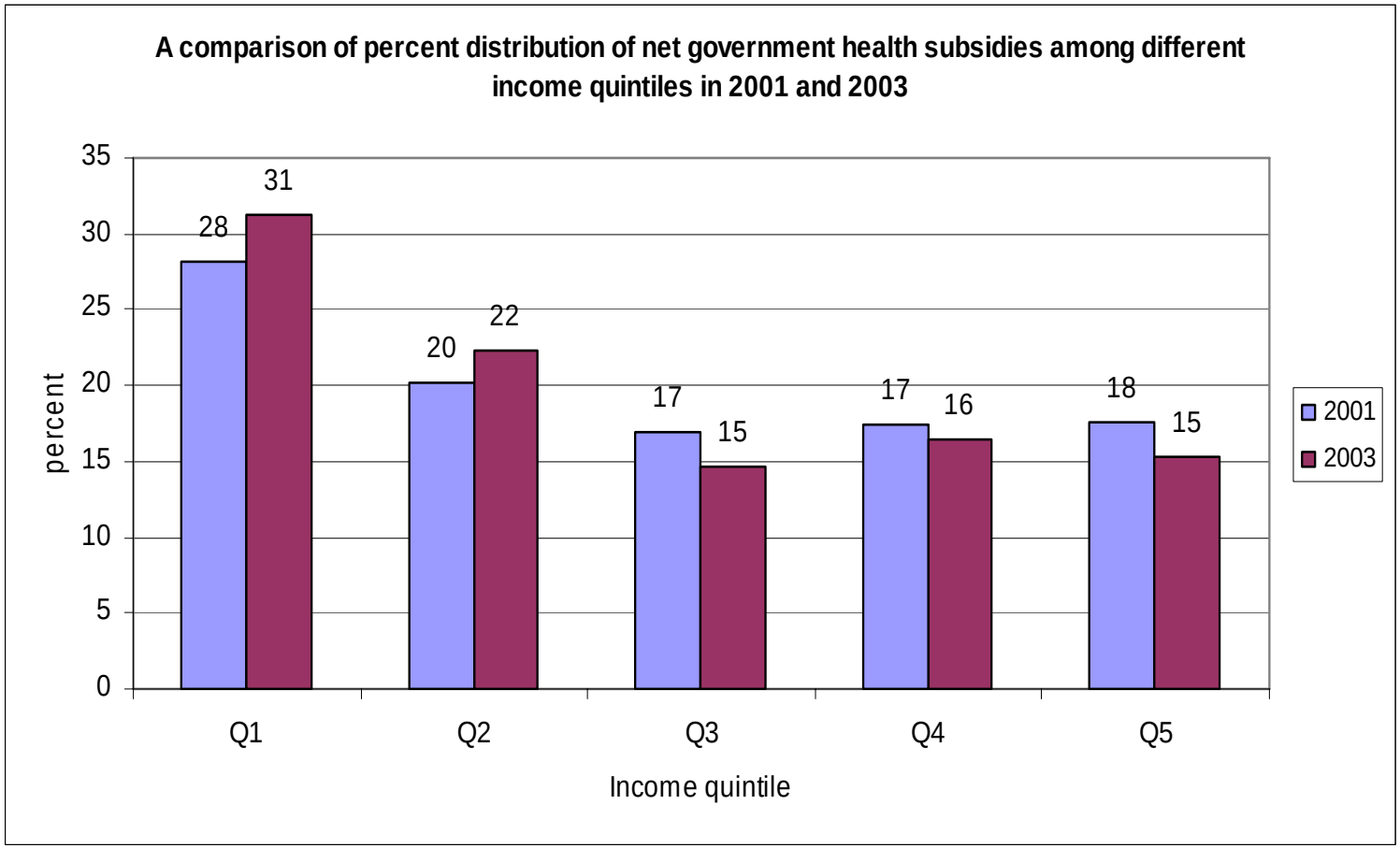
Note: CI range from -1 to + 1. Minus 1 (plus 1 ) means in favour of the poor (rich), or the poor (rich) disproportionately use more services than the rich (poor).

# Equity in utilization: Concentration Index of hospitalization by type of health facilities: 2001 to 2005




| | Community hospitals | Provincial and regional hospitals | Private hospitals | Overall |
|---|---|---|---|---|
| 2001 | -0.316 | -0.069 | 0.32 | -0.079 |
| 2003 | -0.293 | -0.138 | 0.309 | -0.121 |
| 2004 | -0.294 | -0.114 | 0.254 | -0.127 |
| 2005 | -0.266 | -0.156 | 0.366 | -0.114 |

# Equity in budget subsidies: BIA, 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

| | 2000 | 2002 | 2004 | 2006 | 2007 |
|---|---|---|---|---|---|
| Q1 (poorest) | 4.0% | 1.7% | 1.6% | 0.9% | 1.9% |
| Q5 (richest) | 5.6% | 5.0% | 4.3% | 3.3% | 2.8% |
| All quintiles | 5.4% | 3.3% | 2.8% | 2.0% | 2.2% |

**Note: Catastrophic health expenditure refers to household out-of-pocket payments for health exceed 10 % of household consumption expenditure**

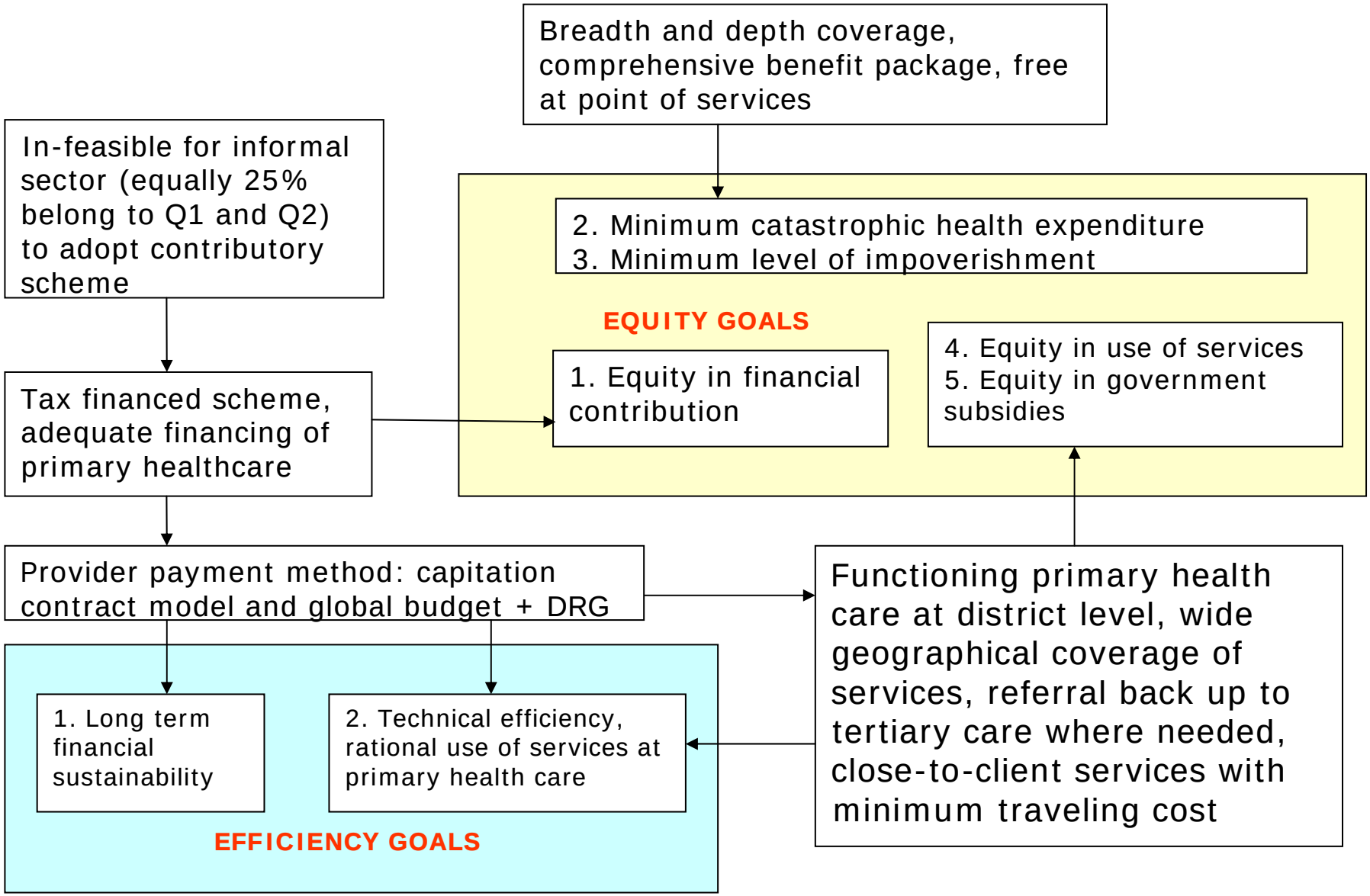
# Kakwani indexes of different health care finance from 2000 to 2006 (Kakwani = Conc. Index – Gini)

| | 2000 | 2002 | 2004 | 2006 |
|---|---|---|---|---|
| Out of Pocket | -0.1502 | -0.0755 | -0.0764 | -0.0450 |
| Direct tax | 0.3913 | 0.4159 | 0.4424 | 0.3617 |
| Indirect tax | -0.0964 | -0.0691 | -0.0435 | -0.0831 |
| Premium Insurance | -0.3623 | -0.3906 | -0.3233 | na |
| Social health Insurance Contribution | 0.1650 | 0.1121 | 0.1046 | na |
| Premium Insurance+SHI Contribution | na | na | na | -0.0491 |

# 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?



# 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