Achievements and challenges in financing UHC in Thailand

Phusit Prakongsai, MD. Ph.D.
Supon Limwattananon, Bsc. Ph.D.
Viroj Tangcharoensathien, MD. Ph.D.
Wilailuk Wisasa, Bsc. Msc.

International Health Policy Program (IHPP)
Ministry of Public Health, Thailand

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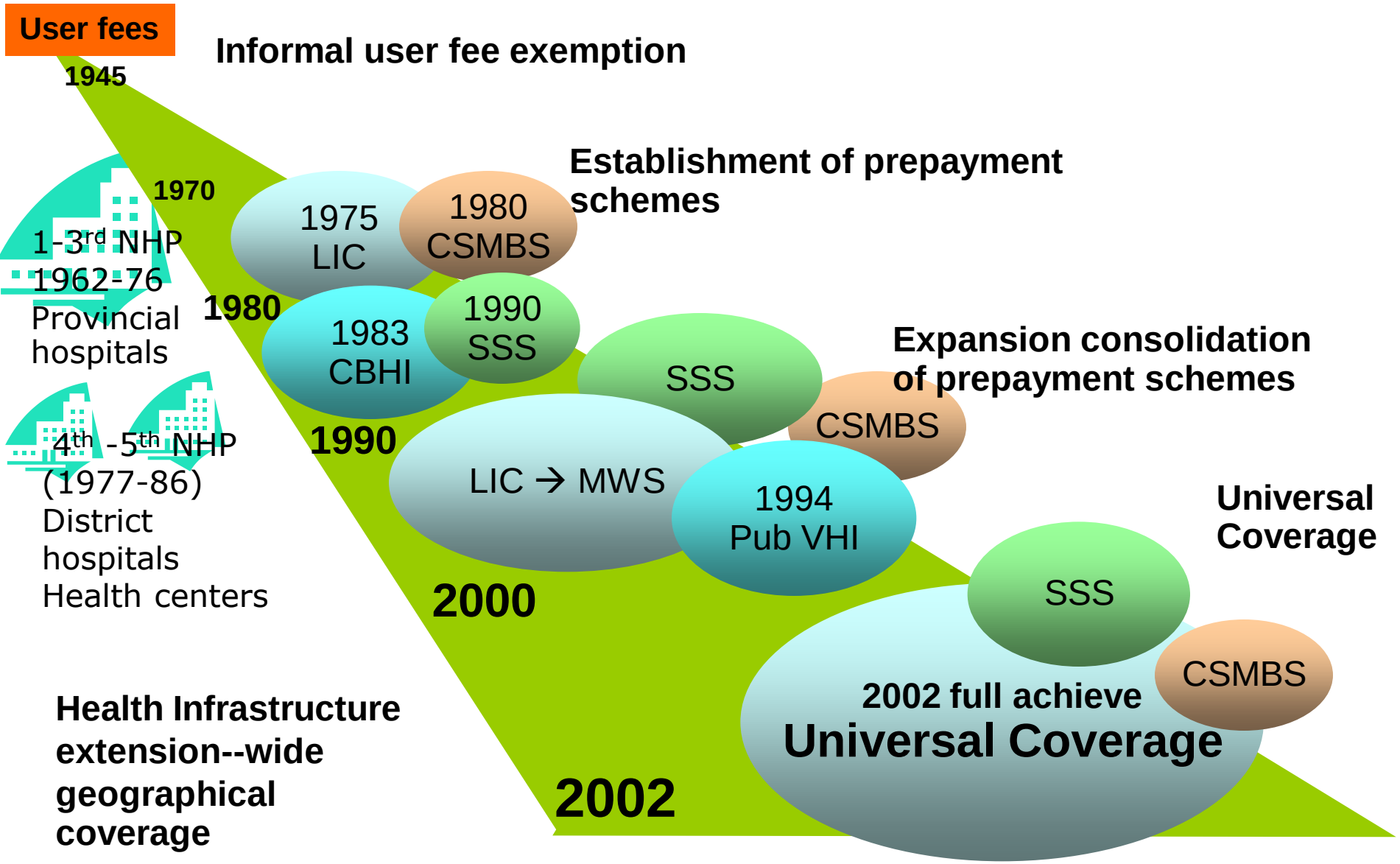
Outline of presentation

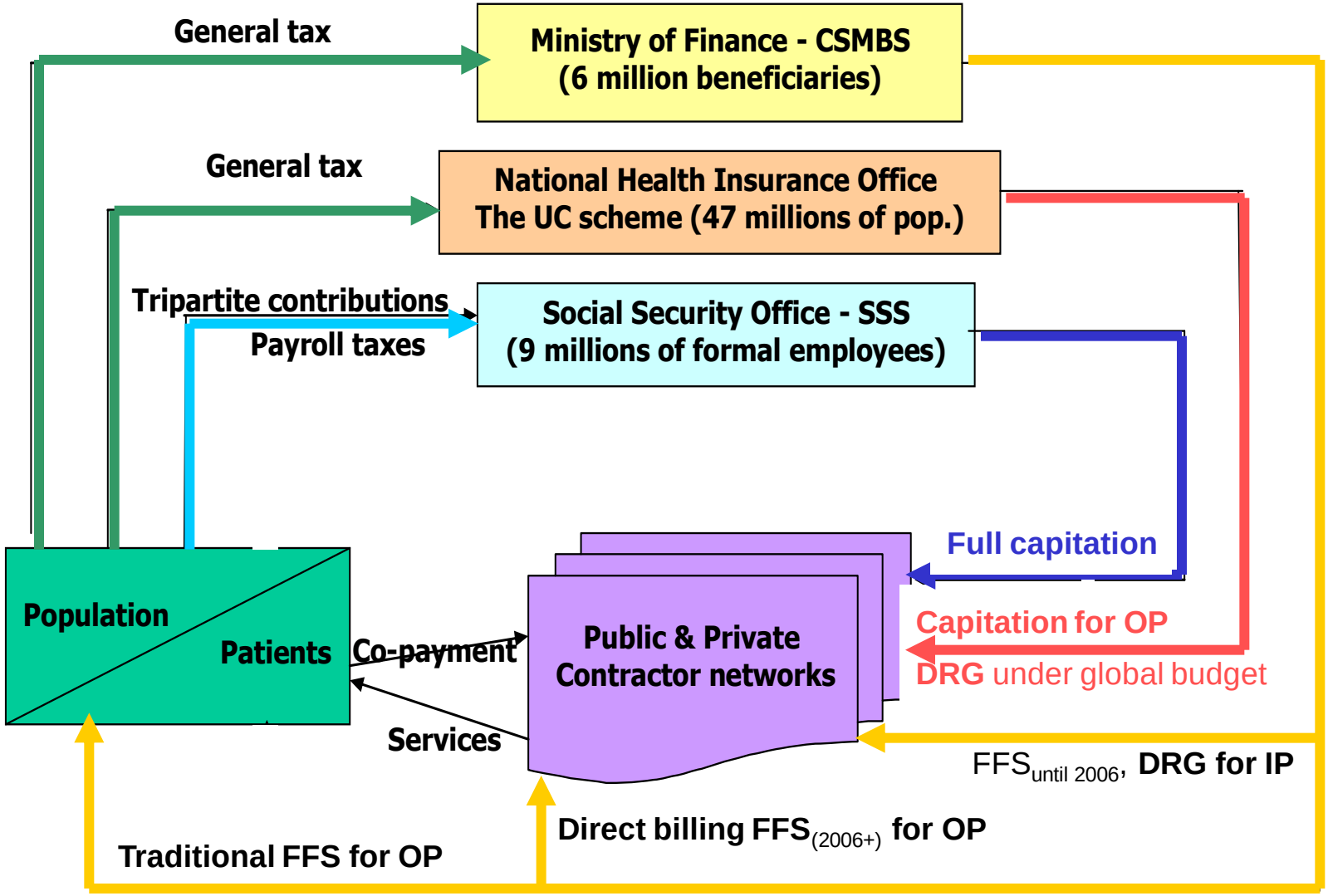
- Health financing arrangements of universal health coverage (UHC) in Thailand
- Achievements after achieving UHC
  - Equity improvements
  - Financial risk protection
  - Poverty reduction
- Key challenges in financing UHC in Thailand
- Conclusions

Historical development of the Thai health system:
Infrastructure development + financial protection extension



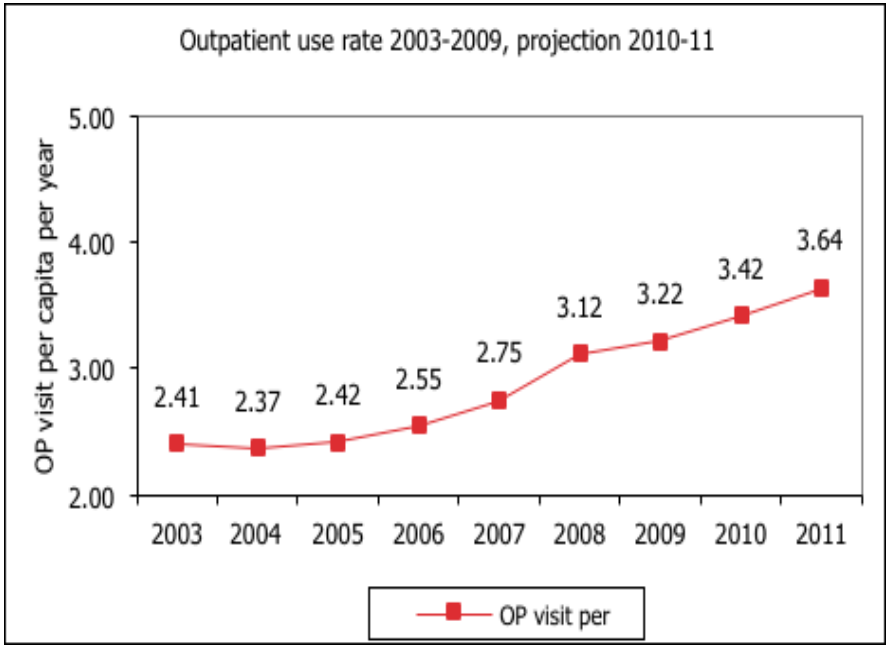
How health care providers are paid by insurance ?

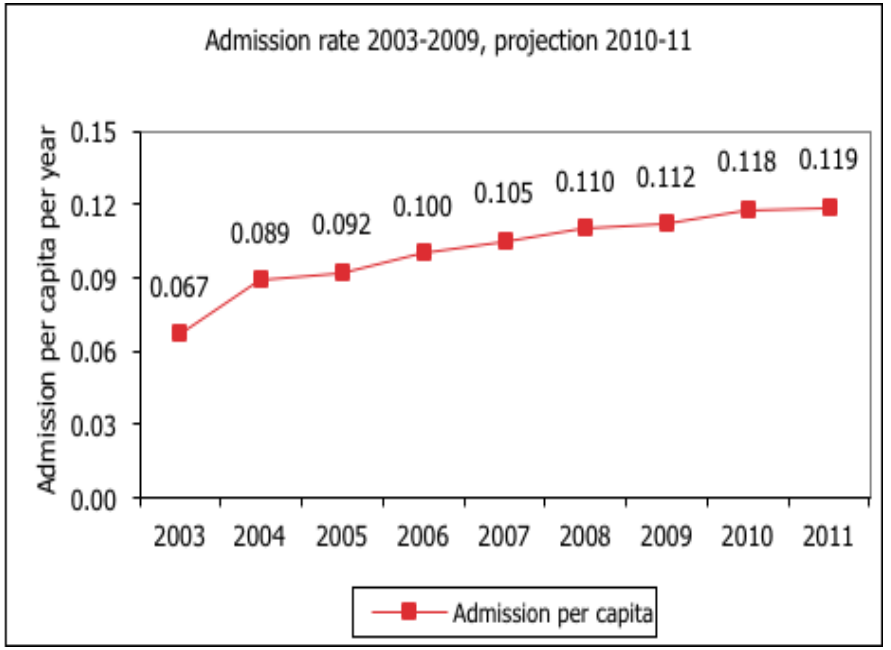
Financing sources and payment methods for CSMBS, UCS, and SSS



Source: Tangcharoensathien et al. (2010)

Increased access to and utilization of health services with very low unmet needs

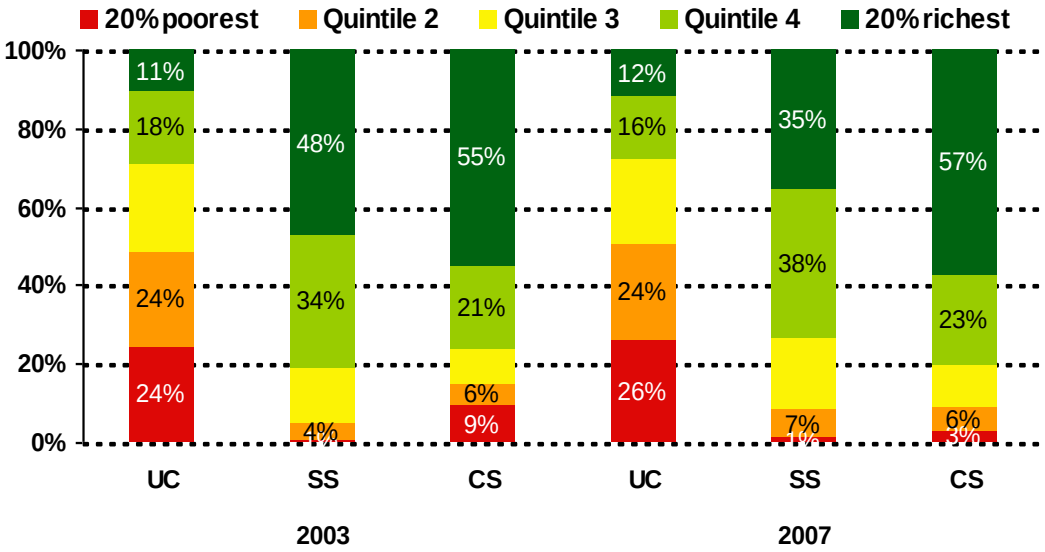




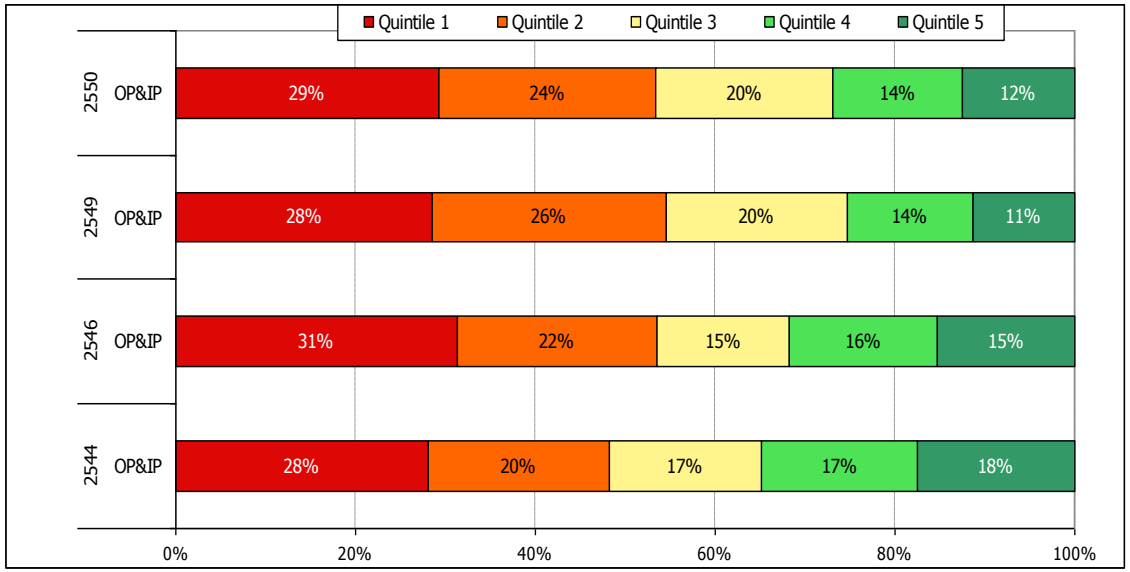
Prevalence of unmet need	OP	IP
National average	1.44%	0.4%
CSMBS	0.8%	0.26%
SSS	0.98%	0.2%
UCS	1.61%	0.45%

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

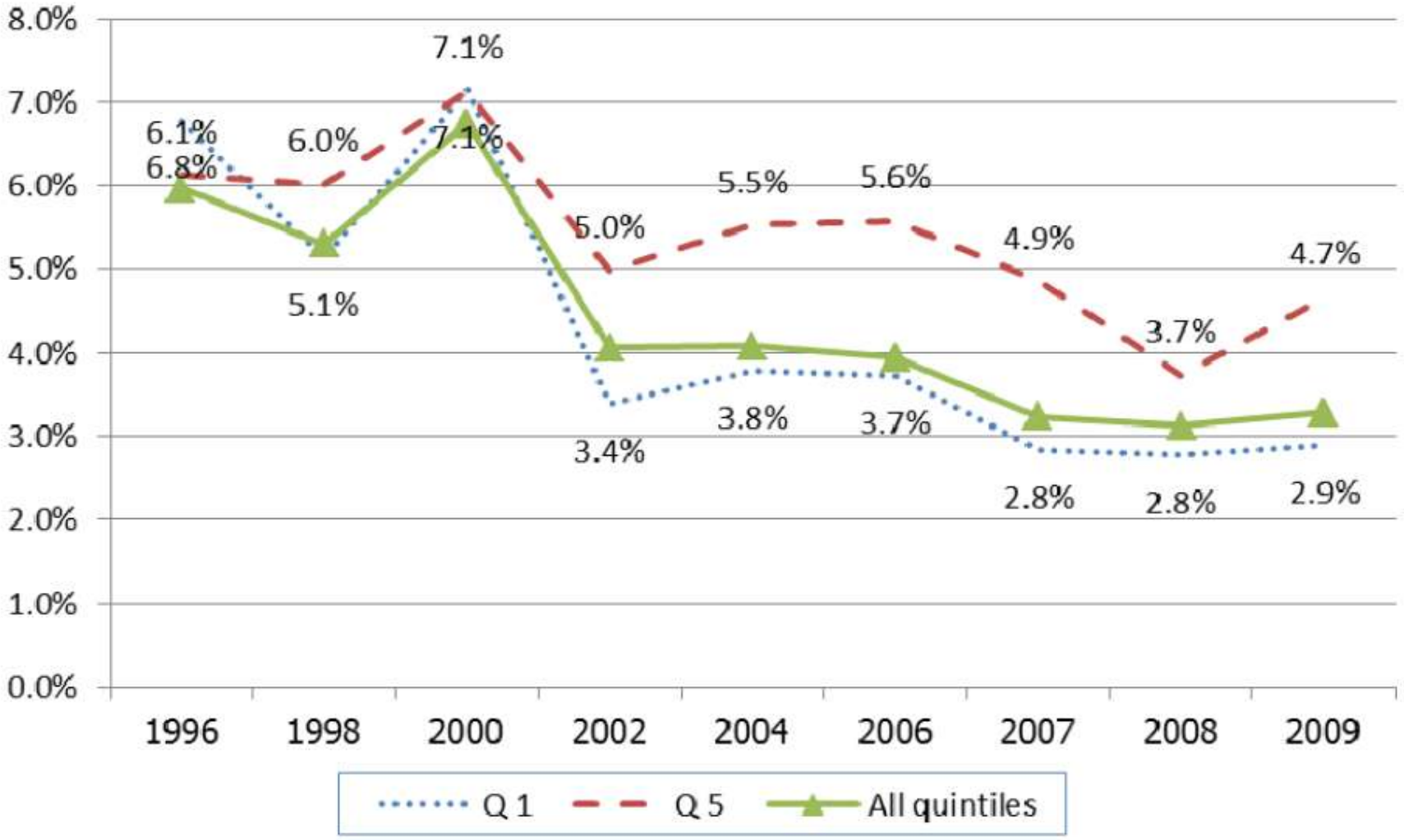


Distribution of government subsidies for health: BIA from 2001 to 2007



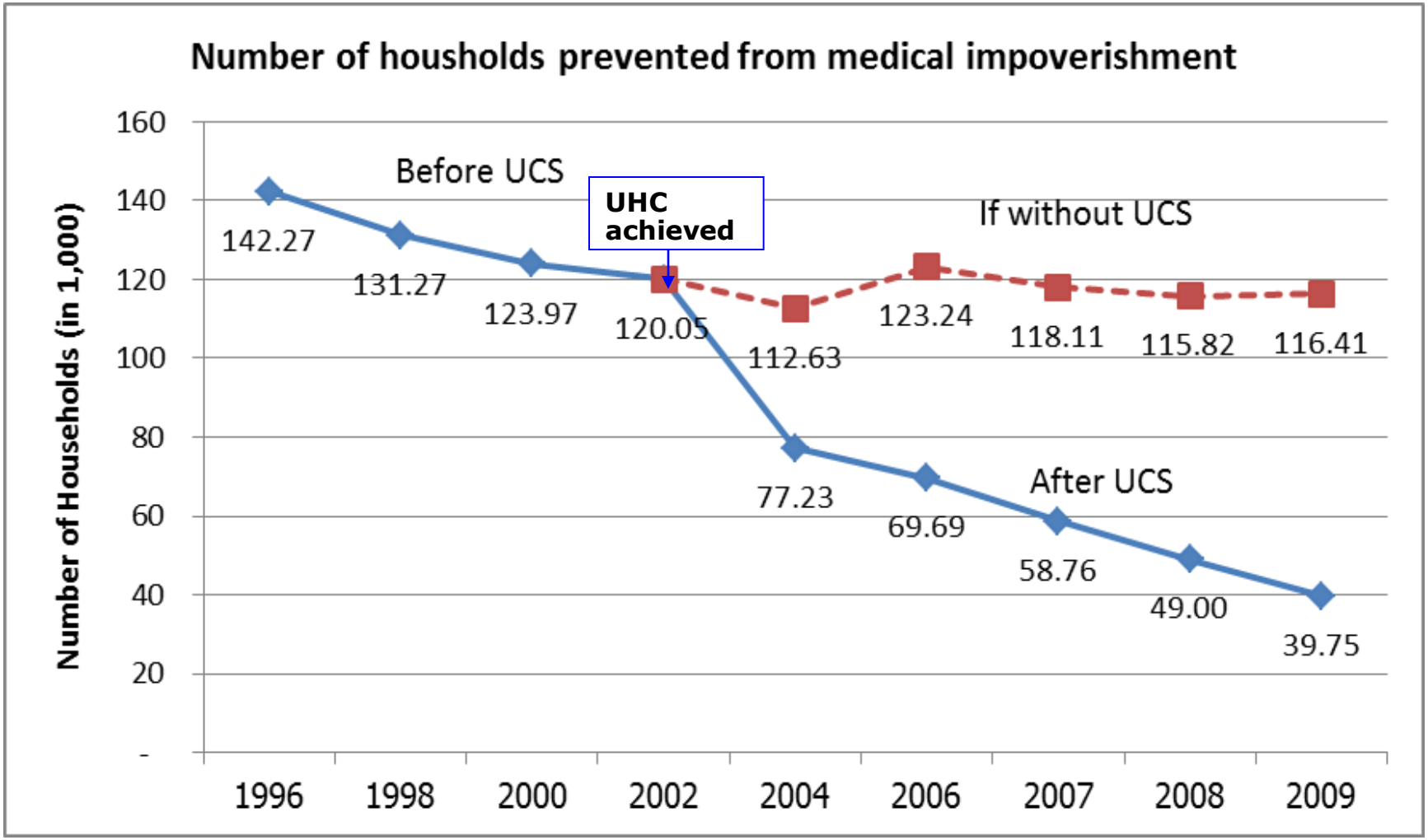
Incidence of catastrophic health spending

OOP>10% total consumption expenditure

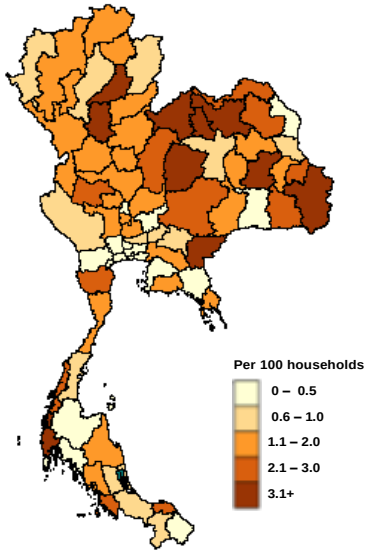


Source: Analysis of Socio-economic Survey (SES)

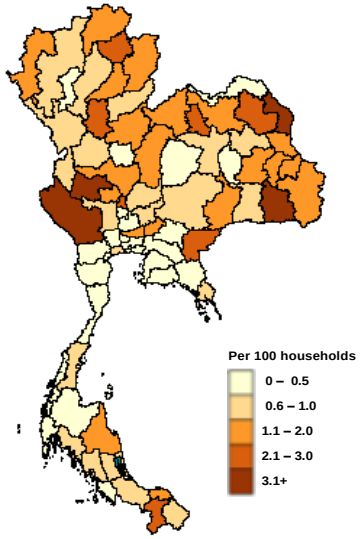
Protection against health impoverishment



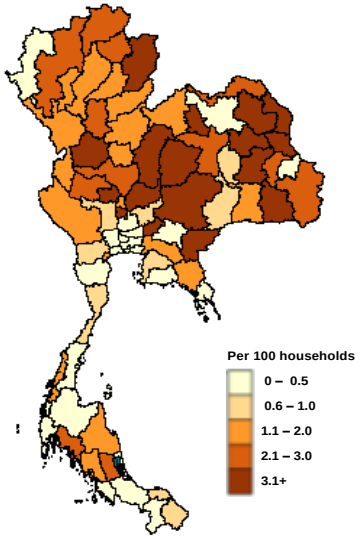
Sub-national health impoverishment 1996 to 2008



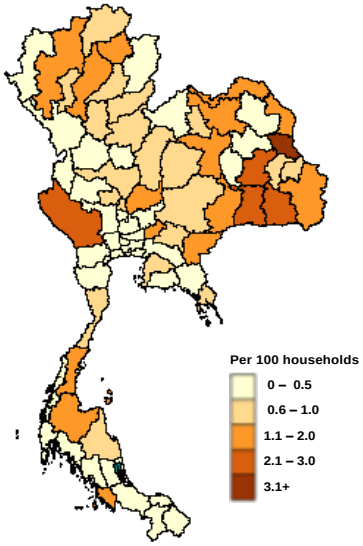
1996



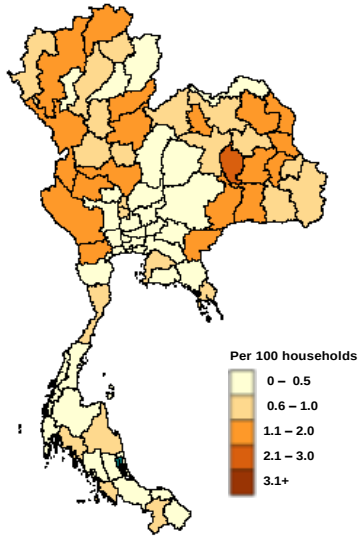
1998



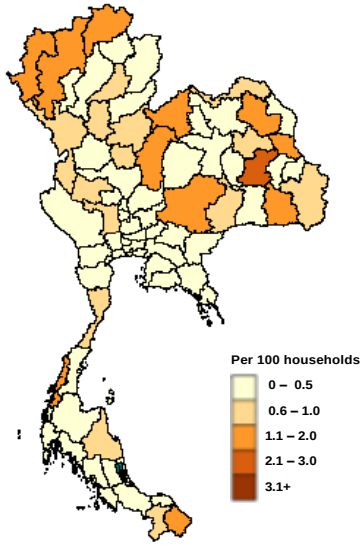
2000



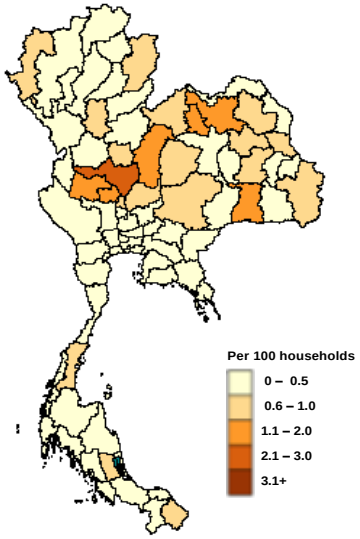
2002



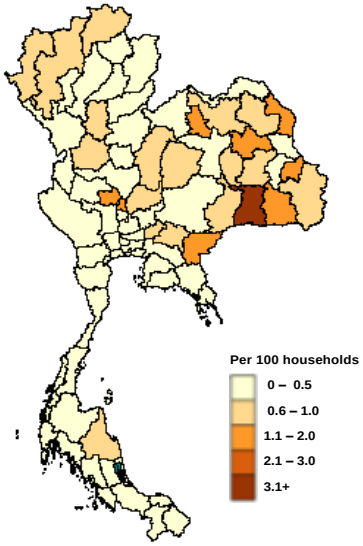
2004



2006

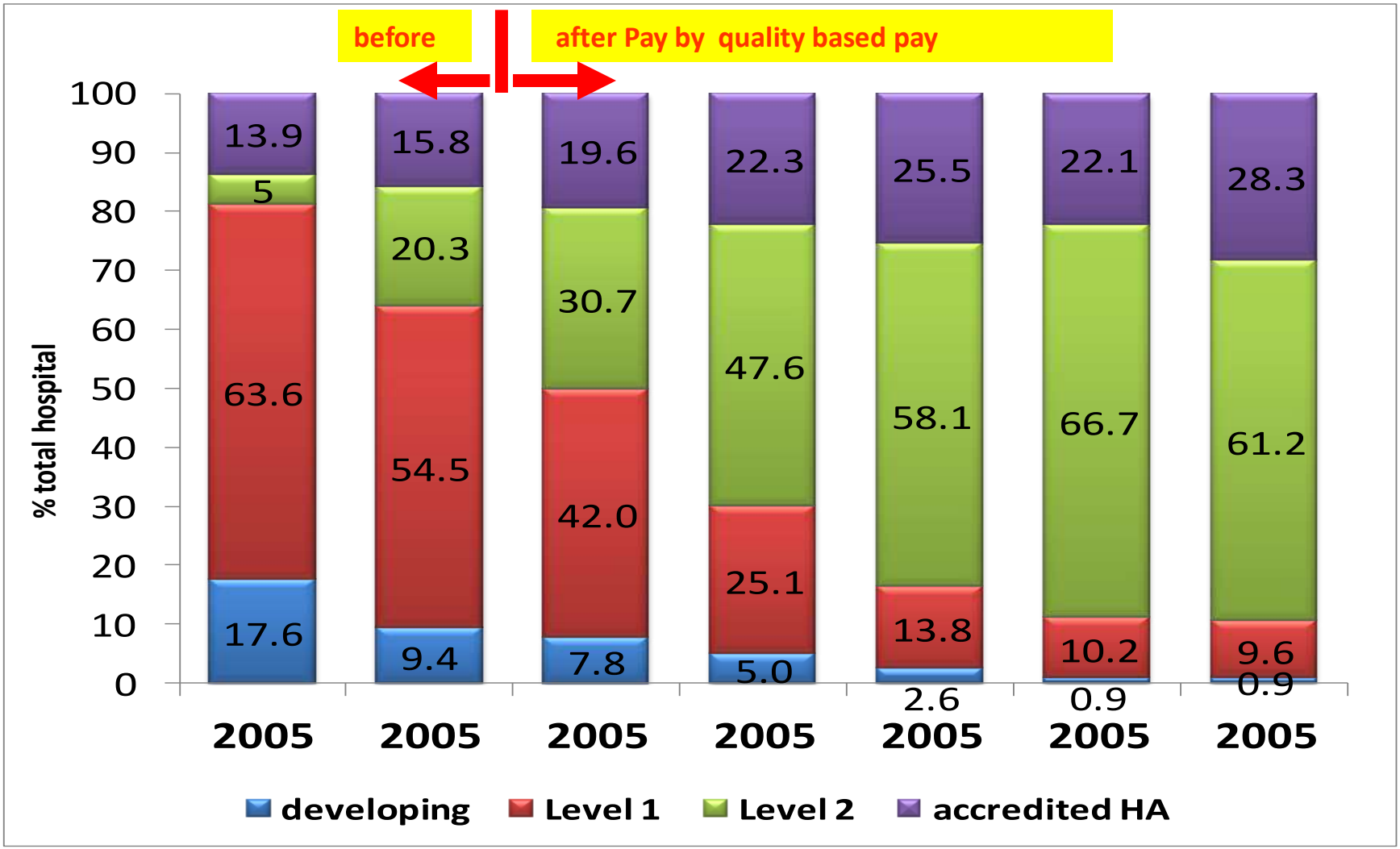


2007



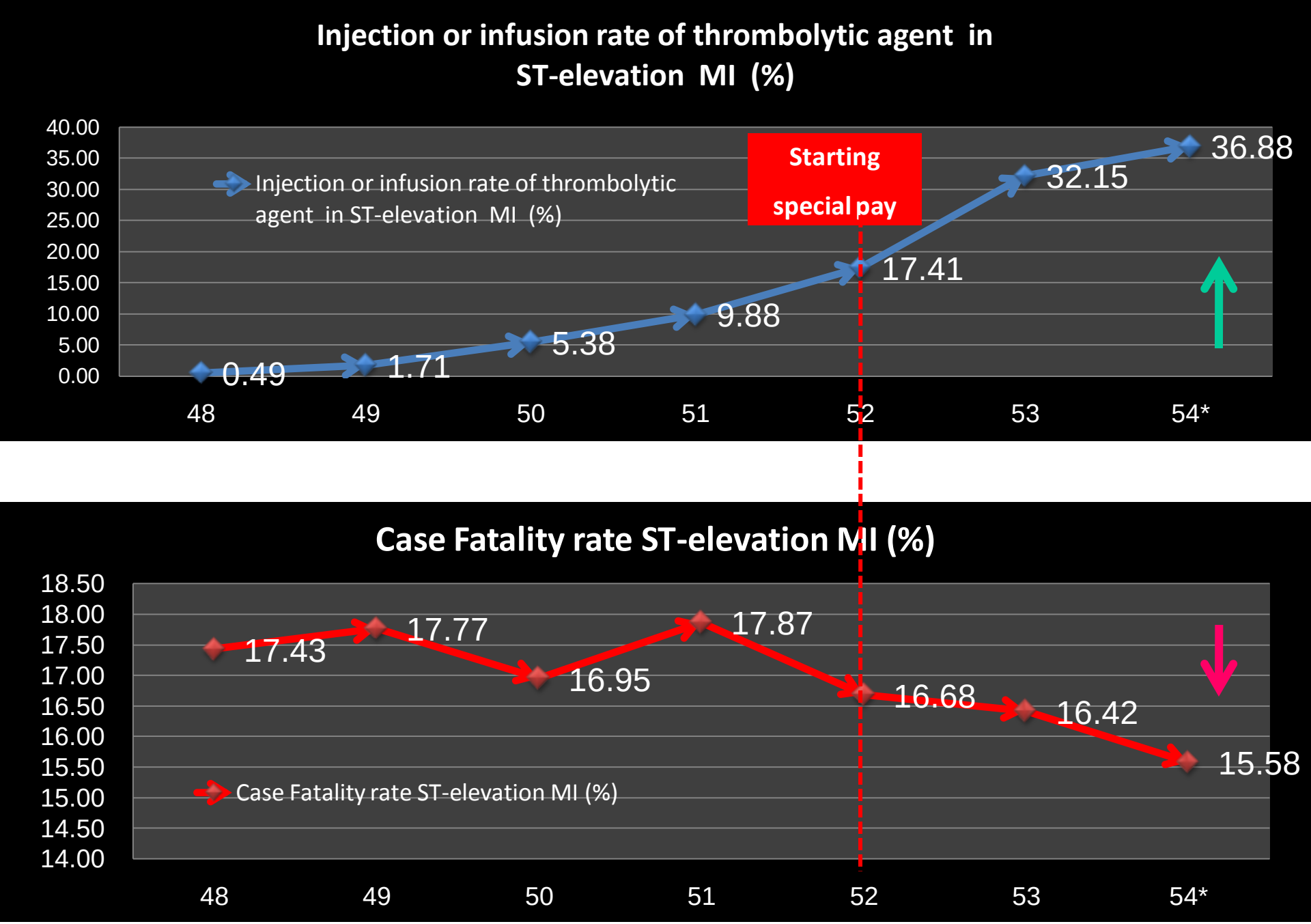
2008

Increased hospital accreditation status in 2005-2011



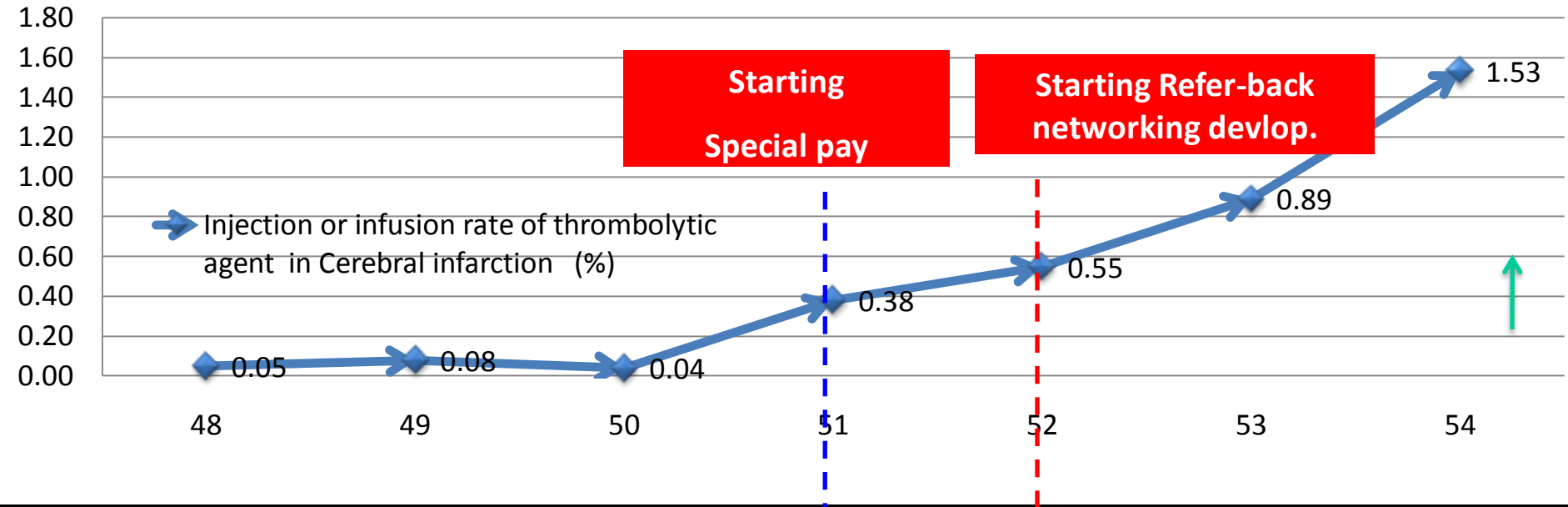
Sources : Healthcare Accreditation Institute (Public Organization), 2011.

adapted by Bureau of Service Quality Development, NHSO.

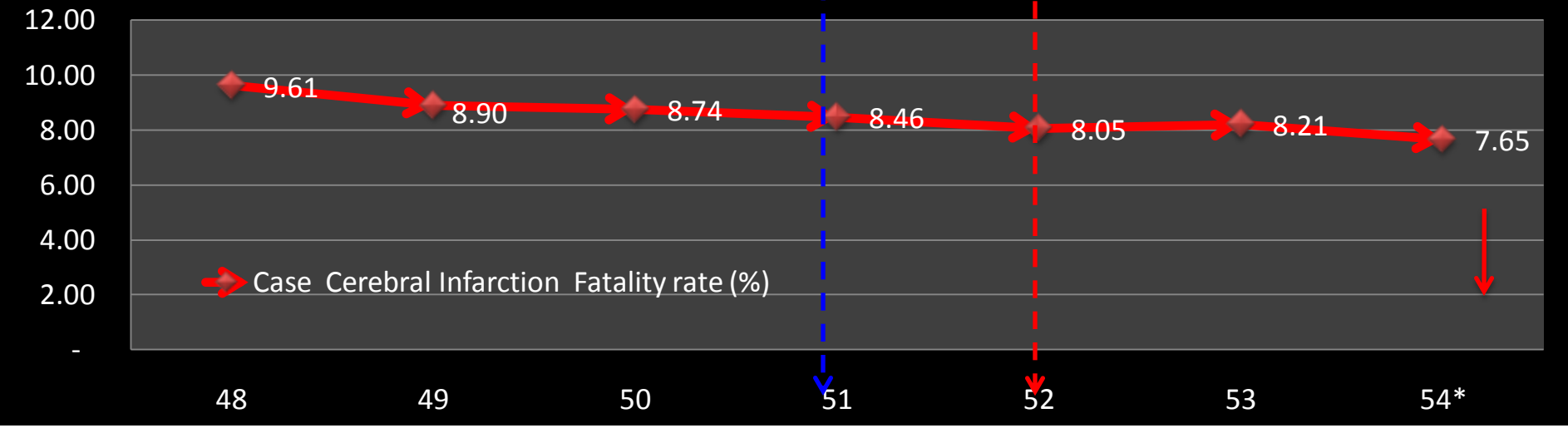


*54 = estimation from Aug. 2010 – Jul.2011 Source : IP individual record 2005- 2011 , NHSO

Injection or infusion rate of thrombolytic agent in Cerebral infarction (%)



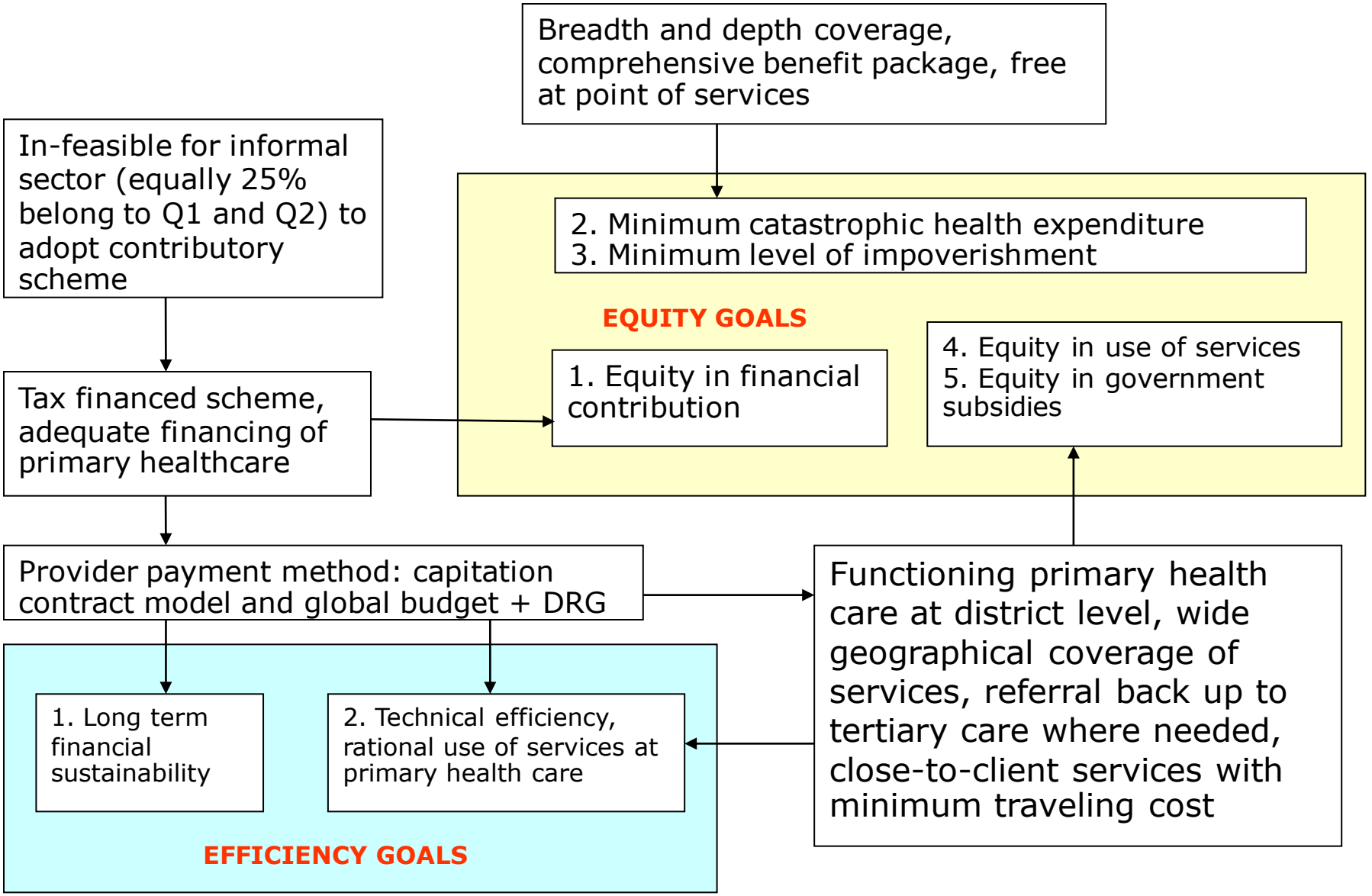
Case Cerebral Infarction Fatality rate (%)



*54 = estimation from Aug. 2010 – Jul.2011

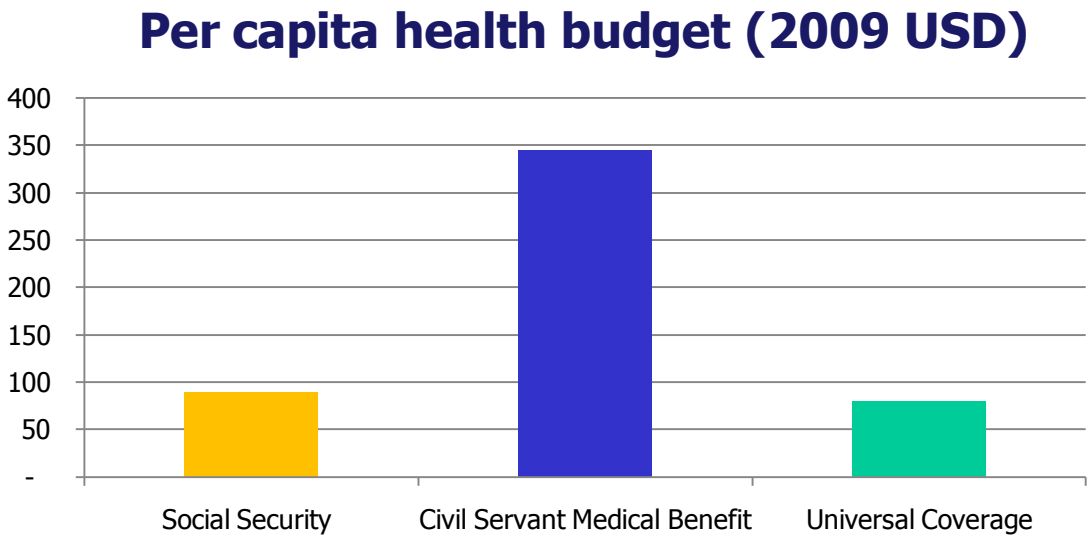
Source : IP individual record 2005- 2011 , NHSO

How health equity and efficiency were achieved?



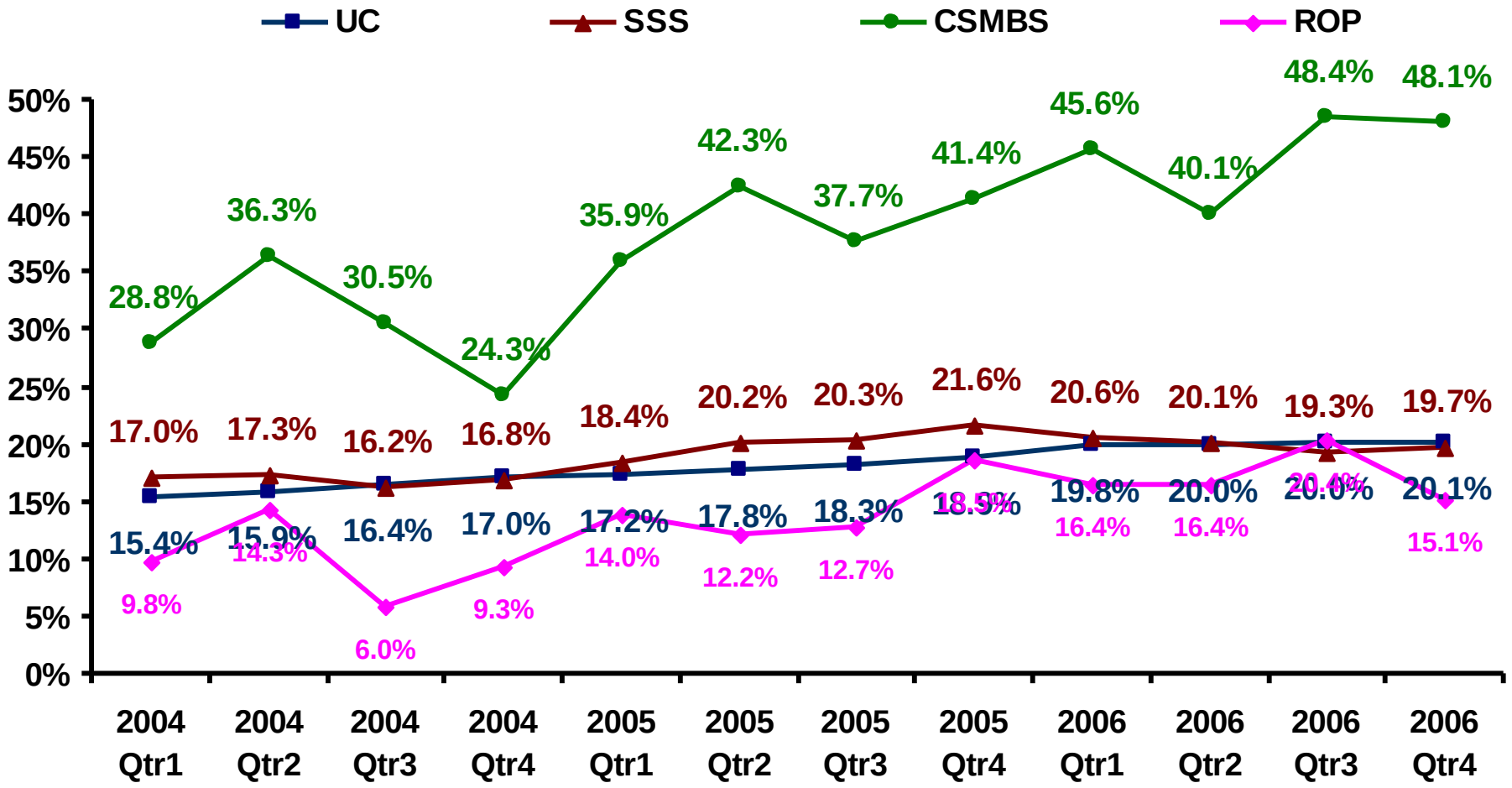
Remaining key challenges in financing UCH in Thailand

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

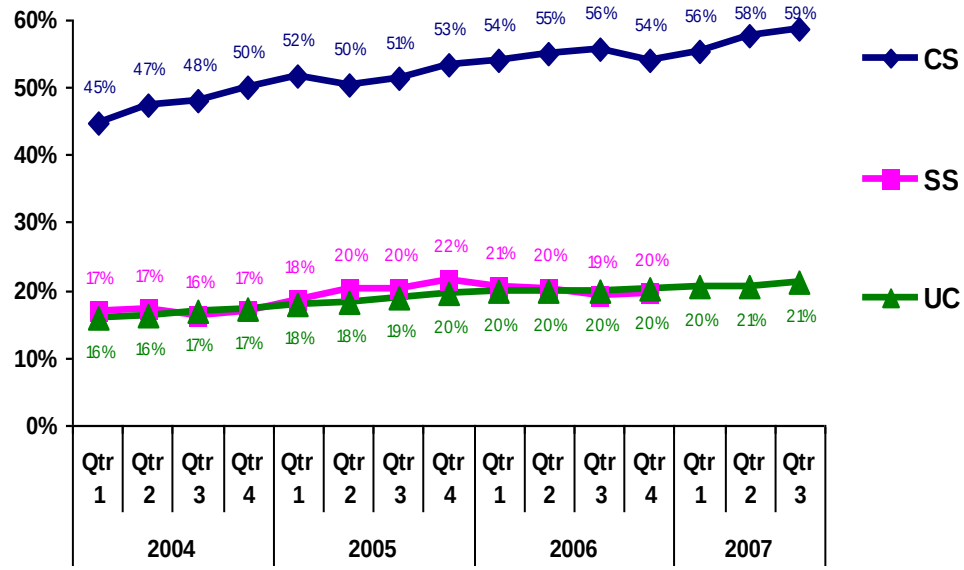


Source: Electronic claim database of inpatients from National Health Security Office, 2004-2006 (N=13,232,393 hospital admissions)

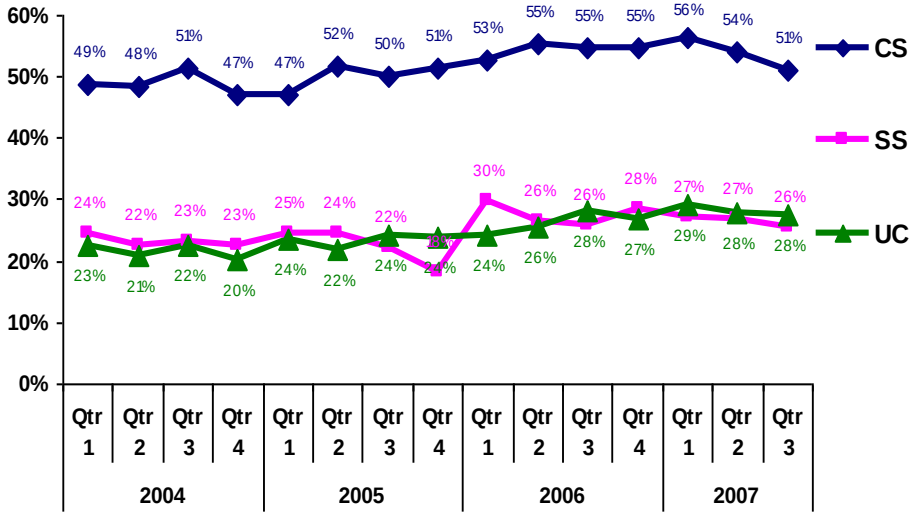
Use of expensive procedures

Variations across 3 public insurance schemes

Cesarean section



Laparoscopic cholecystectomy

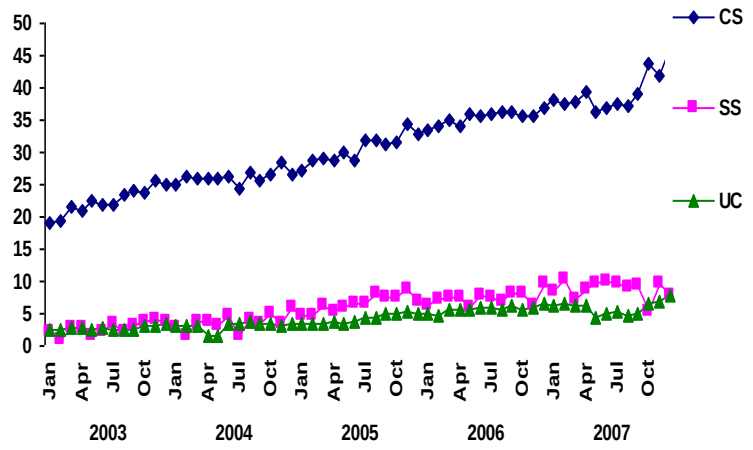


Source: Limwattananon et al. (2009)

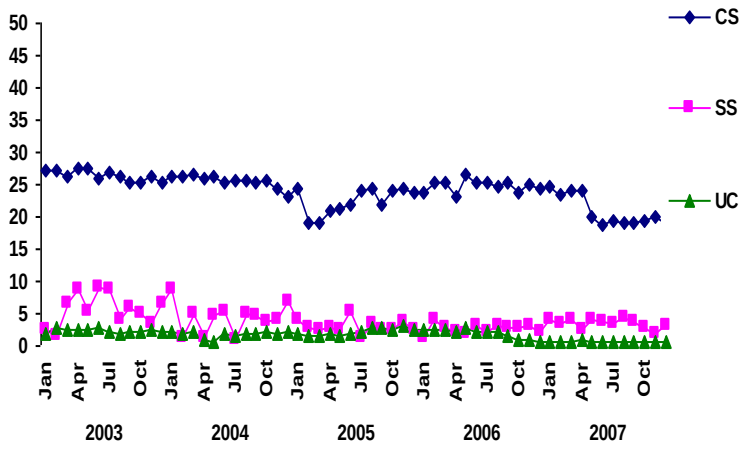
Use of expensive OP medicines

Variations across 3 public insurance schemes

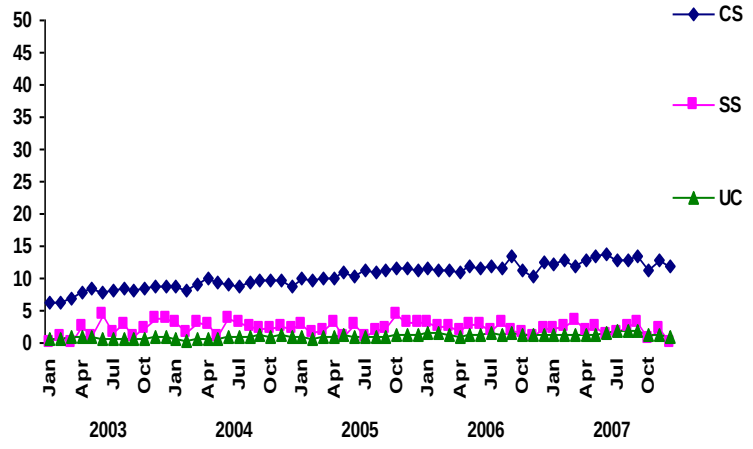
Angiotensin II receptor blockers



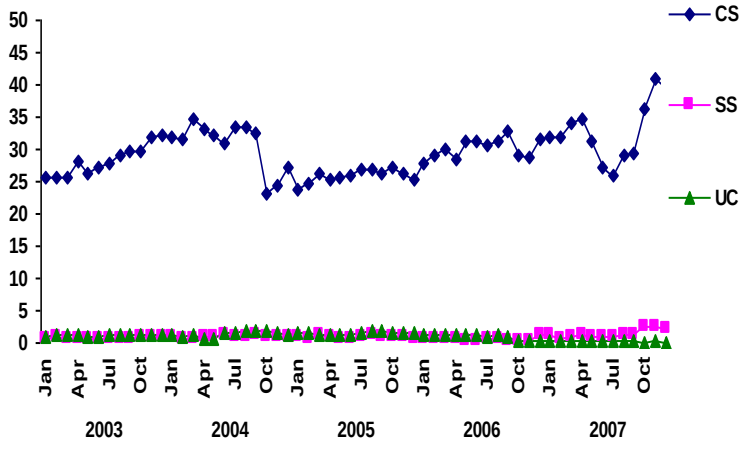
Single source statins and new antihyperlipidemia



Clopidogrel



Coxibs

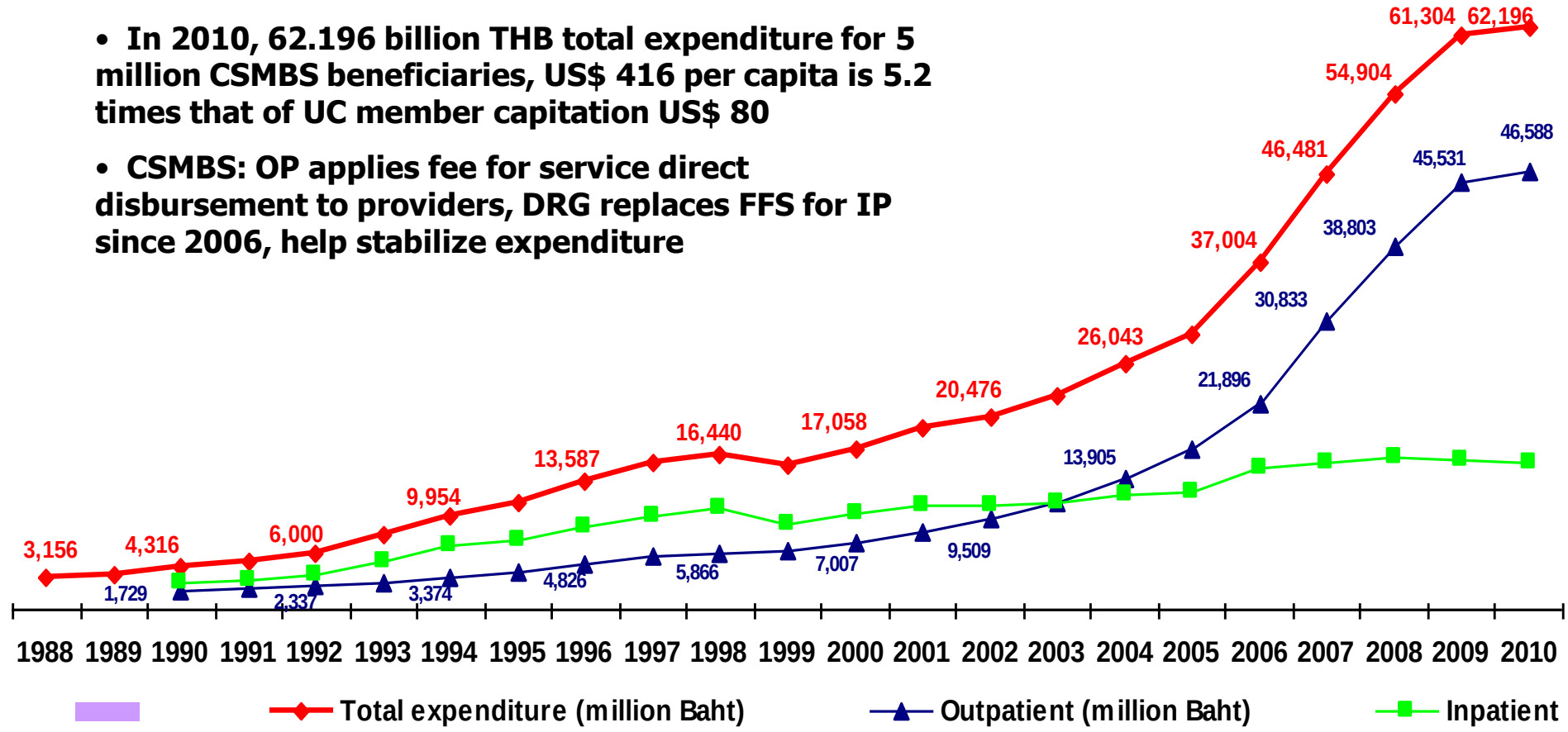


Source: Limwattananon et al. (2009)

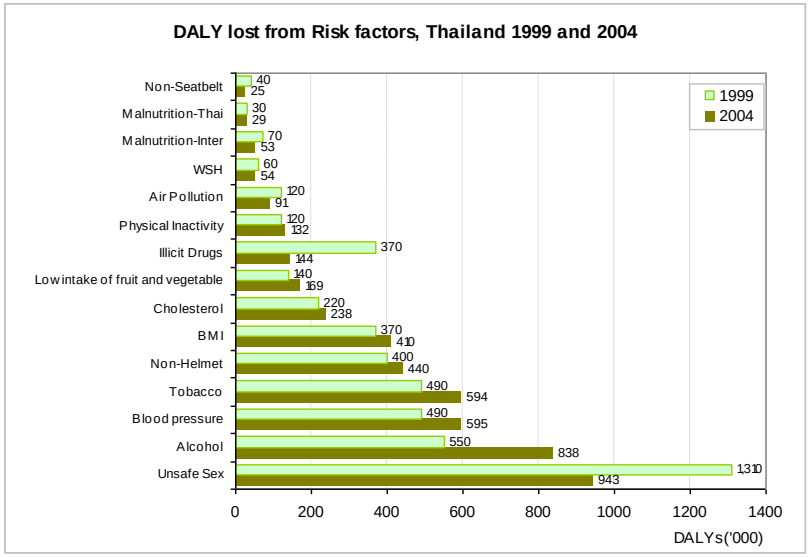
Cost escalation: Consequence of fee for services in Civil Servant Medical Benefit Scheme

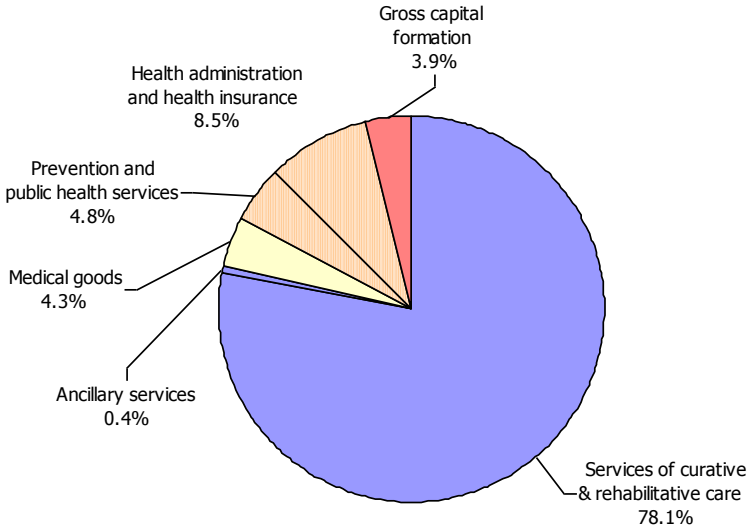
Evidence:

- **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**

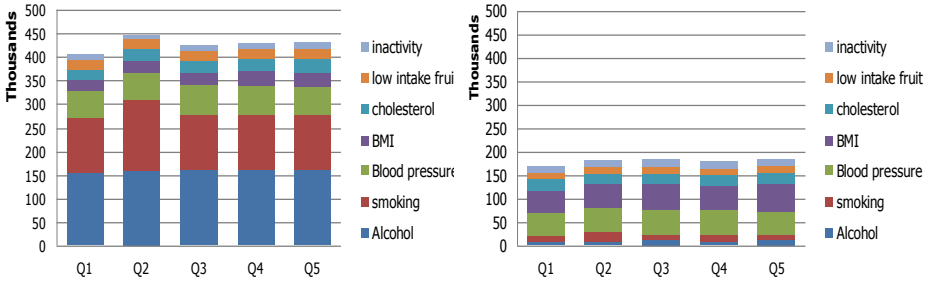


Mismatch between increasing burden of disease from NCD and low investment in HP and disease prevention





DALYs attributable to risk factors

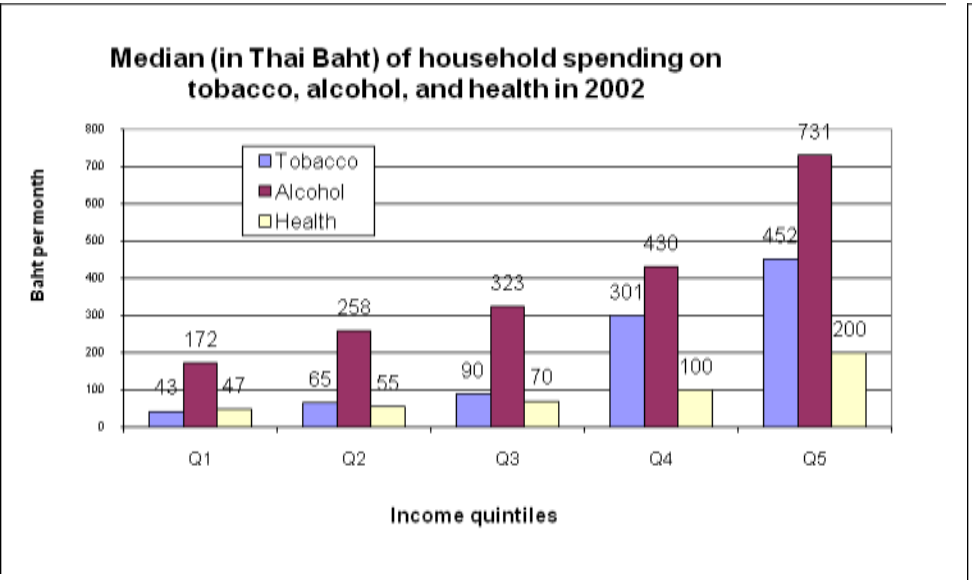


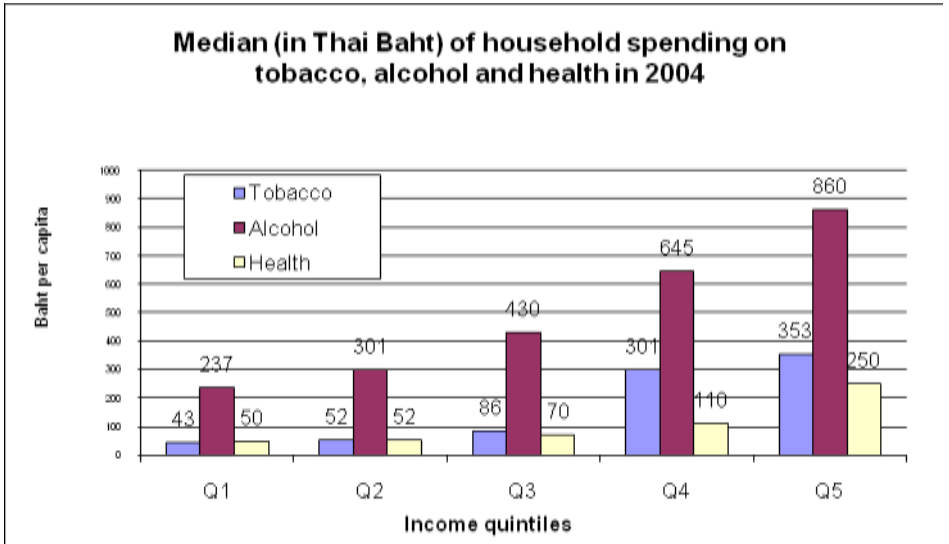
HIV/AIDS Financing
(Source: UNGASS Reports 2008 & 2010)

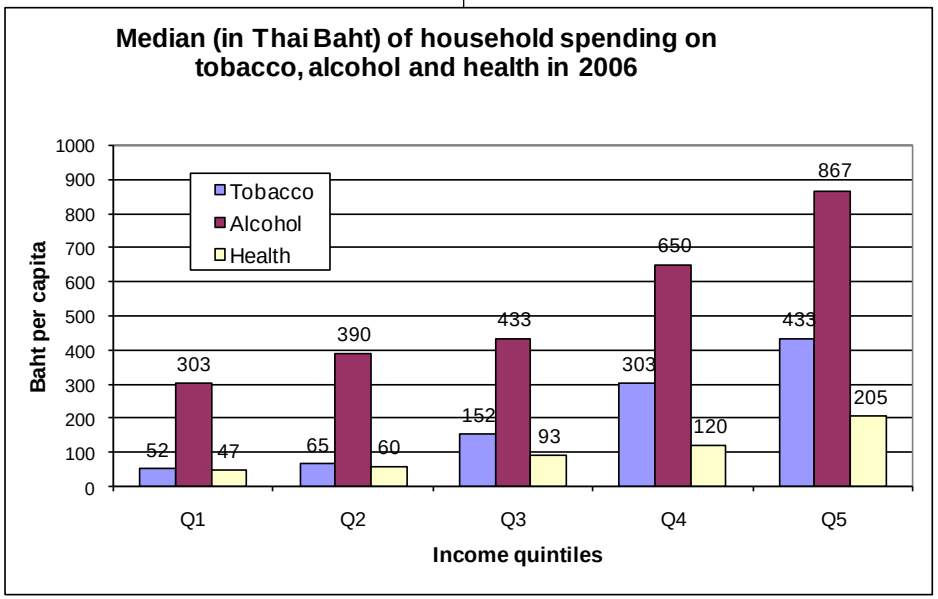
	2007		2008		2009
Total Expenditure:					
Total AIDS expenditure, million Baht	6,728	↑2.97%	6,928	↑4.01%	7,208
Total Health Expenditure, million Baht	248,852		363,771		383,051
Total AIDS expenditure, as					
per capita population, Baht	105		110		114
per capita PLWHA, Baht	11,600		14,275		14,417
% GDP	0.08%		0.08%		0.08%
% THE	2.7%		1.9%		1.9%
Sources of Fund:					
• Domestic, % of Total AIDS Expenditure	83		85		93
• International, % Total AIDS Expenditure	17		15		7
Types of Expenditure:					
• Treatment, % Total AIDS Expenditure	71.8		65.8		76.1
• Prevention, % Total AIDS Expenditure	14.1		21.7		13.7

Household expenditure: tobacco, alcohol and health

Median household expenditure (Baht per month), 2002-2006

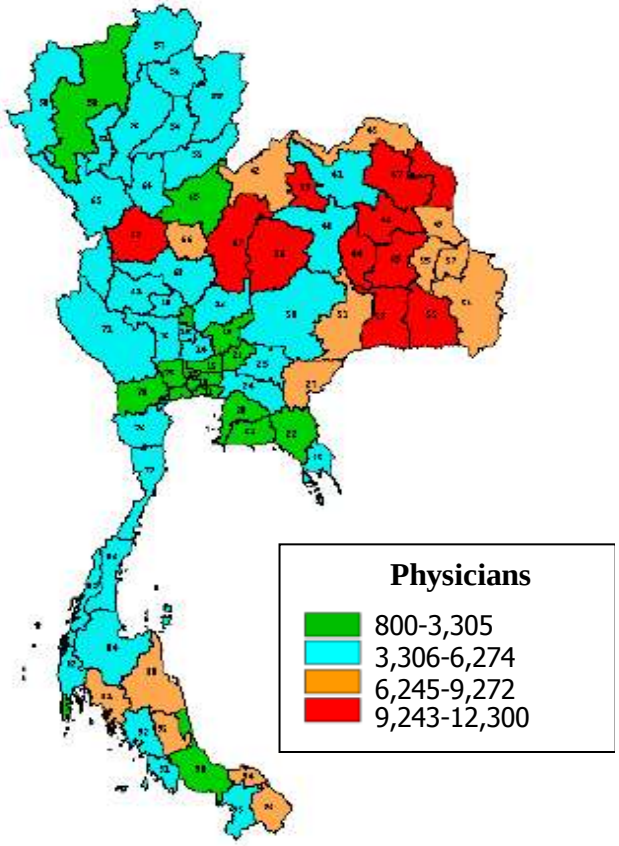


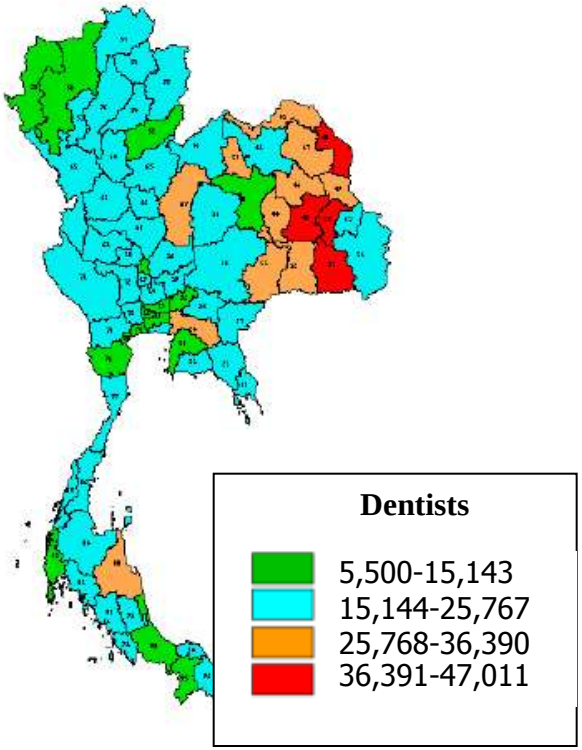


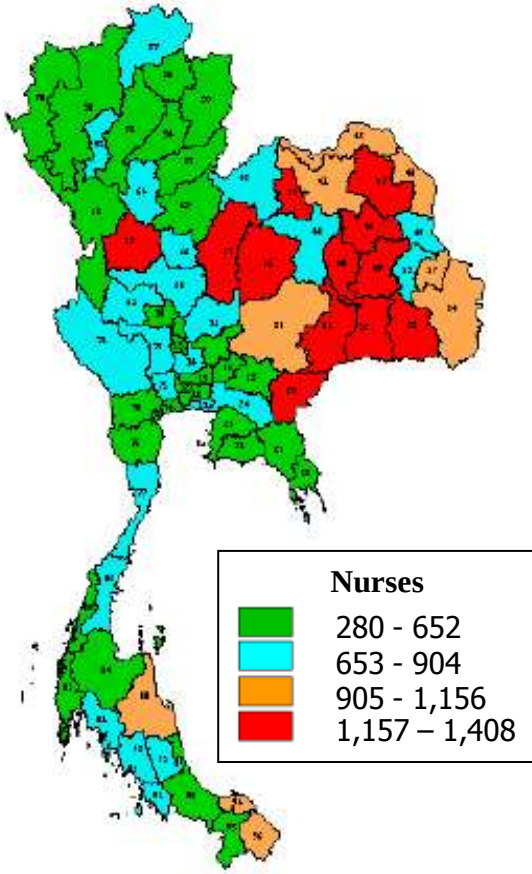


Sources: Analyses from the 2002, 2004, and 2006 SES

Inequity in geographical distribution of Health workforce in 2007







Economic loss of 12 priorities BOD in Thailand for prioritization of health investment in the 10th NHDP

	diseases	DALY loss (1)	Curative expenditure (2)	Productivity loss due to premature death(3)	Productivity loss due to absenteeism (4)	Total (2+3+4)
1	**HIV/AIDS**	**19%**	**17%**	**35%**	6%	**30%**
2	**Traffic accidents**	**15%**	**31%**	**26%**	**30%**	**27%**
3	**CVD**	**13%**	7%	9%	5%	**9%**
4	**DM**	9%	**18%**	4%	**32%**	**8%**
5	Liver cancer	8%	1%	**10%**	1%	8%
Total		100%	100%	100%	100%	100%
Total top 12 disease burden		4,780,000 yr	61,936 million Baht	208,287 million Baht	11,273 million Baht	281,497 million Baht
Percent by row			22%	74%	4%	100%
% 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

Key stakeholders

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

Submission of topics of concerns for consideration

Topic selection meeting

Key stakeholders

- 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)
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