

Thailand's Universal Coverage System and Preliminary Evaluation of its Success



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Presentation Outline

- Country Profile
- History of Health System in Thailand (before UC)
- The Road towards Universal Coverage
- The 30 Baht Program (UC)
- Preliminary Evaluation
- Lessons for Other Countries
- Challenges

Country Profile



- ❑ Area: 513120 sq. km.
- ❑ Population: 67 million (in '08)
- ❑ GDP: US\$ 260 billion (in '08)
- ❑ GDP/Capita: US\$ 3869 (in '08)
- ❑ Health Exp/Capita: US\$ 113 (in '06)
- US\$ 6719 in the US
- ❑ Physician/10,000 pop: 4 (in '00)
- 26 in the US
- ❑ Life Expectancy: 68.8 years (in '07)
- 78 years in the US
- ❑ Birth Rate/1000 pop: 14.6 (in '07)
- 14.2 in the US
- ❑ Death Rate/1000 pop: 8.9 (in '07)
- 8.1 in the US

History of Health System in Thailand (Before UC)

- There were five main health insurance schemes in Thailand prior to UC

Health Insurance Scheme	Target population	Source of health care finance	Government health expenditure per capita in 1999	Provider payment method	Majority of health care provider
Low-Income Card Scheme (LIC) since 1975	The poor, elderly, children < 12, disabled, monk, community leaders, health volunteers	General tax	363 Baht + additional subsidy	Global budget	Public providers, referral line for inpatient care
Voluntary Health Card (VHC) since 1983	Non-poor household not eligible for LIC (i.e. personal income > 2,000 Baht/month)	Household 500 Baht + General tax 1,000 Baht	250	Proportional reimbursement among 1 st , 2 nd , and 3 rd care level	Public providers, referral line for inpatient care

History of Health System in Thailand (continue)

Feature Health Insurance Scheme	Target population	Source of health care finance	Government health expenditure per capita in 1999	Provider payment method	Majority of health care provider
Civil Servant Medical Benefit Scheme (CSMBS) since 1980	Gov't employees, their dependents, and retirees from the public sector	General Tax	2,106	Fee-for-service	Public providers, (Private providers only for emergency)
Social Security Scheme (SSS) since 1990	Private formal sector employee, > 1 worker establishment	Payroll tax tripartite contributions (employee, employer, and the gov't)	519	Capitation	Private providers (Contracted hospital or its network)
Private Health Insurance	Better-off individuals	Household or employer in addition to SSS	N/A	Fee for service with ceiling	Public providers and private providers

Problems before UC

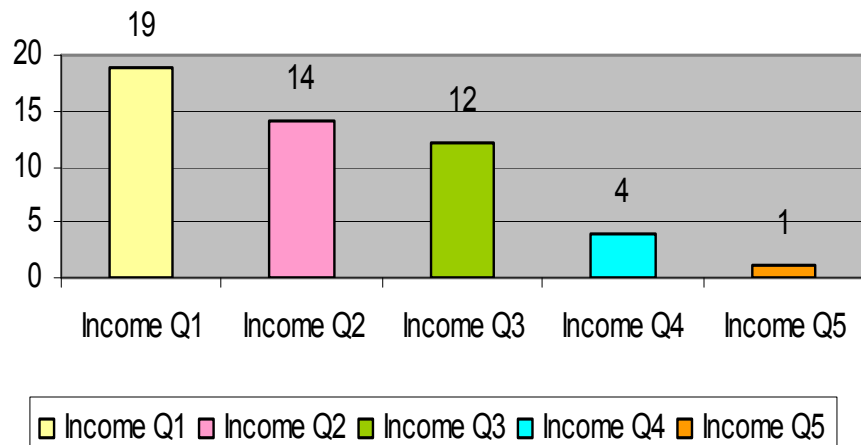
□ Uninsured

- 18.5 million or 26.6% of the population remained uninsured in 2001

□ Mis-targeting the poor

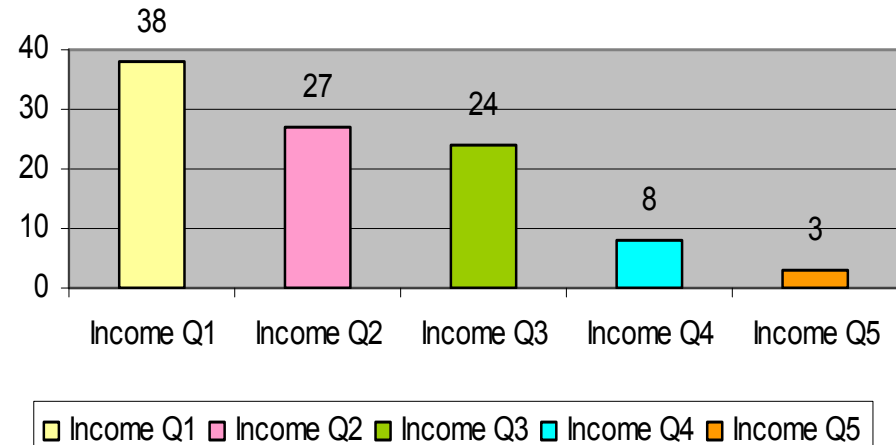
Coverage

% of population covered by LIC in 1999



Incidence

% share among all LIC beneficiaries in 1999

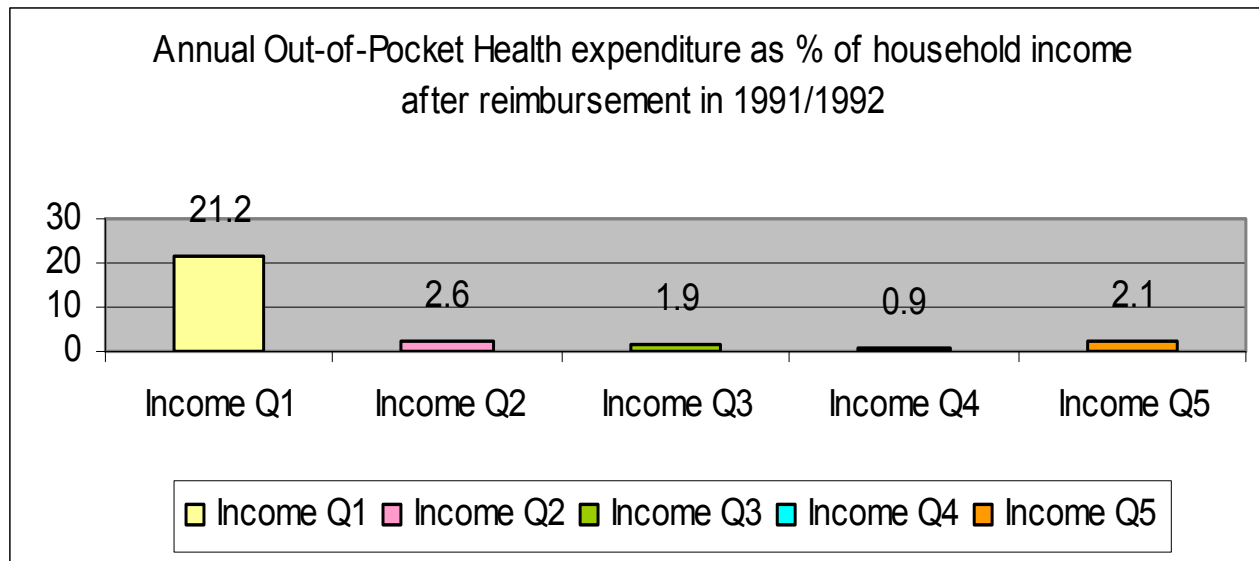


Source: World Bank. Thailand Social Monitor (2001)

Problems before UC (continue)

□ Inequity

- Varying per capita budget subsidy across schemes
- CSMBS consumes more resources than any other schemes; subjects to unnecessary admission, longer hospital stay, and cost escalation at 14% per year between 1988-1997
- Inequitable pattern of household healthcare expenditure



Sources: Overview of health insurance systems in Thailand (Tangcharoensathien et al. 2001)
The poor pay more: health-related inequity in Thailand (Pannarunothai et al. 1997)

The Road towards Universal Coverage

- The 1997 Constitution

“Address the right of Thai citizens to get equal access to healthcare and define the role of both public and private sectors in providing healthcare services”

- The 8th National Socio-Economic Development Plan (1997-2001)

“Access to healthcare services for all”

The Road towards Universal Coverage (continue 1)

Three main factors that leads to UC reform

(1) Political factor

- Thai Rak Thai (TRT) Party used a slogan “30 baht treat all diseases” as one of its campaigned policies
- After winning the election in 2001, the TRT party kept its election campaign promise by making the universal coverage one of its nine high priority policies

The Road towards Universal Coverage (continue 2)

(2) Civic movement towards UC

- In 2001, eleven NGO networking groups were able to collect more than 50,000 signatures and submitted their drafted bill on UC to the Parliament

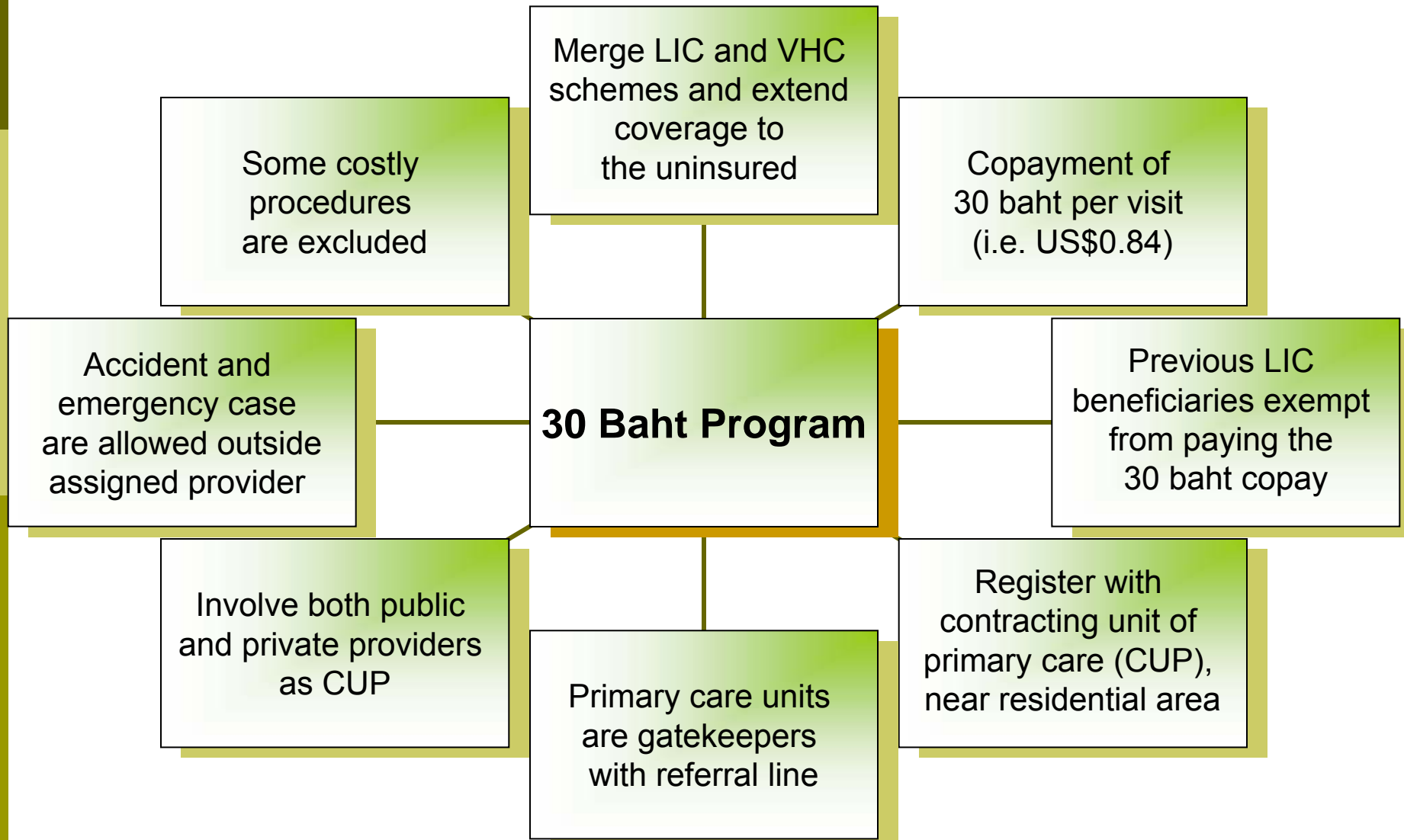
(3) Strong support from MoPH leaders, MoPH reformists (mostly are medical doctors) and policy researchers in the health field

- In 2000, a Working Committee was formed to study the feasibility and design of UC

The 30 Baht Program - UC

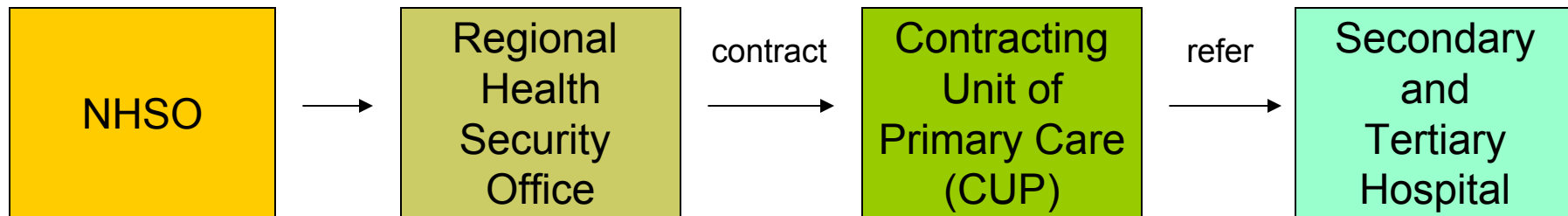
- Thailand eventually adopts a dual health insurance system for
 - (1) the formal sector (i.e. CSMBS and SSS), and
 - (2) the informal sector (i.e. the 30 baht program)

The 30 Baht Program – UC (continue 1)



The 30 Baht Program – UC (continue 2)

- ❑ Financing mechanism of UC
- ❑ General tax financed scheme – public health spending increases from 66.25 billion baht in 2000-01 to 72.78 billion baht in 2001-02
- ❑ Purchaser-provider split with National Health Security Office (NHSO) as an autonomous purchasing agency separates from MoPH
- ❑ Contracting unit of primary care (CUP) receives capitation payment on the basis of population registered → “people follow money” model



The 30 Baht Program – UC (continue 3)

Details of Capitation Rate for UC scheme

Category	2002	2003	2004	2005	2006
OP	574	574	488.2	533.01	583
IP	303	303	418.3	435.01	460
P&P	175	175	206	210	225
AE	25	25	19.7	24.73	52
High cost	32	32	66.3	99.48	190
Ambulance	-	10	10	10	6
Capital Replacement	93.4	83.4	85	76.8	129
Remote area	-	-	10	7	7
No fault liability	-	-	5	0.2	1
Total	1202.4	1202.4	1308.5	1396.3	1659

Source: From Policy to Implementation: Historical events during 2001-2004 of Universal Coverage in Thailand (IHPP 2005) and Healthcare Financing in Thailand: an update in 2007 (IHPP 2007)

The 30 Baht Program – UC (continue 4)

□ Sequence of the 30 baht program implementation

Periods	Events of Thailand regarding the UC policy
Jan 2001	Election of Thaksin Shinawatra government
Feb 2001	Policy declaration in the parliament – official announcement of UC policy
Apr 2001	Phase 1: Implement the 30 bath program in 6 provinces
Jun-Oct 2001	Phase 2: Expansion of the 30 baht program to 15 provinces with collaboration from private providers and university hospitals
Oct 2001	Phase 3: Nationwide implementation except the inner Bangkok districts
Apr 2002	Phase 4: Achieve universal coverage by expanding the 30 program to the whole country including inner Bangkok
Nov 2001-2002	Parliamentary process of the National Health Security Act - Formation of National Health Security Office as autonomous purchaser

Preliminary Evaluation

- Early results from Thailand's 30 baht health reform: something to smile about

by Kannika Damrongplisit and Glenn Melnick (Health Affairs 28, no.3 (2009))

Preliminary Evaluation (continue 1)

Objective:

- (1) Does the 30 baht health scheme succeed in making coverage universal?
- (2) Is it effective at providing access to care?
- (3) Is it able to enforce the regulated out-of-pocket price of medical care to control informal payments?

Data: 2001 and 2005 Health and Welfare Surveys (HWS)

Sample: 222,470 in 2001 and 67,815 in 2005

Method: Descriptive statistical method with the construction of three sets of variables

- (i) insurance coverage
- (ii) outpatient contact rate
- (iii) mean, median, 90th percentile of the out-of-pocket medical spending by type of insurance coverage and health facility

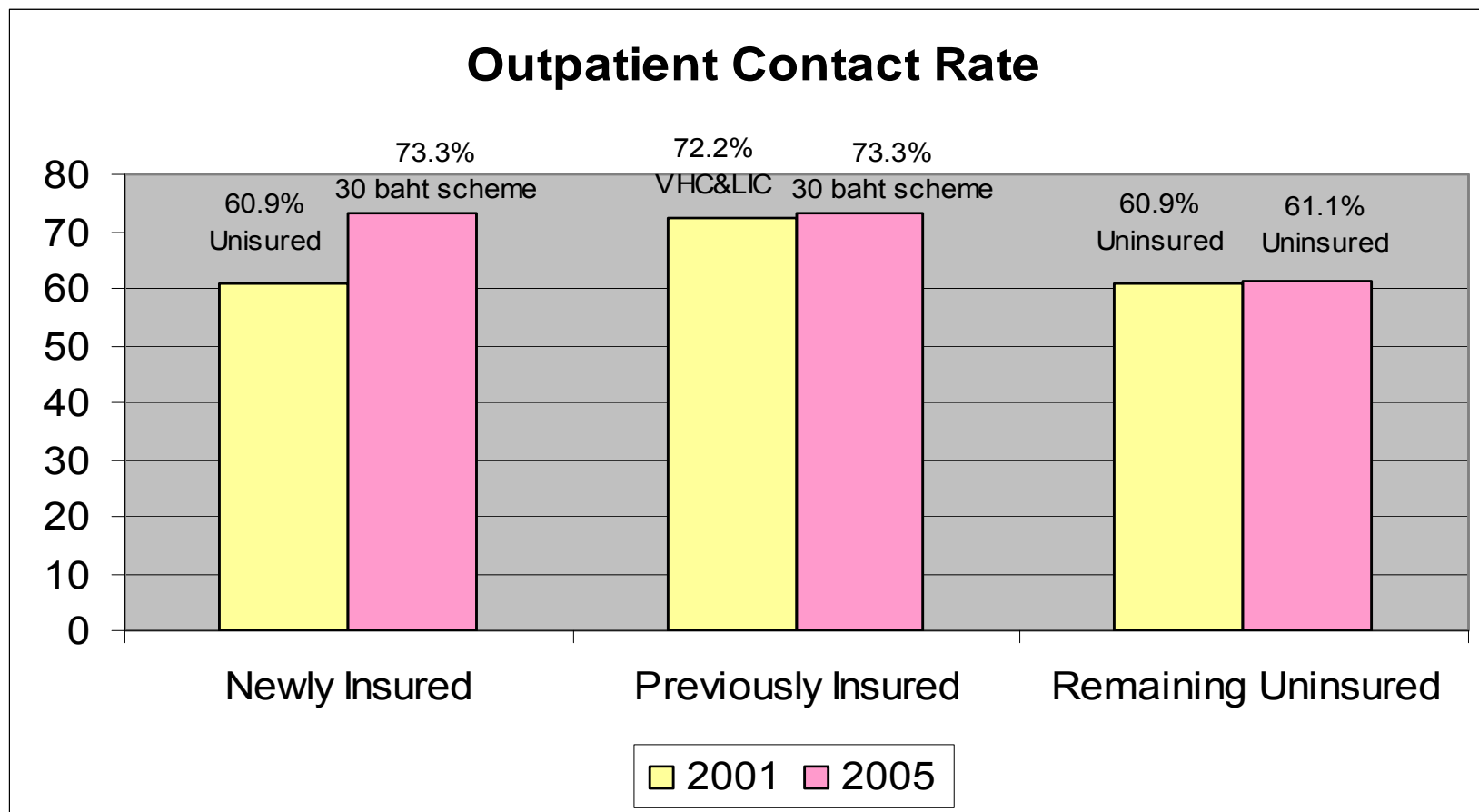
Preliminary Evaluation (continue 2)

Result: Insurance coverage in Thailand by type of insurance (in million & percent)

Type of Insurance	2001	2005
Uninsured	16.5(26.6%)	2.9 (4.4%)
Informal employment sector		
Voluntary Health Card Scheme (VHC)	13.6 (22%)	-
Low Income Card Scheme (LICs)	17.9 (28.9%)	-
30 Baht - no payment	0.6 (0.9%)	17.9 (27.9%)
30 Baht - with payment		27.4 (42.7%)
Formal employment sector		
Civil Servant Medical Benefit Scheme (CSMBS)	8.5 (13.6%)	9.5 (14.8%)
Social Security Scheme (SSS)	3.9 (6.3%)	5.9 (9.1%)
Private Health insurance	1 (1.6%)	0.7 (1%)
Total population	62 (100%)	64.2 (100%)

Preliminary Evaluation (continue 3)

Outpatient contact rate (percentage of the ill who receive outpatient care)



Preliminary Evaluation (continue 4)

Outpatient out-of-pocket payments per visit, by type of insurance coverage and healthcare facility in 2005 (in Thai Baht)

Insurance type	Statistics	Health center	Community Hospital	General hospital	University hospital	Other public hospital	Private clinic	Private hospital
30 baht no payment (previous LIC)	Mean	1	4	6	143	1	210	59
	Median	0	0	0	0	0	200	0
	90%	0	0	0	1000	0	250	0
30 baht with payment	Mean	32	34	44	24	30	235	28
	Median	30	30	30	30	30	225	30
	90%	30	30	30	30	30	500	30
No insurance	Mean	71	487	976	3060	1703	291	1962
	Median	30	185	500	800	200	210	550
	90%	200	1500	3000	9998	9998	500	9000

Preliminary Evaluation (continue 5)

- ❑ Summary of preliminary evaluation
 - ❑ The 30 baht program succeeds in making the coverage universal or near-universal
 - ❑ Improvement in access to care for OP as measured by contact rate
 - ❑ Individuals appear to pay the regulated price of 30 baht when seeking care (i.e. no evidence of in-cash informal payment)
- Future study should focus on the impact of UC on waiting time, quality of care, patient's and provider's satisfaction, and long-term sustainability of the program

Preliminary Evaluation (continue 6)

- Two additional papers

- Which households are at risk of catastrophic health spending: experience in Thailand after universal coverage
by Terawit Somkotra and Leizel Lagrada (Health Affairs (2009))

Households that are likely to experience catastrophic health spending after UC are those in highest income quintile; with elderly, chronically ill, or disabled family members; with hospitalization

- Evaluating and analyzing impacts of the universal health care coverage
by Thailand Development Research Institute 2008

After UC, household out-of-pocket medical expenditure ↓ by 334 baht monthly
of outpatients ↑ by 28.6%,
of outpatient visits ↑ by 33%
inpatient death rate ↑ by 0.04%

Lessons for Other Countries

- (1) The Thai experience shows that UC or near-UC is achievable in a lower-middle income country
- (2) Three facilitating factors are needed in order for the health care reform to be successful
 - political commitment
 - strong civic/public support
 - support from MoPH leaders, reformists, and policy researchers in the field
- (3) Investment in healthcare infrastructure especially in the rural area is essential for the implementation of UC
 - Over several decades prior to UC, Thailand has built up
 - primary care health centers (no doctor or bed) in all subdistricts
 - community hospitals (10-120 beds) in almost all districts
 - provincial hospitals in every province

Lessons for Other Countries (continue 1)

(4) Strategy towards human resource distribution into rural area

- 3 years mandatory rural services for new graduate doctors, nurses, dentists, and pharmacists

(5) Accumulation of experience through managing other health insurance schemes

- SSS → provide experience on capitation payment, contract model, purchaser-provider split, comprehensive coverage
- LIC → provide experience on resource allocation especially in the rural area

Lessons for Other Countries (continue 2)

(6) Promoting use of primary care

- Shift away from tertiary care to primary care
- Locate close to the community makes provider better realize the socio-cultural context of the people
- Work as a gatekeeper to lower the overall health care cost

(7) UC should provide comprehensive package

- Focus on “building good health” through preventive and promotion services instead of “fixing health” as done in the past

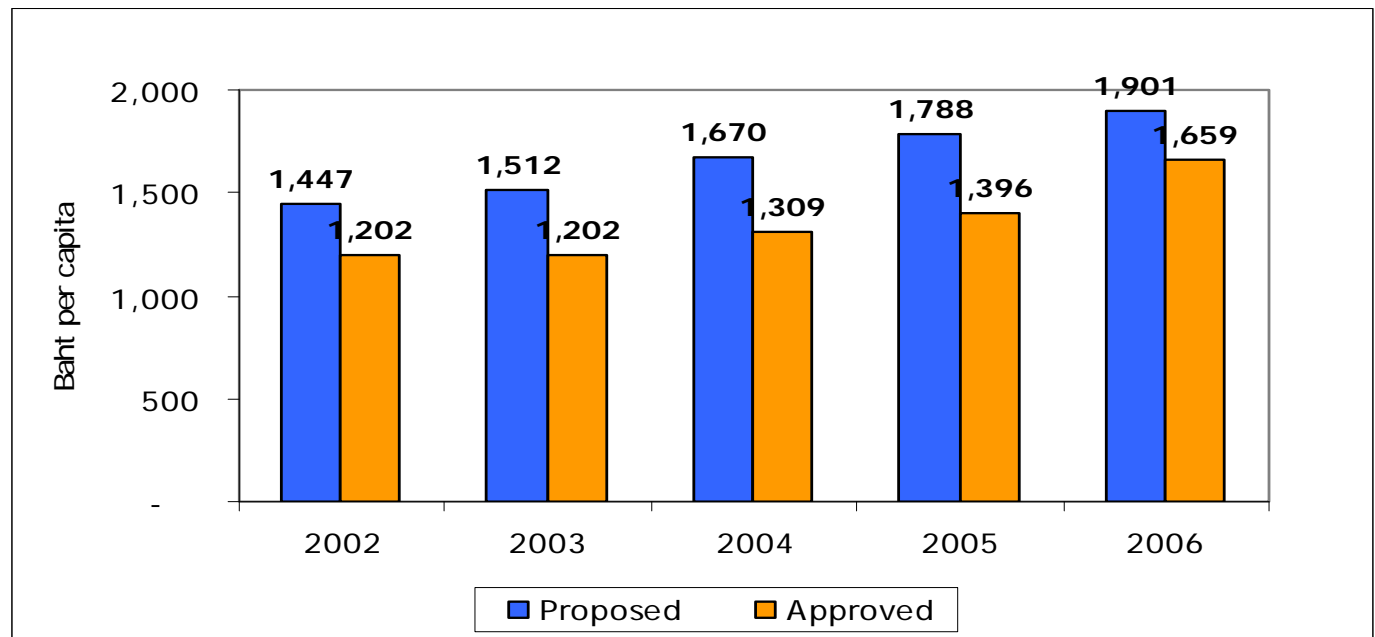
(8) Use close-ended provider payment method in UC

Challenges

- Implementation of UC in Thailand is often known as a “big bang” approach or a “do-and-correct” approach that leads to many challenges

(1) UC scheme is underfunded

- The approved capitation is always less than the amount requested by NHSO/MoPH



Source: Healthcare Financing in Thailand: an update in 2007 (IHPP 2007)

Challenges (continue 1)

- Lead to financial constraint on the provider side
(contingency fund of 5 billion baht was available for financially troubled health facilities in 2001-2002)
- Adversely affect quality of care

(2) Long-term financial feasibility of the program

A few recommendations for UC fund

- Earmark 2/3 of the 100% additional tobacco tax revenue, and 1/2 of the 50% additional alcohol tax revenue
- Expand coverage of SSS to non-working spouse and dependents (estimated at 6 million who are current UC beneficiaries). This is estimated to save UC by 9 billion baht
- Require individuals to pay premium on the basis of ability to pay
- Increase co-payment

Challenges (continue 2)

(3) Harmonization of three public health insurance schemes (UC, CSMBS, SSS)

- There is still problem of inequity due to unequal government subsidy in each scheme

(4) Purchaser provider split confronts with challenges due to rapid implementation

- Overlap of responsibilities and tension between NHSO and MoPH
- NHSO and its local purchasing office must step up their roles and act as effective purchaser

Challenges (continue 3)

- (5) Very little involvement of private providers in the UC (less than 10%)
- (6) Change in provider payment method to capitation payment makes providers face difficulty in adapting themselves because of unequal distribution of human resources among regions and among urban and rural areas
 - Health facilities in areas with over supply with budget deficiency
 - Capitation funding could not achieve redistribution of resources and staffing
- (7) Quality control aspect of UC should be strengthened
 - NHSO and Health Care Accreditation Institute must work together to ensure quality of care especially for the public health facilities

Post-Thaksin Government (after September 2006)

- UC continues to exist; however, the 30 baht copayment has been abolished

- NHSO figures show that total income from collecting the 30 baht fee is about 1.07 billion baht, accounting for about 2% of the total budget allocation for the scheme

Source: Co-payment in universal coverage scheme: a policy analysis (Tangchareonsathien et al. 2005)

- A new expert panel has been formed to study the potential source of funding for the UC scheme in order to make it sustainable in the long-run

Thank you