Key platform for successful Universal Health Coverage in Thailand

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Country profiles: Thailand

- 67 million population
- GNI 2010 US$4,210 per capita, Gini 40
- Total Health Expenditure (2010 NHA)
  - 3.9% GDP
  - US$194 per capita
  - Public sources 65%, OOP 14% of THE
  - Govt exp on health 13.1% Govt Exp
- Health status
  - Total fertility rate 1.6 (2009)
  - Life expectancy at birth 74.1 years
  - U5MR 14/1000
  - MMR 48/100,000
- Physicians per capita 4/10,000
- ANC & hospital delivery 99-100% (2009)
GNI and UHC trajectory 1975-2002

- Started from targeting the vulnerable groups, expanded to specific groups (government officers, informal workers by voluntary basis and private formal workers by mandatory) and finally UHC in 2002
- No need to wait until rich to start UHC – Thailand started since 390 US$ per capita
**UC cube: what has been achieved by 2012?**

- **Population coverage:**
  - 99% pop coverage by 3 schemes [UCS 75%, SHI 20%, CSMBS 5%]

- **Financial protection:**
  - Free at the registered **primary health care services**

- **Service coverage:**
  - Comprehensive package i.e. OP, IP, disease prevention, health promotion
  - High cost interventions i.e. renal replacement therapy, ART, chemotherapy, major surgery, medicines (Essential drug list)
Increased utilization, low unmet needs

### Prevalence of unmet need

<table>
<thead>
<tr>
<th></th>
<th>OP</th>
<th>IP</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average</td>
<td>1.44%</td>
<td>0.4%</td>
</tr>
<tr>
<td>CSMBS</td>
<td>0.8%</td>
<td>0.26%</td>
</tr>
<tr>
<td>SSS</td>
<td>0.98%</td>
<td>0.2%</td>
</tr>
<tr>
<td>UCS</td>
<td>1.61%</td>
<td>0.45%</td>
</tr>
</tbody>
</table>

Source: NSO 2009 Panel SES, application of OECD unmet need definitions
Changes in utilization: primary secondary and tertiary 1977-2010

1977
- Regional / General Hospitals: 46% (5.5)
- Community Hospitals: 24% (2.9)
- Rural Health Centres: 29% (3.5)

1987
- Regional / General Hospitals: 27% (11.0)
- Community Hospitals: 35% (14.6)
- Rural Health Centres: 38% (15.7)

2000
- Regional / General Hospitals: 18.2% (20.4)
- Community Hospitals: 35.7% (40.2)
- Rural Health Centres: 46.1% (51.8)

2010
- Regional / General Hospitals: 12.6% (18.1)
- Community Hospitals: 33.4% (33.4)
- Rural Health Centres: 54.0% (78.0)
Source of finance 1994-2010

UHC achieved

<table>
<thead>
<tr>
<th>Year</th>
<th>Public</th>
<th>SHI</th>
<th>Households</th>
<th>Other private</th>
</tr>
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<tbody>
<tr>
<td>1994</td>
<td>42%</td>
<td></td>
<td>44%</td>
<td>4%</td>
</tr>
<tr>
<td>1995</td>
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<td>42%</td>
<td>3%</td>
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<td>1997</td>
<td>50%</td>
<td>37%</td>
<td>50%</td>
<td>3%</td>
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<tr>
<td>1998</td>
<td>50%</td>
<td>35%</td>
<td>50%</td>
<td>3%</td>
</tr>
<tr>
<td>1999</td>
<td>51%</td>
<td>35%</td>
<td>50%</td>
<td>3%</td>
</tr>
<tr>
<td>2000</td>
<td>50%</td>
<td>34%</td>
<td>50%</td>
<td>3%</td>
</tr>
<tr>
<td>2001</td>
<td>50%</td>
<td>33%</td>
<td>50%</td>
<td>3%</td>
</tr>
<tr>
<td>2002</td>
<td>58%</td>
<td>27%</td>
<td>57%</td>
<td>3%</td>
</tr>
<tr>
<td>2003</td>
<td>58%</td>
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<td>57%</td>
<td>3%</td>
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<td>2004</td>
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<tr>
<td>2008</td>
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<td>3%</td>
</tr>
<tr>
<td>2009</td>
<td>67%</td>
<td>15%</td>
<td>57%</td>
<td>3%</td>
</tr>
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<td>67%</td>
<td>14%</td>
<td>57%</td>
<td>3%</td>
</tr>
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</table>
## Incidence of catastrophic health expenditure

- Reducing trend of incidence of catastrophic health expenditure

<table>
<thead>
<tr>
<th>Year</th>
<th>All households</th>
<th>LIC/VHC</th>
<th>UC scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Quintile 1</td>
<td>4.0%</td>
<td>2.7%</td>
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<tr>
<td></td>
<td>Quintile 5</td>
<td>5.6%</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>All Quintiles</td>
<td>5.4%</td>
<td>4.7%</td>
</tr>
<tr>
<td>2002</td>
<td>Quintile 1</td>
<td>1.7%</td>
<td>1.7%</td>
</tr>
<tr>
<td></td>
<td>Quintile 5</td>
<td>5.0%</td>
<td>6.1%</td>
</tr>
<tr>
<td></td>
<td>All Quintiles</td>
<td>3.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>2004</td>
<td>Quintile 1</td>
<td>1.6%</td>
<td>1.6%</td>
</tr>
<tr>
<td></td>
<td>Quintile 5</td>
<td>4.3%</td>
<td>5.2%</td>
</tr>
<tr>
<td></td>
<td>All Quintiles</td>
<td>2.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>2006</td>
<td>Quintile 1</td>
<td>0.9%</td>
<td>0.9%</td>
</tr>
<tr>
<td></td>
<td>Quintile 5</td>
<td>3.3%</td>
<td>3.0%</td>
</tr>
<tr>
<td></td>
<td>All Quintiles</td>
<td>2.0%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

Note: Households with health payment > 10% of total expenditures
Source: Socio-economic Survey conducted by National Statistical Office-Thailand (various years)
Thailand: UHC prevents health impoverishment

- UHC can reduce poverty, in addition to improving health and better access to health
- Thai experience: UHC can reduce the number of households with impoverishment

Source: analysis from Health and Welfare survey conducted by National Statistical Office, Thailand
Sub-national health impoverishment 1996 to 2008
Contributions to UHC: health delivery systems
Pre-UC expansion of health infrastructures and human resources

**Hospitals**

- **UC scheme**
- **Asian economic crisis**

**Doctors and nurses**

- **Doctors**
- **Nurses**

**Population per bed**

- **Asian economic crisis**
- **UC scheme**

**Population per doctor and nurse**

- **Asian economic crisis**
- **UC scheme**

Sources: MOPH's Health Resource Surveys (various years)
PHC focus: better access and efficiency gains

• District health system is a typical contractor provider network
  – Gate keeping role for OP and IP
    • Patient bypassing contractor provider network without referral are liable for full payment
  – Low cost and better access
    • lower transport cost by patients
    • Better outcome: continuity of NCD control, DM, HT, ease home visit for chronic care

• Backup by regional specialised centres for referral within region
  – e.g. heart and brain surgery, cancer, trauma, premature new-borns
Conclusion
Summary 1: Lessons

1. Long journey: 27 years to achieve UC 1975 - 2002
   - Health system development, rural development - health infrastructure, medicines and health staff since 1971
   - Health financial protection: the vulnerable groups 1975 -> UC 2002

2. System design is most critical
   - UC is funded by general tax \(\rightarrow\) equity in financing
   - Effective strategic purchasing \(\rightarrow\) improved access, equity and efficiency gains;
   - The use of primary health care-Close to Client Services

3. Windows of opportunities - during the election
   - Health is one of the major political campaigns
Summary 2: effective implementations

4. Supply side capacity to deliver services
   – Extensive coverage of PHC and district health systems
   – Bonding of all graduates, 3 yr rural services since 1972

5. Strong leadership with sustained commitment
   – Continued political support despite changes in government
   – Technocrats and active civil society

6. Strong institutional capacities
   – Information systems, Health technology assessment
   – Key platforms for evidence informed decisions
   – Health systems and policy research: Self-reliance, national resources supporting HSR
Key reading list


Terima kasih
Thank you for your attention