Thailand:
Contributions of researches in formulating and sustaining UHC

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Background

- Thailand,

- A long march: 27 years of gradual coverage extension
  - Application of piecemeal targeting approaches
    - The poor, children, elderly, vulnerable: tax financed social welfare schemes
    - Civil servants and family: tax financed medical welfare
    - Formal sector private employee: payroll tax financed SHI
    - Informal sector: CBHI, transform to public subsidized voluntary insurance
    - The 30% uninsured was “last pushed” by general tax financed scheme

- By 2002 Thailand achieved full population coverage
  - Formal sector private employee by SHI
  - Tax financed scheme for civil servants and dependants.
  - The rest of population by tax financed scheme, free at point of service
Under-five mortality per 1,000 live births

1970-2000: District health system development + financial risk protection extension

- MD mandatory rural service (1972)
- Low Income Card scheme (1975)
- District hospitals (1977)
- Technical nurses (1982)
- Village health volunteers (1977)
- National EPI (1978)
- Commuity health funds (1983)
- Civil Servant Medical Benefit scheme (1980)
- Voluntary Health Card scheme (1994)
- Social Security Act (1991)
- Universal Coverage scheme (2001)
- Asian economic crisis (1997)

Source: USMR was analysed from IHME data
Economic context: SHI and UC Scheme

Source: WB Atlas methods

Thailand GNI per capita US$, current year price, 1980-2009


1997 Asian Economic Crisis

2002: Universal coverage achieved, capitation rate 1202 B = 27US$ [Ex Rate 42.96]
Factors contribute to UC achievement [1]

• Political decision plays not less critical role than evidences
  – Revenue generation
    • General tax-financed:
      • progressive than SHI contribution, contribution collection from informal sector not feasible, within fiscal capacity using close end payment methods
  – Risk pooling
    • Why universality instead of continued targeting approaches? Why should the government subsidize the rich who can afford to pay instead of saving cost and better subsidize the poor?
      • Purely political decisions, keeping political promise during the 2001 general election campaigns.
Factors contribute to UC achievement [2]

- Political decision plays not less critical role than evidences
  - Purchasing
    - Why initially a favourable benefit package
      - Historical precedence from Low Income Scheme,
    - Why initial 30 Baht (US$0.7) copay and later zero?
      - Political gimmic, termination of copay is political decision + very minimum contribution to funding UC, also limited moral hazards from supply side based on capitation contract model
    - Why contract model with limited choice to district provider network, instead of free choice fee for services reimbursement model?
      - Policy objective to promote the use of PHC- better access by members
      - Extensive geographical coverage of district health service
      - Evidence of cost escalation from fee for service Civil Servant Scheme—“no go”
Challenges after 10 years achievement: implications for research

- Sustain efficiency, equity and quality achievement while strengthen capacity to address new challenges through evidence.
- Demand for research outpaces the capacity in generating evidence
- Demographic and epidemiological transition
  - Chronic long term care versus hospital acute care
  - Effective coverage of interventions
  - Primary prevention of risk factors
- Non-health sector actions against determinants of ill-health
  - Tobacco, alcohol, transfat, obesity, physical inactivity, safe environment and injury prevention
- Benefit package
  - Institutional capacity to generate evidence on ICER, fiscal impact, equity and ethical considerations of new medicines, interventions
    - Health Intervention and Technology Assessment Program (HITAP) and its network play significant role
    - Subcommittees on benefit package, on National Essential Drug List are vital platforms of policy decisions
- Fiscal space: tax was 16.8% of GDP in 2007
  - Long term financial sustainability
Fiscal space; large gap across income group
HIC: 22.5%, MIC: 19.2%, LIC: 13.4% [2007]
Conclusion

- Multiple contributing factors toward achievement of UHC
  - Political leadership: politics sets UHC agenda, technocrat and research communities contribute to policy formulations
    - Close relationship of reformists, bridging evidence to political decisions
  - Extensive trust base networks
    - Policy networks, research networks and linkages among them.
  - Government effectiveness:
    - Capacities to translate policy intention into actual implementation,
  - Civil society movements
    - Agenda setting on various policies: ART, renal replacement therapy
  - Health service platform is vital
    - Otherwise UC is a “citizen right in paper”
  - Knowledge management: application of tacit knowledge
    - HSR contributes mostly on policy evaluation,
    - Pragmatism rather than idealism--“Mend the wreck boat while sailing”
    - Health Intervention and Technology Assessment Program contributes to upstream benefit package development
UC Budget

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Thank you for your attention