



# Universal Health care Coverage: Thailand Experience

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# Outlines of presentation

1. General information
  - Country background
  - Health care delivery system
  - Development of health financial protection -> Universal Health Care Coverage (UC)
2. Feature and achievement of UC
3. Lessons drawn and challenges



# 1. General information: country background, health delivery system and health financial protection



# Thailand: Country Background

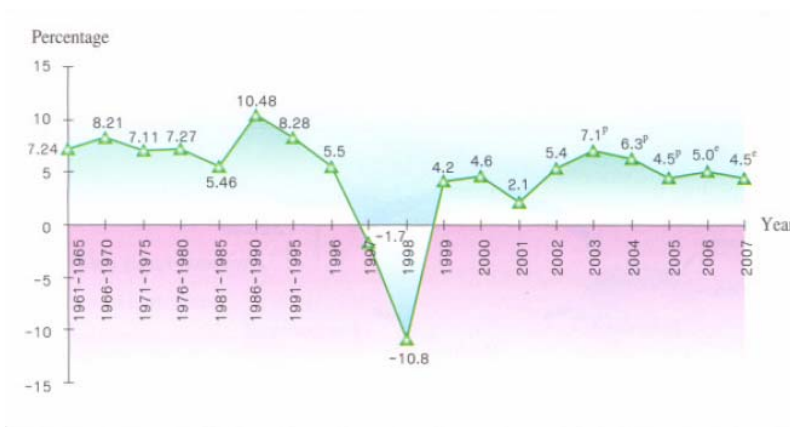


Population in million (2006)	63
Administrative areas (provinces)	76
Population in urban area	31%
Life expectancy at birth (2004)	70
% Gov. revenue from direct taxes (2001)	30
% Total health exp. of GDP in 2005	3.5



# Thailand: Country Background

### Economic growth, 1961-2007



### Proportion of poverty, 1962 - 2006



Source: Wibulpolprasert S ed. Thailand Health Profile 2005-2007.

- GDP growth, 2007 = 4.5%
- GNI per capita, 2005 = \$2750
- Poverty prevalence, 2006 = 9.6%
- Poverty head count ~ 6.1 million
- Poverty in rural is 3 times greater than that in urban areas.



# Profile: Top 10 DALY loss, Thailand 2004

Total DALY loss 9.17 million years

DALY						
		Male			Female	
Rank	Disease	DALY ('000)	%	%	DALY ('000)	Disease
1	HIV/AIDS	645	12.3	7.7	302	Stroke
2	Traffic accidents	600	11.4	7.5	291	HIV/AIDS
3	Alcohol dependence/harmful use	329	6.2	6.9	268	Diabetes
4	Stroke	300	5.7	4.9	191	Depression
5	Liver and bile duct cancer	295	5.6	3.6	140	Liver and bile duct cancer
6	Ischaemic heart disease	178	3.4	3.5	136	Traffic accidents
7	COPD	176	3.3	3.0	118	Ischaemic heart disease
8	Diabetes	169	3.2	3.0	117	Osteoarthritis
9	Depression	137	2.6	2.9	113	COPD
10	Cirrhosis	133	2.5	2.8	111	Cataracts

Source: Burden of Disease Working Group, MOPH-Thailand, Journal of Health Science, 2006

**Top 10 DALY shares 52% of total national DALY loss**



# Health Delivery System

- Public health care providers: extensive geographical coverage at all levels
- Number of health personnel: gradually increase

Manpower to pop ratio	1994	2004
Doctor	1 : 4165	1 : 3305
Dentist	1 : 19677	1 : 15143
Registered nurse	1 : 1150	1 : 652

- Acceptable quality staff and quality health care
- But mal-distribution of public health resources among regions remained problem
- Increasing role of private sector in health care service provision (but was still limited in urban area);
  - Private hospital 25.6% of total hospitals but 21.6% of total number of hospital bed



# Health Financial Protection

- Before UC, multi-schemes covered 70% of population with different benefit packages, government budget subsidies and payment methods.

Scheme	Civil Servant Medical Benefit Scheme (CSMBS)
Introduced in	1960s
Target beneficiaries	Govt employees & dependents, retirees
Pop Coverage	9%
Funding	Govt budget
Payment to health facilities	Fee-for-service, reimbursement





## 2. UC: its feature and achievements



## Health Financial Protection: UC-era 2002

Scheme	Civil Servant Medical Benefit Scheme (CSMBS)	Social Health Insurance (SHI)	Universal Coverage (UC)
Target beneficiaries	Govt employees & dependents, retirees	Private sector employees	The rest of pop who are not covered by CSMBS and SHI
Pop Coverage	9%	16%	75%
Funding	Govt budget	Payroll contribution Tripartite	Govt budget
Payment to providers	Fee-for-service, reimbursement	Capitation	Capitation
Access to service	Free choice	Registered providers	Registered providers
Benefit	Comprehensive package	Comprehensive package	Comprehensive package with P&P
Exp per capita, 2006	8,785 baht	1,738 baht	1,659 baht
Tax subsidy, 2006	8,785 baht plus adm cost	579 baht plus adm cost	1,659 baht plus adm cost



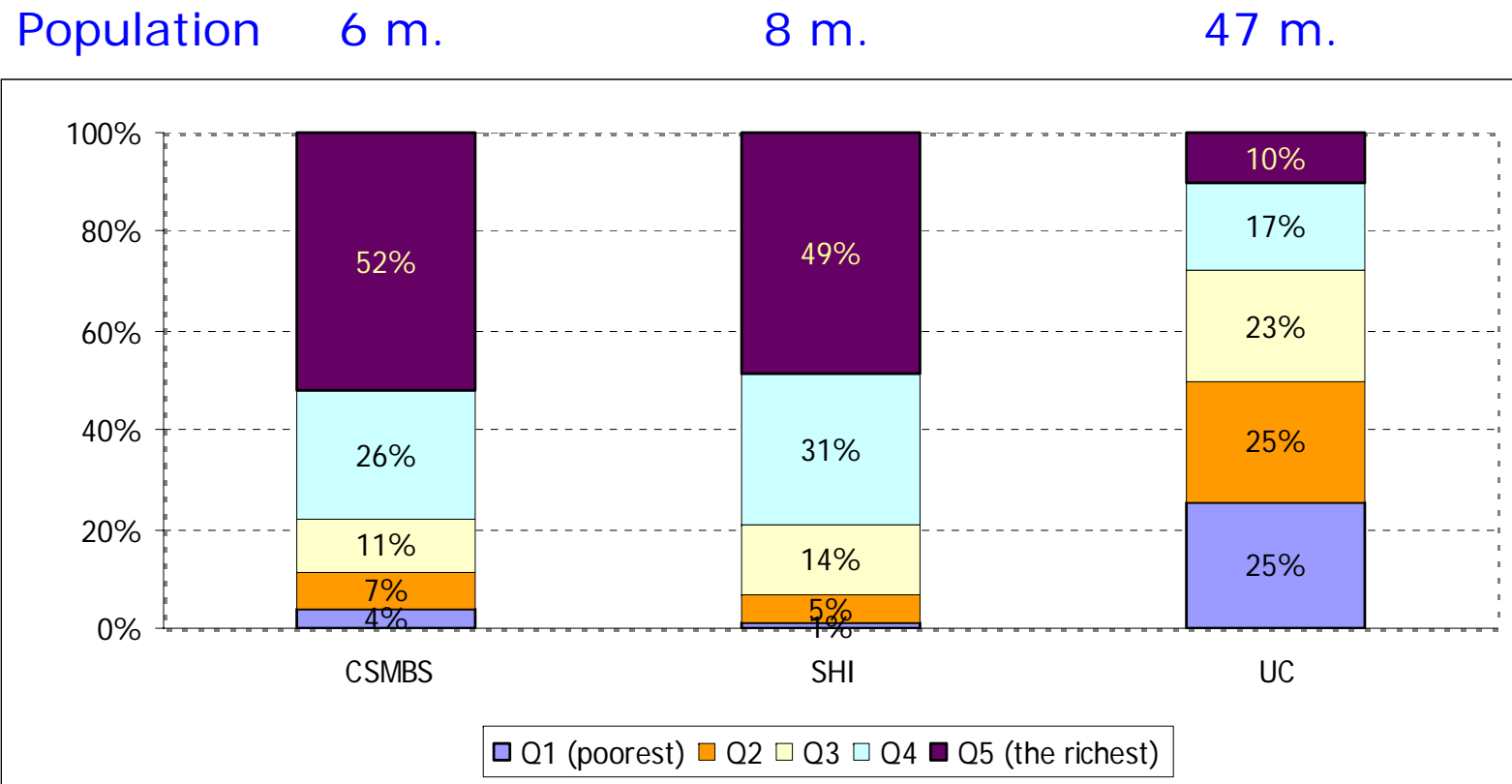
# Main Features of UC Scheme

- Benefit packages
  - Comprehensive package, OP, IP, A&E, high cost care,
  - Drug - reference to National List of Essential Drug.
  - Personal preventive & promotion services
  - Minimum exclusion lists
- Use of primary health care services
  - Registration required to a contractor
  - A typical contractor is a District Health Systems in rural areas (District hospital + 5-10 Health centres)
  - Approx 700 contractor, each responsible 70,000 population
  - Bypassing the registered provider
    - Beneficiaries have freedom to access to any healthcare providers, if not registered, at their own cost.
  - Contractor provider ensures proper referral to upper level of care
    - Contractor provider is a fund holding for OP services, and pay for referral OP services



## Scheme beneficiaries by income quintiles, 2004

- UC Schemes covers the poor, half belongs to Q1 and Q2
- Majority of CSMBS and SHI beneficiaries are rich (Q4 and Q5)



Source: Health and Welfare Survey 2004, conducted by Thai National Statistical Office.



# Increase Demand and Utilization

- Utilization is increasing for both out-patient (OP) and in-patient (IP)
- Utilization is shifted from provincial hospitals to primary care unit and district hospitals

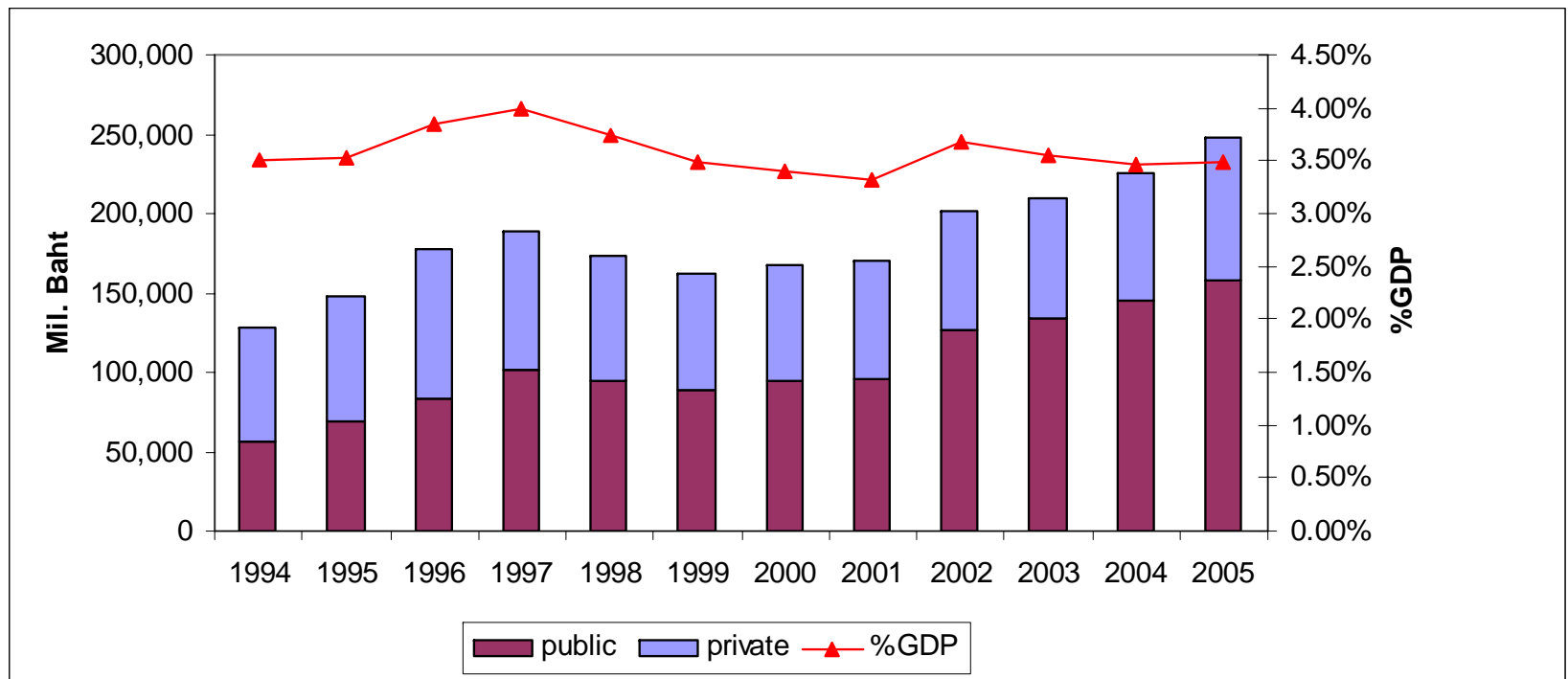
Level of care	OP million visits			IP million admissions		
	2001	2003	2004	2001	2003	2004
Primary Care Unit	29.7	43.7	63.8			
District hosp.	19	36.7	46.2	1.1	2.1	2.2
Provincial Hosp.	24.5	14.8	20.1	2.1	1.4	1.8

source: NSO HWS2001, 2003 and 2004



# Total health expenditure 1994-2005

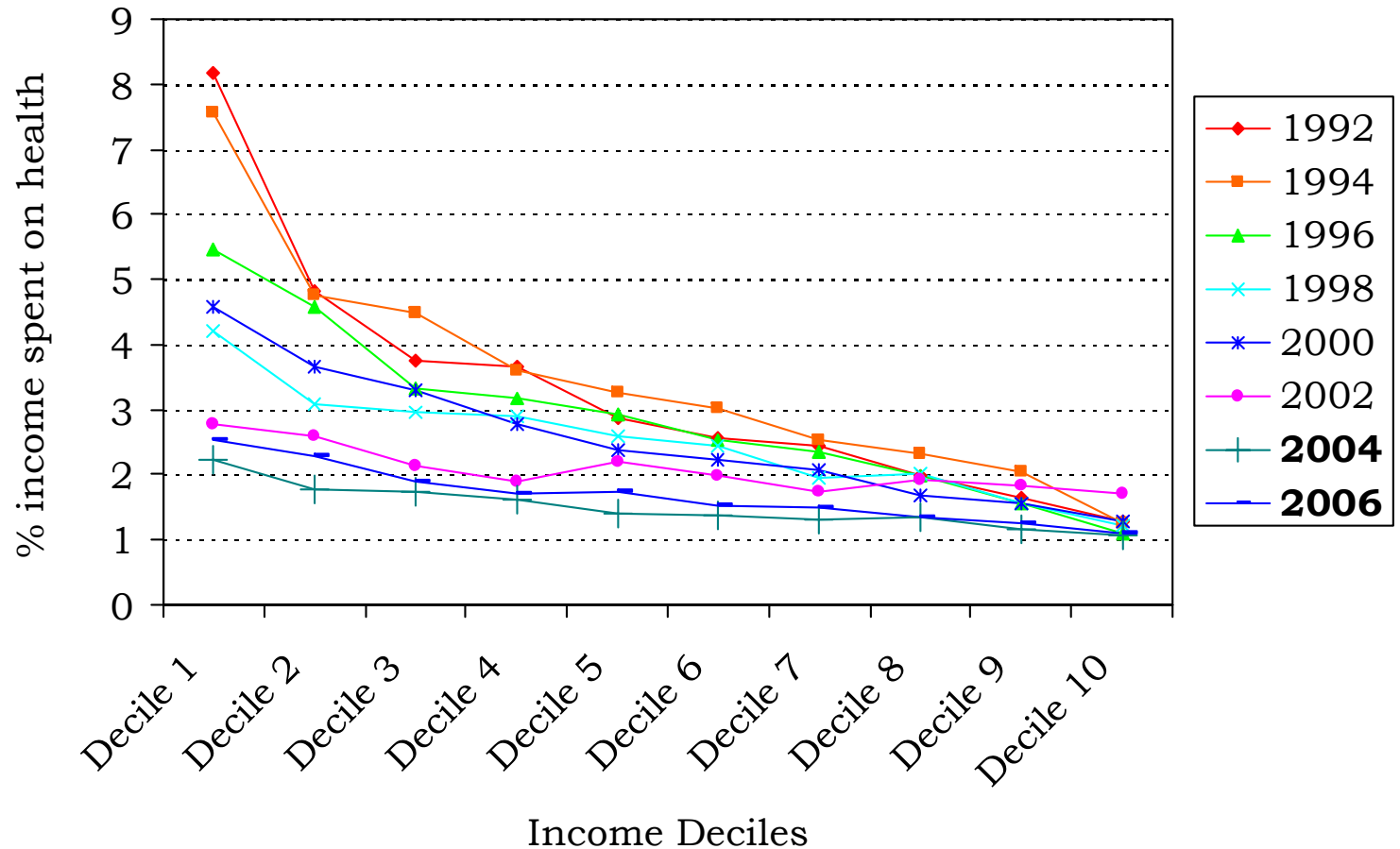
Total health expenditure as % GDP, 2005	3.5%
Public finance as % of THE, 2005	64%
Per capita expense/ year, 2005	\$98



source: NHA working group, IHPP-Thailand, Thai National Health Account 2002-2005.



# Improved fairness of HH burden due to health expenditure



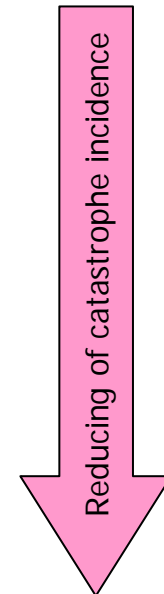
Source: Socio-Economic Survey 1992 - 2002 conducted by NSO.



## Incidence of catastrophic health expenditure

- Data of national representative survey presents a reducing trend of incidence of
  - Catastrophic health expenditure
  - Impoverishment due to medical bills

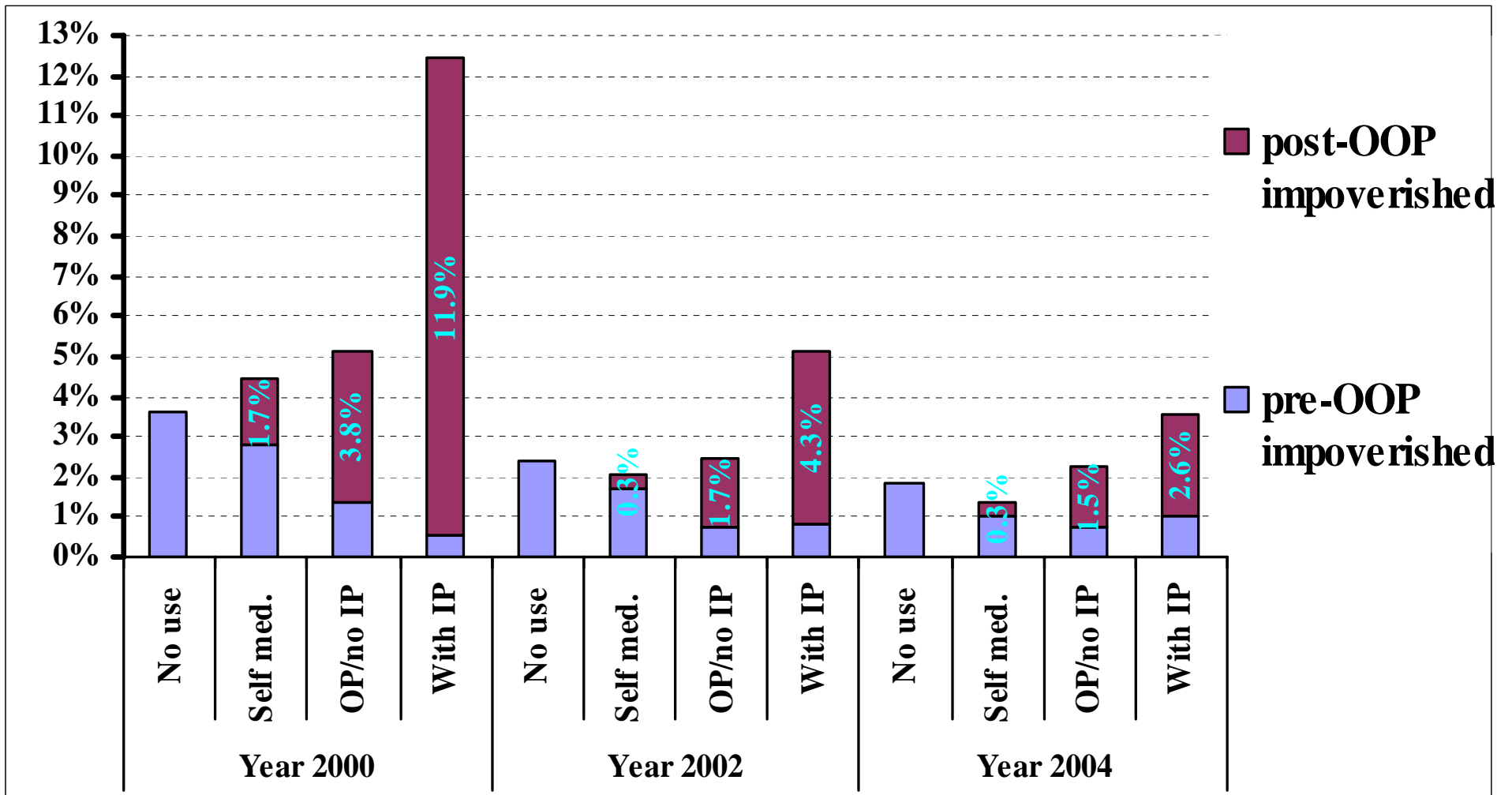
Year		All households	LIC/VHC	UC scheme
2000	Quintile 1	4.0%	2.7%	
	Quintile 5	5.6%	7.1%	
	All Quintiles	5.4%	4.7%	
2002	Quintile 1	1.7%		1.7%
	Quintile 5	5.0%		6.1%
	All Quintiles	3.3%		3.2%
2004	Quintile 1	1.6%		1.6%
	Quintile 5	4.3%		5.2%
	All Quintiles	2.8%		2.6%
2006	Quintile 1	0.9%		0.9%
	Quintile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



Note: Households with health payment > 10% of total expenditures

Source: Socio-economic Survey conducted by National Statistical Office-Thailand (various years)

# Poverty Incidence by level of healthcare All households



**Source:** Limwattananon et al. (2005)



### 3. Lessons drawn and further challenges



# Lessons Drawn

1. A 27 year long march to achieve UC in 2002
  - Investment in infrastructure and health staff since 1971
  - Health financial protection: LIC 1974 -> UC 2001
2. System design is most critical
  - UC is funded by general tax
  - Affordable, efficiency, equity
  - The use of primary health care-Close to Client Services
3. National institutional capacity is critical
  - Health systems and policy research -> evidence
  - Effectively translate evidence into policy decision, program design, implementation and monitoring & evaluation



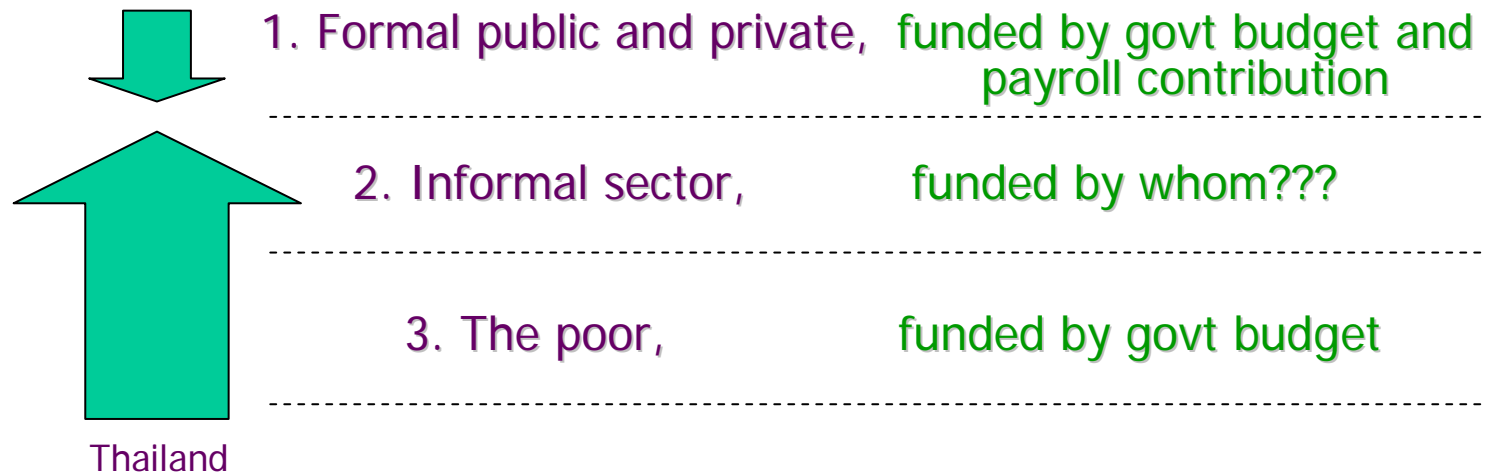
# Future Challenges for Thailand

1. Debates on free choices reimbursement model versus limited choice registration
2. Rapid change towards chronic non-communicable diseases
  - Requires innovative policy interventions on primary prevention,
3. Inequitable distribution of health infrastructure and health staff
4. Three different schemes -> harmonization
5. Long term financial sustainability
6. Quality of care



# Challenges for the Meeting

Q1. How to achieve breadth of UC in developing countries?



Q2. When achieve breadth of UC, how to achieve ultimate aim of health financial protection? [depth of UC]

- If small package, not able to access and use service; household is likely to be catastrophe
- If large package, affordability and sustainability of funding?



Ministry of Public Health-Thailand

Thank you for your kind attention