Health Insurance System Research Office
Health System Research Institute

THAILAND:

Universal Health Care Coverage Through PLURALISTIC APPROACHES

Stakeholders Meeting on Healthcare Financing in Kenya
30 August 2012

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สำนักงานวิจัยเพื่อการพัฒนาหลัก

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- Health Care Delivery in Thailand
- Social Health Protection
- Performance of Health Care System
- Is Thai UC sustain?
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สำนักงานวิจัยเพื่อการพัฒนาหลัก

- Constitutional monarchy in Southeast Asia
- GNI per capita - US $ 4,210 (2010)
- Unemployment rate is 1.4%
- Health Expend/cap – US $175 (2009)

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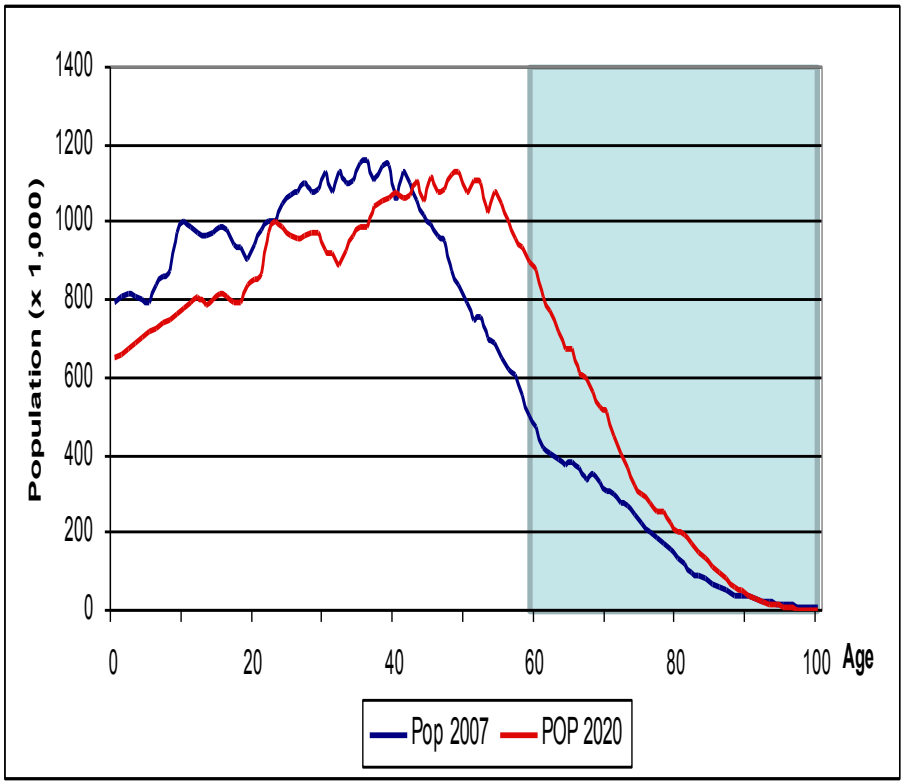
Population: Elderly Society



Source: Health Care Reform Project (2008)

Population - 67 million
Total fertility rate: 1.6 (2009)

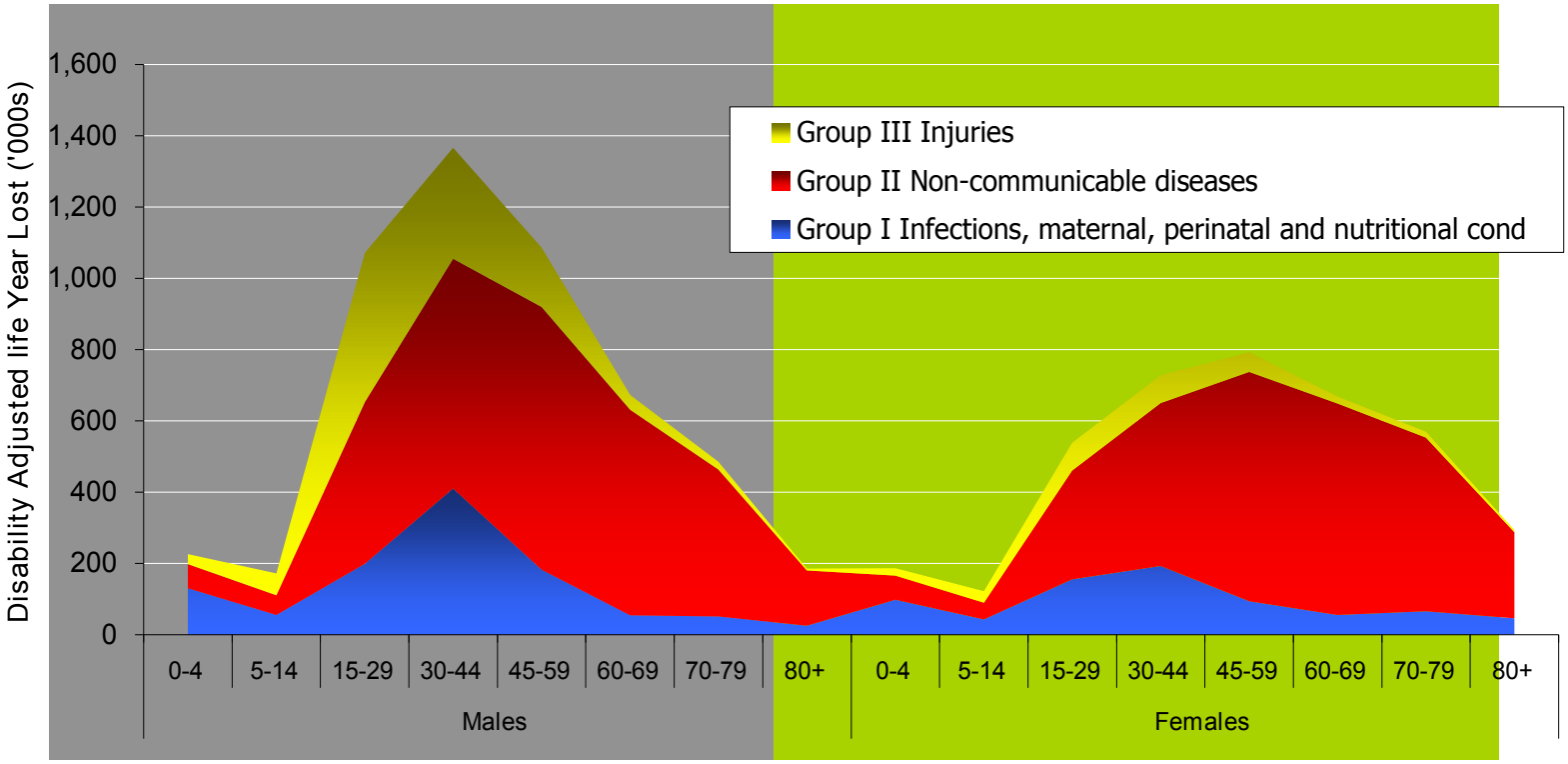
Life expectancy at birth:
74 Years

Under 5 Mortality:
14/ 1000 live births

Maternal mortality:
48/100,000 live births

Burden of Disease: Thailand (2004)

Total **Disability adjusted life years (DALY)** loss **9.17 million years**



Source: IHPP (2007)

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Health Care Delivery

Nation-wide coverage by
Pubic Providers

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Health Care Delivery Development

- Successful centralized (Public) health care coverage plan for distribution of health care infrastructure nationwide before financing for universal coverage for health care
- Public – private mixed
  - Public providers are majority
  - Ministry of Public Health (MoPH) owns two-third of all hospitals and beds across the country
  - Private providers are almost in urban area
- New Graduated Health care professional are compulsory to work for Government
- Maldistribution of health care providers among rural and urban areas

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Health Care Delivery Development

Coverage of health facilities
Mainly under Ministry of Public Health (MOPH)

- Provinces (76) exclude Bangkok
  - General/Regional hospitals 100%
- Districts
  - Community hospitals nearly 100%
- Subdistrict or Tambon
  - Municipal health centres (214)
  - Tambon Health centres (9,738) nearly 100%

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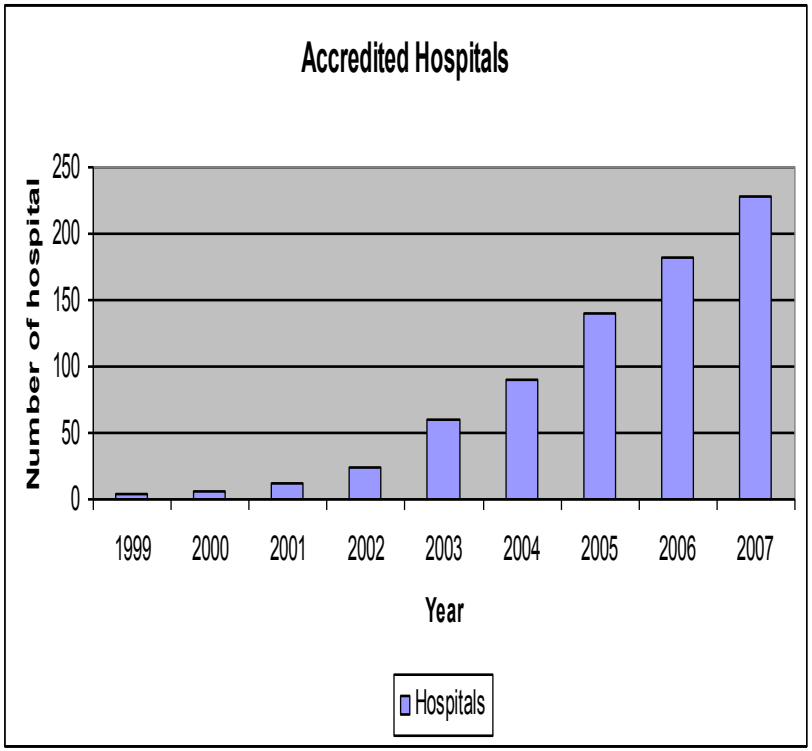
Quality:
Hospital Accreditation



Voluntary program which is conducted by the Institute of Hospital Quality Improvement and Accreditation

This Thai accreditation process is demanding from both public and private hospitals

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Social Health Protection

Public Managed Schemes

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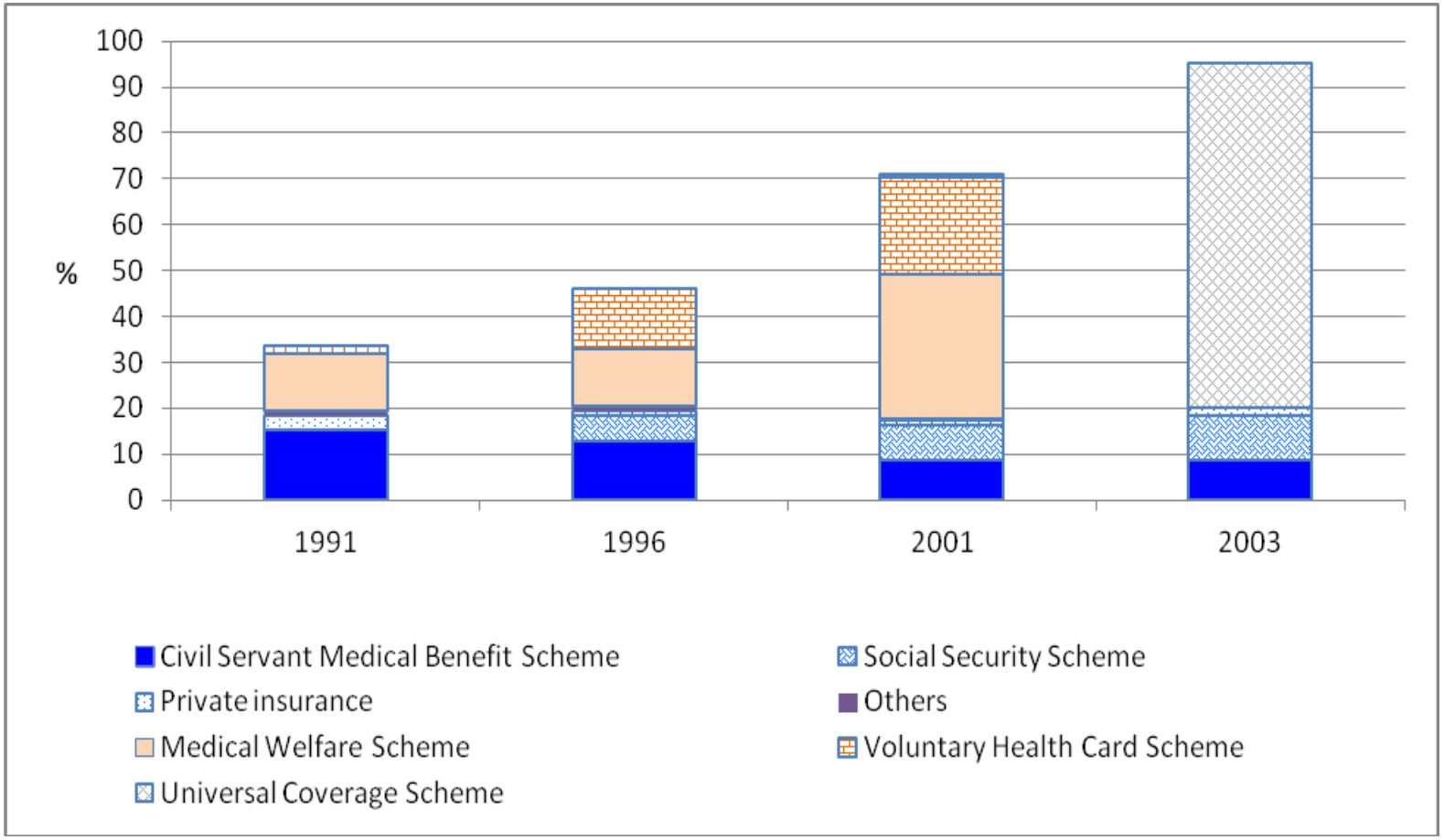
Thailand:
Path to Universal Coverage



Source: National Statistic Office, the Health and Welfare Surveys in 1991, 1996, 2001 and 2003.

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Services cover under National Health Security Act

- Promotive and preventive cares;
- Diagnosis;
- Ante-natal care;
- Curative care;
- Medicine, medical supplies, organ substitutes, and medical equipments;
- Delivery;
- Boarding expense within health care unit;
- Newborn and child care;
- Ambulance or transportation for patient;
- Transportation for disability person;
- Physical and mental rehabilitation;
- Other expenses necessary as prescribed by the Board.

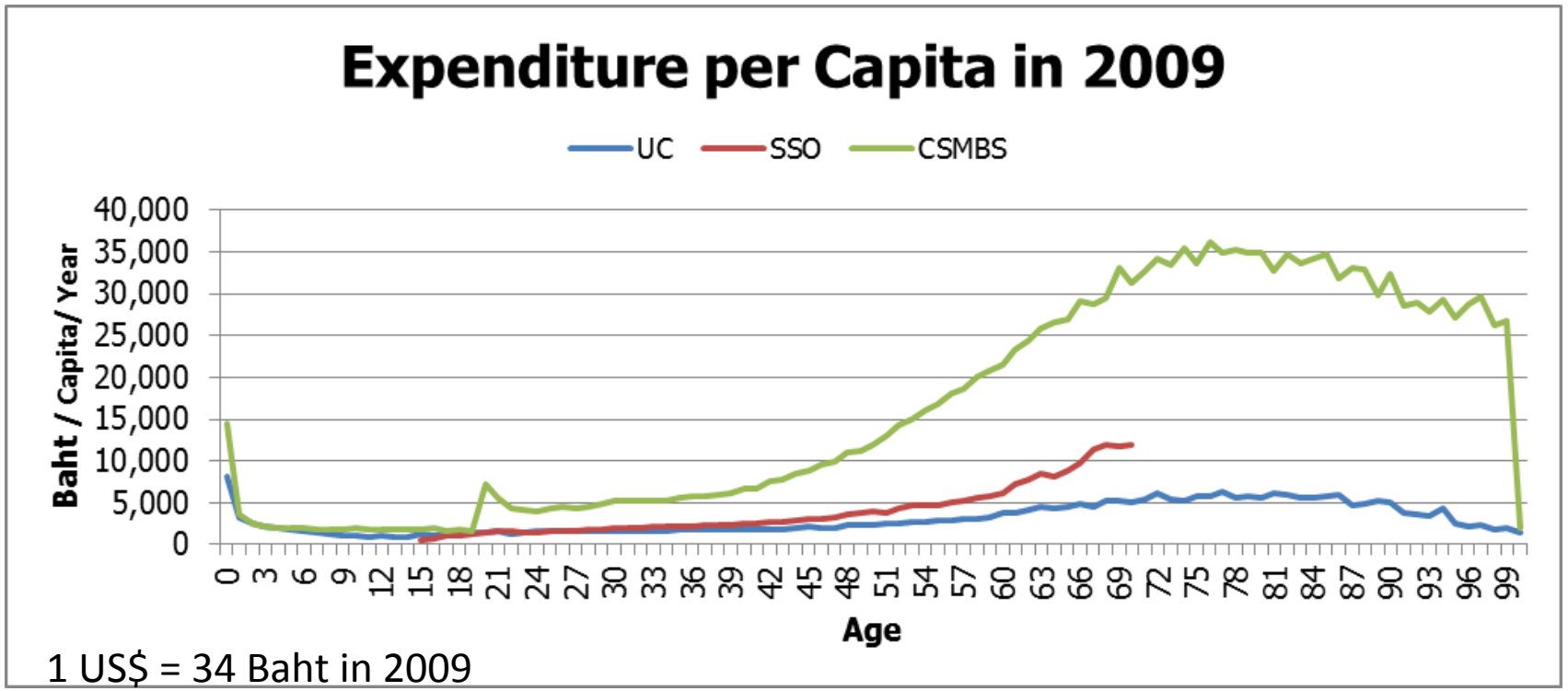
Current
Social Health Protection Schemes

Social health protection schemes have covered all Thai citizen since 2002

Major Schemes	Civil Servant Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)	Universal Coverage (UCS)
Introduced in	1960s	1990s	2002
Target beneficiaries	Govt employees & dependents, retirees	Private sector employees:	To whom which not covered by CSMBS nor SHI,
Pop Coverage	7%	13%	80%
Funding	Govt budget	Payroll contribution, Tripartite	Govt budget
Payment to health facilities	Fee-for-service for OP, and DRG for IP	Capitation (use DRG in risk adjusted part)	Capitation + DRG

Current
Social Health Protection Schemes

Differences in utilization and expenditures across the schemes



1 US$ = 34 Baht in 2009

Source: HISRO (2010) calculate from database for the three schemes

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Performance of Health Care System after 10 years of the UC

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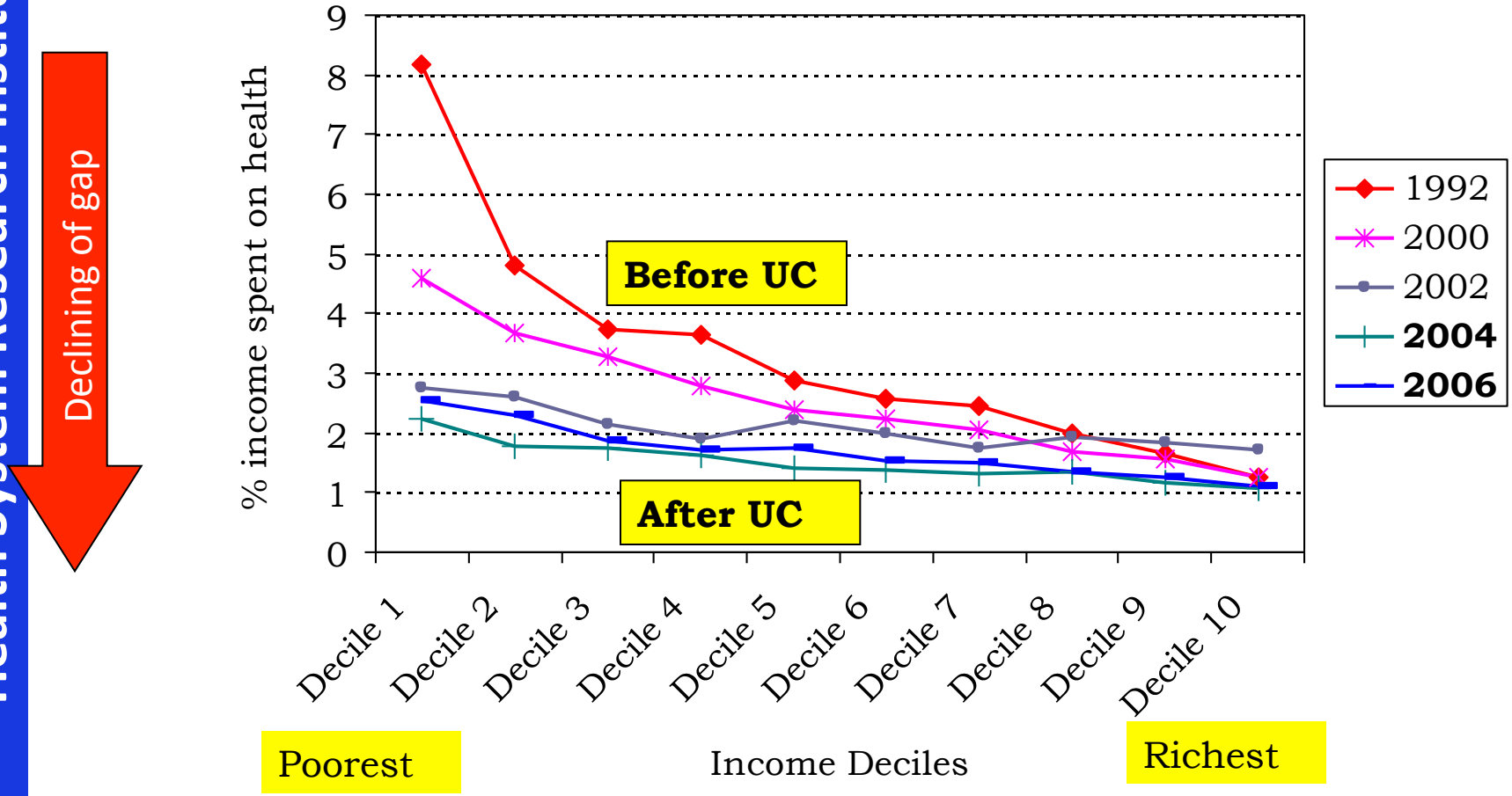
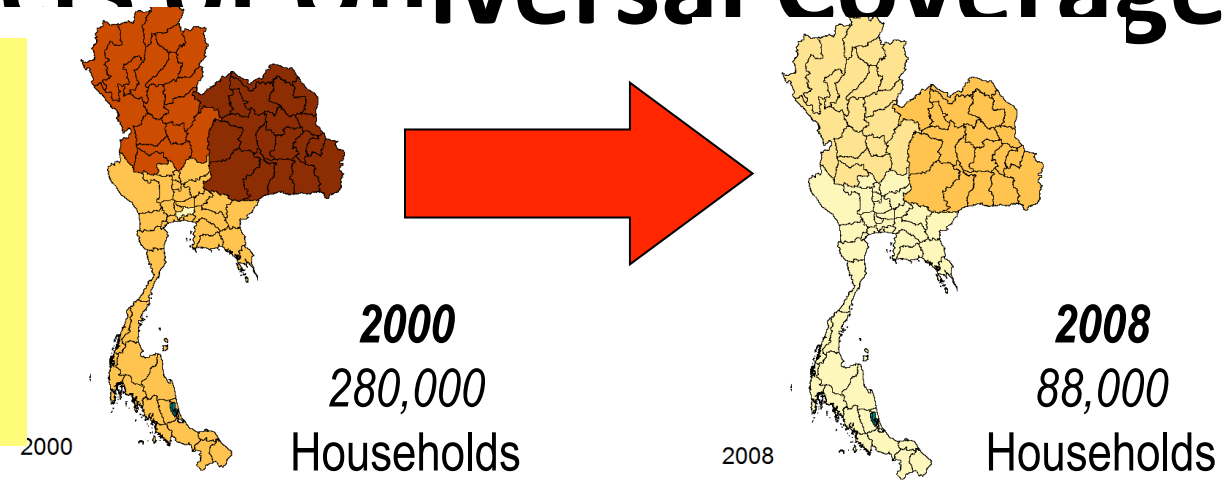
EQUITY:
Income Spending on Health by Income Groups



Source: Socio-Economic Survey 1992 - 2006 conducted by NSO

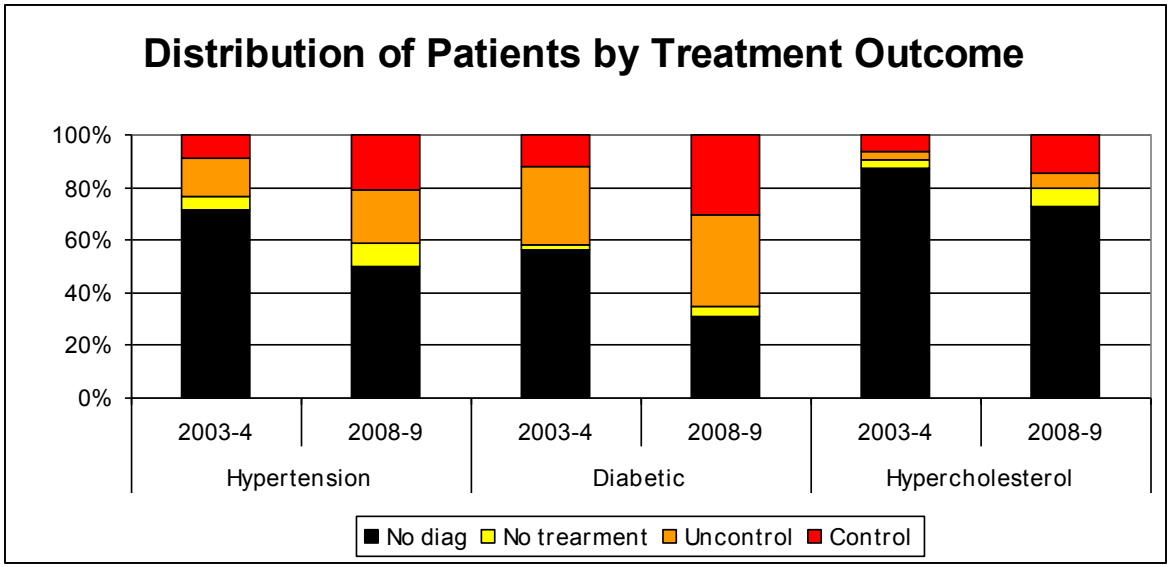
Impacts of Universal Coverage

Decrease Poverty from Health Care Spending



Source: Limwattananon (2010): analysis of Socioeconomic Survey (various years)

Improve Health Outcome



Source: National Health Examination Survey 2003-2004 and 2008-2009

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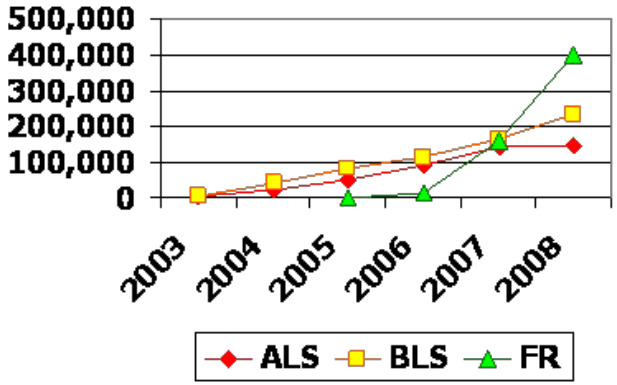
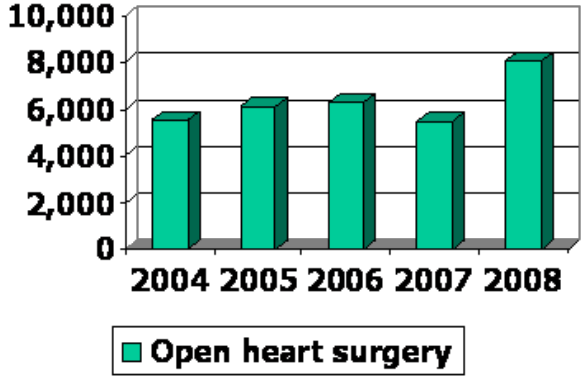
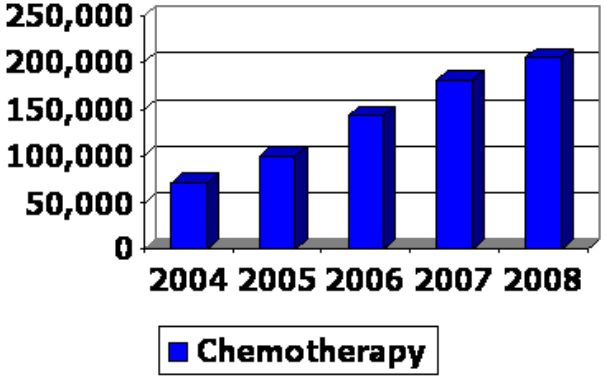
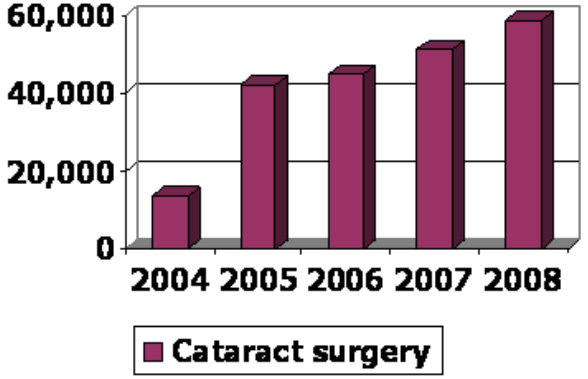
Accessibility

- Increase utilization of out-patient and in-patient









Source: HISRO (2008)

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Enabling Factors for UCS

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Enabling Factors for UCS

- State commitment to health
  - Socioeconomic (growth & poverty reduction)
  - Legitimacy -> constitution & political perspective
- Centralized (Public) health care coverage plan
- Planning and utilization of human resource
- Improvement of Institution Capacity on Health system:
  - health system research, health care financing, model development
- Support and collaboration with health care professional, civil societies and politicians

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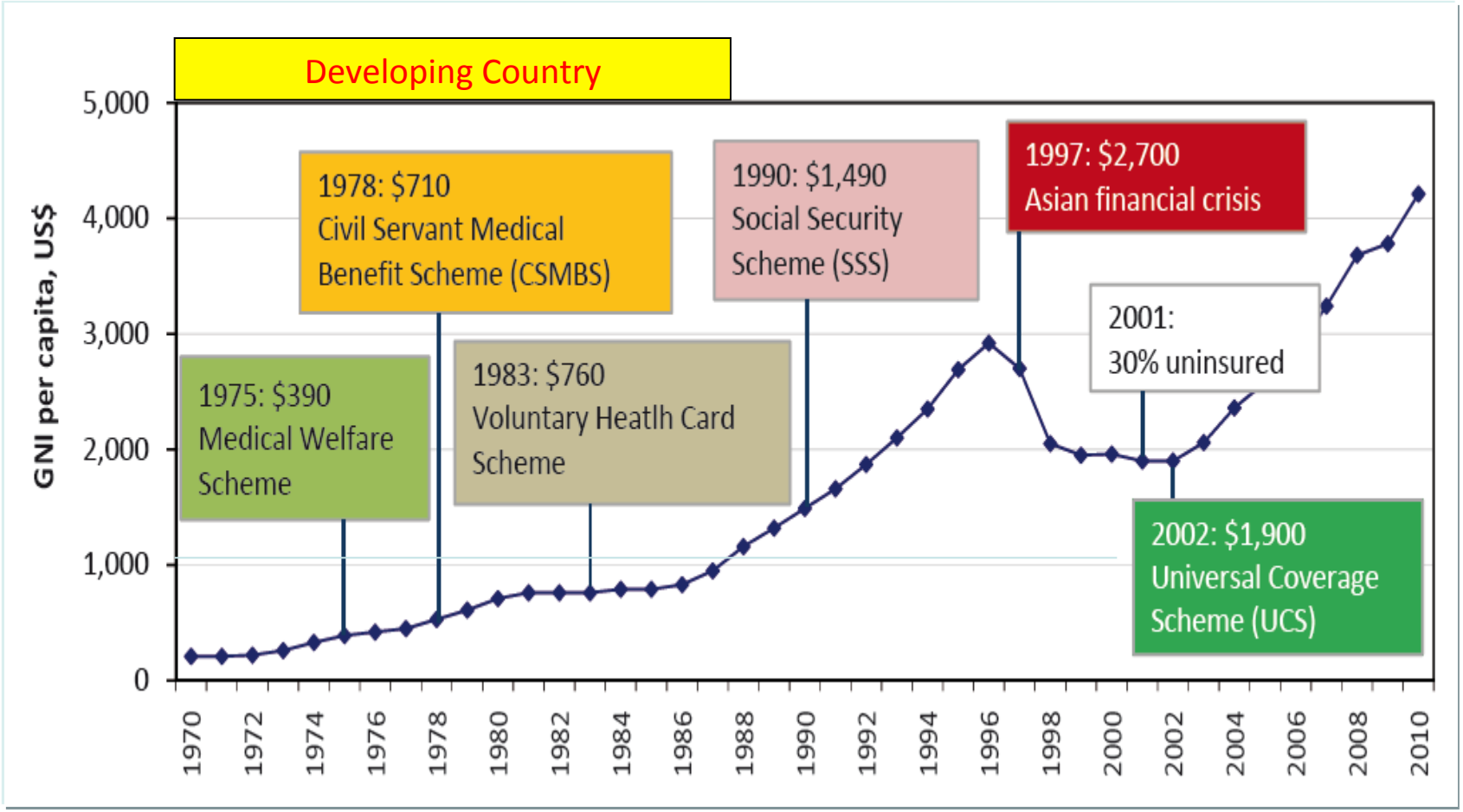
State Commitment to health



Source: HISRO (2012) Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010).

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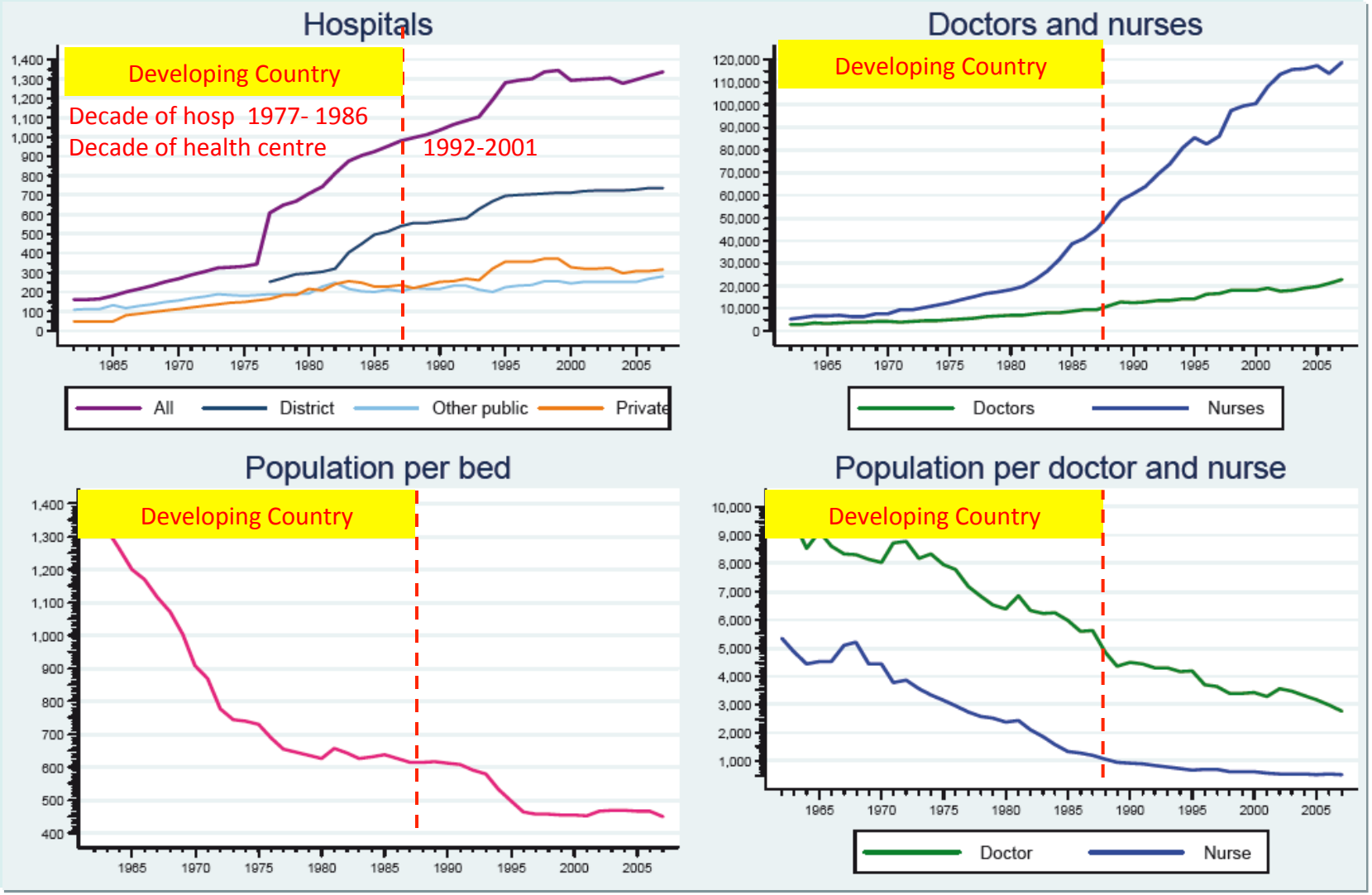
Centralized (Public) health care coverage



Source: Patcharanarumol W et al (2011). Why and how did Thailand achieve good health at low cost?10

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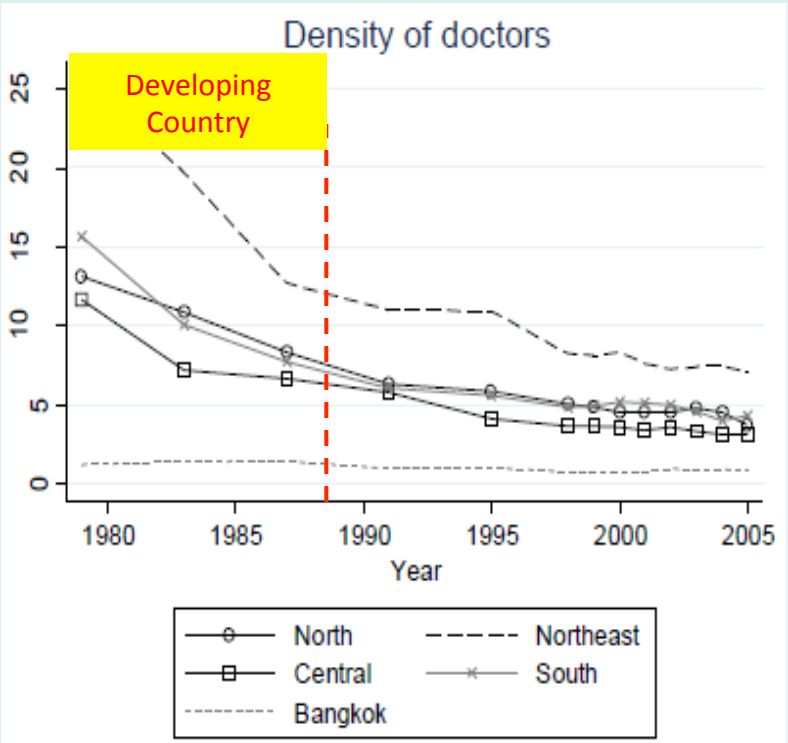
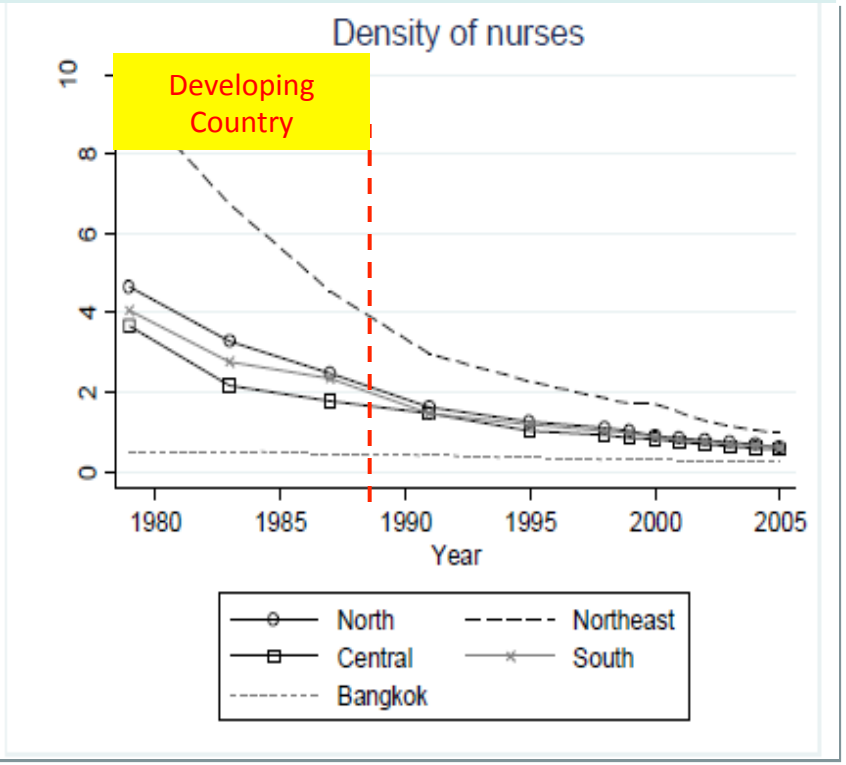
Centralized (Public) health care coverage

Regional disparities: Improve but Still Exist





Source: Pagaiya, N, et al (2008) Thailand's Health Workforce: A Review of Challenges and Experiences. & Thailand Health Profile. From World Bank (2012) Government Spending and Central-Local Relations in Thailand's Health Sector. Health, Nutrition and Population (HNP) Discussion Paper (Forth coming)

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Centralized (Public) health care coverage

- Public Health Care Provides have been allowed to keep revenue since 50+ year ago.
  - Sense of ownership,
- Step by step increase flexibility and autonomy to health facilities
  - 1990 Competition between Public and Private facilities for SSO member
  - 2002 (the UC era): Almost money to public facilities come from “Insures” (except salary)
- Provincial health officer is responsible to integrated health service in provincial level

Planning and utilization of human resource

- Compulsory Service for Government
  - Start in 1968: Medical students have to work for government for three years. Finally, it applied to dentist, pharmacist, nurse, and other paramedical personnel
- Increase number of new-comers
- Non-financial incentive & Moral Motivation
- Financial Incentive
  - Hardship allowances for working in rural area, no-private practice allowances, Pay for performance

Improvement of Institution Capacity on Health system:

- Strong leadership in MOPH to create its “brain” from generation to generation
- Talent new comers have been identified
  - opportunity to join model development researches, intensive apprenticeship type training, formal training aboard and come back to work in those fields
  - Researches and model developments can traced back to before 1980
- In 1992 Health System Research Institution, which is autonomous agency equivalent to Department level is established in MoPH

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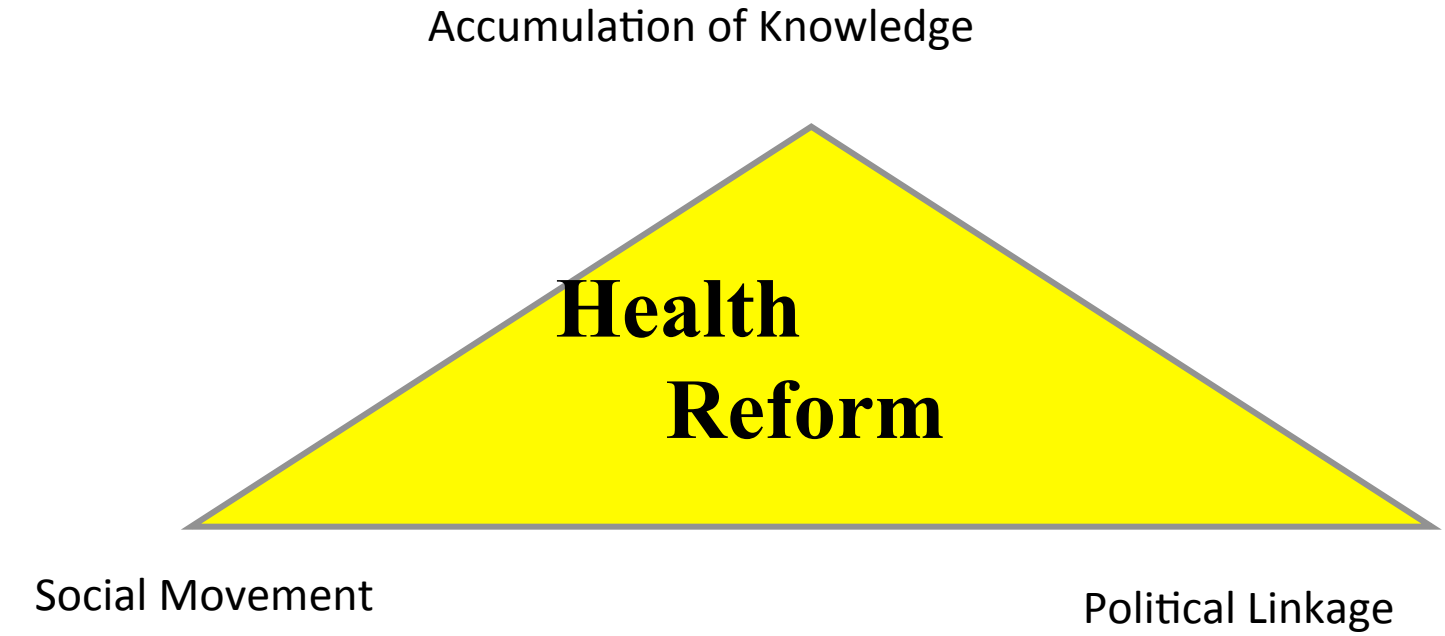
Improvement of Institution Capacity on Health system (Example)

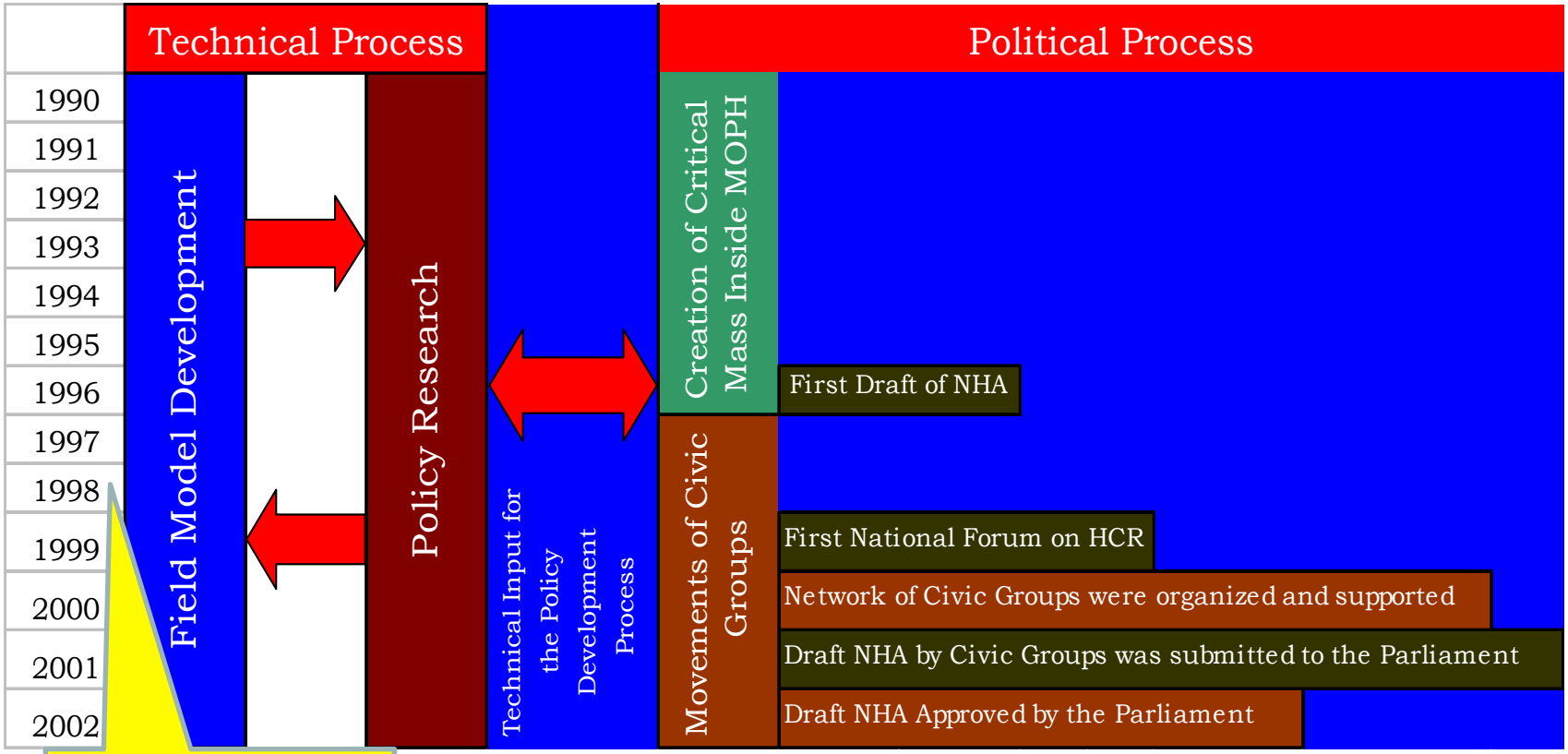
- Capitation
  - Aggregate performance reports was in placed since 30+ year ago
  - Research on hospital cost accounting's started since 1980
  - First use of Capitation of SSO in 1990
- DRG
  - Before 1990: Research on DRG has started
  - 1990+: implemented ICD10, Basic Minimum Data Set, Simple Computerized Hospital System
  - DRG version 1 has implemented in 1999
- Model developments were implemented during 1980 – until now.

Collaboration Among Health Care Professional, Civil Societies and Politicians: Triangle that moves mountain



Source: Dr. Prewase Wasi

Chronological Events of UC Policy Development Process



Source: NHSO (2009)

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Is Thai UCS Sustain?

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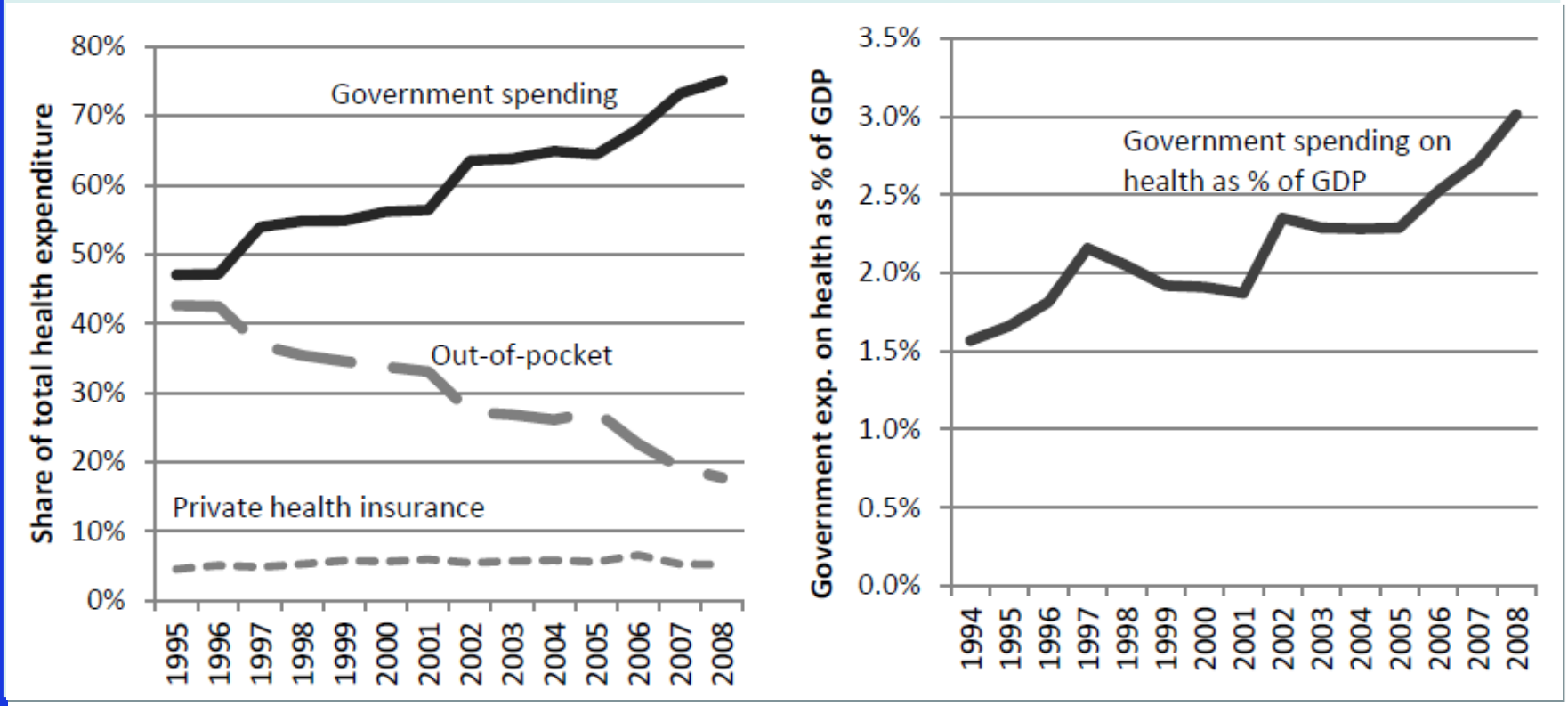
Financial Sustainability

Political Sustainabi

Social Sustainab

Source: Saltman et al (2004). *Social health insurance systems in western Europe*. European Observatory on Health Systems and Policies Series

Share of Total Spending Financed by Government Has Been Rising



Source: World Bank (2012) Government Spending and Central-Local Relations in Thailand's Health Sector. Health, Nutrition and Population (HNP) Discussion Paper (Forth coming)

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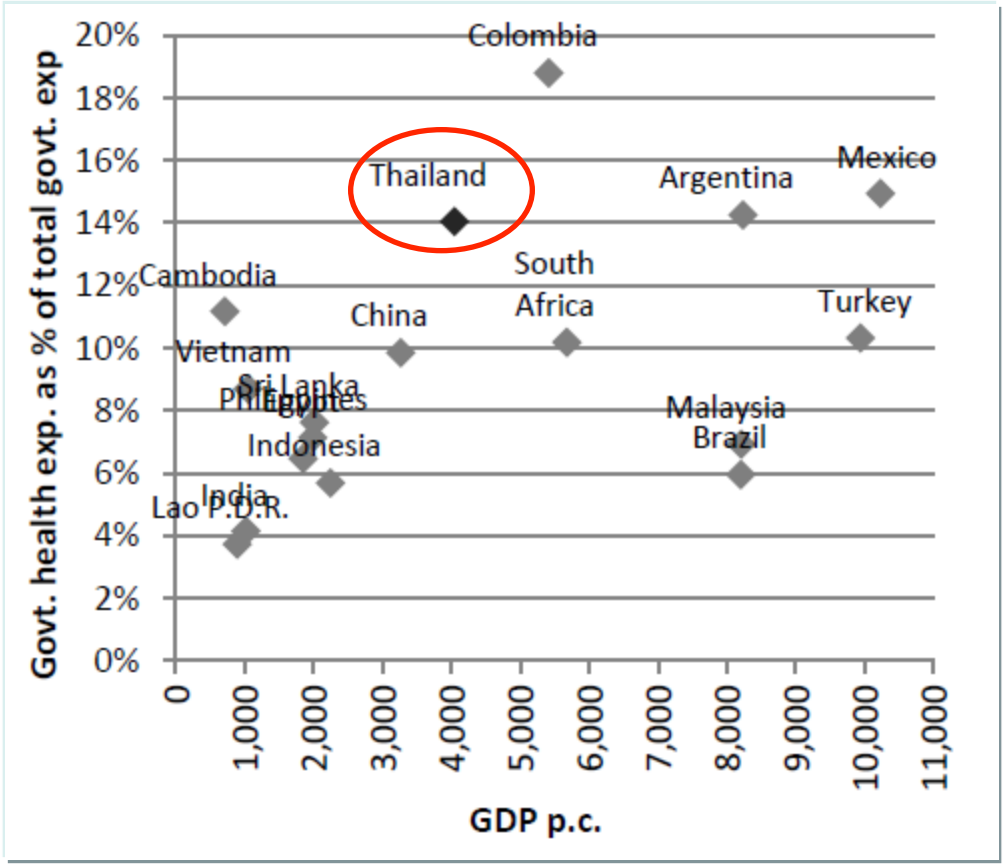
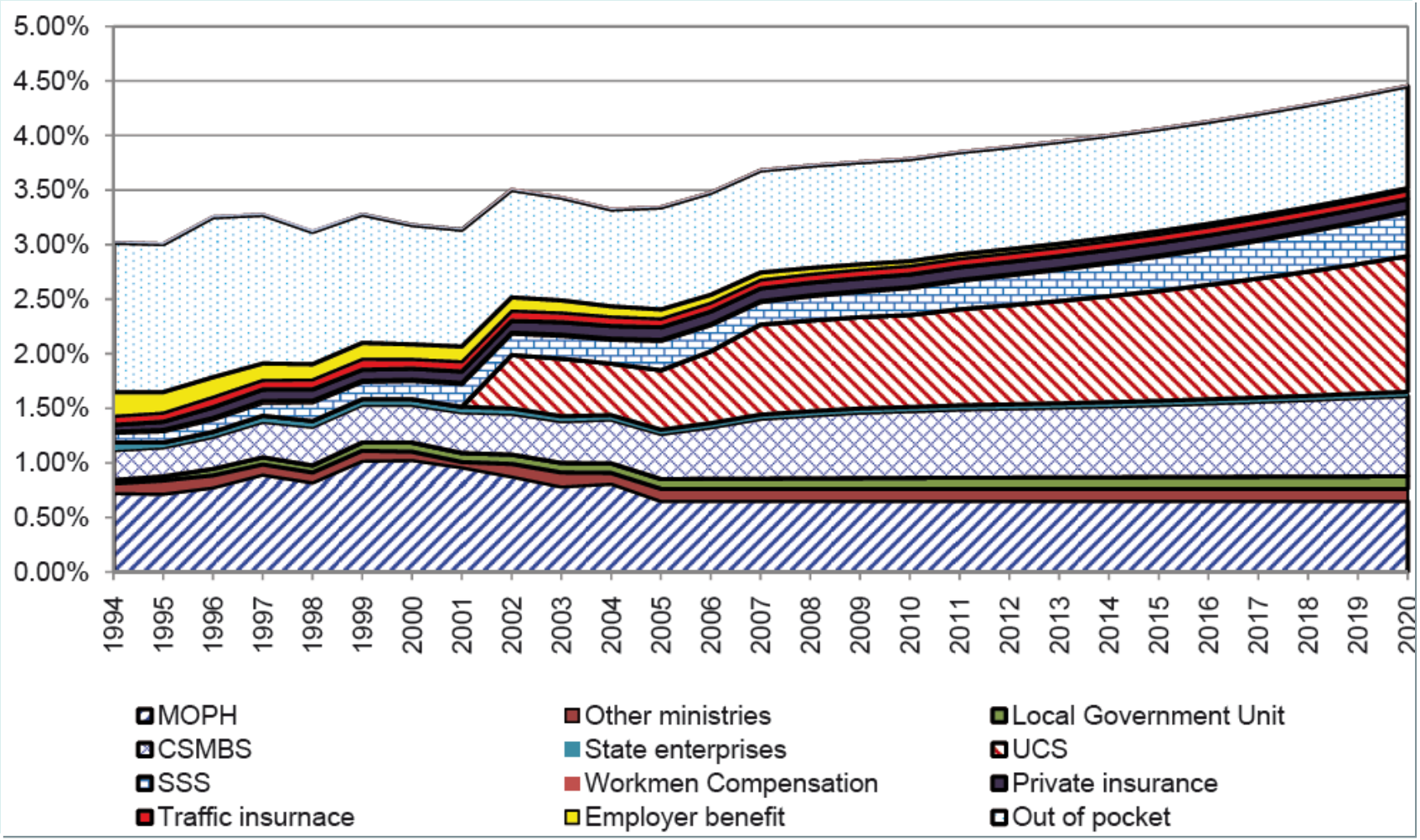
Thailand Spends a Relatively High Share of Government Spending on Health



Source: World Bank (2012) Government Spending and Central-Local Relations in Thailand's Health Sector. Health, Nutrition and Population (HNP) Discussion Paper (Forth coming)

Projection of Total health expenditure as Percentage of GDP (1994-2020) is not High



Source: Hennicot JC, Scholz W and Sakunphanit T. Thailand health-care expenditure projection: 2006–2020. A research report. Nonthaburi, National Health Security Office, 2012

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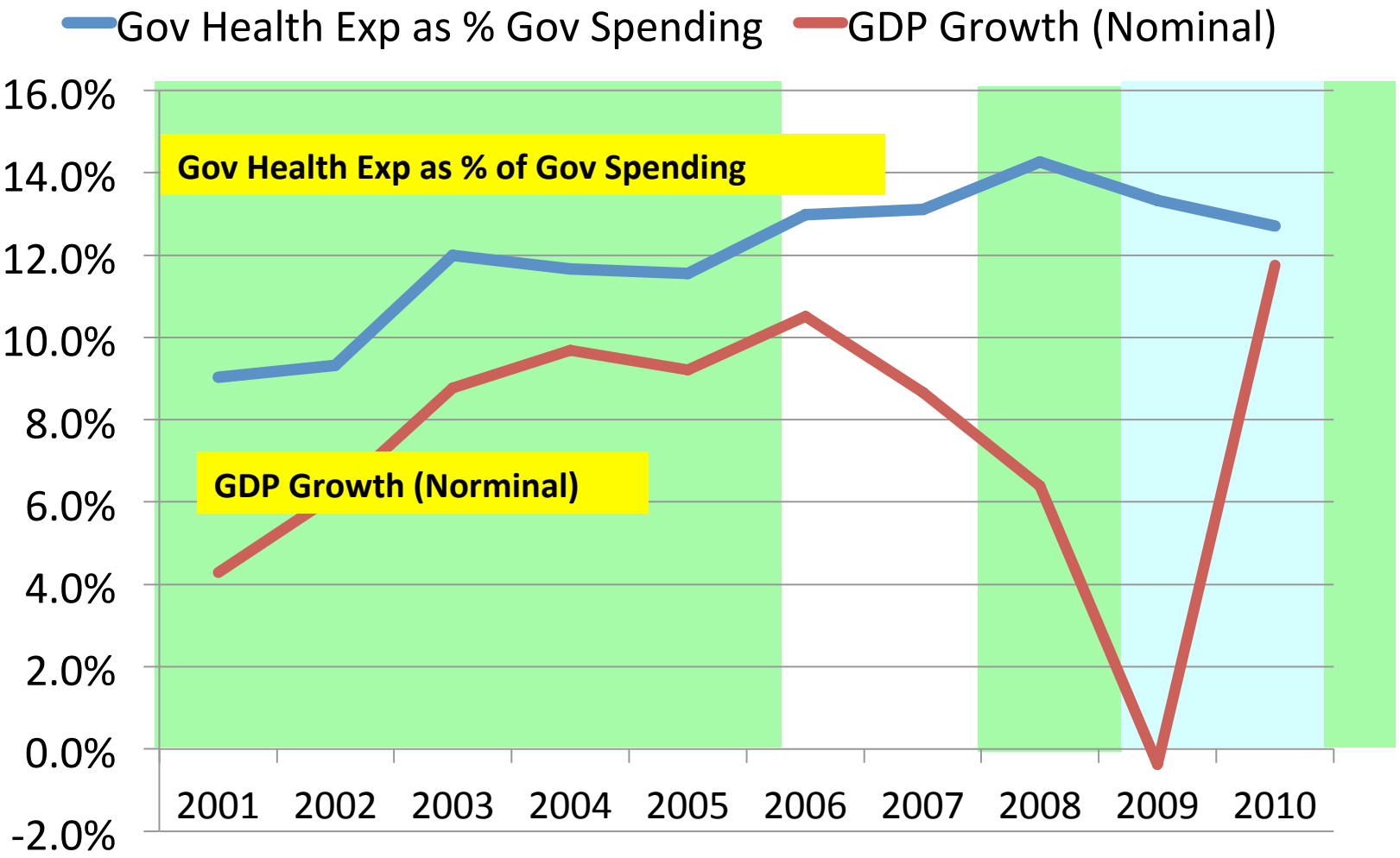
Political Sustainability: Commitment of Political Parties



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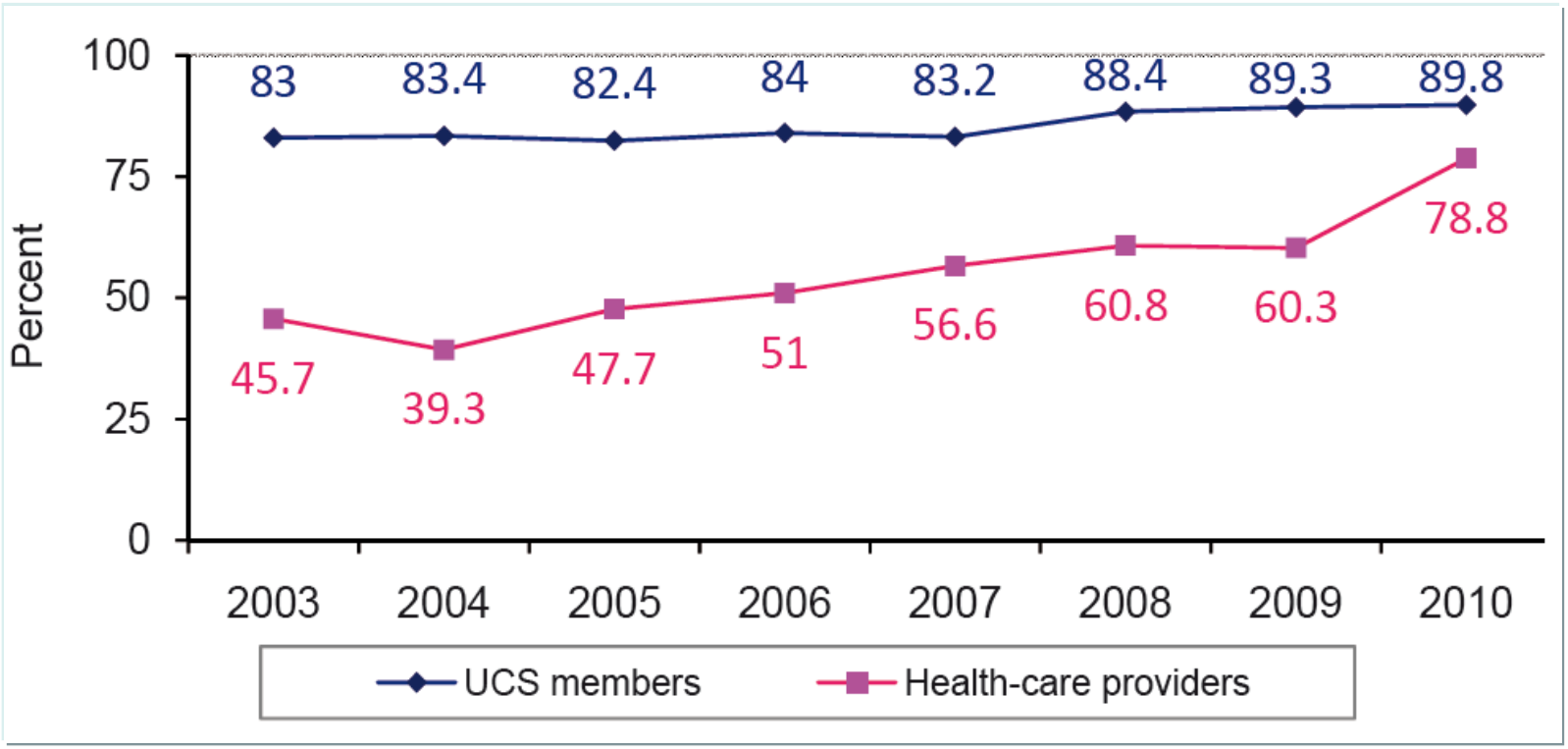
Social Sustainability: Legitimacy, People Satisfaction Solidarity?



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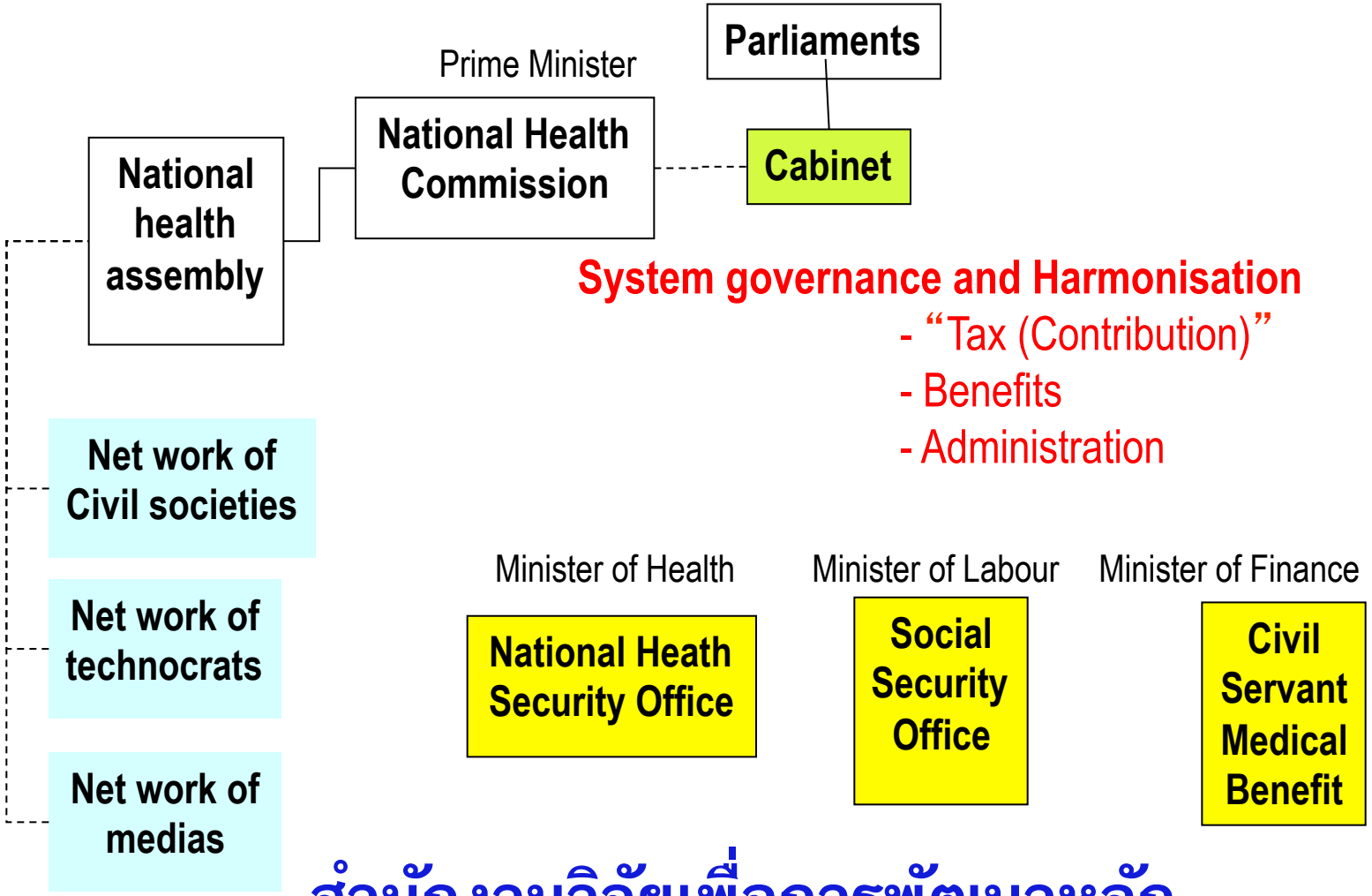
Challenges

Harmonized Social Protection Scheme

- Multiple schemes using the same payment mechanism
- Harmonized life serving and high cost care among three schemes
- Try to identify basic health care package
- Services more than basic package are depended on Schemes or People

Harmonized Social Protection Scheme:

System Governance at national Level



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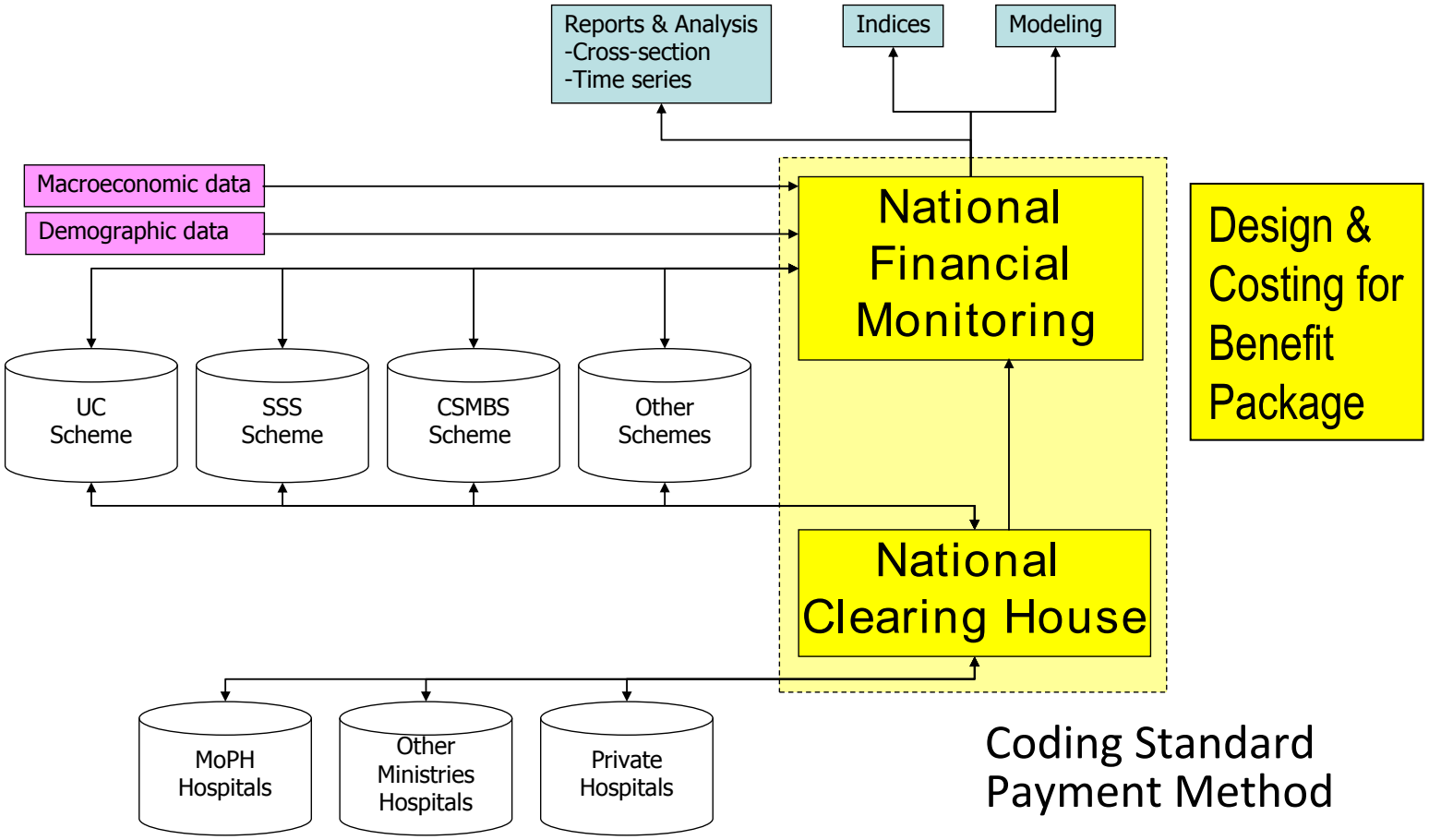
Harmonized Social Protection Scheme:

Proposed Functions at national Level



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More Efficient and more Quality Health Care

- Cost containment focus on Drug and Investigation
  - Promote using of “Generic name” not Trade name
  - Practice guide lines and indications for new drugs
  - National Procurement for some expensive drugs and/ or compulsory licensing
- Continuum of care
  - Primary care and Referral Center in every regions
- More “Efficient” public provider & public private partnership

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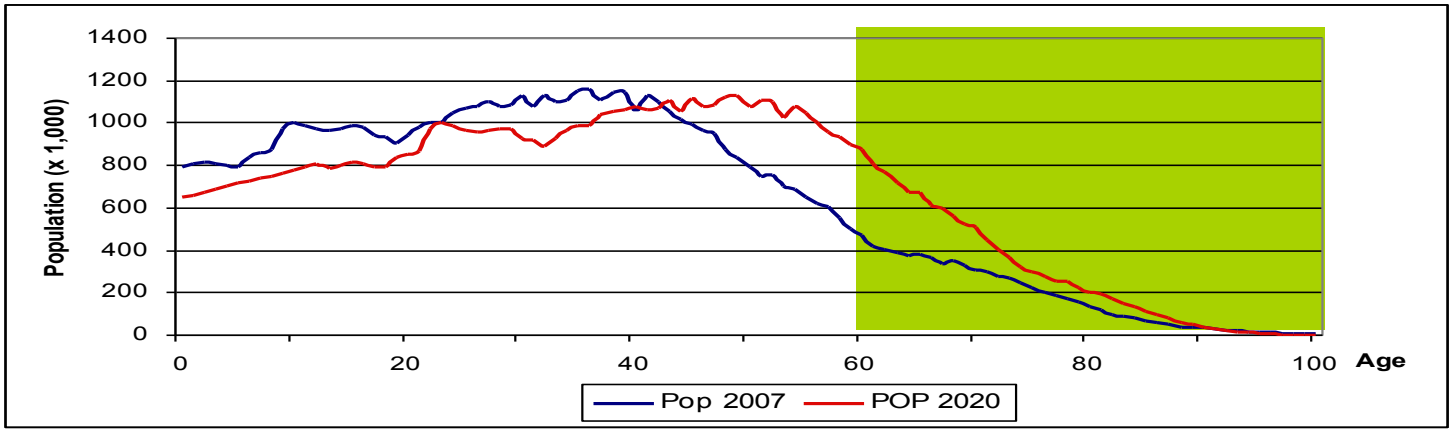
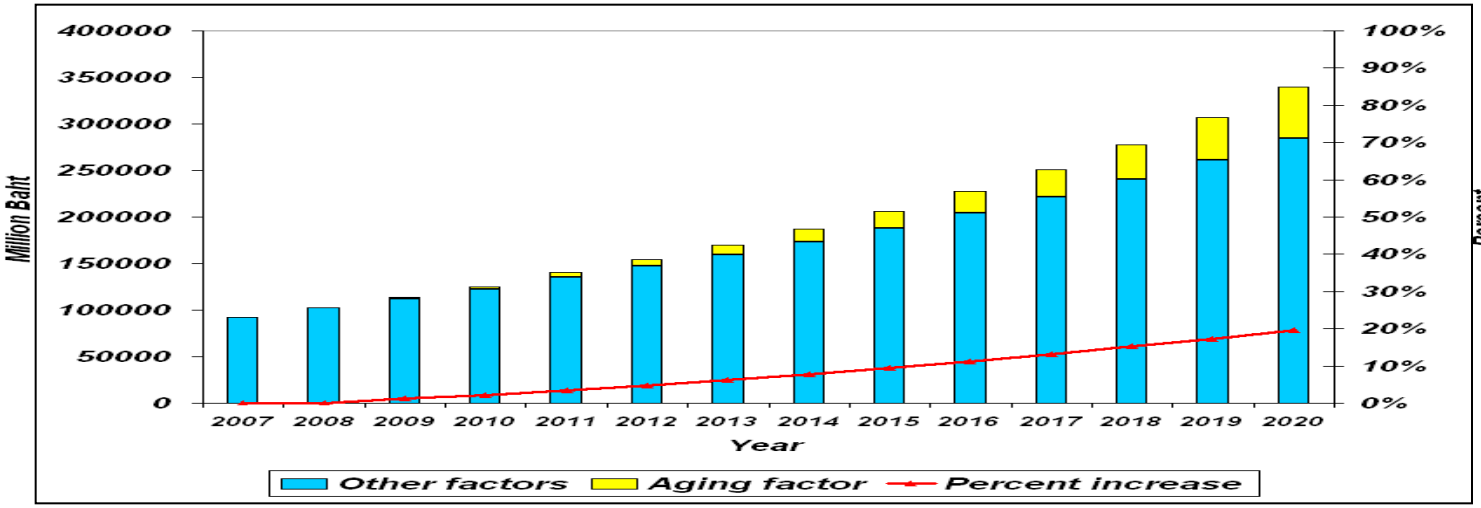
Mitigating and Coping of Aging Society: New Continuum of Care

Self care, Acute, Subacute, Chronic and Long Term Care





Source: Health Care Reform Project (2008).

THANK YOU

Questions?