Key platform for successful Universal Health Coverage in Thailand

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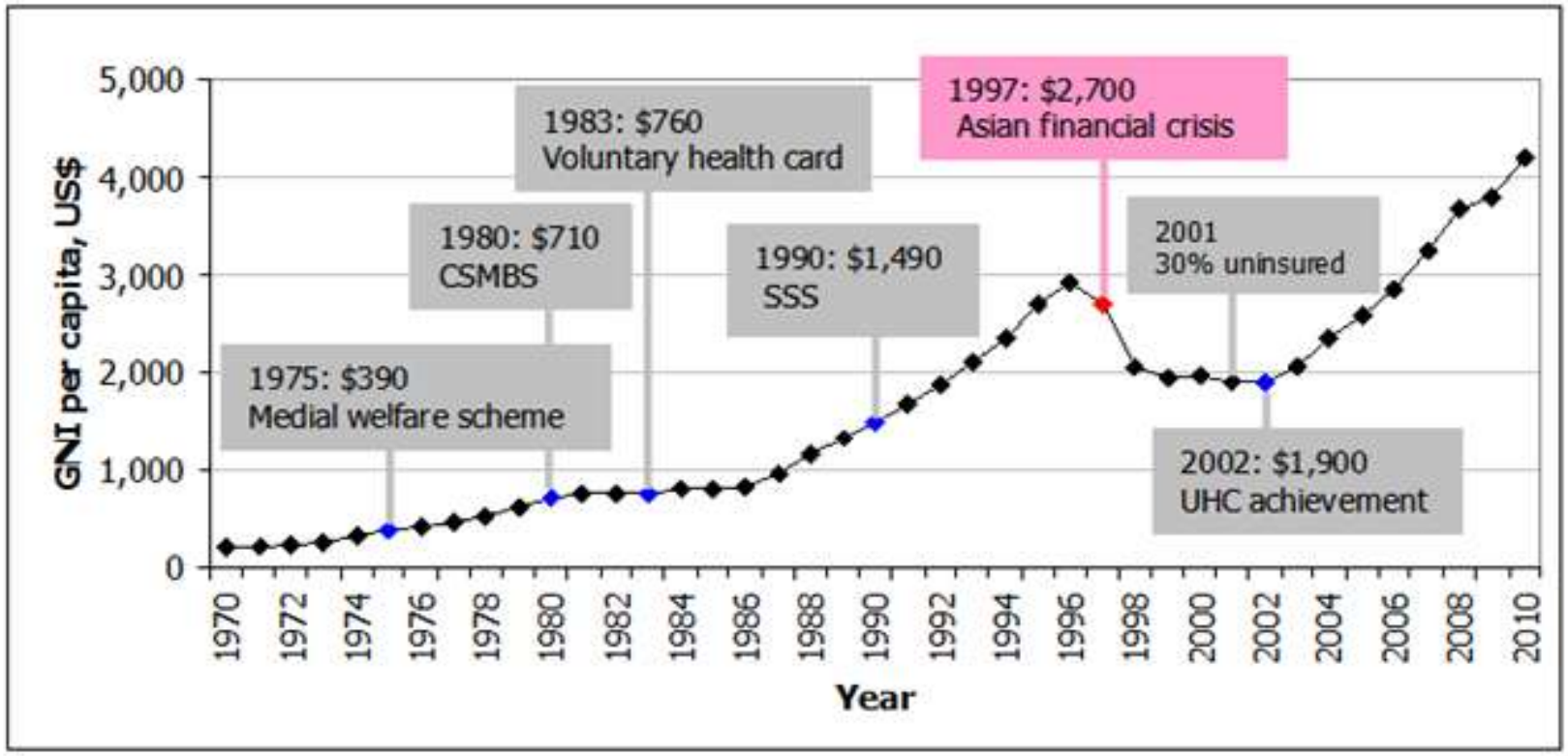
Country profiles: Thailand

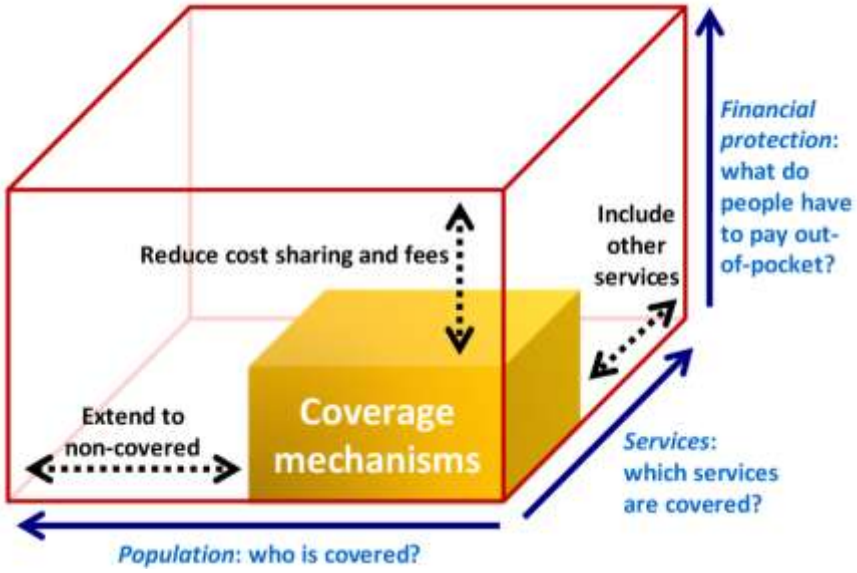
- 67 million population
- GNI 2010 US$4,210 per capita, Gini 40
- Total Health Expenditure (2010 NHA)
  - 3.9% GDP
  - US$194 per capita
  - Public sources 65%, OOP 14% of THE
  - Govt exp on health 13.1% Govt Exp
- Health status
  - Total fertility rate 1.6 (2009)
  - Life expectancy at birth 74.1 years
  - 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



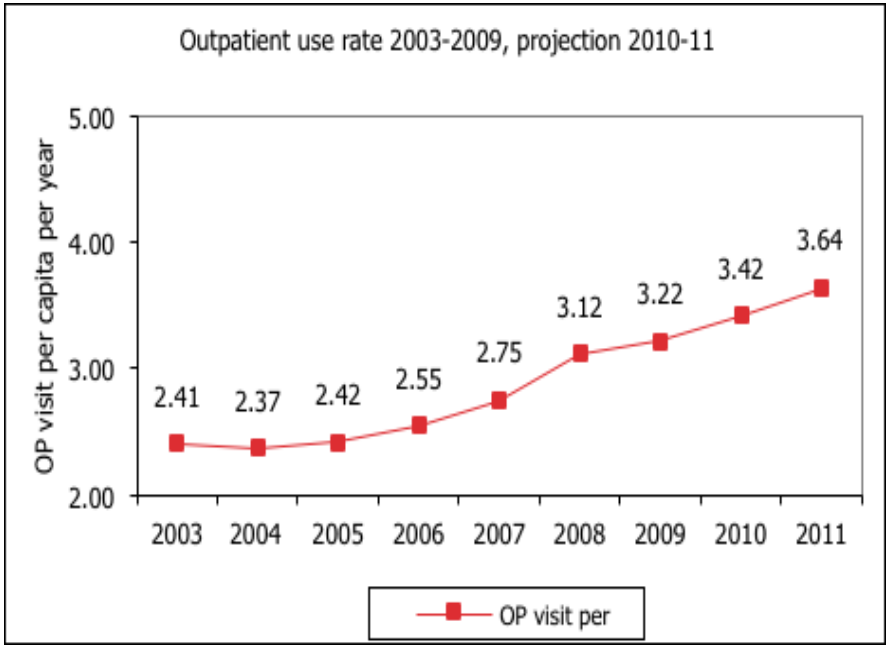
- Started from targeting the vulnerable groups, expanded to specific groups (government officers, informal workers by voluntary basis and private formal workers by mandatory) and finally UHC in 2002
- No need to wait until rich to start UHC – Thailand started since 390 US$ per capita

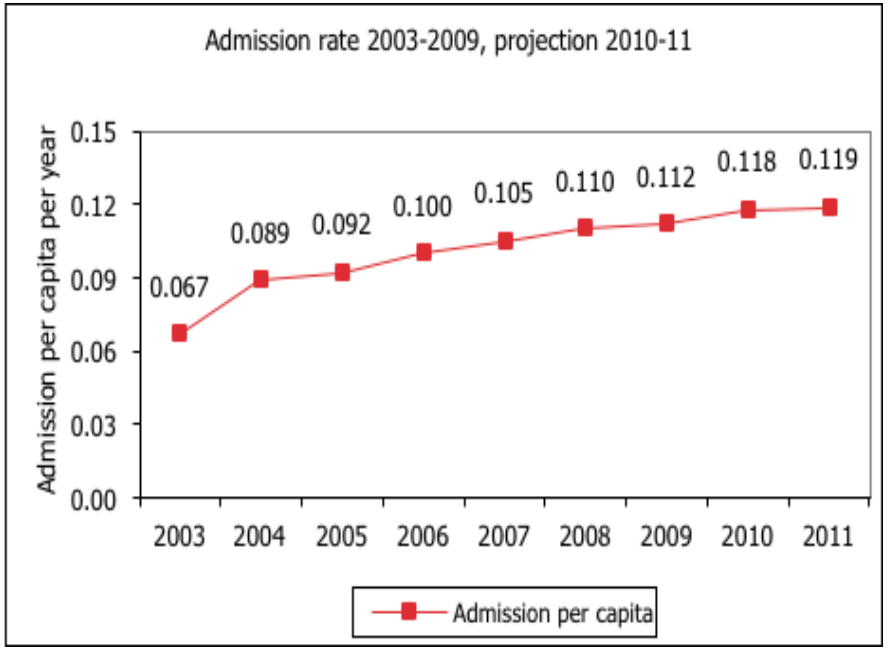
UC cube: what has been achieved by 2012?



- Population coverage:
  - 99% pop overage 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

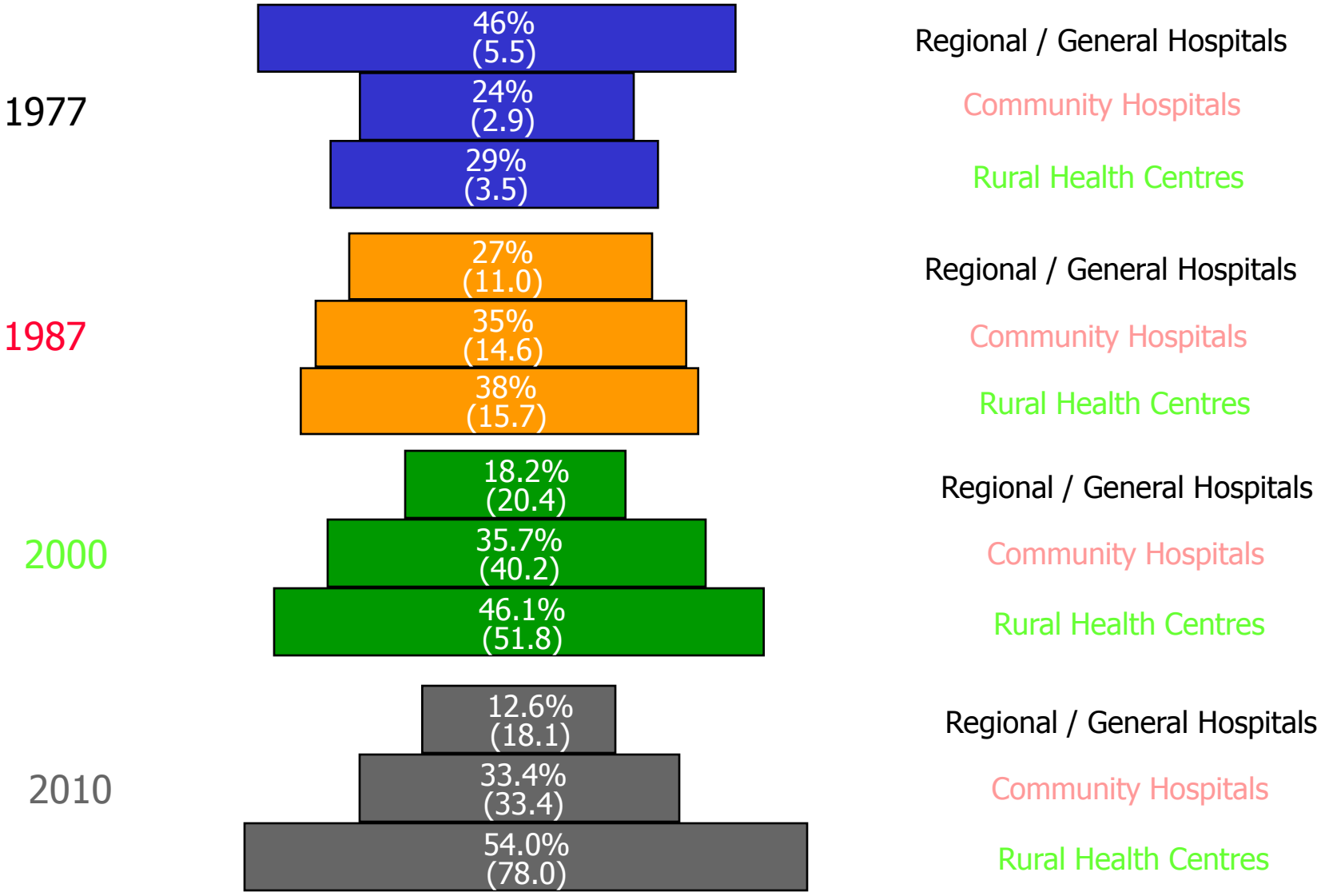




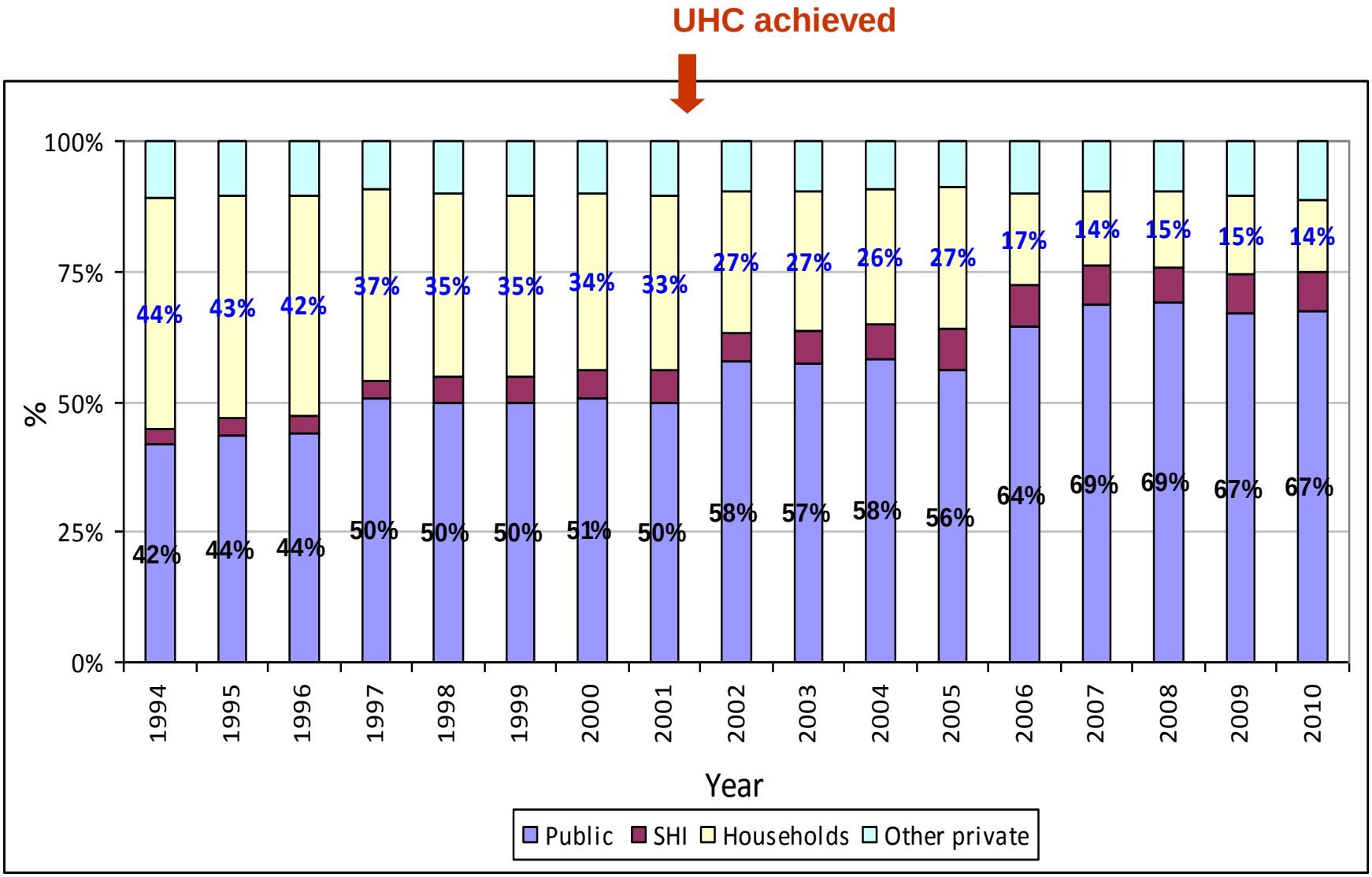
Prevalence of unmet need	OP	IP
National average	1.44%	0.4%
CSMBS	0.8%	0.26%
SSS	0.98%	0.2%
UCS	1.61%	0.45%

Source: NSO 2009 Panel SES, application of OECD unmet need definitions

Changes in utilization:
primary secondary and tertiary 1977-2010



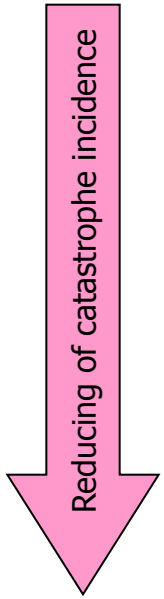
Source of finance 1994-2010



Incidence of catastrophic health expenditure

- Reducing trend of incidence of catastrophic health expenditure

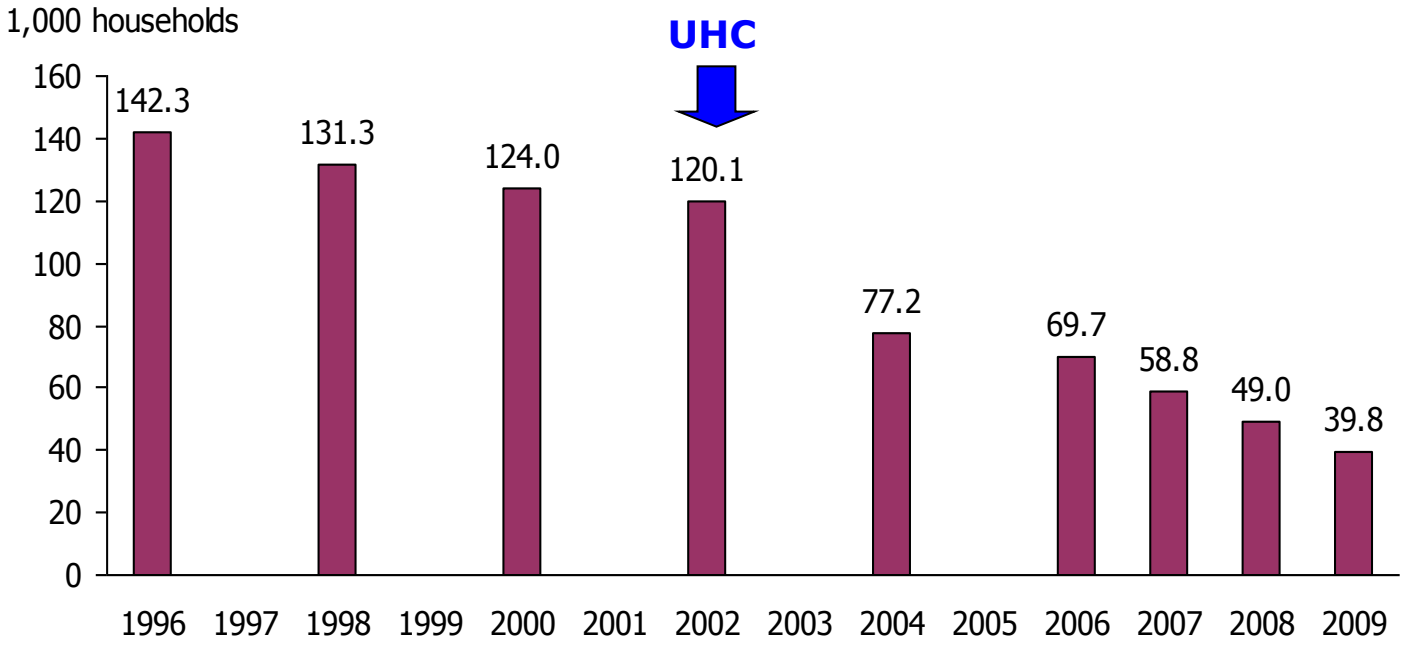
Year		All households	LIC/VHC	UC scheme
2000	Quintile 1	4.0%	2.7%	
	Quintile 5	5.6%	7.1%	
	All Quintiles	5.4%	4.7%	
2002	Quintile 1	1.7%		1.7%
	Quintile 5	5.0%		6.1%
	All Quintiles	3.3%		3.2%
2004	Quintile 1	1.6%		1.6%
	Quintile 5	4.3%		5.2%
	All Quintiles	2.8%		2.6%
2006	Quintile 1	0.9%		0.9%
	Quintile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

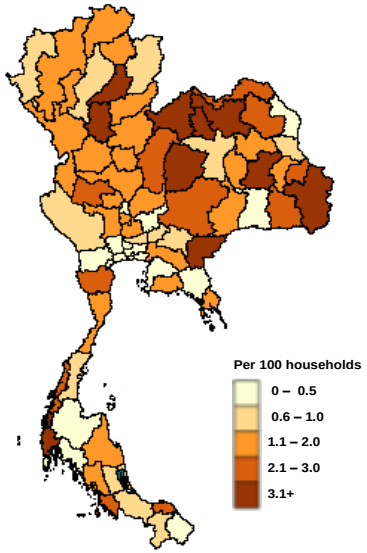
Thailand: UHC prevents health impoverishment

- 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

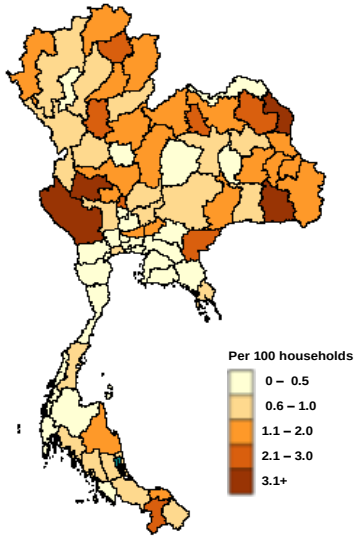


Source: analysis from Health and Welfare survey conducted by National Statistical Office, Thailand

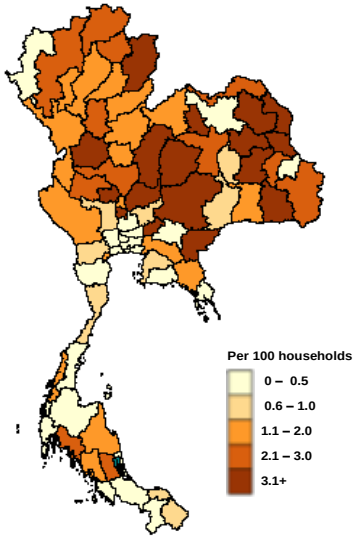
Sub-national health impoverishment 1996 to 2008



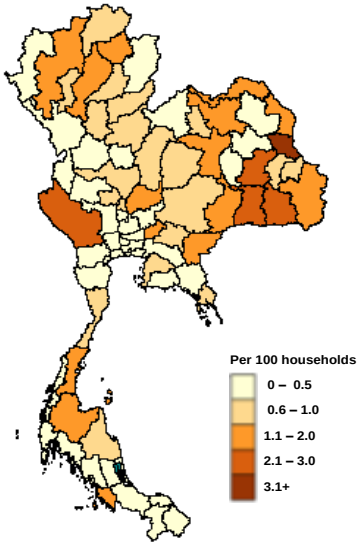
1996



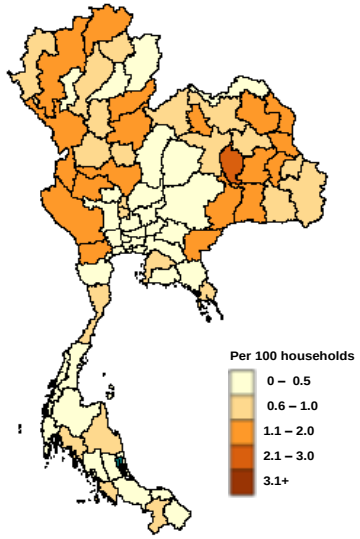
1998



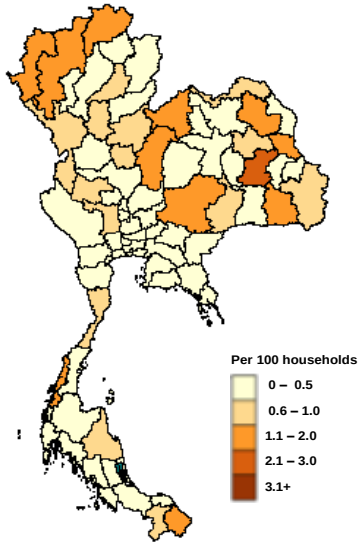
2000



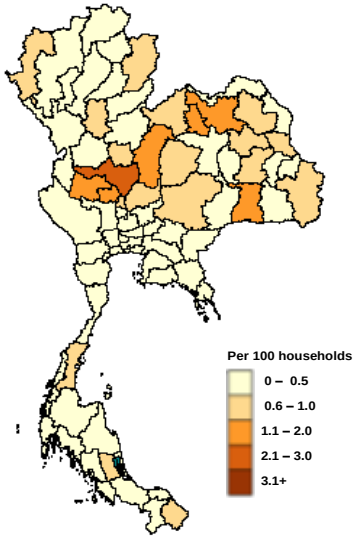
2002



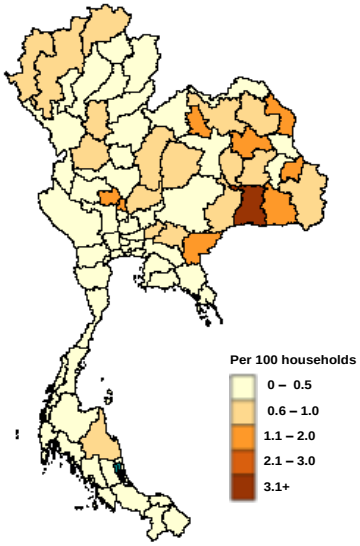
2004



2006



2007

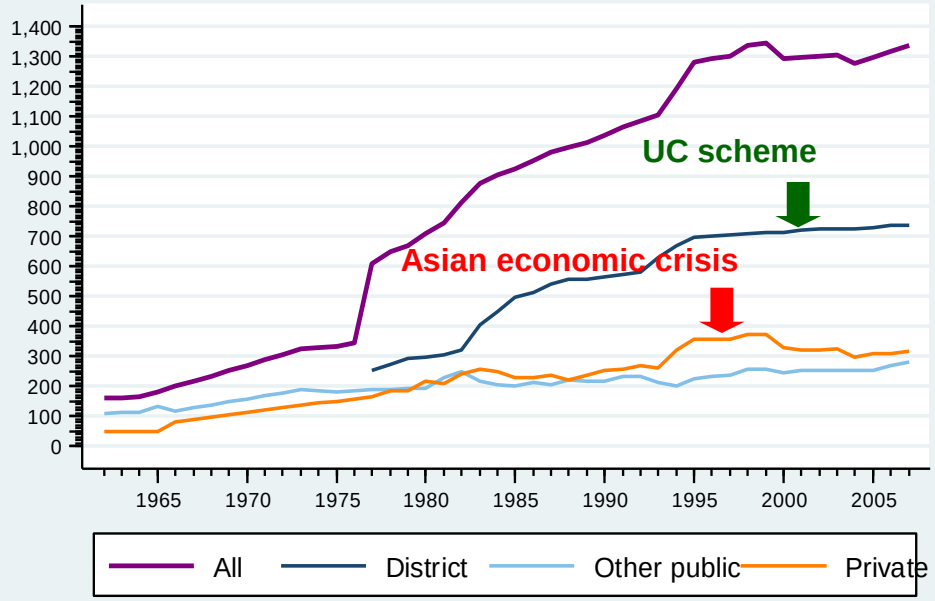


2008

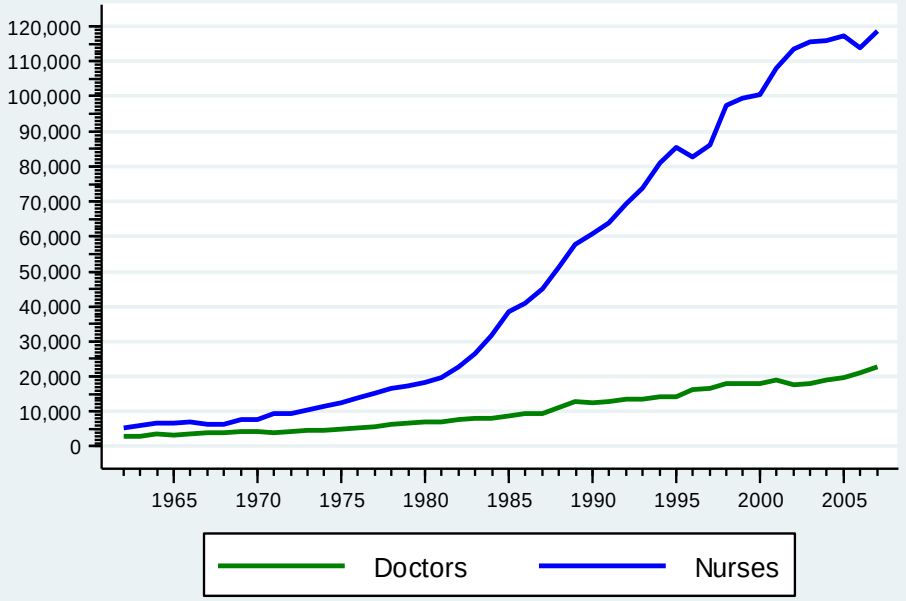
Contributions to UHC:
health delivery systems

Pre-UC expansion of health infrastructures and human resources

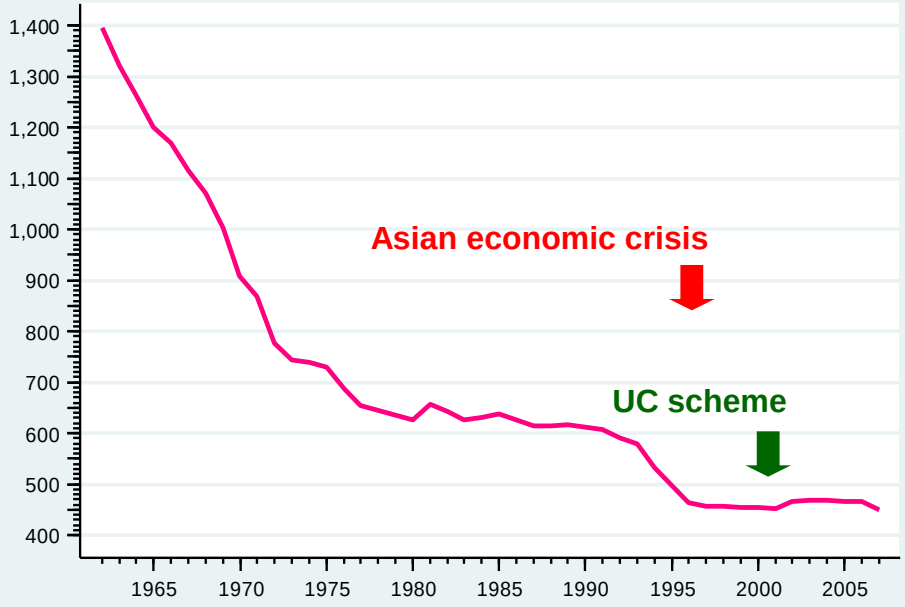
Hospitals



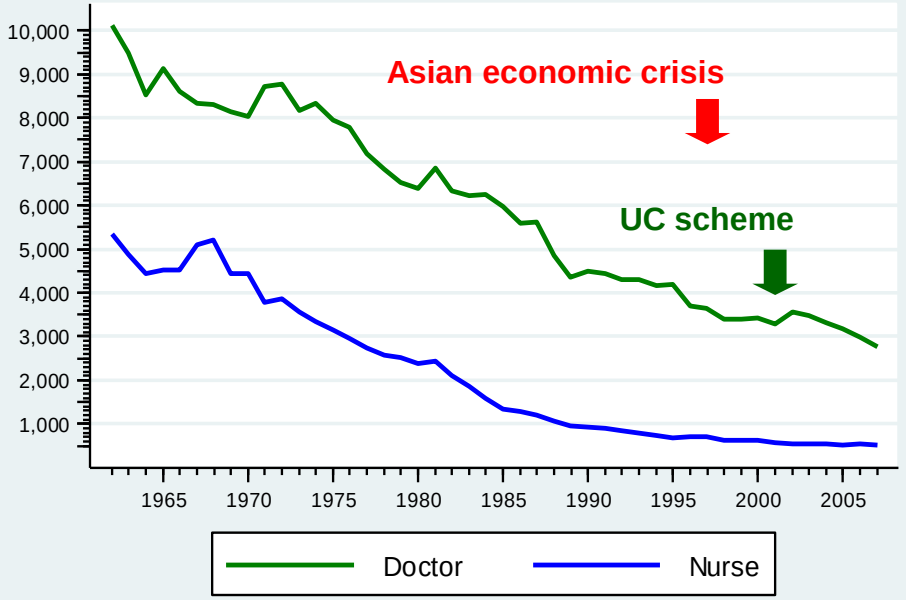
Doctors and nurses



Population per bed



Population per doctor and nurse



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
3. Windows of opportunities - during the election
   - Health is one of the major political campaigns
2. System design is most critical
   - UC is funded by general tax → equity in financing
   - Effective strategic purchasing → improved access, equity and efficiency gains;
   - The use of primary health care-Close to Client Services

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

- Patcharanarumol W, Tangcharoensathien V, et. Al. Chapter 7: Why and how Thailand did achieve Good Health at Low Cost? In Balabanova D., McKee M., and Mills A., eds. Good health at low cost' 25 years on. What makes a successful health system? London : LSHTM, 2011.
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- Limwattananon S., et al. Equity in maternal and child health in Thailand. Bulletin of the World Health Organization 2010; 88: 420-427.

Terima kasih
Thank you for your attention