

Thailand UC Scheme: achievement and challenges

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“ Thailand’s universal coverage reform dates from 2001. The program has **substantially increased health care utilization**, especially among the previously uninsured.

And, as of 2009, the program had already **reduced by more than 300,000 the number of Thai people suffering catastrophic health care costs.**

And let me acknowledge that Thailand launched its universal coverage program against concerns over fiscal sustainability initially raised by my own institution, the World Bank Group. Thailand’s health leaders were determined to act boldly to provide access for their whole population.

Today the world learns from Thailand’s example.”



**World Bank Group President
Jim Yong Kim’s Speech at
66th World Health Assembly:
Poverty, Health and the
Human Future**



Outlines

1. Background and health systems performance
2. Outcomes of UC Scheme
3. Contributing factors: strategic purchasing
 - Closed end provider payment methods
 - Cost effective new interventions into benefit package
 - Monopsonistic purchasing power

I. Background and health systems performance

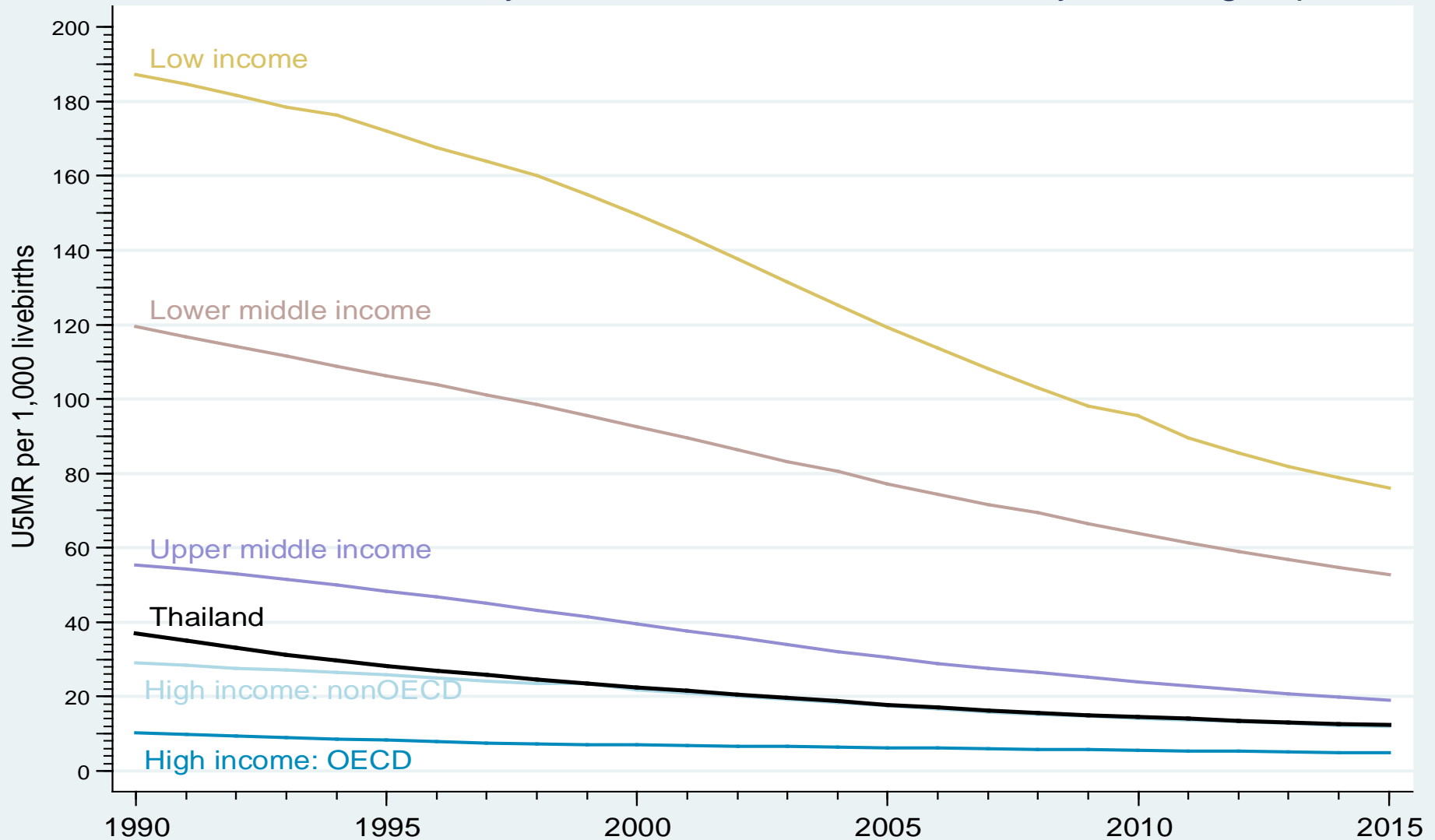
Thailand at a glance, 2014



- Population 67.7 million
- GNI per capita US\$ 5,410 (UMIC)
- Health status
 - Life expectancy 77 (F)/ 71(M)
 - U5MR 12.6/1,000 LB
 - MMR 26/100,000 LB
- Skilled birth attendance 99.6% (2012)
- UHC achieved by 2002 with comprehensive package, almost zero co-payment
- Health Expenditure
 - THE 4.6 % GDP, US\$ 264 per capita
 - Public source
 - 56% THE, 3.3% GDP (2001) prior UHC
 - 80% THE, 4.6% GDP (2014) post UHC
 - GGHE, 17 % of GGE
 - Out of pocket 11.3% of THE

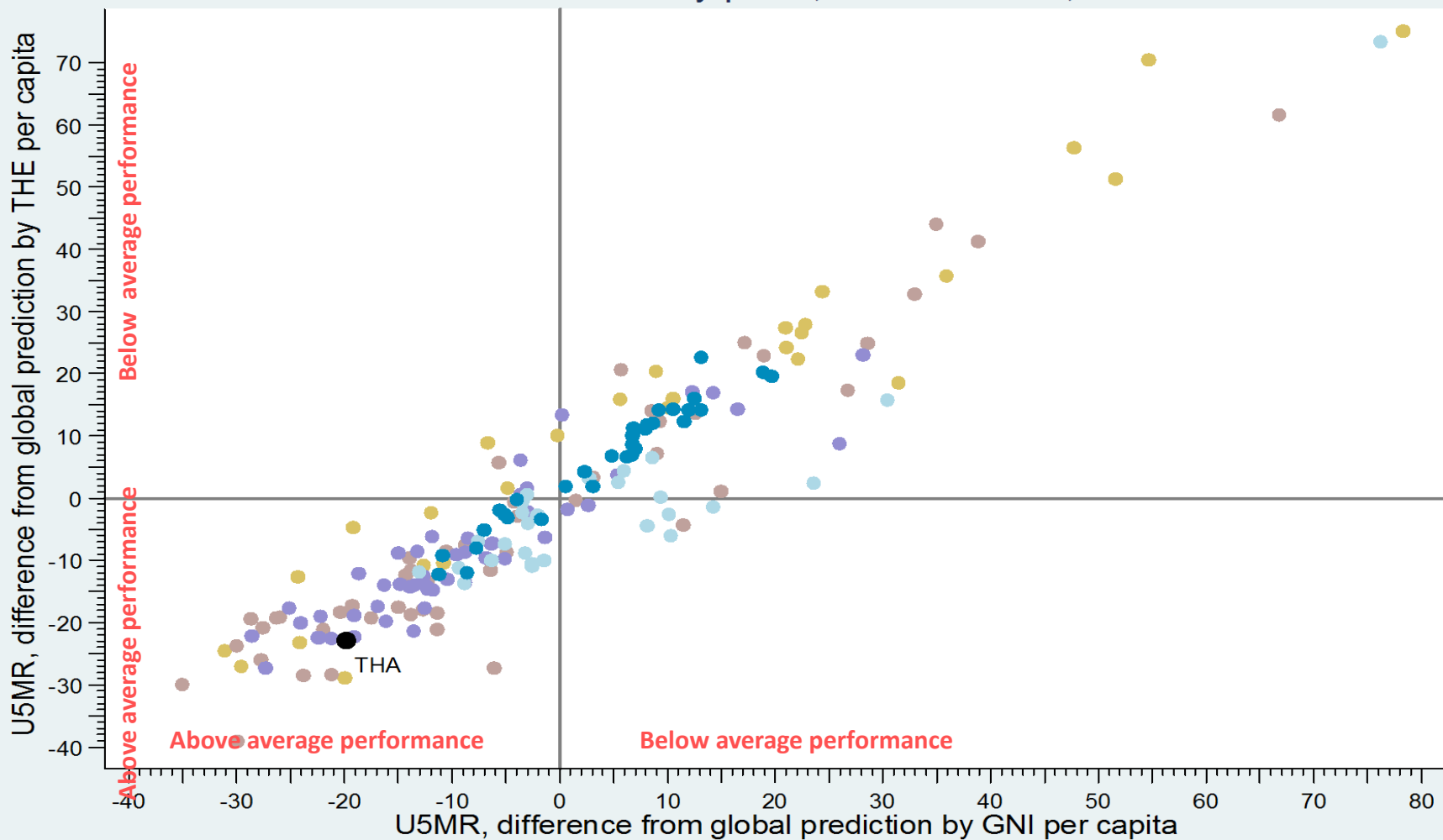
U5MR trend 1990-2015

Under-five mortality, Thailand and other countries by income groups



U5MR in relation to THE and GNI per capita

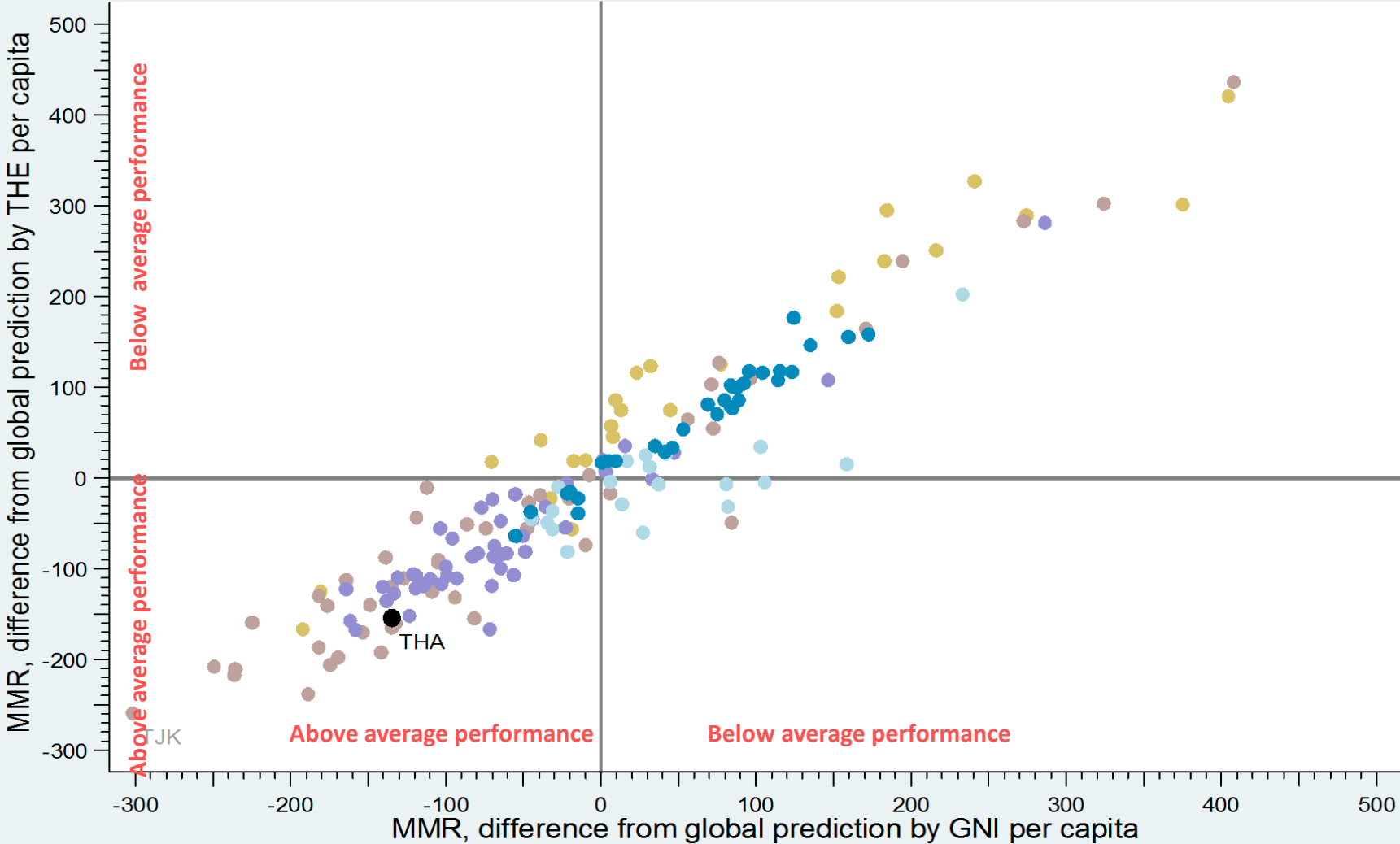
Under-five mortality per 1,000 live-births, 2015



Color: Black, Thailand; Other by country income (Sand, LIC; Rose, LMIC; Lavender, UMIC; Bright blue, OECD; Light blue, other HIC)

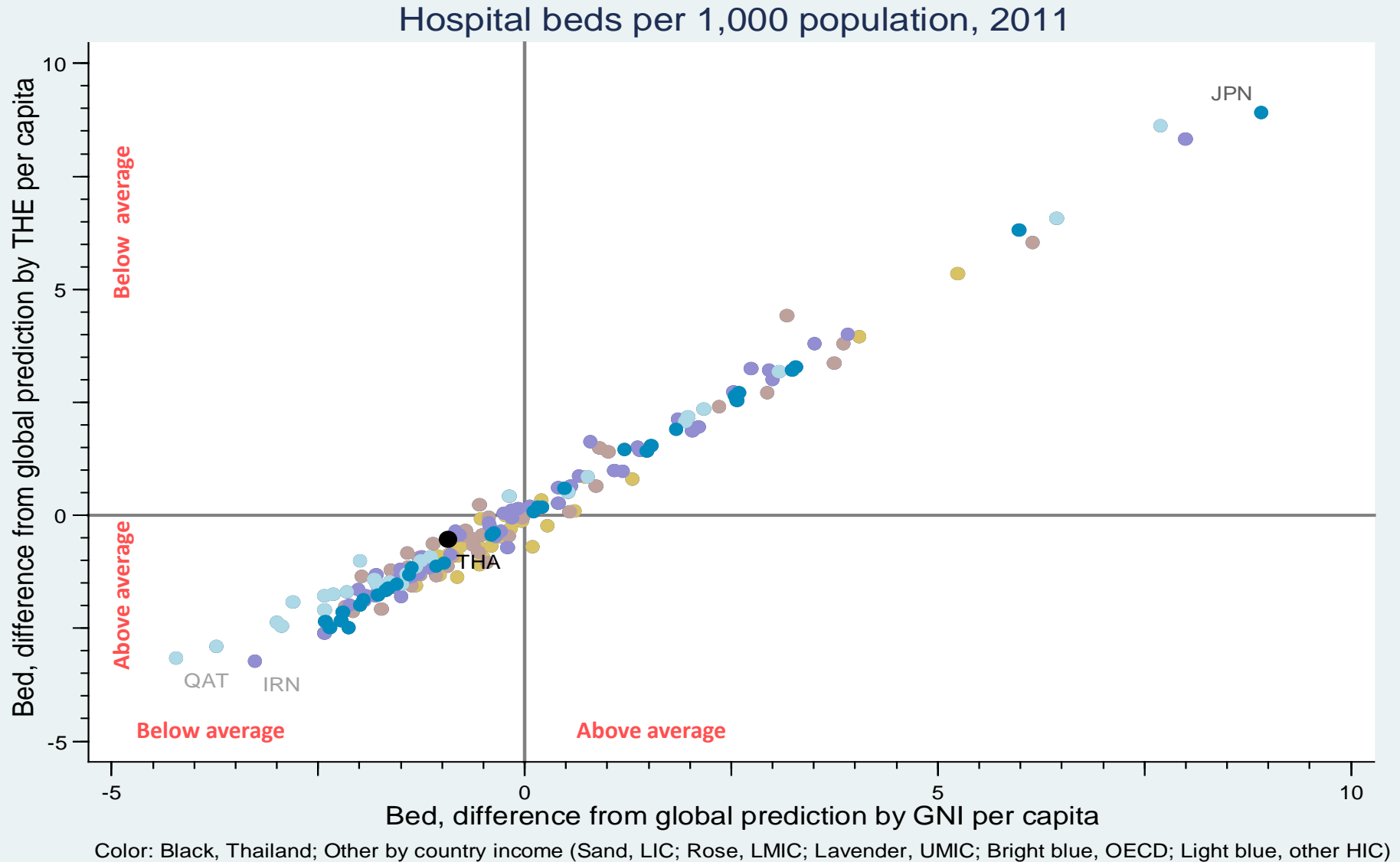
MMR in relation to THE and GNI per capita

Maternal mortality per 100,000 live-births, 2013

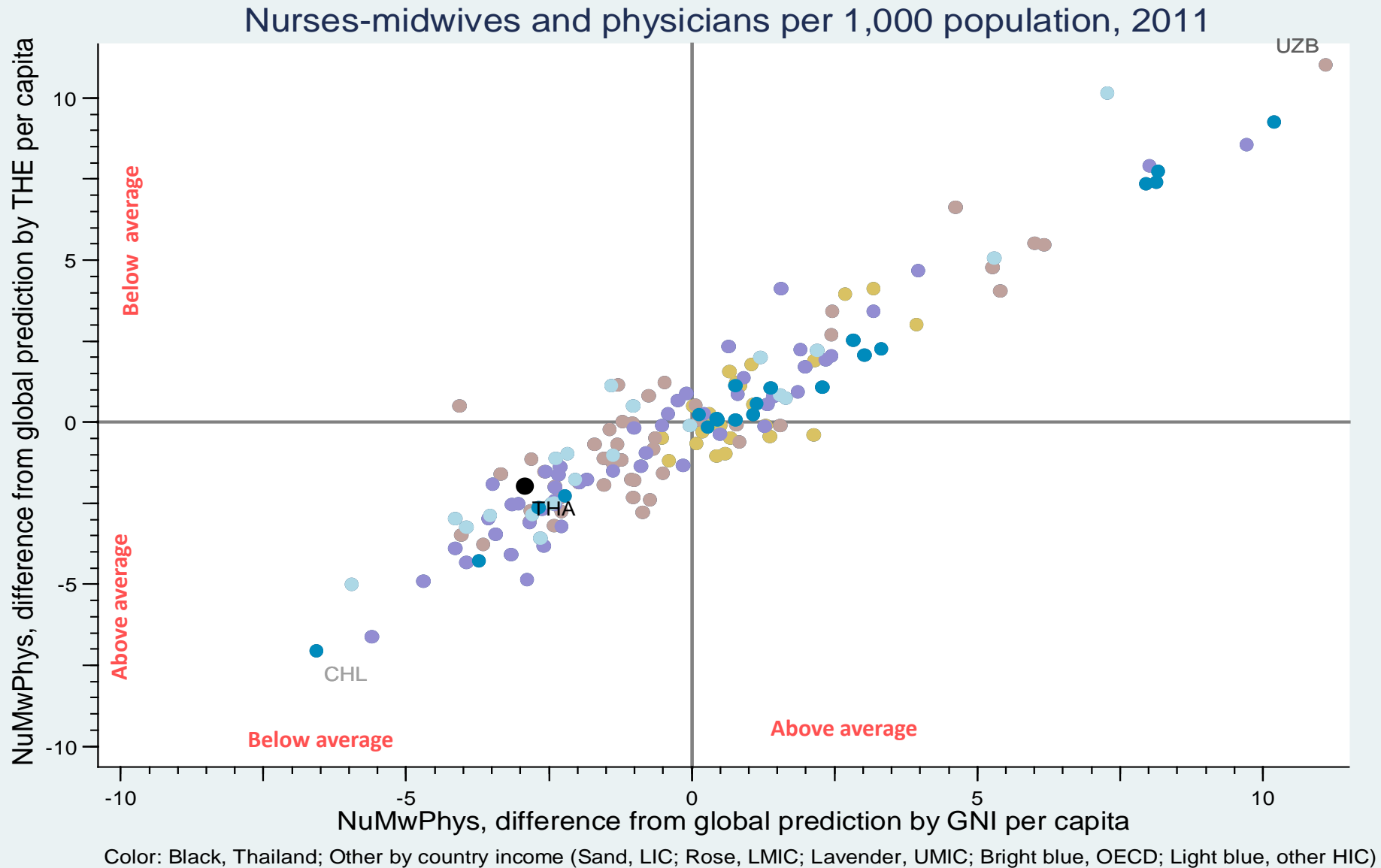


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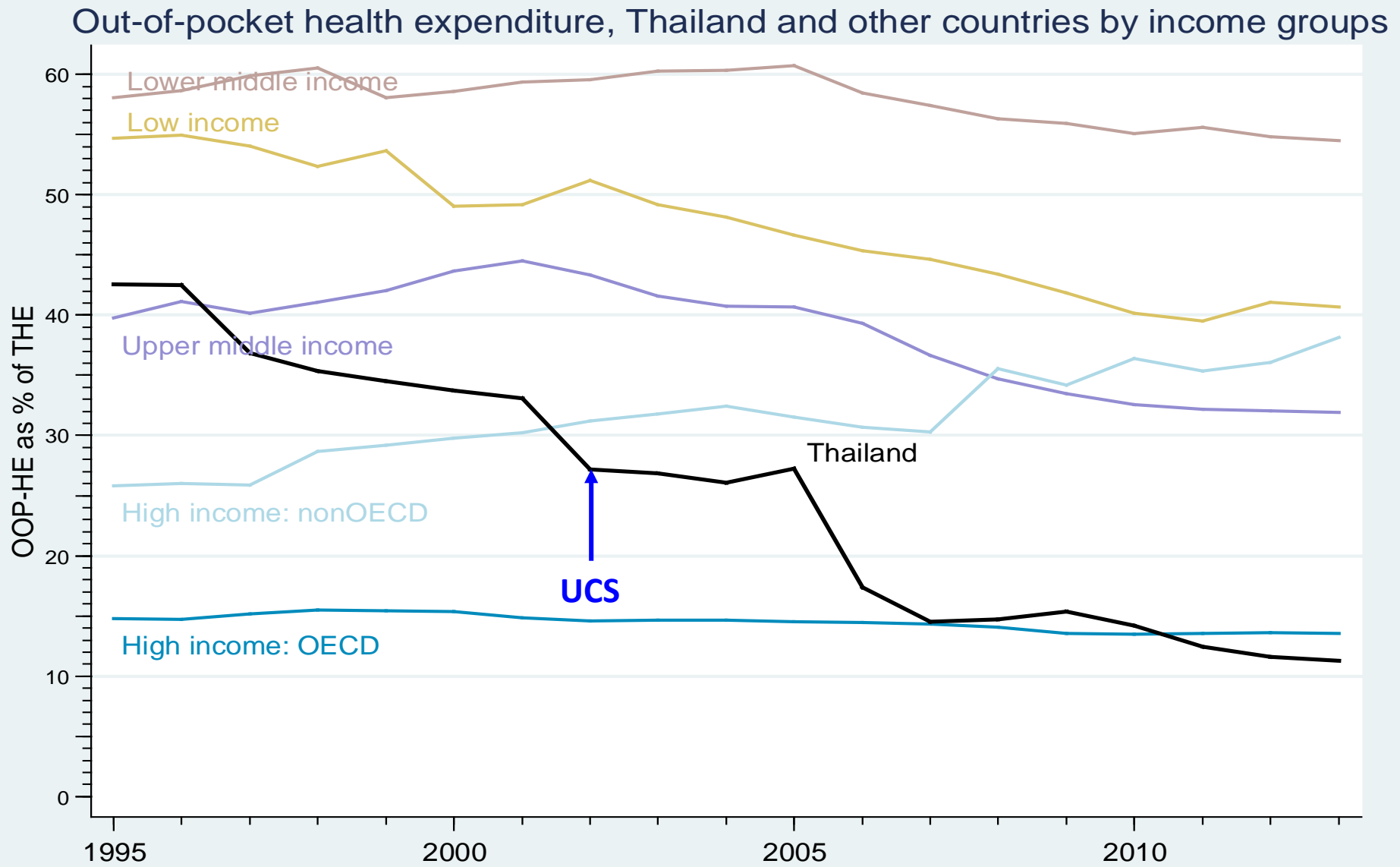
Hospital beds in relation to THE and GNI per capita



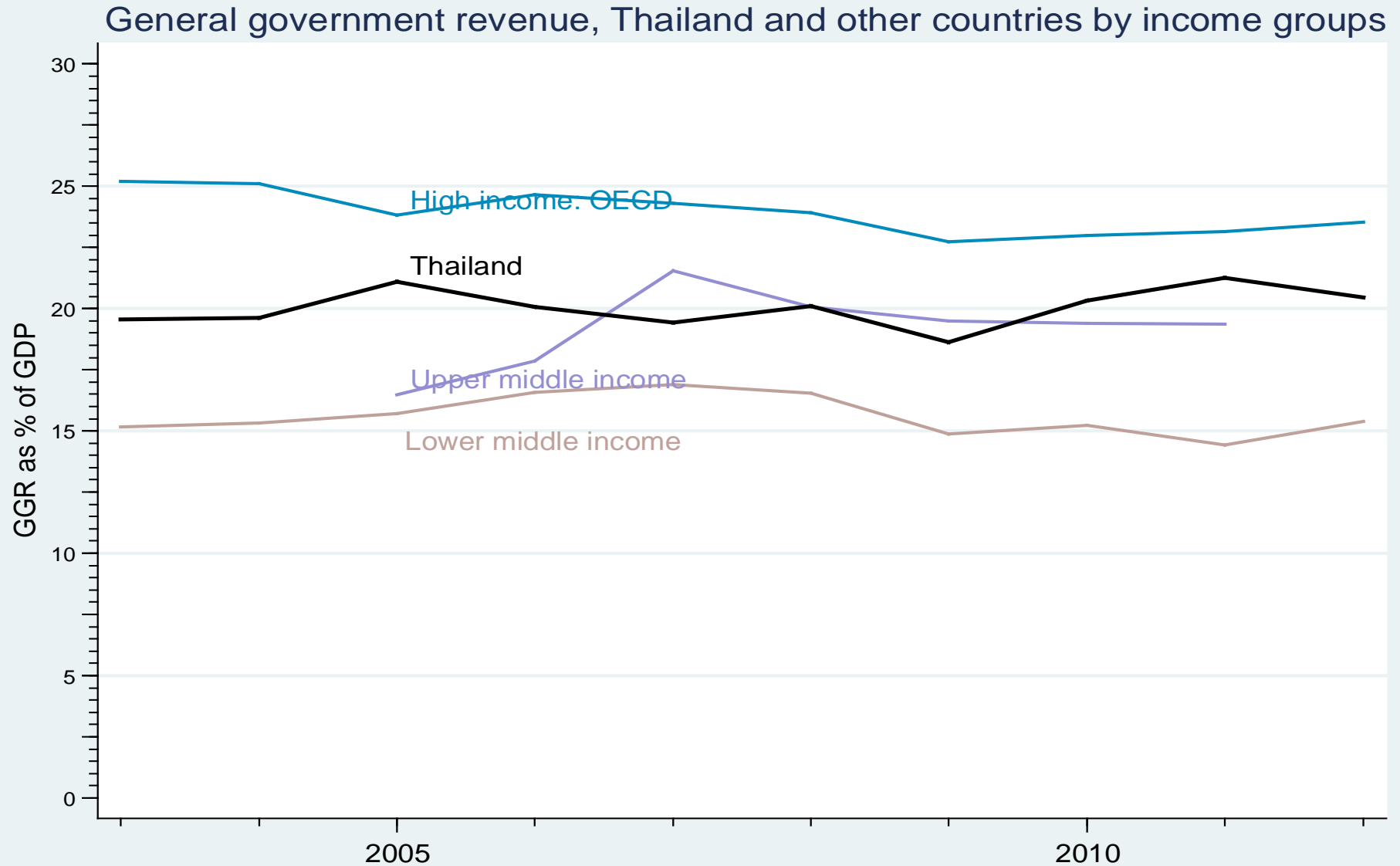
Health workforce in relation to THE and GNI per capita



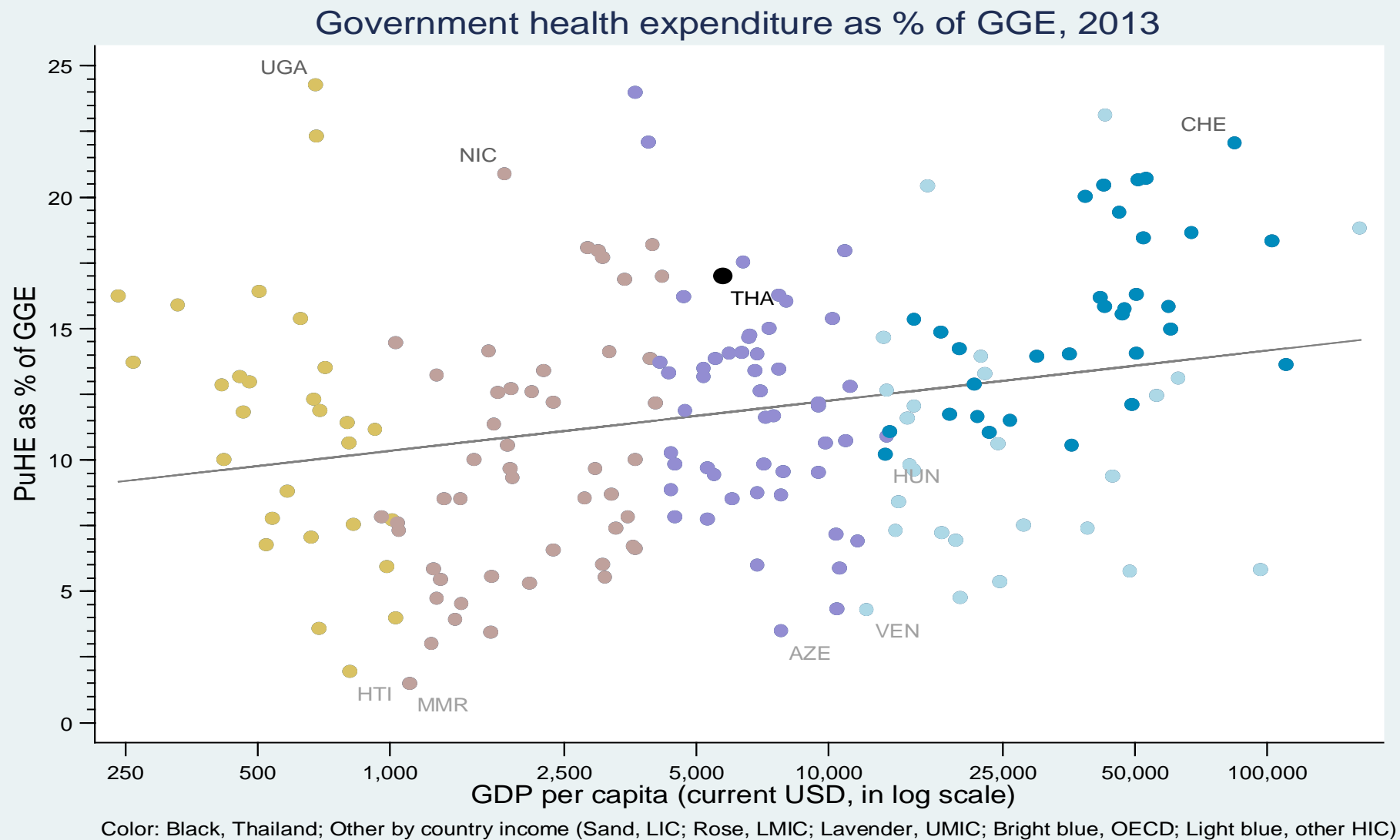
OOP as %THE, trend 1995-2013



Trend of fiscal space, circa 2000 and 2010

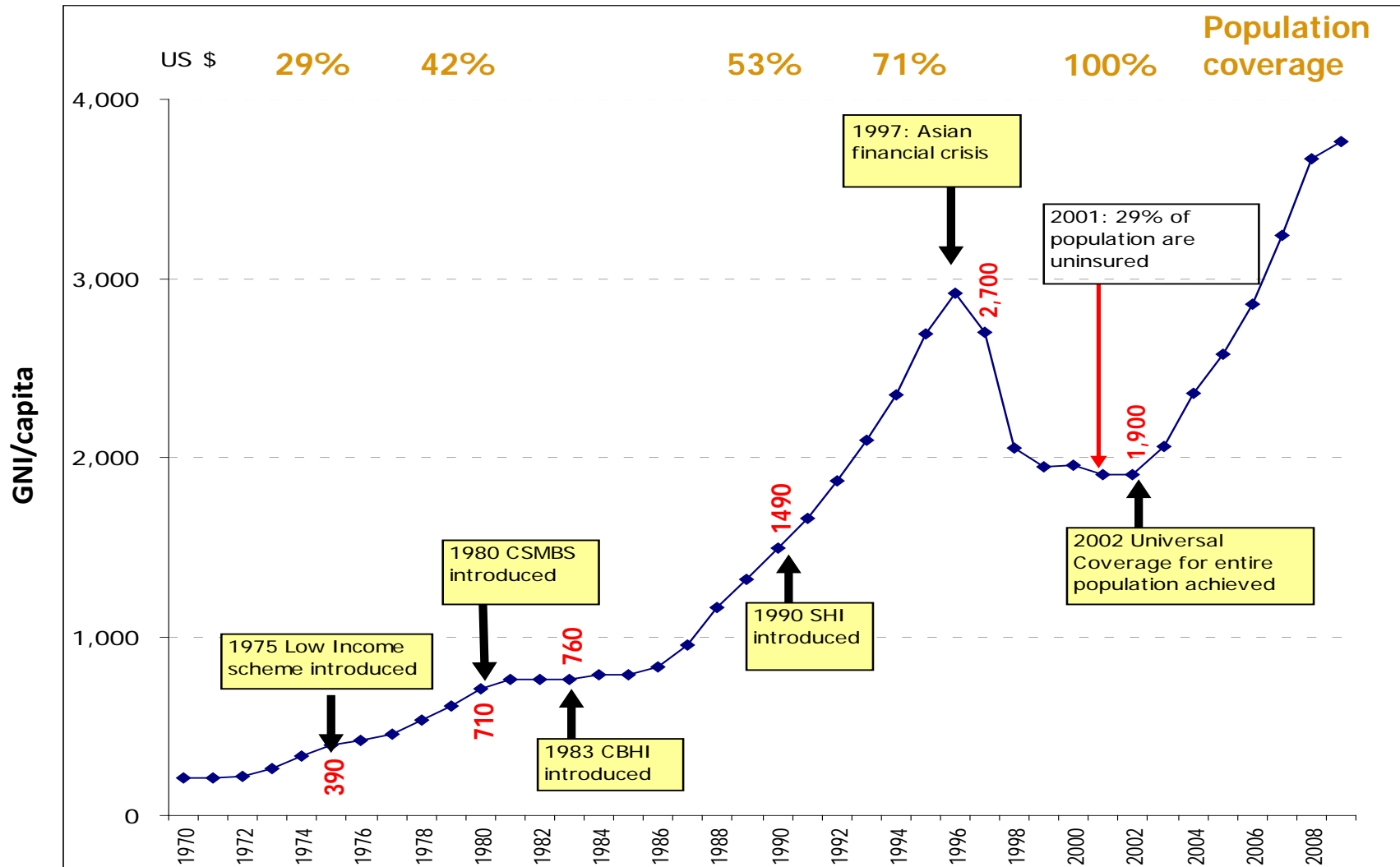


Fiscal space for health 2013



Long march towards UHC 1975-2002

Progressing towards UHC is feasible at low and middle income level



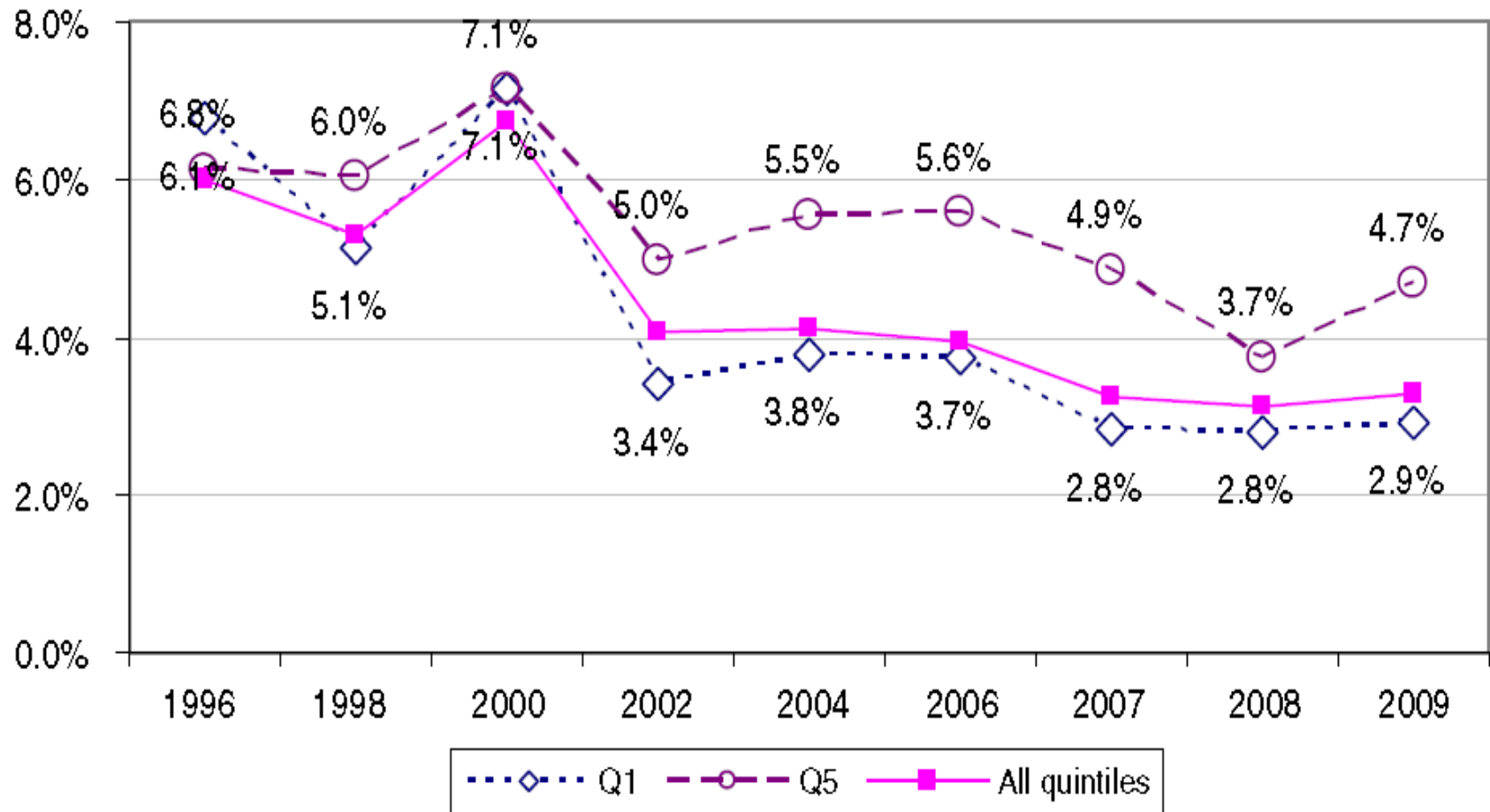
II. UC Scheme achievements



UCS achievements

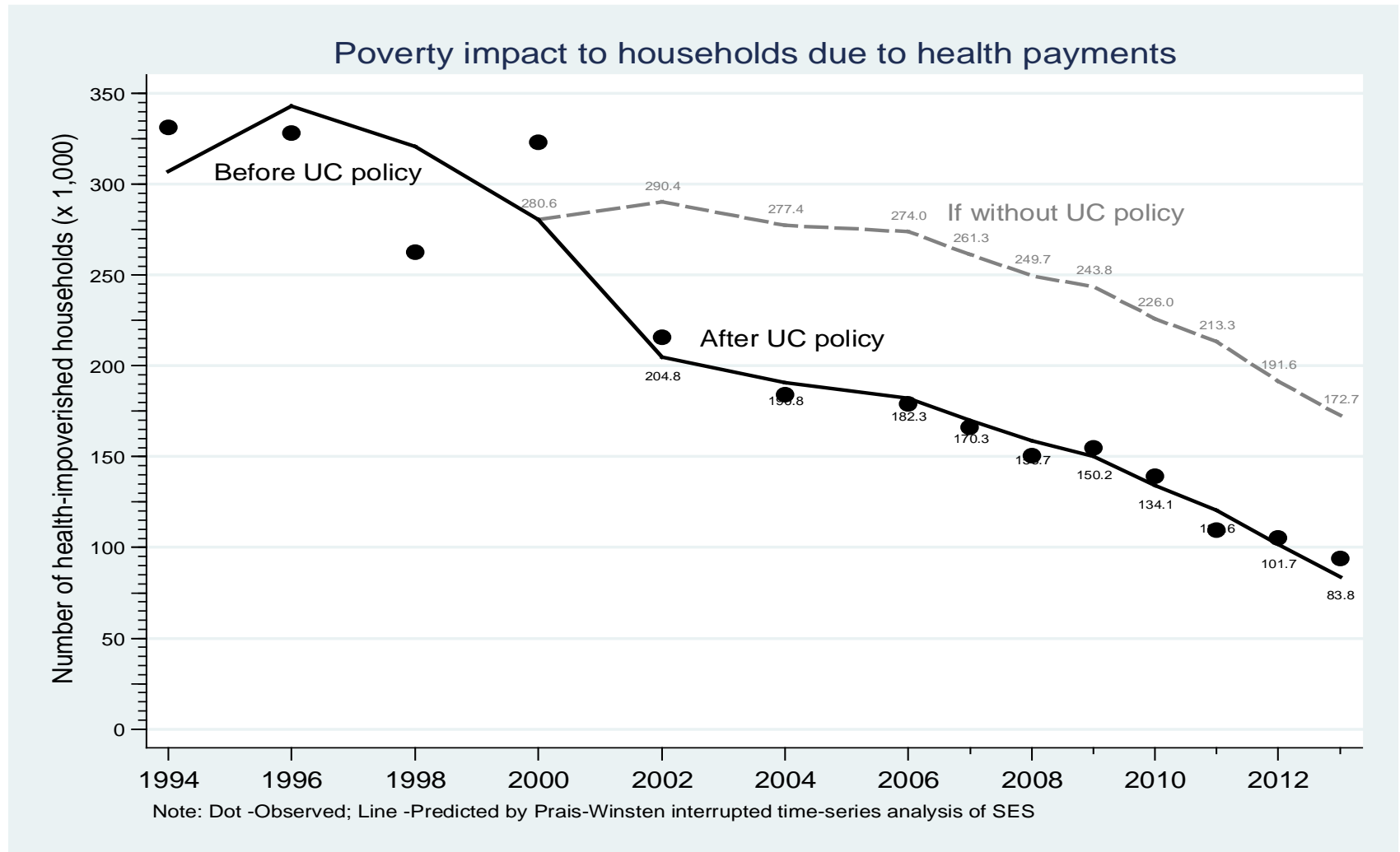
- Some key achievements
 - Improved equity in financing healthcare;
 - [Health Research Policy and Systems](#) 2013;11:25
 - Increased access to care by beneficiaries;
 - [Journal of Public Economics](#) 2015;121:79-94
 - Pro-poor utilization and benefit incidence;
 - [BMC Public Health](#) 2012; 12(suppl 1): S6
 - Preventing non-poor households become poor from medical bills;
 - [Bulletin of the World Health Organization](#) 2007; 85: 600–6
 - Gaining efficiency and cost containment;
 - [Economic & Political Weekly](#) 2012; 47: 53-7
 - UCS flourishes despite eight rival governments, six elections, two coup d'état, thirteen health ministers, between 2001-2015
 - UCS gradually owned by the people, not political party who initiated it.

Incidence of catastrophic health spending >10% of household expenditure, before and after UCS in 2002



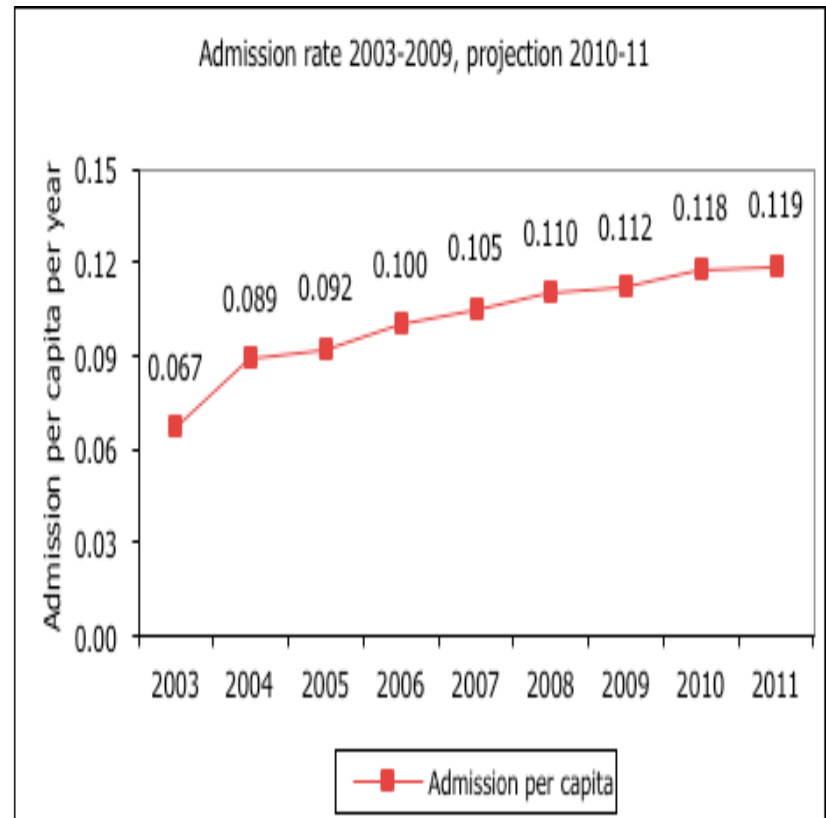
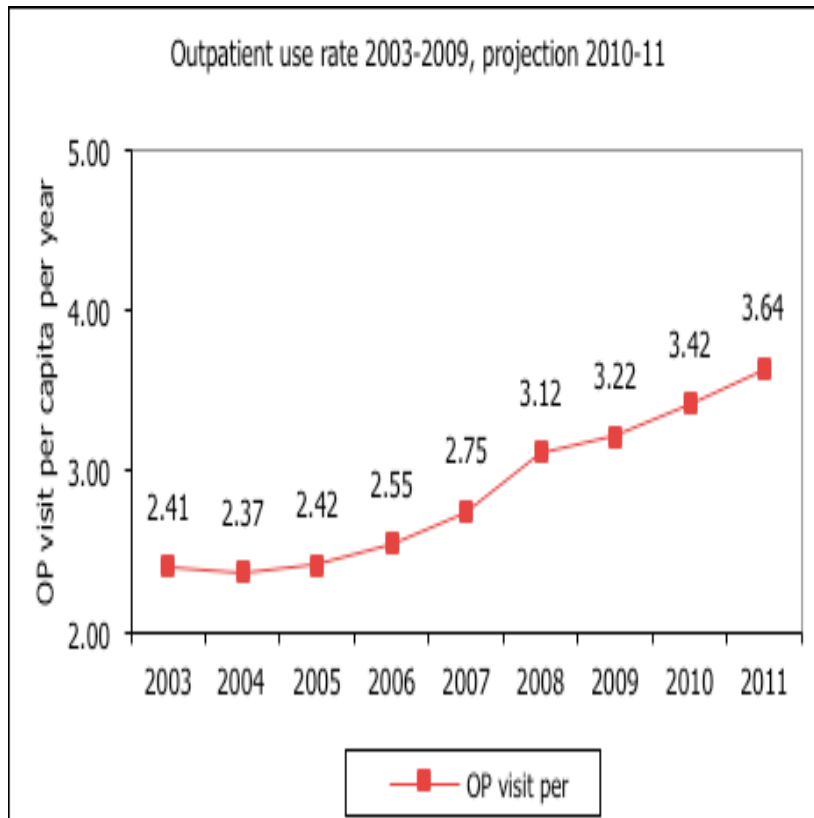
Incidence of medical impoverishment

UCS versus counterfactual 2000 onwards



Source: analysis from Socio-Economic Survey conducted by National Statistical Office, Supon Limwattananon

Increased utilization with low unmet healthcare needs



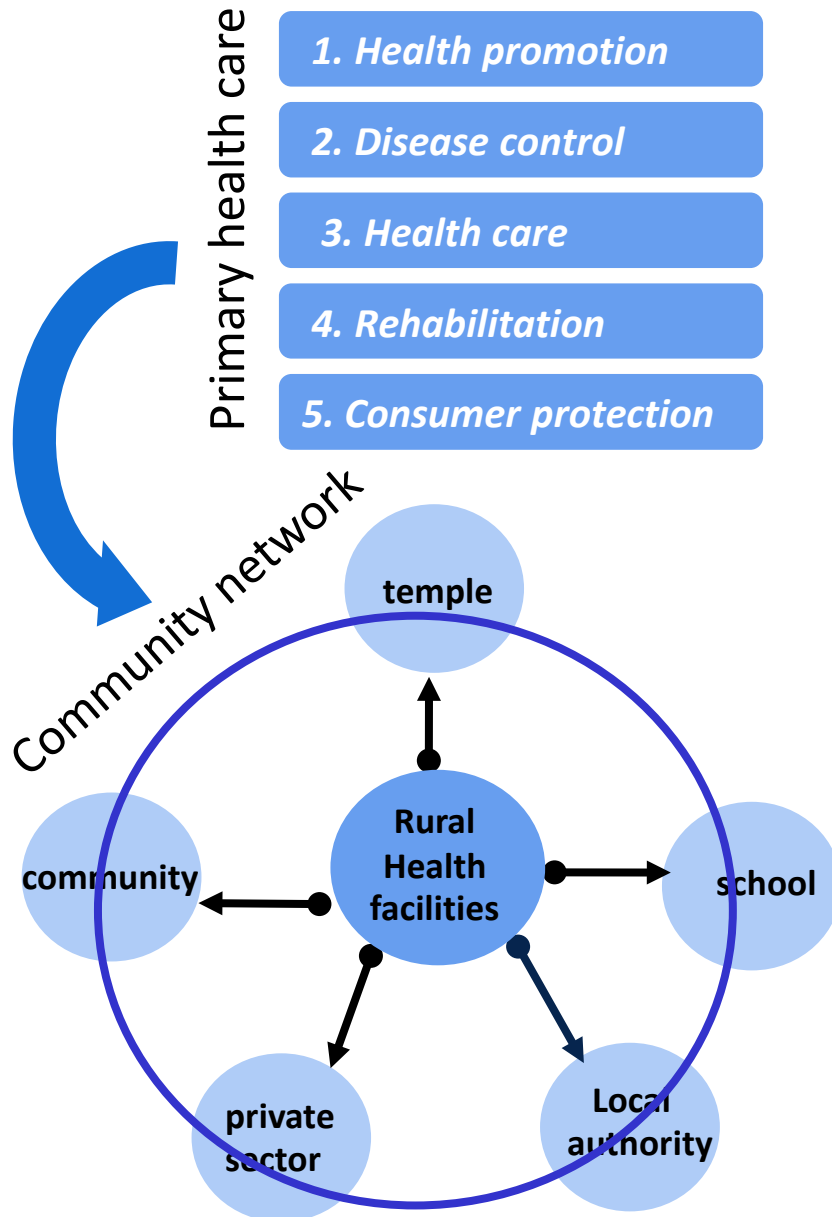
Source: [Health Research Policy and Systems](#) 2013;11:25

Annual prevalence of unmet healthcare need was very low, on par with OECD countries; Outpatient 1.4%, Inpatient 0.4%

Source: [BMC Public Health](#) 2012; 12: 923

District health system: hub for pro-poor outcomes

The Lancet 2013;381:2118-33.

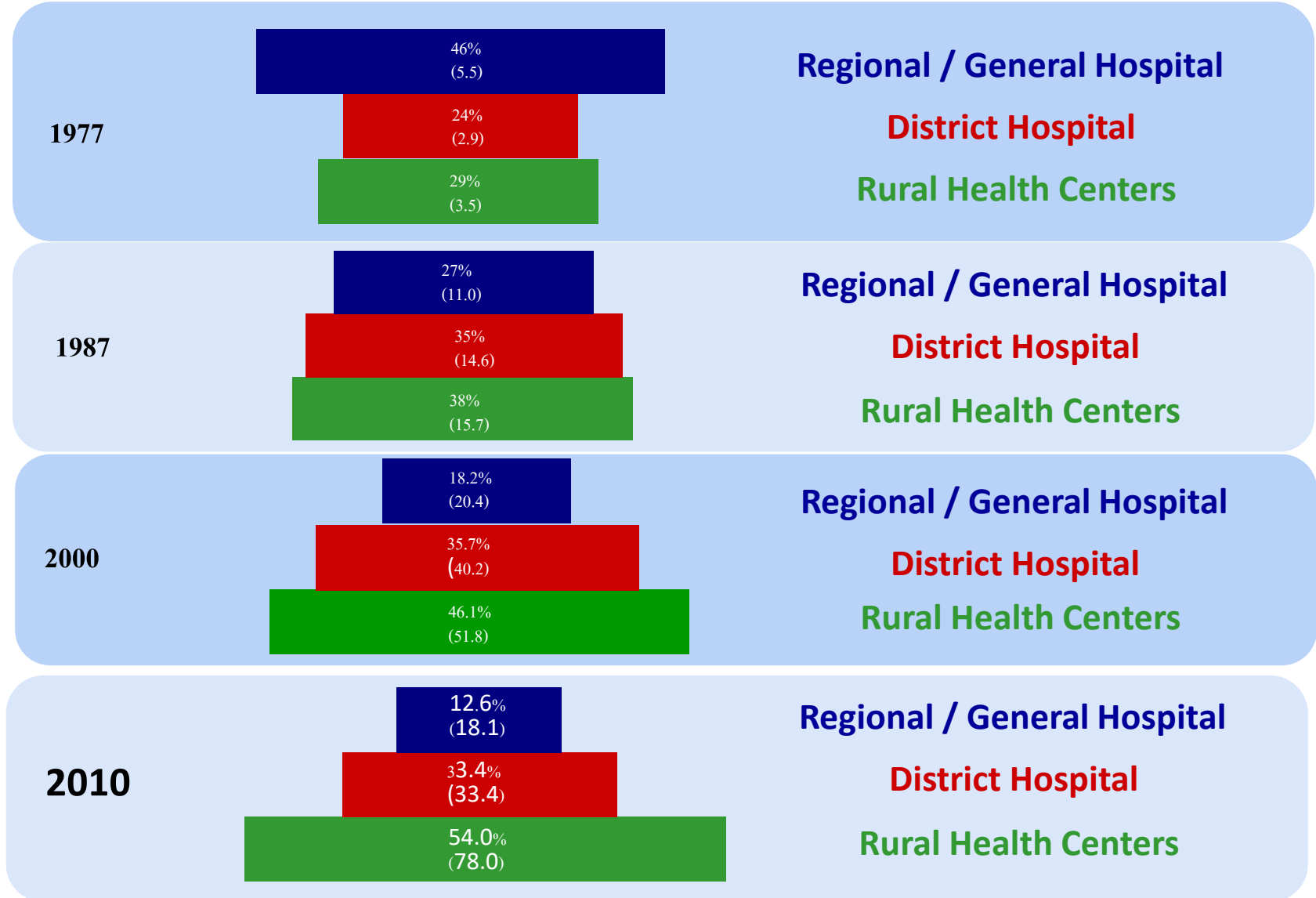


Rural health centers with 3-6 nurses and paramedics cover 2,000-5,000 population



Rural community hospitals with 2-8 doctors cover 30-80,000 population

Huge increase in access to primary care

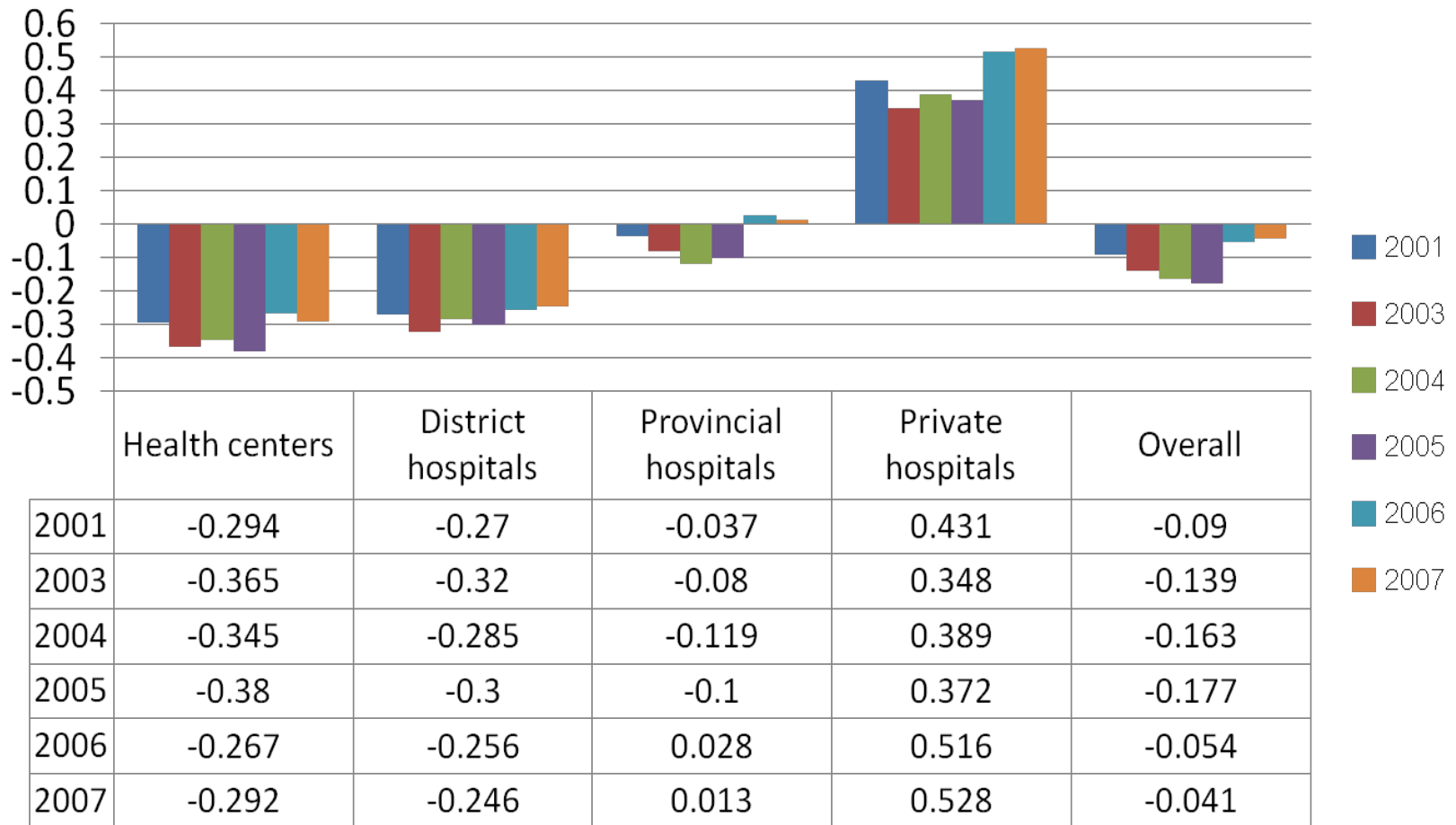


Note: (number of OP visits in million)

Source: Suwit's presentation on 30 Sep 2011 and updated 2010 data

DHS: a hub for pro poor outcomes

Equity in OP utilization 2001-2007

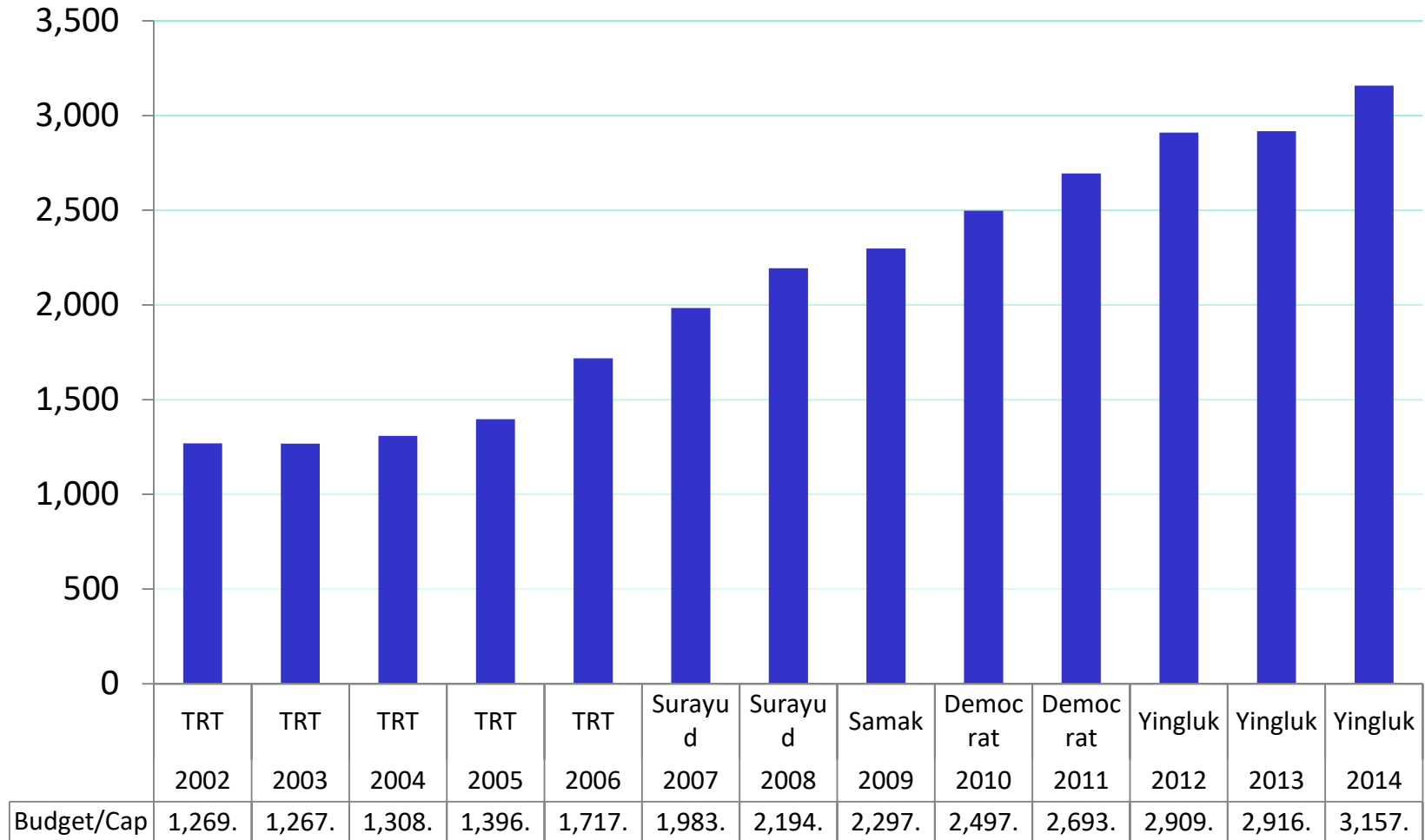


Note: CI range from -1 to + 1. Minus 1 (plus 1) means in favour of the poor (rich), or the poor (rich) disproportionately use more services than the rich (poor).

III. Contributing factors: strategic purchasing

Continued political commitment to UCS:

Budget, Baht per capita, by Regime 2002-2014



UC budget include all budget eg. Contingency fund, ARV, RRT, 2ry prevention DM, HT



Cost containment:

the merits of close end provider payment

- Closed-end provider payment methods
 - Capitation: OP, prevention and health promotion
 - Global budget for IP
 - DRG single base rate for all type of providers
 - Fee schedule for high cost care, medical devices
 - Send strong signal to
 - Use generic medicines, appropriate dispensing of medical technologies, effective prevention of supplier-induced demand
 - Risk of under-service provision, counteracted by
 - Complaint management through 1330 call centre,
 - Quality assurance, accreditation, medical audit
- Ensure access to some specific disease with high burden by single out from regular payment and paid by fee schedule such as cataract, stroke fast tract.



Managing benefit package: gradual deepening financial risk protection

- Negative list approach: comprehensive with few exclusion list
 - No maximum ceiling of financial coverage, free at point of service,
 - High level financial risk protection
- Extend coverage to high cost RRT
 - Initially excluded from UCS due to high cost (Kasemsup et al 2006).
 - RRT not cost-effective, long-term fiscal burden (Tangcharoensathien et al 2005), But catastrophic for UCS members (Prakongsai et al 2007).
 - Despite cost ineffective, RRT was included by 2006
 - To prevent catastrophic spending and ensure equity across 3 Schemes (Tangcharoensathien et al 2013). PD first was adopted (Tantivess 2013).
- Inclusion of new interventions: subject to rigorous HTA
 - ICER <1 GDP per capita per one QALY gain.
 - Long term budget impact assessment,
 - Ethical and equity consideration,
 - supply side capacities

New interventions assessed for coverage decisions

Contribution by IHPP and HITAP

Interventions (Indication)	Cost-effectiveness	Budget impact	UHC coverage
Lamivudine (Chronic hepatitis B)	Cost-saving	Low	Yes
Cyclophosphamide + azathioprine (Severe lupus nephritis)	Cost-saving	Low	Yes
Peg-interferon alpha 2a + ribavirin (Chronic hepatitis C)	Cost-effective (ICER=86,600*)	High	No
Adult diapers (Urinary and fecal incontinence)	Cost-effective (ICER=54,000*)	High	No
Anti IgE (Severe asthma)	Cost-ineffective	High	No
Implant dentures	Cost-effective (ICER= 5,147*)	Low	No

Note: * THB per QALY; Threshold: ICER ≤ 1 GDP per capita/QALY; GDP per capita =130,000 THB

Source: UC Benefit package project

NHSO: prudent monopsonistic purchaser

	Market unit price, \$	Negotiated price, \$	Cost savings, US\$ million
Medical supplies			
Folding lens (2011-2012)	133	93	2.6
Unfolding lens (2011-2012)	133	23	0.8
Balloon stent (2009-2012)	667	333	8.9
Coronary stent (2009-2012)	1,000	167	8.8
Drug coated stent (2009-2012)	2,833	567	76.6
DES Alloy stent (2012)	1,833	833	0.3
Medicines			
ARV (2010-2012)	747	658	2.7
High cost drug (2010-2012)	4,508	3,197	6.1
Influenza vaccine (2010-2012)	7	5	1.3
Erythropoietin (2009-2012)	22	8	22.9
CAPD solution (2010-2012)	7	4	57.3
<i>Total cost saving to UCS</i>			188.3

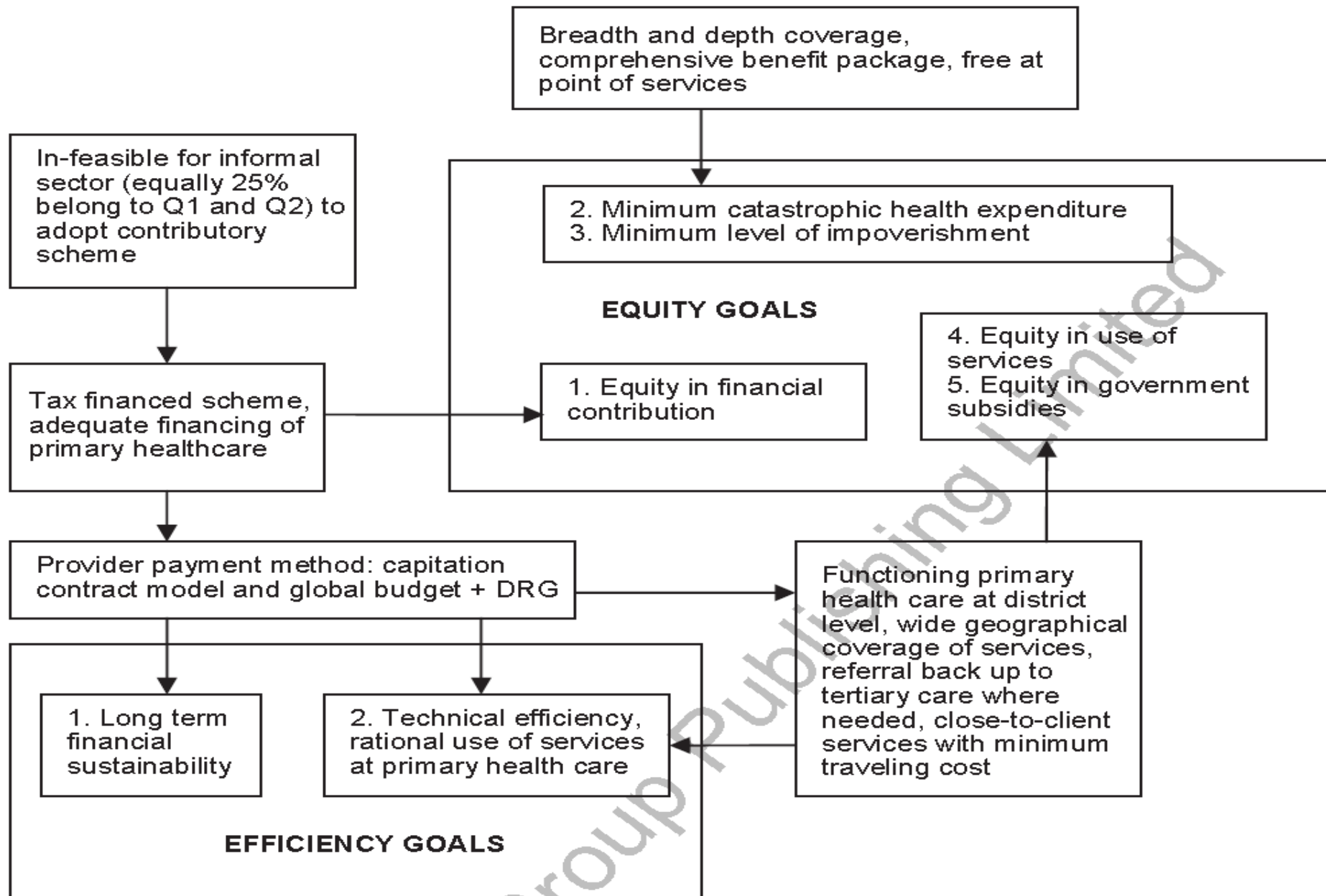
Cost saving = cost difference X unit purchased



Conclusions

- Health delivery systems context
 - Public sector dominant role in services provision, extensive geographical coverage of DHS
 - DHS as main contractor for OP, Prevention, Promotion, gate keeping function,
 - DHS is a hub for pro-poor utilization and benefit incidence
 - Gate keeping contributes to efficiency
- Reliance on general tax financed UCS: risk and benefit
- Close-end provider payment
 - Better contain cost but risk under provision of services, or DRG creep
 - Counteract by audits and adequate capitation allocation
- Comprehensive benefit package free at point of services
 - Deepening financial risk protection, minimize medical impoverishment.
 - New interventions are subject to HTA for coverage decision

How health equity and efficiency were achieved?



“countries do not need to wait to become rich before they provide all these sanitation and health services to people. Thailand, for example, started moving towards its programme for universal health coverage when per capita national income was only at \$400. Thailand is a middle-income country but they started a long time ago.

So, you don't have to wait to be rich to provide these health services to people.”



**UN Secretary General
Ban Ki-Mon**

Challenges

- Inequity among the three public schemes
 - Government subsidy
 - Provider payment methods
- Urbanization
 - Primary care in urban setting has not yet improved
 - Growing of % population in urban setting

	1990	2000	2010	2014
% Urban	29%	31%	44%	49%
% Rural	71%	69%	56%	51%
Total population (mln)	56	63	67	68

- Demand increases
 - Aging society
 - Elderly > 60 yrs = 11.9% in 2010 and will be 25% in 2030
 - Service utilization rate of elderly = 2.3 times of general population
 - Risk factors: tobacco, alcohol, high salt, high sugar intake
 - NCDs
 - Emerging diseases

Thank you for your attention