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Session 1:
What do we expect on healthcare financing?

ILO-WB-MOPH Workshop on Model Development for Sustainable Healthcare Financing

Holiday Inn, Bangkok

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Background

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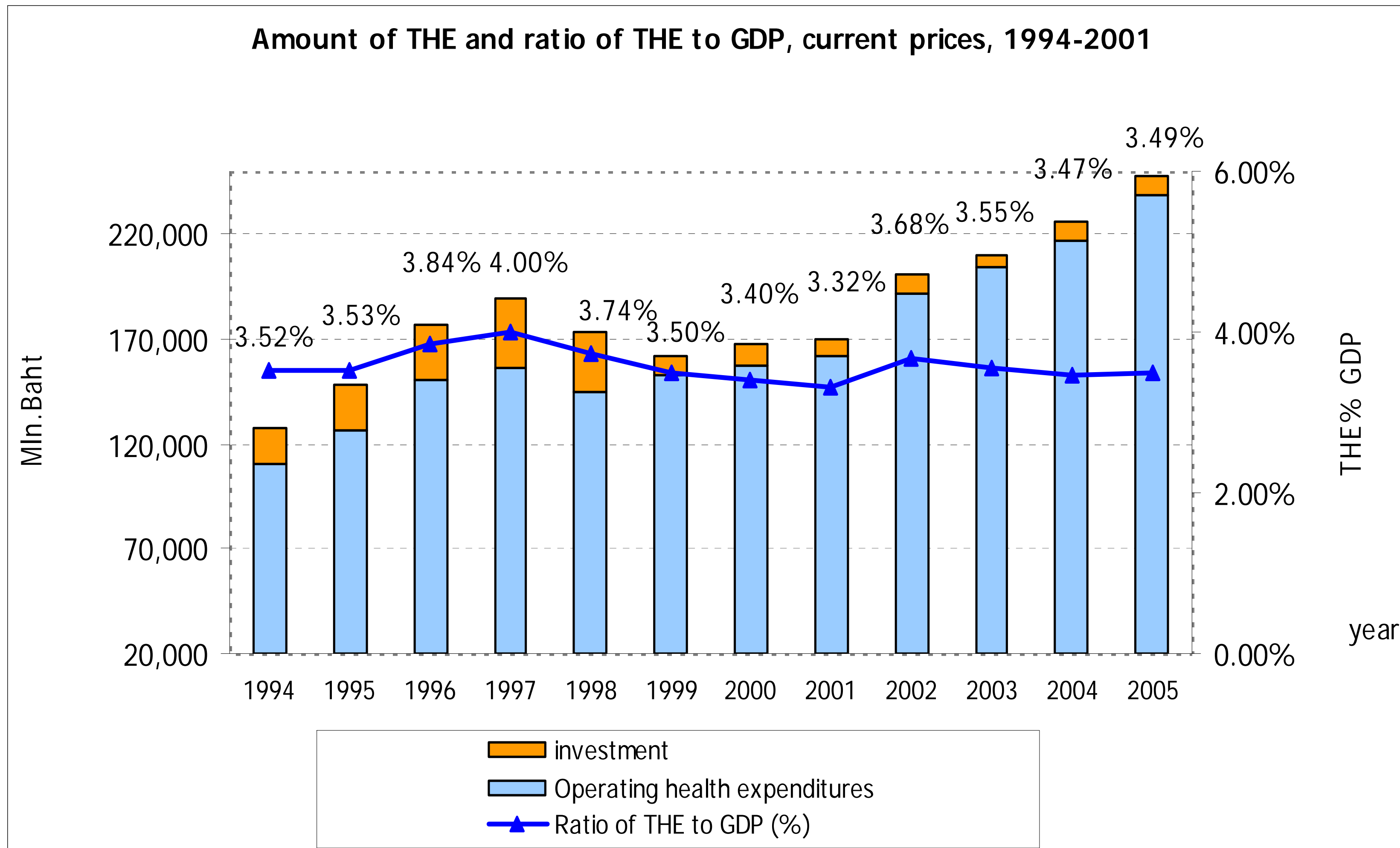
Total Health Expenditure,

NHA 1994 – 2005



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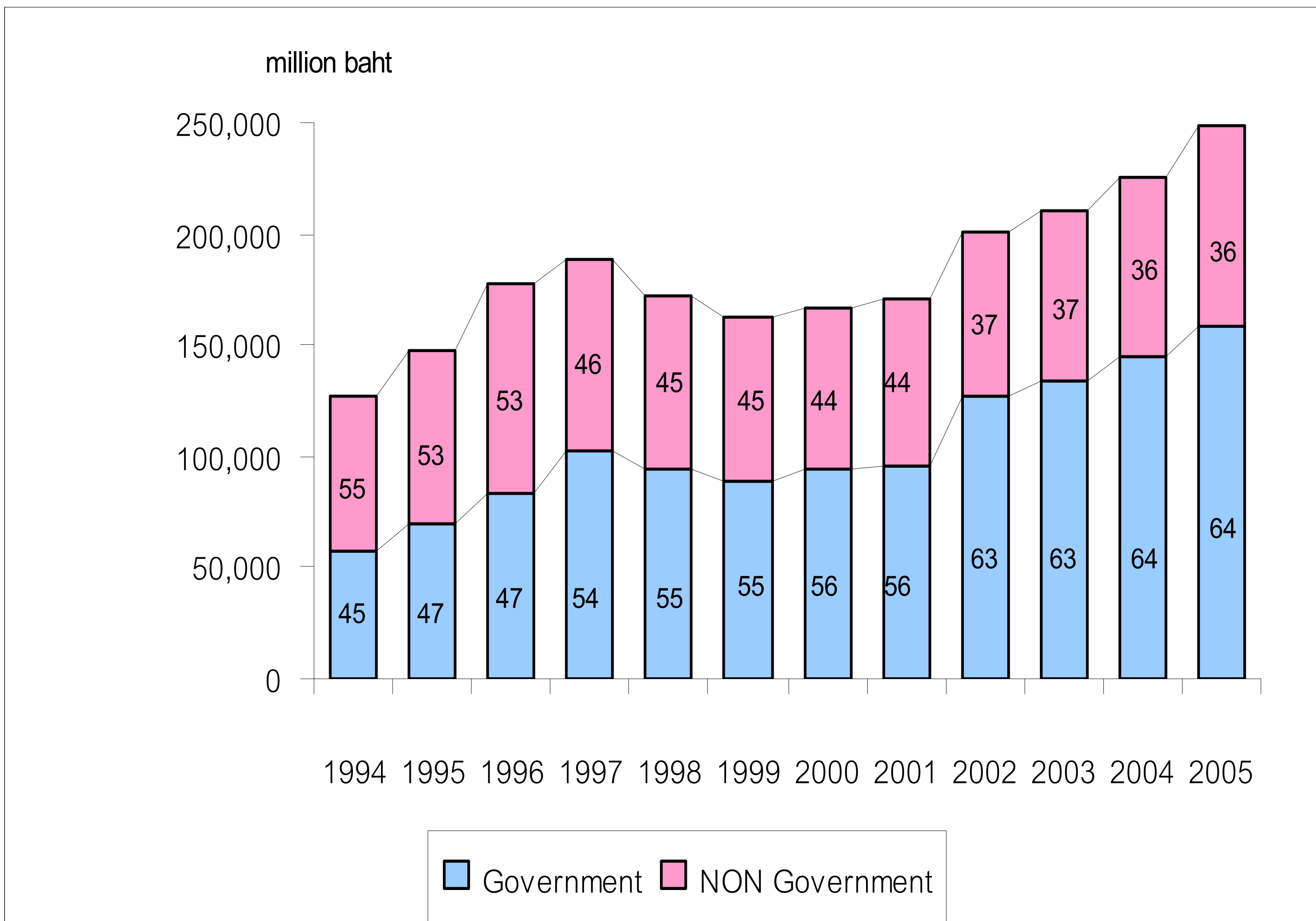
Trend of financing sources

NHA 1994-2005



Objectives

- What do we expect on healthcare financing in Thailand?
- Have we achieved these expectations?
  - If yes, how to sustain them?
  - If no, how to achieve – roadmap?

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What do we expect on healthcare financing? (1)

1. Has high capacity to prevent
   - Catastrophic health expenditure by the households
   - Impoverishment from sickness and medical bills
2. Can achieve vertical equity
   - Payment according to ability to pay: namely the poor pay less for their medical care and the rich pay more
   - Use of healthcare according to health needs
3. Large pool of risk sharing across population
   - Pre-payment schemes replacing out of pocket at point of services

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What do we expect on healthcare financing? (2)

4. Achieve health systems efficiency
   - Technical efficiency: purchase services from the lower cost given equal quality of care.
   - Allocative efficiency: purchase the interventions that achieve maximum health gain of the population
5. Has capacity to contain cost in long term
   - Provider payment methods send appropriate signals to healthcare providers and consumers towards efficiency
   - Annual growth of healthcare spending is within an acceptable limit

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What do we further expect?

1. Institutional and human capacity to
   - Generate and maintain evidence for decision
     - National representative household information–illness rates, access and utilization, catastrophic, impoverishment, and its SE differentials for equity monitoring
     - Administrative data
       - Utilization information,
       - Clinical outcome data
       - Cost of production
   - To achieve these goals, there requires
     - Better quality, timely, accessible database for M&E of financing situation
     - Improvement of database for M&E
     - Institutional capacity to maintain series of database

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Have we achieved? (1)

- Yes, achieved some expectations, but not all
- What has Thailand achieved?

1. Minimum incidence of
    - Catastrophic health expenditure
        - Comprehensive benefit package
        - Literally zero copayment in all 3 public insurance schemes
        - Though some beneficiaries opt out and use services outside the entitlements and face full payment
        - One service not covered: renal replacement therapy for UC members
    - Impoverishment due to medical bills
        - Especially the virtue of universal coverage scheme since 2002

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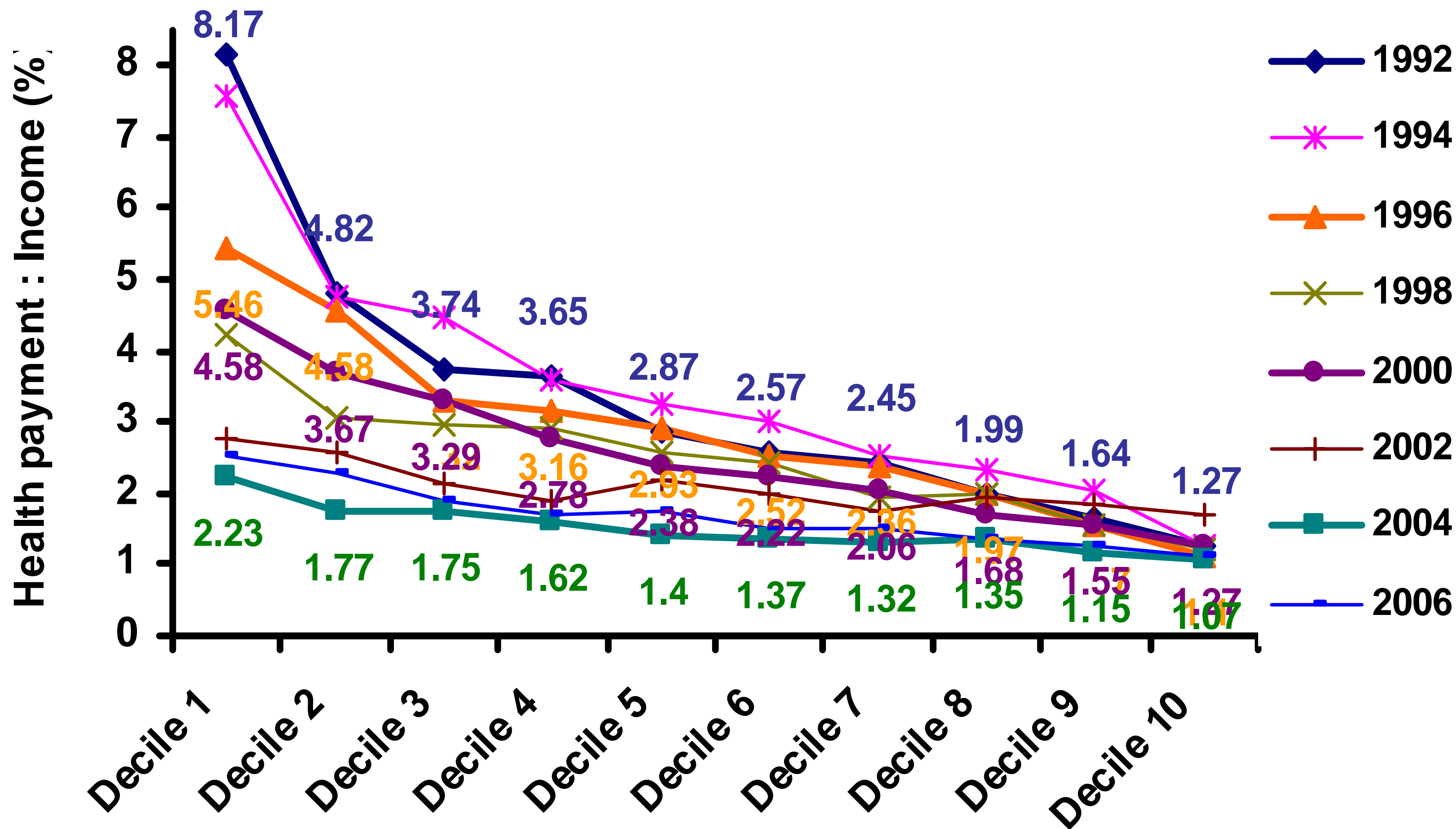
Household health expenditure as % of household income by income deciles

prior to UC (1992-2000) and after UC 2002-2006



Source: NSO SES (various years)

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Pre-post UC incidence of catastrophic expenditure

Households with health payment > 10% of total consumption expenditures

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

Source: NSO's SES (various years)

Have we achieved? (2)

2. Vertical equity

- Equity in financial contribution
  - Direct tax is most progressive than indirect, than social health insurance contribution, than private insurance premium and OOP
  - General tax finance is therefore progressive (the rich pay more), and the dominant role in financing healthcare in Thailand
  - SHI contribution, the maximum wage for calculation of contribution was 15,000 Baht/month since 1991, it has not been indexed ever since

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Various Financing Sources for Healthcare

Progressivity - Thailand

Source	2002		2004	2006
	CI*	Fraction**	CI*	CI*
Direct tax	0.8221	18.68%	0.8162	0.7687
Indirect tax	0.5594	31.55%	0.5958	0.5512
Social insurance	0.4975	5.82%	0.4561	0.4492
Private insurance	0.3785	6.68%	0.4221	0.4188
Direct payment	0.4883	37.28%	0.4626	0.4705
Total	**0.5663**	100%		

*** CI – Concentration Index based on Socio-Economic Survey (SES: 2002, 2004, 2006)**

**** Fraction of health expenditures per source derived from Thailand National Health Account (NHA)**

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Have we achieved? (3)

2. Vertical equity (continue)
   - Equity in healthcare utilization
     - Concentration index indicates the poor use more service in public sector
     - Better access to services in vicinity areas: the pivotal role of district health system (DHS) as a major hub of equity achievement
     - DHS is the main contracted provider for UC Scheme
   - Equity in public health spending
     - Benefit incidence: public subsidy favours the poor especially at DHS
     - Available of alternative private services for the better off
   - Equity in health of the population
     - Other social determinants of health plays significant role

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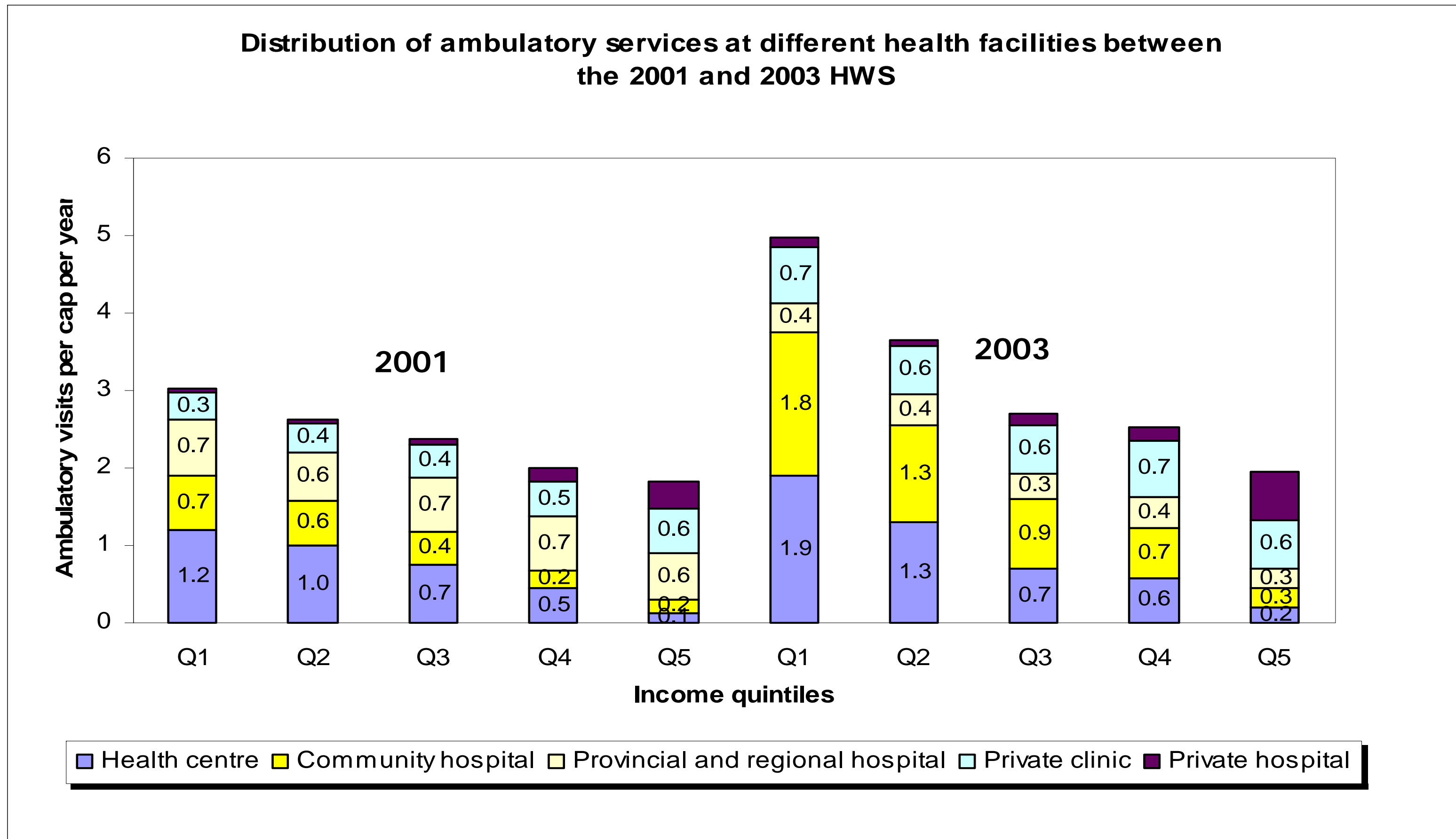
The distribution of ambulatory service use among different income quintiles in 2001 and 2003, by types of health facilities



Concentration indices of ambulatory service use among different types of health facilities in 2001 & 2003

Type of health facilities	2001	2003
Health centers	- 0.2944	- 0.3650
Community hospitals	- 0.2698	- 0.3200
Provincial and regional hospitals	- 0.0366	- 0.0802
Private hospitals	0.4313	0.3484

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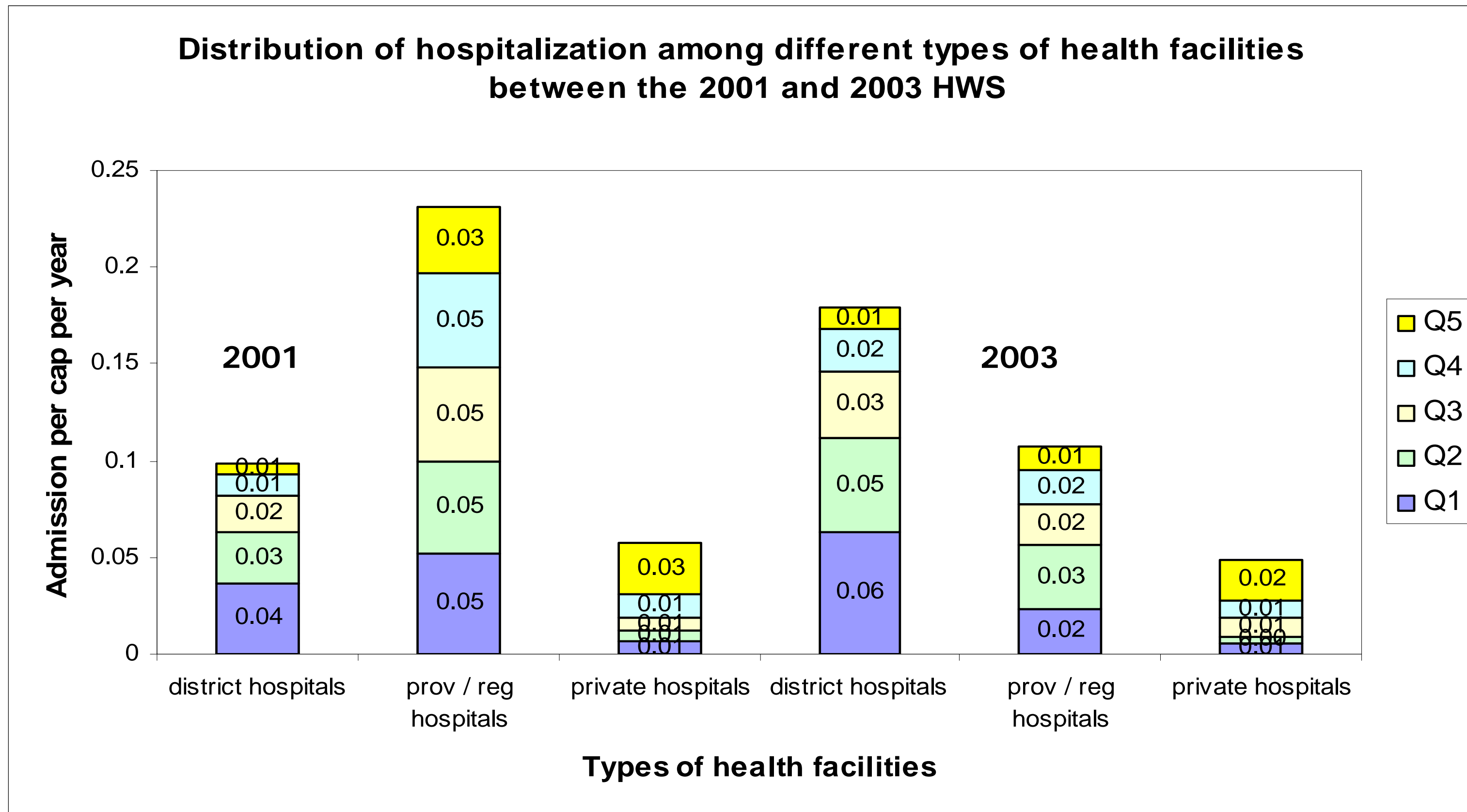
The distribution of hospitalization among different socio-economic groups in 2001 and 2003, by types of health facilities



Concentration indices of hospitalization among different types of health facilities in 2001 & 2003

Types of health facilities	2001	2003
Community hospitals	- 0.3157	- 0.2934
Provincial and regional hospitals	- 0.0691	- 0.1375
Private hospitals	0.3199	0.3094
Overall hospitalization	- 0.0794	- 0.1208

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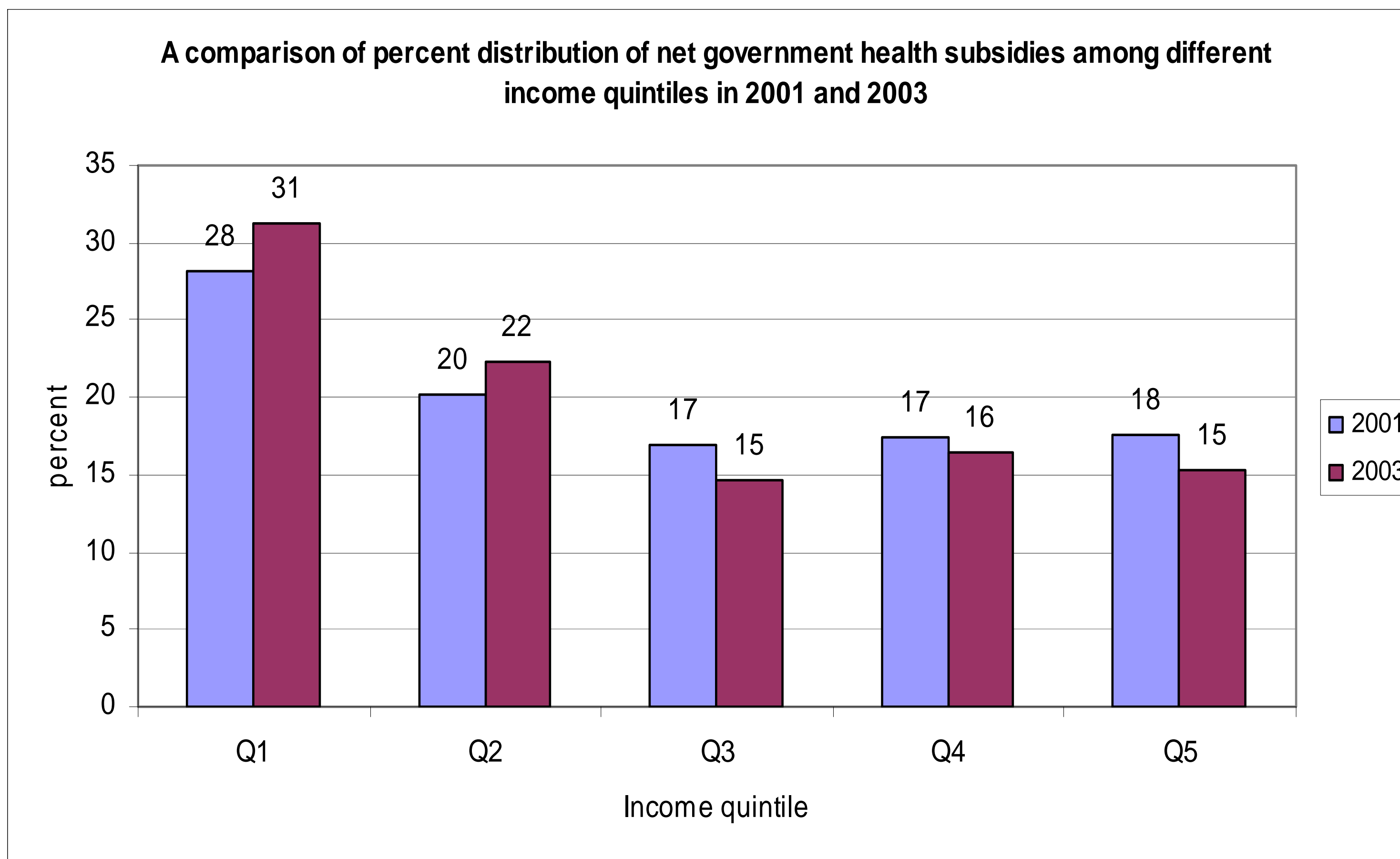
Percent distribution of net government health subsidies among different income quintiles in 2001 and 2003



Note:

-Overall net government health subsidies in 2001 were approximately 58,733 million Baht, and in 2003 were 80,678 million Baht (in 2001-value)

- The concentration index of government health subsidies in 2001 was -0.044 and in 2003 was -0.123

Have we achieved? (4)

3. Large pool of risk sharing

- Three public insurance schemes covers the whole population
  - Social Health Insurance: covers 9 million private formal sector employees; mandatory, tripartite contributory scheme
  - CSMBS: covers 6.5 million govt. employees, pensioners, and dependants; general tax financed, fringe benefit scheme
  - UC scheme : covers rest of pop. (48 million); general tax financed scheme

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Have we achieved? (5)

4. Health systems efficiency

- Technical efficiency: purchase services from the lower cost given equal quality of care
  - DHS provides decent quality of services with lower cost
  - DHS is "close to client services" better accessed – and lower access cost paid by the beneficiaries
  - Referral backup well in place
- Allocative efficiency:
  - Active purchase of prevention and health promotion services for the whole population – but still on clinical personal preventive services.
  - However, community based public health interventions were financed by Thai Health Foundation
  - Unsure if we achieve this.
  - Require more evidence on cost effectiveness of various interventions and re-design of benefit package
  - Awaiting the contributions from the Health Technology Institute (IHPP HITAP)

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Have we achieved? (6)

5. Long-term cost containment

- Partially achieved for the whole country
  - CSMBS – fee for service reimbursement model is the remaining problem – high cost escalation and difficult to sustain
  - UC scheme: application of contract model: capitation for ambulatory care and P&P package, global budget + DRG for inpatient services
  - Social Health Insurance: application of contract model: inclusive capitation for OP + IP services

CSMBS total expenditure and growth
1988-2006

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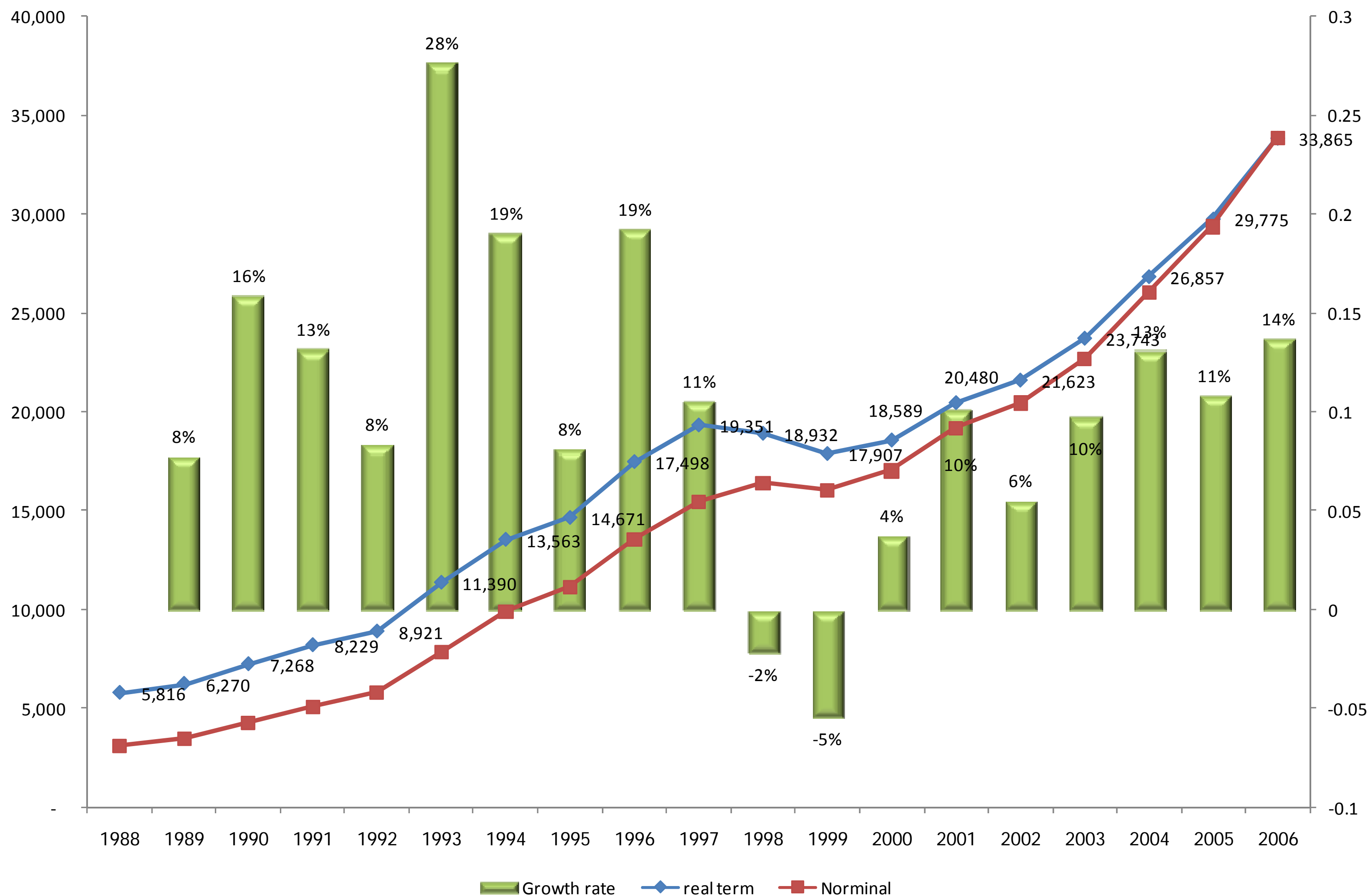

Source: Comptroller General Department, Ministry of Finance (various years)

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Have we achieved? (7)

1. Institutional and human capacity – self assessment score 6/10
   - NSO (national representative household survey dataset HWS, SES, others),
   - NHSO (UC scheme and performance),
   - MOF NESDB (economic dataset)
   - SSO (SHI and its performance),
   - MOF (CSMBS and its performance),
   - CHI (national IP dataset),
   - HSRI (funding supports),
   - HISO (Health Information)
   - HISRO (health insurance),
   - BOD Office (Burden of diseases)
   - IHPP (NHA, NAA)
   - Health Intervention and Technology Assessment Program – HITAP – assessment of priority health technologies and policies

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Sustaining the achievements (1)

1. Catastrophic health expenditure and impoverishment
   - Maintain comprehensive benefit package and zero copayment
     - But moral hazard generated from totally free services should be monitored
   - Improve service quality and consumer satisfaction to prevent opting out
   - Careful decision on extension of renal replacement therapy for UC members
     - Significant long term fiscal implications
     - Rationing may required
2. Vertical equity
   - Maintain the progressivity and dominant role of general tax in financing healthcare
   - Adequate funding for DHS for fostering equity in utilization and public subsidies
   - SHI: need further assessment of the equity in contribution and benefit gained both in cash and in kind among the rich and poor employees.

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Sustaining the achievements (2)

3. Large pooling of risk
   - Already in the Law
   - Challenge to harmonize the 3 public schemes

4. Health systems efficiency
   - Technical efficiency
     - Maintain and foster the role of DHS as primary contractor and gate keeper + optimum referral backups
   - Allocative efficiency
     - Foster the investment of P&P package
     - Rapid generation of evidence on cost effectiveness of interventions for the future re-design of benefit packages
     - Invest more on risk reduction, healthy lifestyle to address chronic NCD

Sustaining the achievements (3)

5. Long-term cost containment
   - Maintain capitation contract model of Social Health Insurance scheme and UC scheme
   - Financing and provider payment reforms of CSMBS
     - Towards close end expenditure

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Future actions: roadmap (1)

1. Modelling/ projection of total resource requirement
    - Stepping stone: NHA 1994-2005
    - Regular exercise and update of resource projection and reviews of fiscal spaces
2. Look for new and sustainable sources of finance
    - Replacing general tax annual budget cycle (sweating political processes, lack of evidence and politicize)
        - Earmark tax dedicated to NHSO
        - Consolidate Third Party Liability scheme
            - Now cream skimming and unethical profit making by private for profit insurance companies
        - Review of fiscal space

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Future actions: roadmap (2)

3. Take into account international experiences, to assess the driving forces of healthcare expenditure
   - Cost of production
     - Technological advancement [diagnostic and therapeutic]
   - Utilization of services
     - Ageing population
     - Utilization intensity
4. National capacity to produce evidence for technology adoptions -
   - Evidence on cost effectiveness, budget impact assessment, societal preference on benchmark of CER for investment
   - Effective interfaces between evidence and decision making and redesign of benefit package
     - Do no under-estimate the power of pharma and medical device industries – therefore need good governance

Acknowledgments

- National partners
  - National Health Security Office (NHSO) and other partners who initiate, design and steer the UC scheme
  - HSRI for supports on NHA development since day one until institutionalized
  - HISRO, HISO for their technical and financial supports
  - Ministry of Public Health (MOPH) major healthcare providers and steer the implementation of UC scheme.
  - National Statistical Office (NSO) for national household surveys
  - Thailand Research Fund (TRF) for institutional grants to IHPP

- International partners
  - **World Bank and MOPH partnership** on Country Development Partnership in Health Sector
  - **ILO** for peer reviews of capitation rate 2002, and long term financing forecast 2005-2020
  - **WHO** and **Harvard** for studies on ethical dimension of RRT extension to UC members
  - **EU** funded Equity in financing, health utilization and public subsidies in Asia Pacific (EQUITAP)

Thank you for your kind attention