Long Term Financing of Universal Health Care Coverage in Thailand

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11 June 2007

Form ILO Technical note paper, June 2004.
"Financing Universal Health Care in Thailand",

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Acknowledgement

- ILO GVA
- NHSO Thailand
- MOF
- NESDB
- SSO
- TDRI
- IHPP

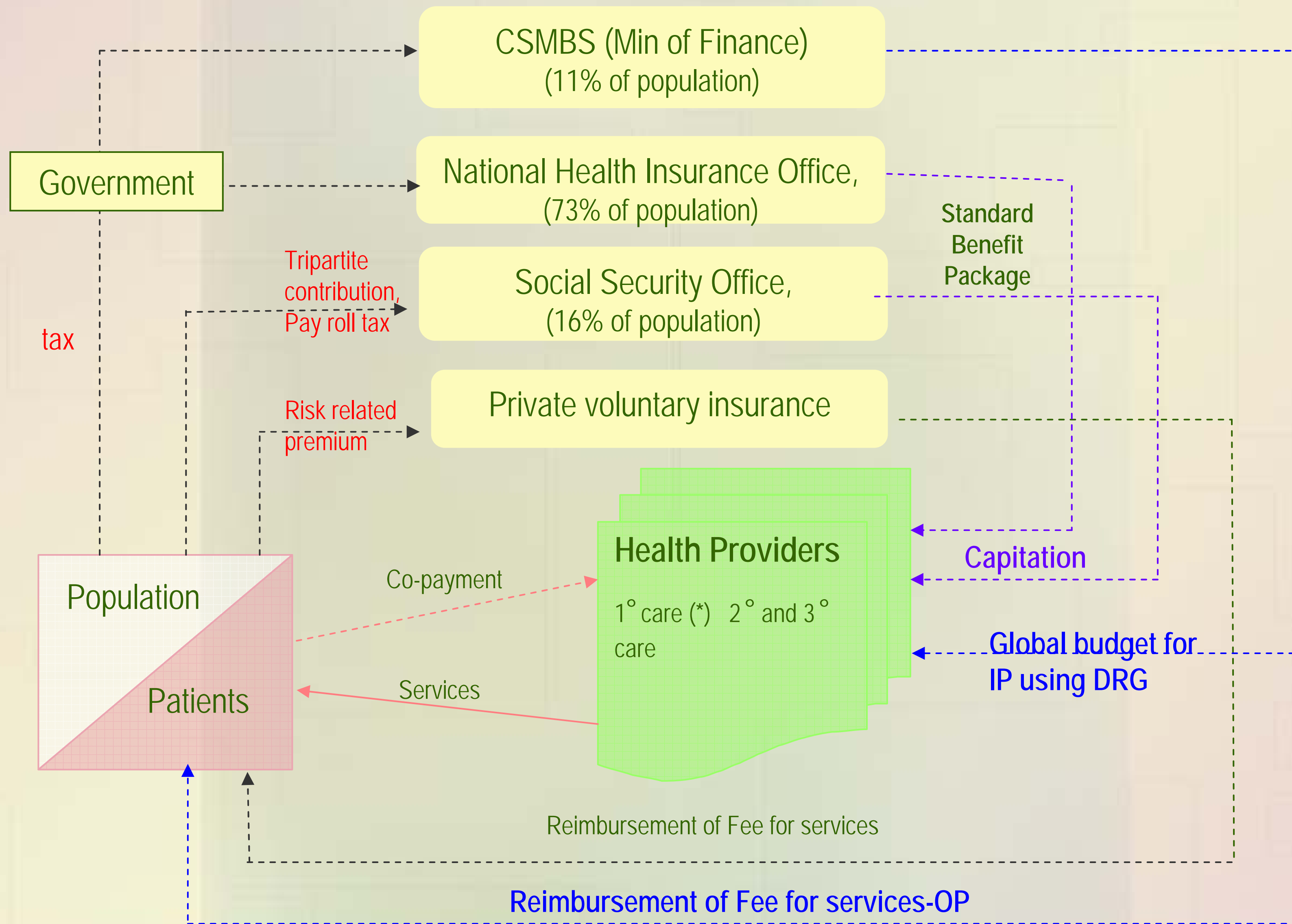
Outline

- Objective
- Methodology
- Assumption
- Result
- Conclusion

Objectives

1. To investigate the pro and con of all possible sources of finance, in order to support a sustainable implementation of UC
2. To review the present and likely future long term financial situation of the UC scheme
    - Expenditure
    - Revenue
3. To provide policy options/recommendation on the most preferable sources of financing UC as well as the determination of the long-term financial strategy for the UC scheme

Financing Structure in Thailand



Source: Tangcharoensathien V, 2002

Part 1

Pro and con of all possible sources of finance for UCS

Rationale: financing of UC

- Currently, the UC scheme is solely financed by general tax revenue which is subject to political climate.
- Politicians and policymakers in Thailand wish to secure a long-term financial sustainability of the Scheme, through the development of UC Fund
- Thai Health Fund was set up according to Health Promotion Act 1999 by an earmark tax, 2% of tobacco and alcohol excise (2,000 mln baht per annum in Y 2002). This sets a precedent for earmark tax to health in Thailand.

Reviews sources of financing UC (1)

- There are eight clauses of Section 39 of NHS Act2002. Each clause stipulates sources of financing UC.

- **Clause 1 Annual regular government budget** (which comes from general tax revenue and subject to annual Budget Scrutiny Committee of the House of Representatives and annual Budget Bill. Financing UC will be constraint by the overall budget envelope of the government and capacity to generate revenue either through positive, balance and negative balance budget.

- **Clause 2 Contributions by the local administrations** Local administrations have no interests, skill, attitude and capacity to support health sectors, most resources were invested in infrastructures.

Reviews sources of financing UC (2)

- **Clause 3 co-payments by patients** were kept at the healthcare providers. The current co-payment was very minimum, 30 Baht (0.7 USD) per visit or per admission. This nominal payment was exempted for the poor, the elderly and children under 12 years, the disabled, war veterans, monks, village health volunteers, etc.

  Prior study indicates limited capacity to generate resource, 1.7% of total medical expenditure of the Scheme (the amount of 1,073 million Baht out of the total 62,392 million Baht)

- **Clause 4 Fines** from the violation of this Act would generate a negligible amount of resources to the Fund.

- **Clause 5 Donation** to the Fund also has limited financing capacity to the Fund.

Reviews sources of financing UC (3)

- **Clause 6 Interest from the assets of the Fund** would not generate any resource if there is no such Fund, and currently relies totally on Clause 1 (annual budget) which is pay as you go without reserves.

- **Clause 7 Other cash or assets from the operation of the Fund** also play a negligible role in financing UC.
- **Clause 8 Contribution by beneficiary** requires an adoption of a Royal Decree for implementation. The Decree will stipulate the operational details regarding collection of contribution, rate and enforcements.

Assessment of the feasibility of creating additional income sources by academic KI

Average weighted score of 20 answers	(A) Political	(B) Social acceptance	(C) Equity	(D) Financial sustainability	(E) Programmatic feasibility	**Total**
Clause 1: General tax	1.26	0.47	0.70	0.76	0.73	**3.92**
Clause 1: Personal H tax	0.39	0.20	0.56	0.62	0.49	**2.26**
Clause 1: VAT	0.31	0.20	0.41	0.61	0.65	**2.19**
Clause 1: Sin tax	**0.71**	**0.41**	0.60	**0.68**	**0.69**	**3.09**
Clause 2: contributions by the local Gov	0.68	0.31	**0.63**	0.61	0.57	**2.81**
Clause 3: Co-payment	0.65	0.33	0.47	**0.68**	0.59	**2.73**
Clause 8: contribution	0.37	0.17	0.48	0.46	0.20	**1.68**
Total	**4.37**	**2.09**	**3.86**	**4.43**	**3.93**	**18.67**

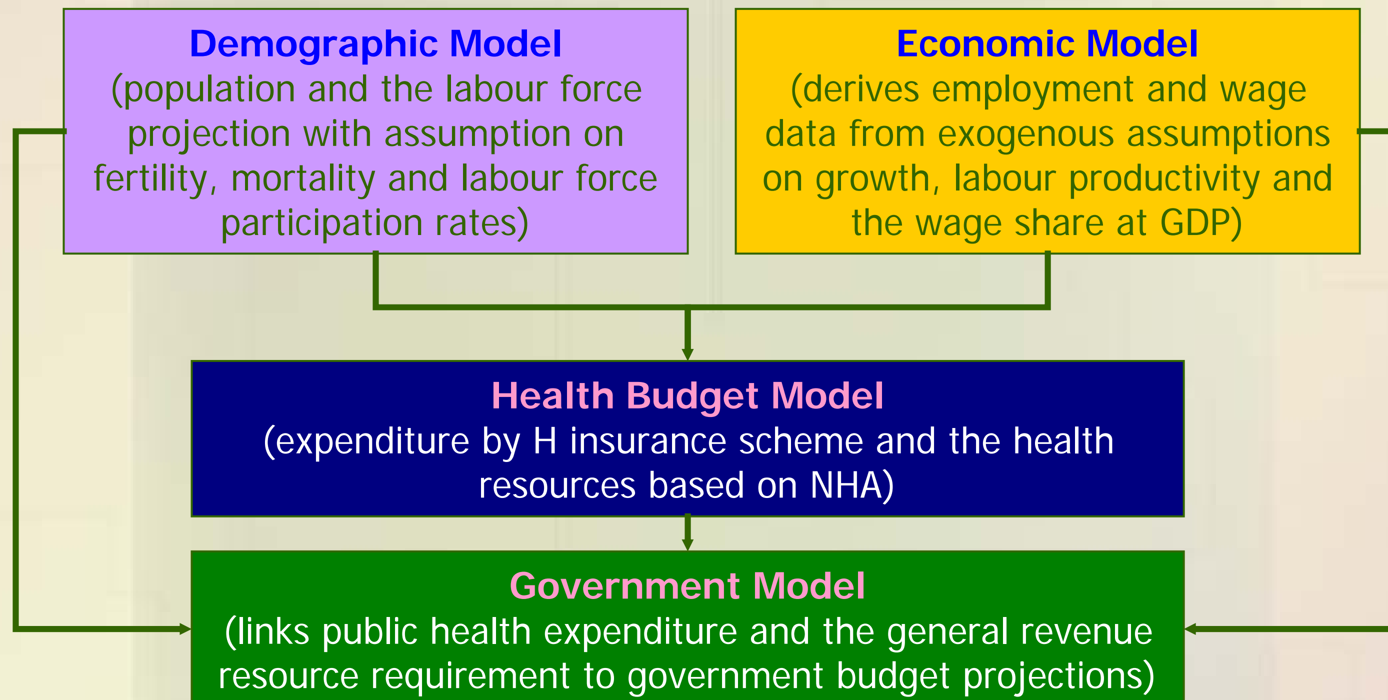
(weighting and preference factors), score 1-5

Part 2

Long Term Financing of UCS

Methodology(1)

1.The model consist of four deterministic sub-models.



Methodology(2)

2. Observation years are 2002 and 2003 and projection years are 2004 to 2020.
3. Two model scenarios were developed.
   - 3.1 The first (status-quo scenario or variant) reflects the legal status quo.
   - 3.2 The second scenario, after 2005,
     - **Identical demographic and economic assumption**
     - **Extension of SSO coverage and CSMBS contributions**

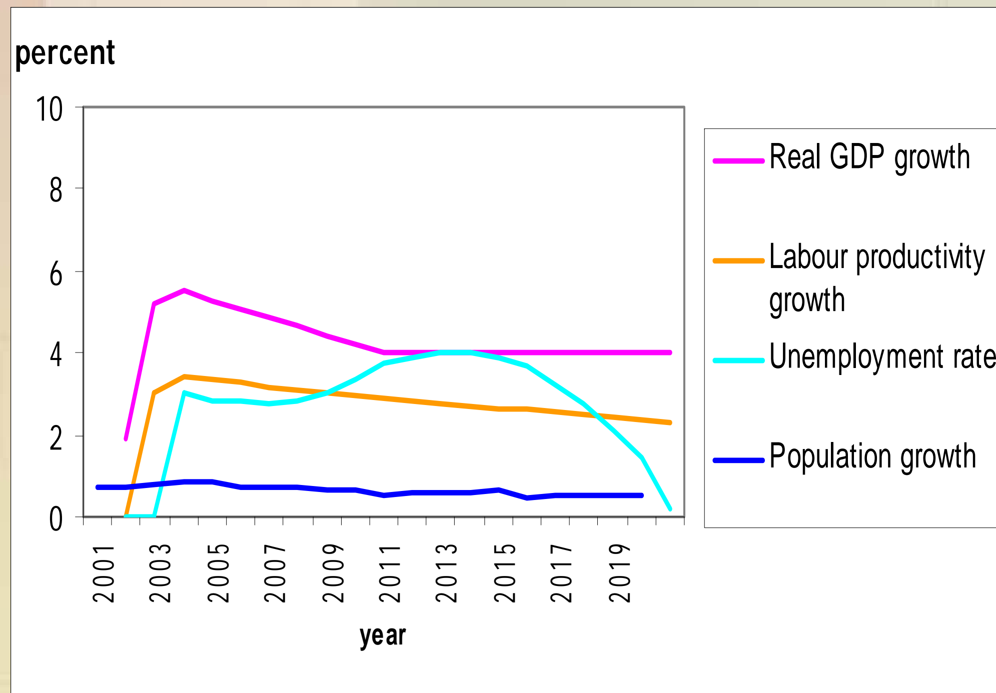
Assumptions (Demographic Model)

- Based on NESDB: formal population projection with medium fertility rate (base year 2000)
- Separated by gender and 5 years age group, broken down by calculation
- LFS 2003: participation rate separated by age group and gender

	2003	2010	2020
Female	64%	68%	71%
Male	81%	81%	80%
Both gender	72%	74%	76%

Assumptions (Economic Model)

The assumed development of key economic variables, 2002-2020



1. The most important: economic growth and labour productivity (GDP/employment).
2. Long-term average productivity 2.9% by 2010 and 2.3% by 2020 and full employment
3. The modest growth of economy, about 4.0 % in real terms by 2010 and keep constant by 2020.
4. Further discussions with experts from economic research institutes to review the GDP growth, productivity, labour force participation and migration assumptions in the model.

Assumptions- H Budget Model (1)

1. Capitation rate in the UC scheme are increase in line with

   1.1 unit cost indicator: medical inflation (1%-point higher than CPI and average wage increase)

   1.2 utilization indicator: an age related utilization factor and a general trend increase of an assumed 2% for a couple year and one per cent per annum for 2005-2020

2. CSMBS expenditure increases in line with CPI plus an additional real increase of 5 per cent per annum (which is lower than the statistically observed residual increase of 8% between 1992 and 2002),

3. SSO expenditure increases according to the same principle as the UC expenditure but an age specific utilization indicator has been constructed,

Assumptions - H Budget Model (2)

4. Contributions to the SSO increase in line with the increase of the projected number of private sector employees and the average wage in the economy,
5. Out of pocket by households and co- payments increase in line with nominal GDP growth. This component is dynamic, changes can be in both ways, increase or reduce.
   - It is arguable.
     - May be decreased due to higher uptake of UC benefits and the increase in public health spending or
     - May be increase due to luxury goods of health service sought by better-off.

Assumptions - Government Model (1)

1. Use the growth rate of nominal GDP as the main driver for all income and revenue items of the central government accounts
2. For the reform scenario

   2.1 the 100% hike of the tobacco tax will lead to a 20% decrease of consumption, that means that the overall increase in tobacco tax revenue only increases by 60% and 2/3 of tax volumes daily go to UC fund.

   2.2 the 50% increase of alcohol and beer tax will also lead to a reduction of consumption by 20%, which means that the net increase of alcohol and beer tax will only amount to 20% and of tax volumes daily go to UC fund.

   2.3 the model simulates a gradual increases of the additional taxes

   - 25%, 50%, 75% and 100% in 2005, 2006, 2007 and 2008 …

Assumptions - Government Model (2)

2. For the reform scenario (cont.)

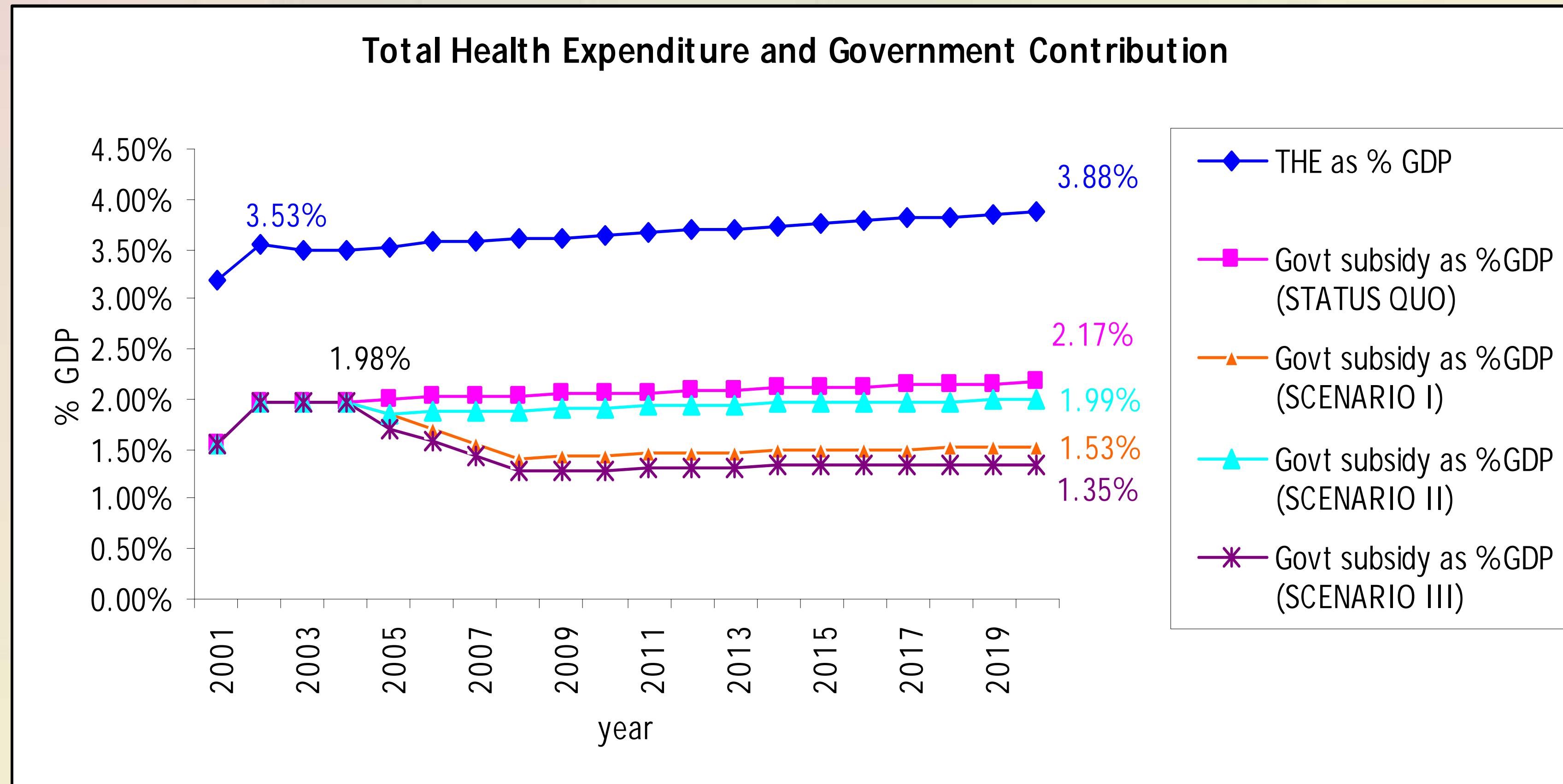
   2.4 the new personal health tax and the new contributions for CSMBS members are phased in at the same pace;

   2.5 the inclusion of dependents into SSO coverage (an estimated number of 6 million people) is simulated to fully take place in 2005 without a phase-in period.

3. All the above assumptions have to be reviewed and refined by the IHPP. These assumptions will be verified its feasibility with expert such as specialist from SSO, MOF.

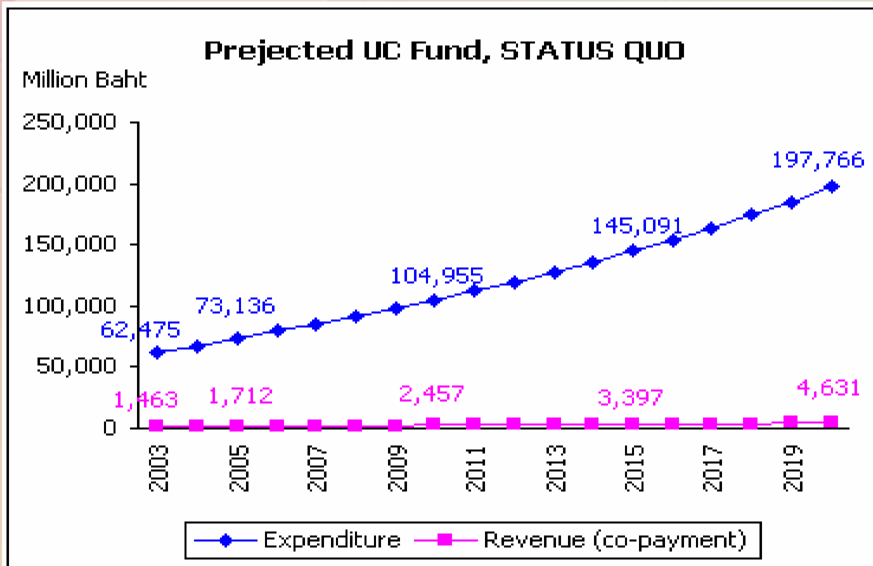
4. For the reform scenario, there is a need to explore consumption effect from increasing tax, price elasticity, may be deep study, deter new cohort smoker

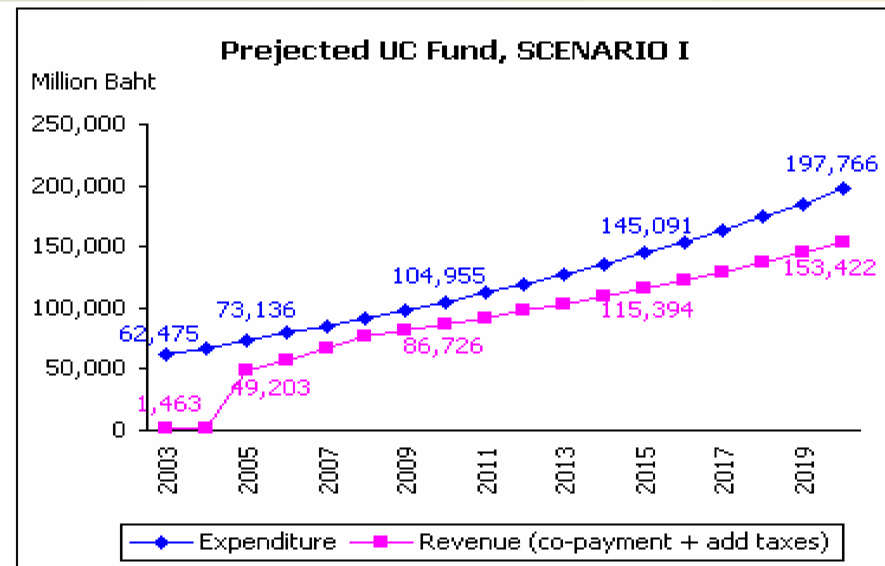
Result (1)

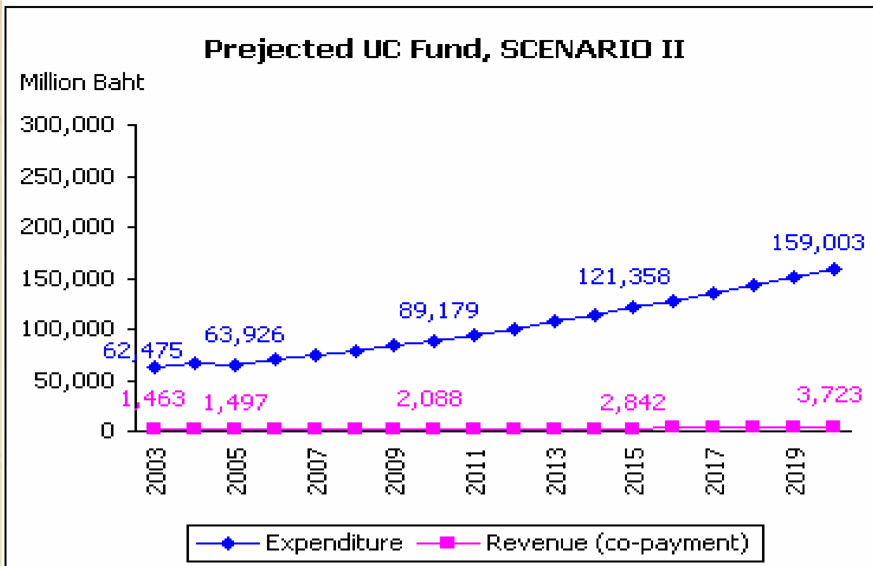


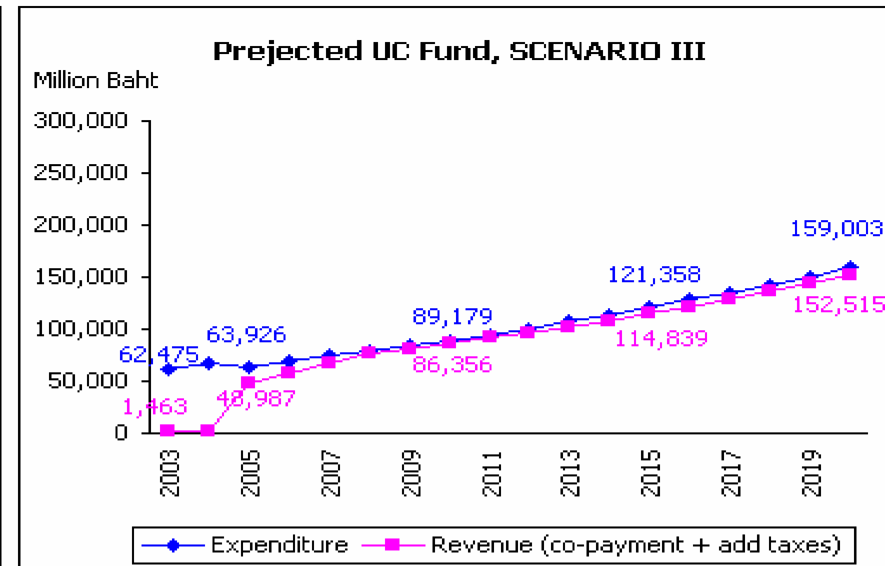
Scenario I = introduce additional taxes
Scenario II = SSO expand coverage to dependents
Scenario III = introduce additional taxes and expand SSS coverage to dependents

Result (2)









Scenario I = introduce additional taxes
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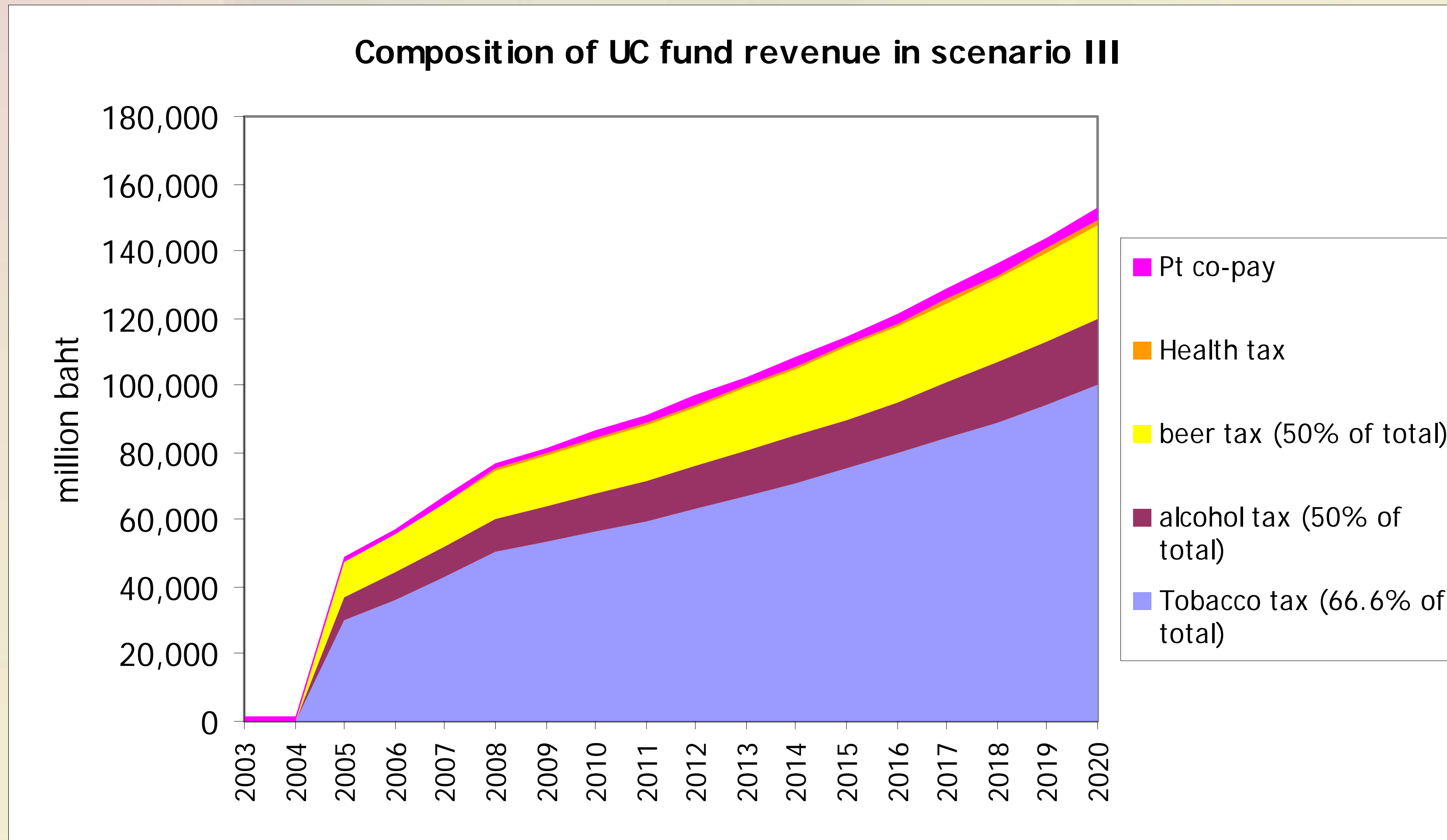
Result (3)



Scenario III = introduce additional taxes and expand SSS coverage to dependents

Conclusion

- As long as the UC scheme depends entirely on general revenue financing it will remain vulnerable to budgetary competition and political manipulation rather than evidence on utilization and cost of services– even if it has effective inbuilt cost containment mechanisms.
- Alternative choices is to create a UC Fund which is fuelled by earmarked resources. The indicative health budget analyses that were undertaken showed that the Fund would probably be self-sustainable if two thirds of the tobacco tax revenues in the country, and 50 % of the excise tax on alcohol and beer as well as a personal health tax for all people that are not members of the CSMBS and the SSO were earmarked for the Fund.

Thank you