

Health financing in Thailand Issues for discussion

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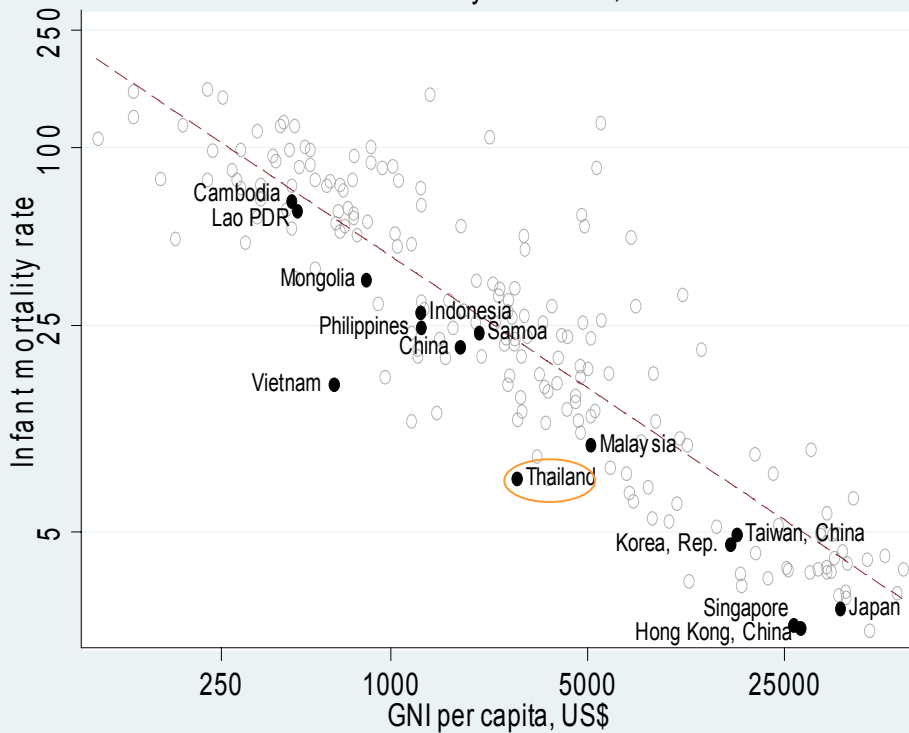
Health and health financing in Thailand — an international success story

- Good health outcomes
- Broad population coverage
- Broad benefit package
- Increased and more equitable utilization of services
- Reduced financial risk – universal health insurance effective safety net against catastrophic out-of-pocket cost
- Efficient – low level of spending as % of GDP



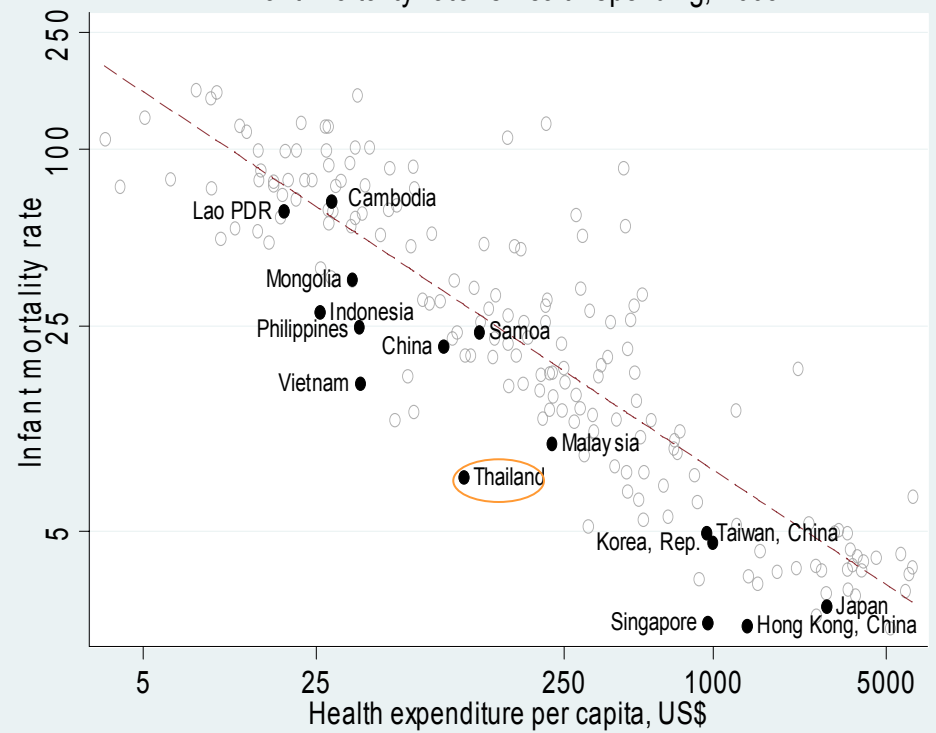
Good Health Outcomes Relative to Level of Economic Development and Health Spending

Infant mortality vs income, 2005



Source: WDI
Note: log scale

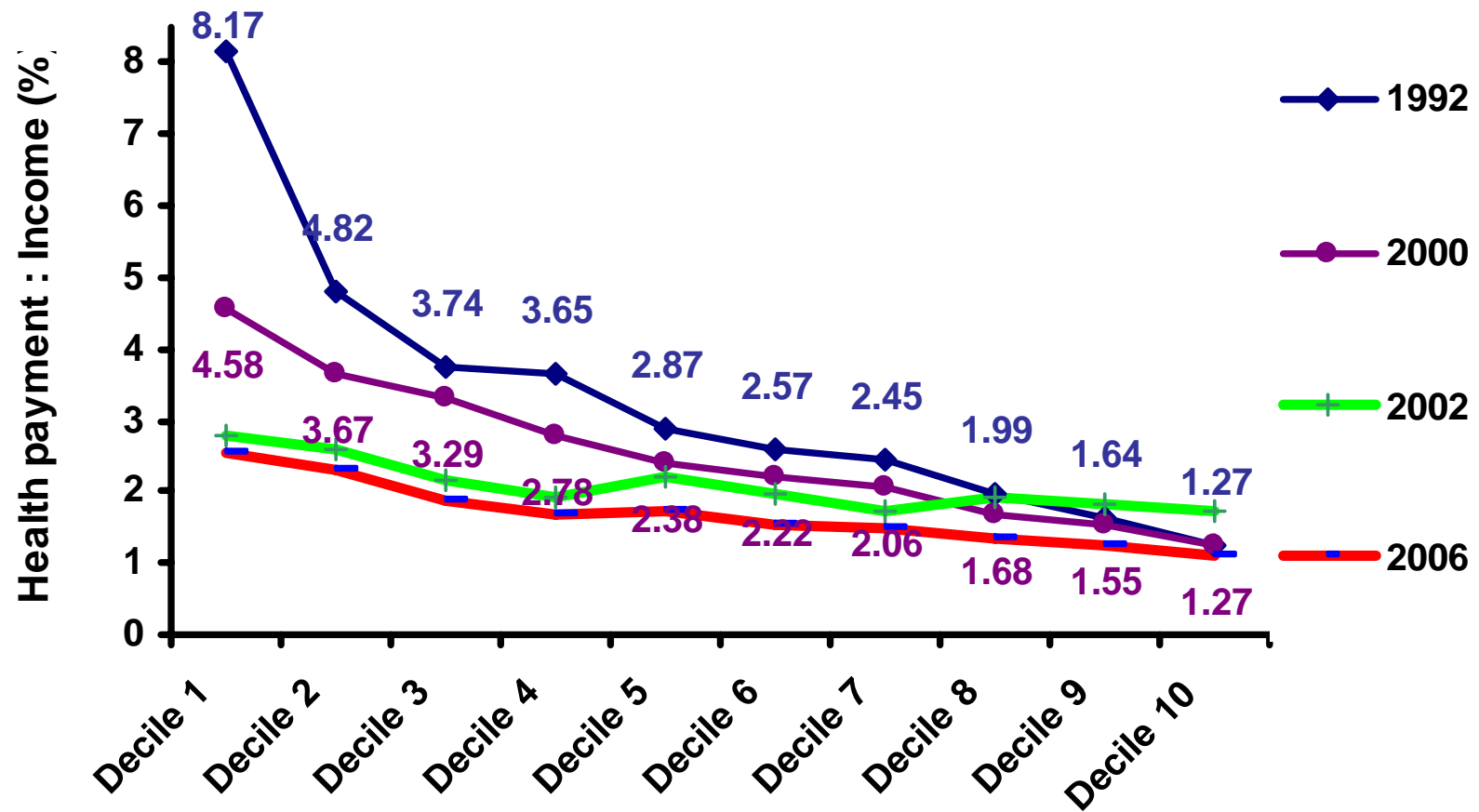
Infant mortality rate vs health spending, 2005



Source: WDI
Note: log scale



Household health expenditure has significantly declined under UC, in particular for the poor



Source: NSO SES (various years)
 Courtesy of NSO



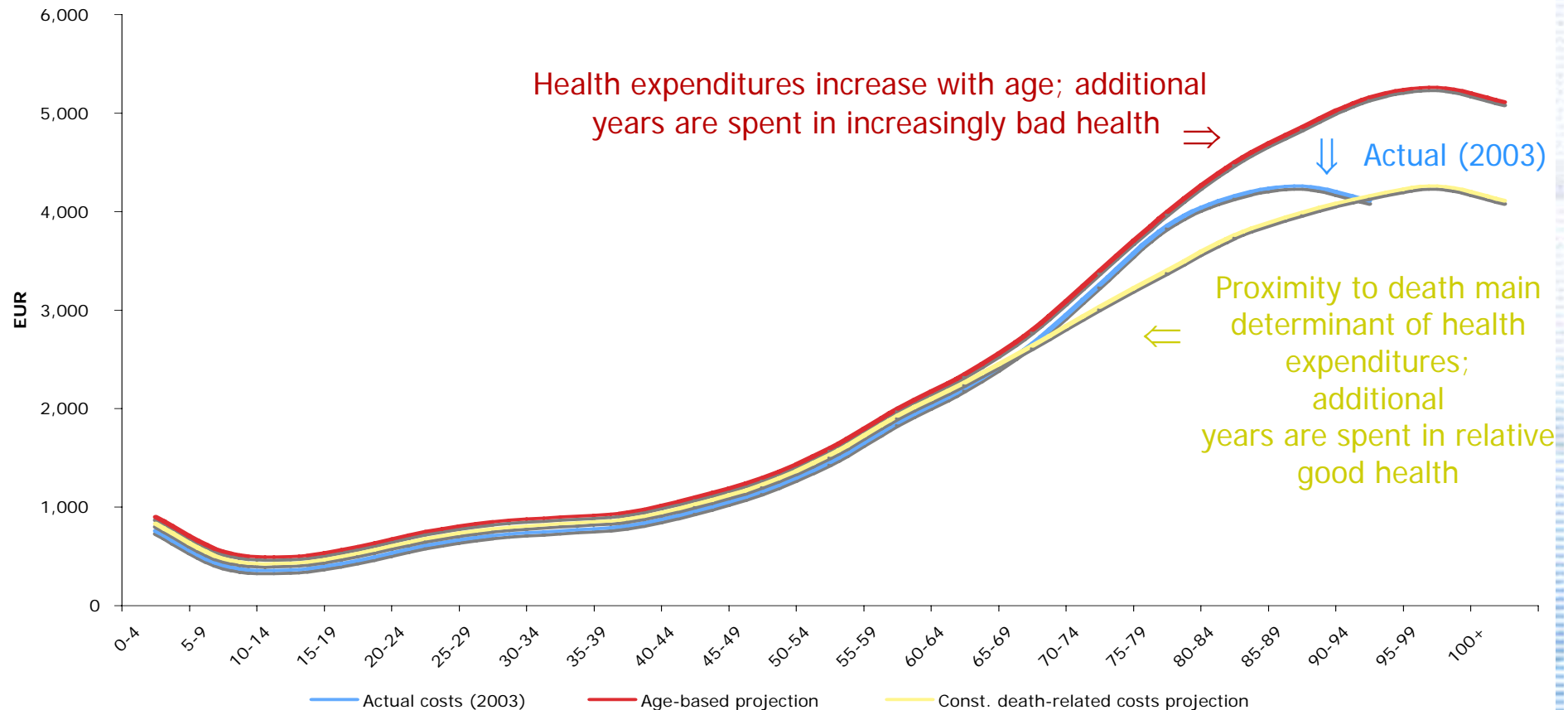
Challenges Ahead

- Cost pressures and financial sustainability
 - Demographics and rise of chronic disease
 - Technology and drugs
 - Cost of other inputs, e.g. human resources
 - Expectations, social values
 - Income growth and high income elasticity of health care
 - Vulnerability to economic and financial crises
- Health Financing Architecture
 - Fragmentation of risk pools and management
 - Universality vs. multi-tiered benefits
- Filling gaps in coverage
 - International Migrant Population
 - Internal Economic Migration



Ageing Impacts Health Expenditures

- Life-cycle health expenditures: actual (2003) and two projections for an increase of 10 years in life expectancy

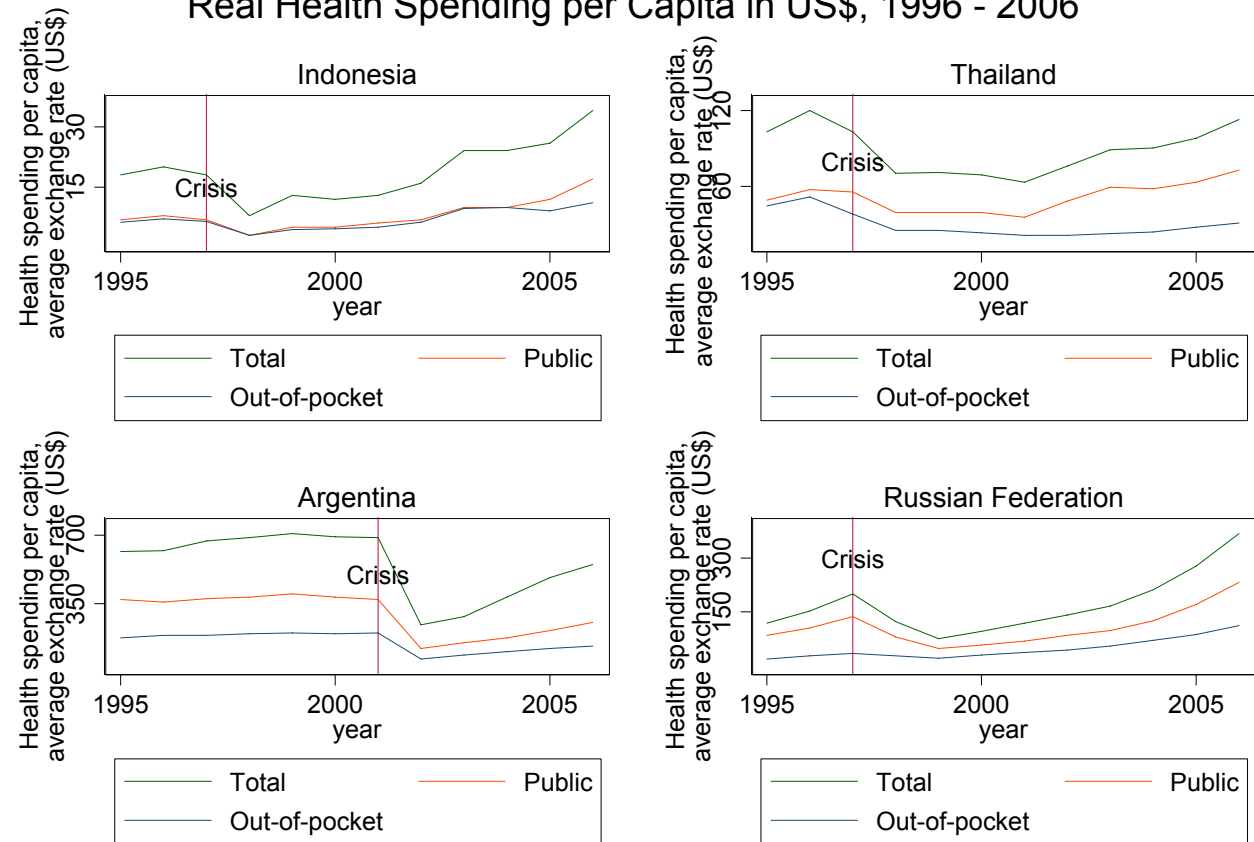




Vulnerability of Health Sector to Crisis

- Social sector expenditures tend to be pro-cyclical
- Social health insurance coverage depending on employment and wages
 - In Thailand about 1 million expected to migrate to Universal Scheme
- Often health is a low priority

Real Health Spending per Capita in US\$, 1996 - 2006



Source: World Health Organization and World Bank



Cost Driver: Role of Technology

- Technology is: pharmaceuticals, medical devices, diagnostic techniques, surgical procedures, etc.
- Technological *change*?
 - Innovation—arrival of new products and techniques
 - Utilization—how new and old technologies are used in the health system
- What determines the availability, utilization, and price of technologies?
 - Needs and expectations (create incentives for development and promotion)
 - Scientific capabilities (in recent decades, advances in genetics, account for fundamental change)
 - Features of the health system
 - Total cost = unit cost X utilization
- *Technology accounts for 1% annual real increase in cost of health care other factors constant (NZ Sustainable Health Financing Path analysis)*



Cost pressures are a reality across all schemes, but in different ways...

CSMBS

- Rapid increases in expenditures in recent years
- Primarily drive by rise in outpatient expenditures, especially pharmaceuticals

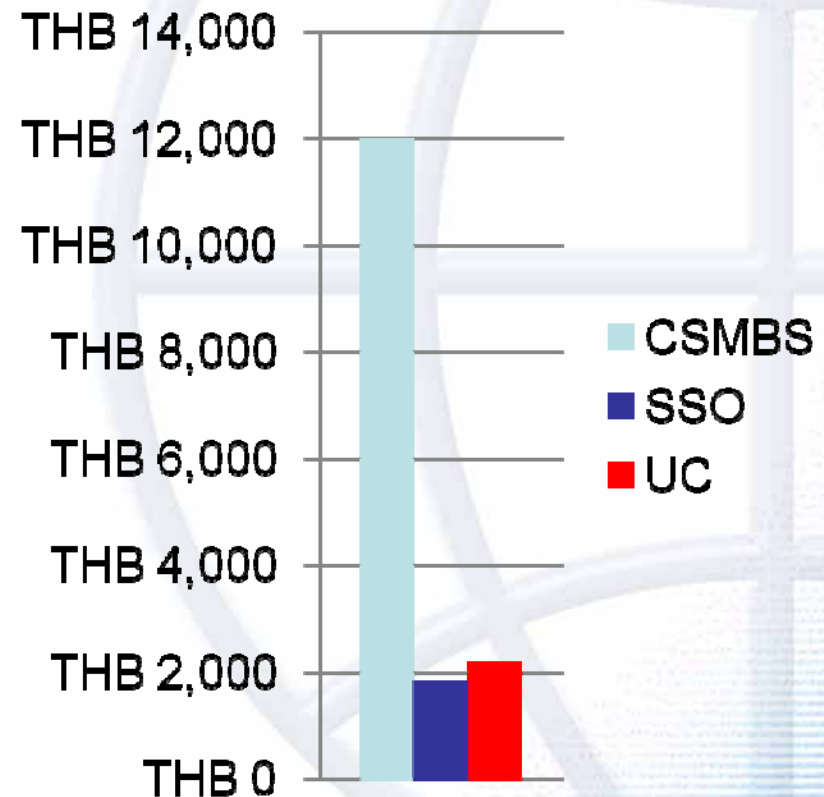
SSO

- Cost increases more muted
- Does not have to deal with high cost care for aged (→ UC)

UC

- Capitation rates have increased, but unclear if enough
- Concerns about deteriorating quality and increased workloads

Per capita allocation (2008)



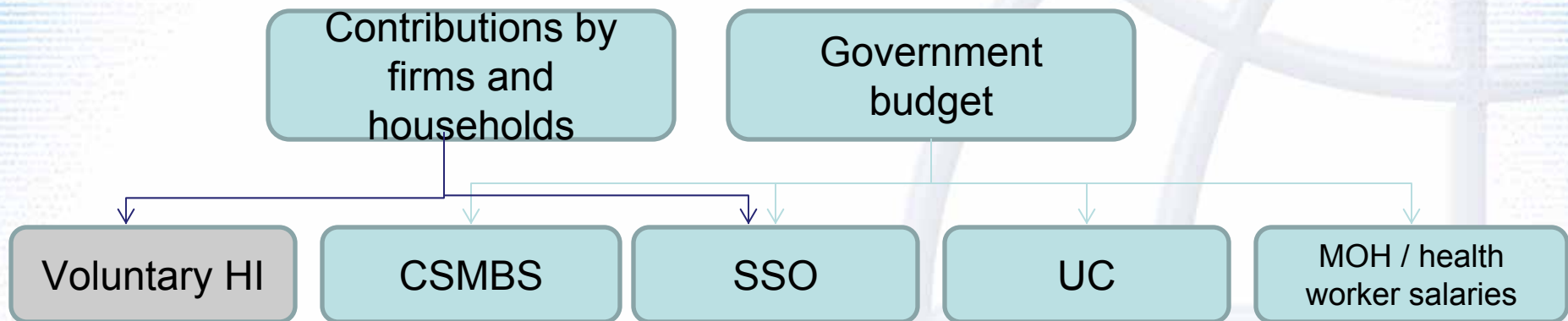


Actual cost pressures at facility level

- Can happen if health care providers are inadequately funded and/or health insurance passes too much cost risk to health care providers
 - capitation, DRGs, cost-volume global budgets pass significant risk to providers
 - expressed by arrears to suppliers, waiting lists, deterioration of quality
- Preliminary findings from a study in Thailand supported by the WB – no significant acute financial pressures were identified in a sample of district health systems and provincial hospitals
 - Evidence that until now the pricing of capitation and DRGs have been adequate
 - Although coping mechanisms were often applied and staff reported significant workload



A mix of financing sources and fragmented institutional arrangements



Social security contributions account for only around 7% of total health expenditures; government budget for around 60%

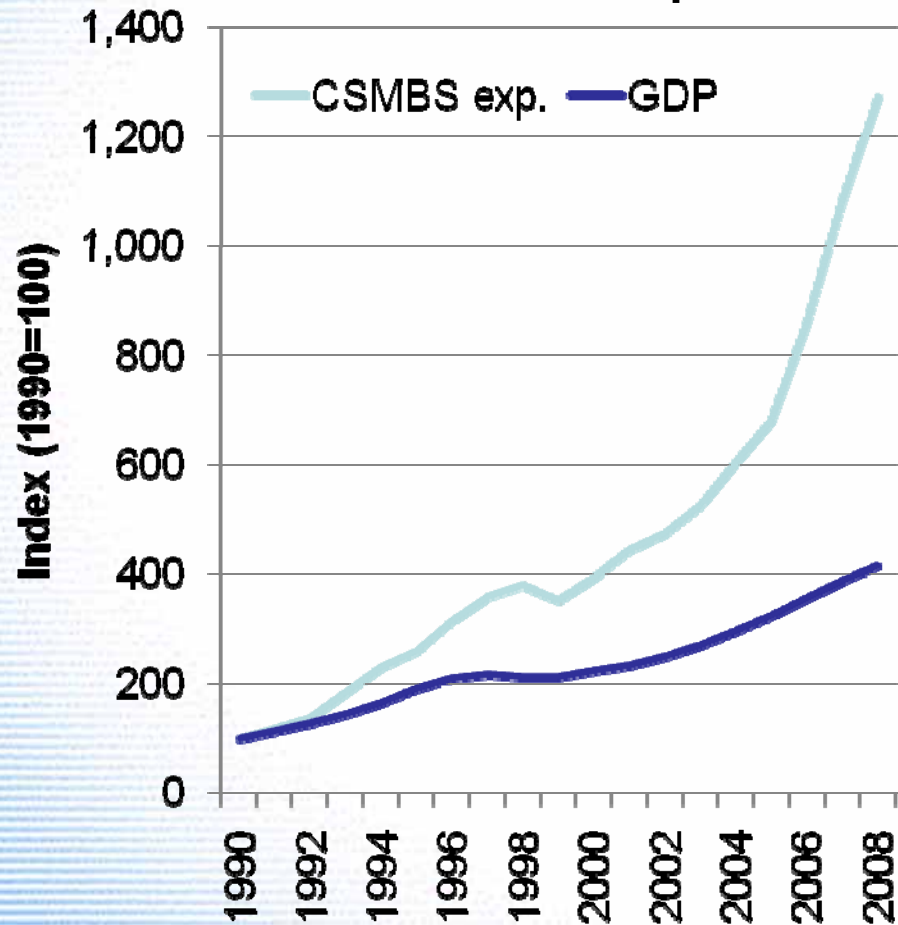
Some downsides of fragmentation

- Contributes to high administrative costs
- Scarce technical capacity not used efficiently
- Makes oversight more challenging
- Weak purchasing power by individual agencies
- Different payment arrangements → incoherent incentives for providers



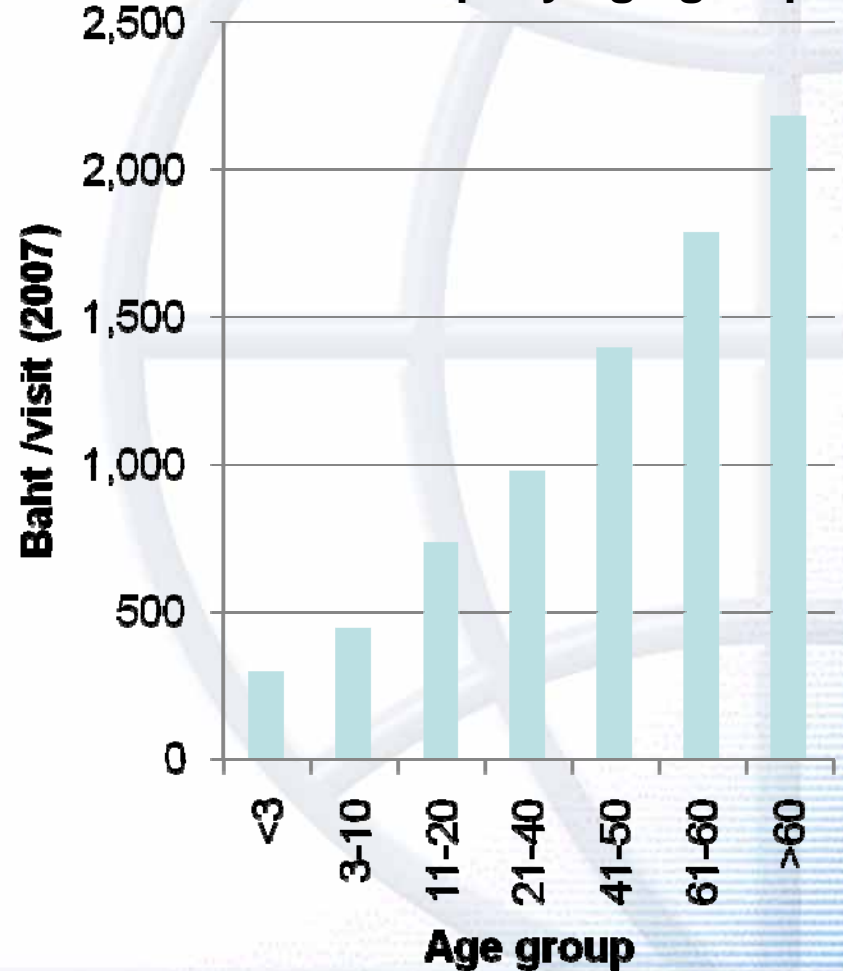
Runaway Costs of CSMBS

Trends in CSMBS expenditures



Courtesy of MOF

CSMBS exp. by age groups





So what can we do?



How can cost pressures be managed

- Ensure value for money
 - Reducing provision of “unnecessary care”
 - Purchasing and appropriate incentives to health providers (CSMBS!)
 - Technology Assessment
- Increase financing for health—how much is needed?
 - In Thailand currently the case is maintaining the Government commitment
 - Prepare for costly chronic disease (invest in prevention, financing options for Long Term Care)
 - Effective prioritization / rationing
- Some budget expenditures could be moved to contributory schemes (compulsory and voluntary)
 - e.g. internationally, in most social health insurance schemes dependents are covered



Impact of provider payment reforms and considerations for Thailand

- Some key lessons from international experiences to date
 - In many cases, reforms have resulted in savings due to shorter length of stay and/or reduction of intensity of care (diagnostic procedures, drug use, etc.)
 - Evidence on impact of quality often limited—represents important risk
 - Case-based payment for hospital services has often resulted in rapid increases in volume
- Provider payment reform has come a long way in Thailand, but...
 - CSMBS has just moved away from FFS for inpatient care, but outpatient fee-for-service payments (and drugs) remain important cost driver
 - Lack of coordination across schemes creates mixed incentives for providers—cost shifting, patient preference, etc.
 - Too much cost risk shifted to providers under UC/SSO scheme?
 - Adequate incentives for quality and prevention?



Cost-sharing

- Cost-sharing with dual objective to moderate demand and raise additional revenues introduced or increased in many OECD countries during 1980s and 1990s
 - Co-payment for services
 - Treatment restrictions through negative or positive lists, in particular pharmaceuticals and dental care (e.g. moving drugs to OTC status)
 - Some countries—e.g. Singapore, China, South Africa, US—have experimented with Medical Savings Accounts
- Best practice co-payment options
 - Not on public goods and primary health care
 - Flat charges and/or capped per episode and annually
 - Administratively simple
 - Implication on poor need to be carefully considered
- Thailand
 - 30 B co-payment may have moderated demand but was not a significant financial barrier



Options for Managing Drug Costs

- International experience offers many options, often used concurrently
 - Regulating market entry – clinical and cost effectiveness
 - Essential Drug Lists
 - Formularies for appropriate drug use
 - Practice Guidelines
 - Reference Pricing
 - Value based cost sharing
 - Compulsory licensing
- Thailand is using some but could do more



Managing introduction and use of technology

- Many countries regulate investment in technology
 - E.g. permission—certificate of need—required for large investments in US in 1970s/80s
 - Mixed evidence—decisions about what services and procedures will be covered may be more effective
- Growing trend toward ‘Health Technology Assessments’
 - Use of clinical evidence and economic evaluation to approve use / cover—does technology represent ‘value for money’?
 - Economic evaluation is often difficult—reliable evidence on effectiveness may take years to emerge
 - Yes/no decisions on technology often contested—effectiveness / efficiency often conditional on patient or circumstance
- Managing *use* of technology equally important
 - Different approaches: clinical guidelines, utilization reviews, second opinions, profiling of clinical practice, etc.
 - Scope for both improving quality and controlling costs, but evidence on impact still limited
- Thailand plans to institutionalize health technology assessment modeled after UK NICE
 - exact institutional mandate and capacity will matter



“Harmonization” of health financing schemes can take different forms...

Administration and oversight

- Single management structure, IT systems, reporting arrangements, etc.
- Funds can be managed separately, with different benefit packages

Fee setting, cost control, purchasing

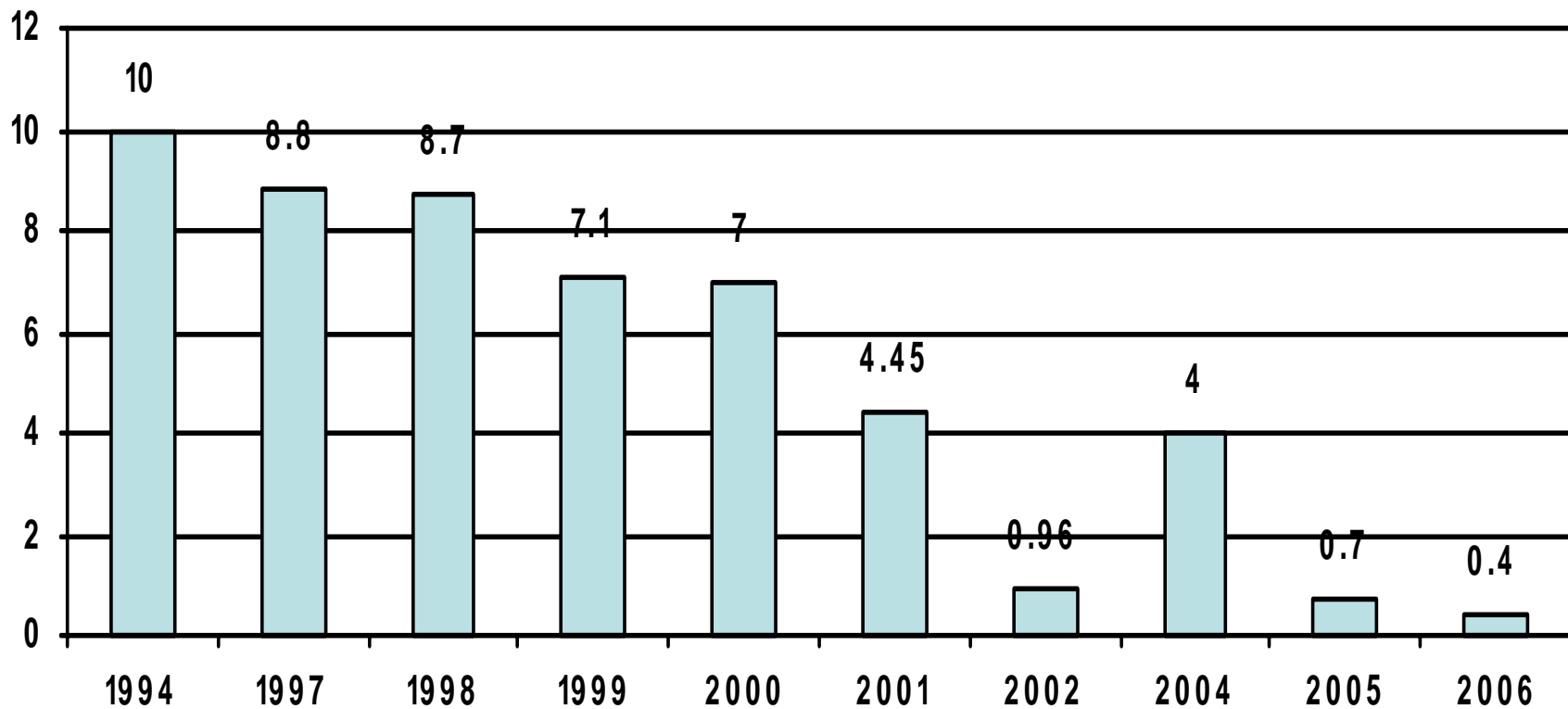
- Different schemes can use same fee-schedule, jointly negotiated with providers (US - Maryland All Payer Rate Setting, Japan)
- Relative purchasing power: single/multiple payer systems
- Common approaches to monitoring quality and controlling costs (e.g. clinical guidelines, drug lists,...)

Benefits

- National scheme with single benefit package
- Difficult to finance through contributions (e.g. South Korea, Taiwan) if LM is highly informalized
- Tax financed → limited benefits → demand for complementary benefits by the better off



Lesson of South Korea: 380 to 1: Admin Costs as % of Payments





Managing Health Sector Reform

- Health is a complex sector of intersected interests and complex ethical and technical issues
- No perfect technical solutions exist
 - “... one can only choose the problems one is willing to live with”
- Implementable reform is a negotiated outcome of
 - Social values and public policy objectives (e.g. Universal Coverage has already become a core social value in Thailand)
 - Stakeholder interests
 - Technically sound interventions
- To help with informed decision making
 - Thailand has already significant technical policy analysis/evaluation capacity
 - World Bank and other international partners have significant international exposure and experience in strengthening health systems and cross-sectoral policies impacting health