

World Bank Seminar

User fees for health care: Protecting the Poor

The case of Thailand

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Bitrán & Asociados



Background

- **Population:**
 - 62.4 million
- **Population under poverty line**
 - National: 12.8%
 - Urban: 17.2%
 - Rural: 1.5%
- **Per capita GDP:**
 - \$ 6,440
- **Health expenditure:**
 - Per capita: \$347
 - Public expenditure: 65.4% of total



User fee system

- **Implemented as a national policy since 1976**
- **MOPH guidelines:**
 - provide charges that can be collected
 - stipulate full cost recovery for non-personnel costs
 - fees are to be retained by the health facility
 - can be used for labor and material expenses
- **Revenue raised from user fees is important**
 - Provincial and district hospitals: ~40% of total revenue, (of which 2/3 from insurance plans, 1/3 from patients)
 - Health Centers: ~ 70% of revenue



Thailand, health insurance schemes

Insurance Program	Nature of Scheme	Coverage (millions)	Coverage (percent)	Population Characteristics	Source of Funds	Financing Body
CSMBS (Civil Servant Medical Benefit Scheme)	Employment Benefit	6,6	11	Civil Servants	MOPH Fund	MOF
SSS (Social Security Scheme)	Compulsory	4,8	8	Employees in Firms Larger than 10 Persons	Tripartite contributions (MOPH, employer, employee, 1,50% of wages ^[1])	Social Security Organization
VHCS (Voluntary Health Card Scheme)	Voluntary	6,0	10	Near Poor	MOPH Fund	Ministry of Health
LIC (Low Income Card Scheme)	Social Welfare	27	45	Indigent, Children < 12, Elderly, Veterans, Handicapped, Religious & Community Leaders	MOPH Fund	Ministry of Health
Private	Voluntary	1,2	2	Richest segment of the population	Premium	Households
Total		50,4	76			

Source: Donaldson et al, 1999.



“Low income card scheme” (LIC)

- Three periods:
 - Getting started 76-81
 - Development 81-84
 - Consolidation >84
- More than 25 years of experience, today LIC system replaced by “30 baht” policy (>2001)



“Getting started”, 1976-1981

- Income threshold, established above poverty line
- No clear guidelines on eligibility criteria, screening procedures and on how to determine eligibility
- No staff, information and administrative systems available to apply means test
 - Facilities used ad hoc criteria to determine ability to pay through health staff interviews



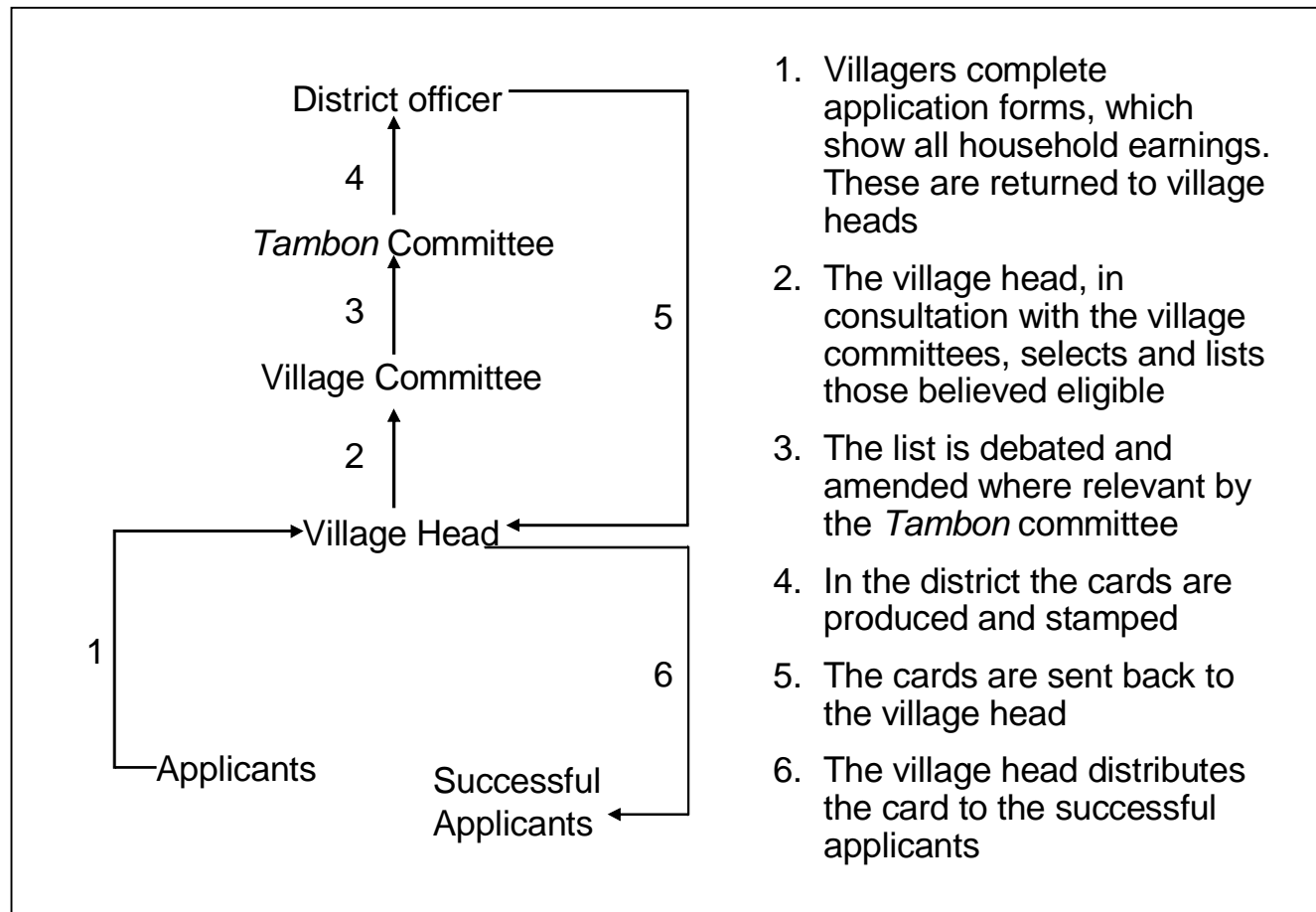
“Development”, 1981-1984

- Policy regulations with three main features:
 - Specification of the target group (income threshold differentiated for single households and married couples)
 - Benefits (free access to designated health center and higher complexity with referral letter, validity of card 3 years)
 - Screening procedures (community)



“Development”, 1981-1984

Official procedures for screening the poor, Thailand, 1981



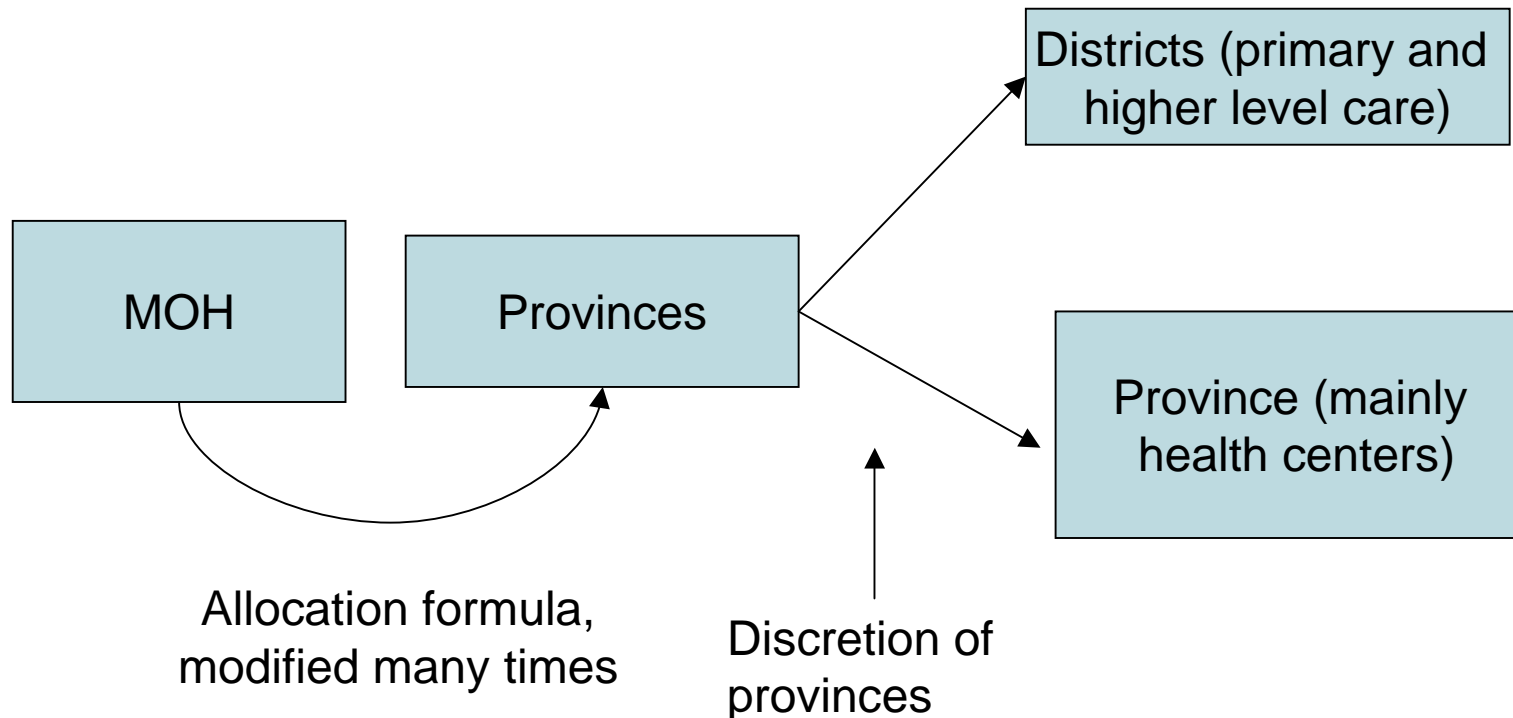
Source: Gilson, 1998



“Development”, 1981-1984

- **Funding**

- LIC financed through general taxation
- Meant to finance non personnel expenditure



“Consolidation” >1984

- Eligibility criteria are adjusted:
 - Include unmarried couples and other groups (children, elderly, veterans, religious leaders, community leaders, handicapped)
- Community screening processes are strengthened
 - Village committee was strengthened by including new members: health volunteer, monk, agricultural worker
 - Health worker now participates directly by assisting the village head when interviewing applicants
 - Changes were introduced as i) the process of beneficiary selection had supposedly been dominated by the village head and ii) members of existing screening bodies only had limited knowledge of exemption processes



“Consolidation” >1984

- Make policy of identifying poor individuals *proactive*
 - Scheme had to be announced and village head was made responsible for conducting a house to house information dissemination visit
- Budget allocation formulas were changed several times; allocation formula introduced at the provincial level



“Consolidation” >1984

Budget allocation formulas to provinces

Criteria	Before 1989	1989-90	1991-93	1994	1995
Number of utilizations	100	50	-	10	-
Population coverage	-	-	-	20	20
Number of eligible	-	50	50-60	20	25
Workload of health facility	-	-	40-50	45	55
Health problem	-	-	-	5	-

Somchai, 1998



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Results

1. Coverage
2. Leakage
3. Financial protection
4. Use of health card
5. Regional distribution
6. Funding



Results

1. Coverage (2000):

- ~37% of the total population has a health card (Tangcharoensathien, 2001)
- ~76% of the low income group as defined by LIC income threshold criteria has a health card
- ~80% of population living below poverty line
- About 1/3 card holders are low income; rest are other target groups (monks, elderly etc.)

2. Leakage

- ~45% of card holders are non-poor according to national poverty line



Results

3. Utilization patterns of card holders:

- No systematic data available on the utilization patterns of the health card owners: .
- Information from focus group discussions indicates that the card is highly valued but that some card holders do not use their cards due to stigma, lack of information of the beneficiaries and perception of discrimination at health facilities
 - “Having LIC was good but it also has disadvantages. My sister in law used it at the hospital. They did not pay attention to us. They thought we did not have money, they paid less attention to us..“(Gilson et al., 1998).
 - “Sometimes I self-treat because I do not want the health worker at the health center to complain that I often get free drugs from the health centre” (Ibid.)



Results

- **Financial protection: no systematic information.**
- **Study based on small periurban sample found the following**

Benefit group	OOP expenditure as a % of annual household income in Phitsanulok
LIC (Low Income Card)	6.4%
CSMBS (Civil Servant Medical Benefit)	4.6%
Social Security Scheme	1.5%
State Insurance	3.1%

Source: Mongkolsmai, 1993



Results

LIC per capita budget allocation by region (in nominal baht), Thailand, 1992-1999

	1994	1996	1998	1999	%Poor 1999
Northeast	132	140	205	264	26.6
North	194	193	263	306	23.2
South	323	160	239	273	9.0
Central	539	183	258	316	14.8

Source: Donaldson et al.

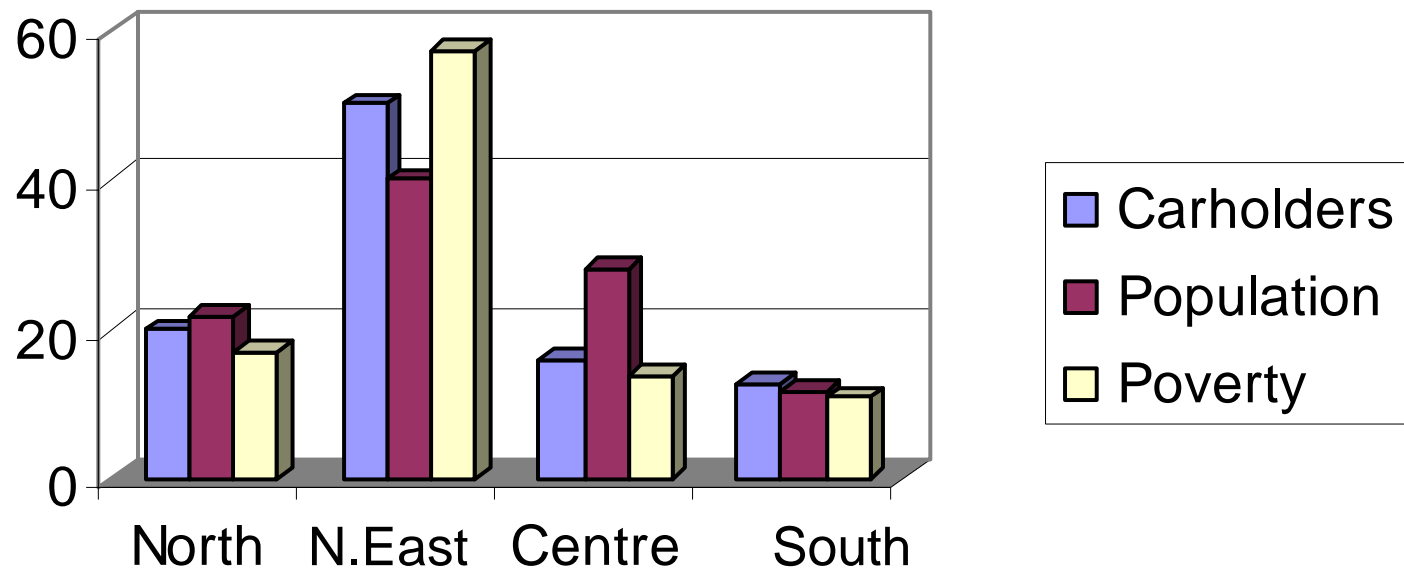
Findings:

- Pro-poor reallocation of public budget (Gap has decreased)
- There is room for improvement: equal allocation is still not pro-poor enough



Results

Regional Distribution of cardholders compared with regional distributions of population and poverty, 1992



Results

Year	Number of people covered by the program (million)	Budget in current prices (million baht)	Budget in 1993 prices (million baht)	Per capita
1988	7.7	706	901	118
1989	7.7	800	936	122
1990	10.7	1,500	1,736	162
1991	10.7	2,000	2,205	205
1992	11.7	2,500	2,625	224
1993	11.7	2,750	2,750	235
1994	11.8	4,273	3,876	328
1995	11.8	4,475	4,059	344
1996	14.0	5,706	4,929	352
1997	15.0	6,703	5,515	368

Findings:

- Real per capita budget has tripled during the period
- Coverage has doubled



Results

Budget and expenditure of the LIC, Thailand, 1987-1997 (millions)

Year	Compensation	Revenue forgone from exemptions	Total cost of exemptions granted	% compensated care (compensation/ total cost)
1987	705.839	2.051.856	2.757.696	26%
1991	2.000.000	2.345.067	4.345.068	46%
1997	6.372.524	9.018.341	15.388.866	41%

Source: Donaldson 1999.

•Findings

- Exemptions are not fully compensated
- Percentage of compensated care has increased



Lessons and challenges

1. High coverage and low leakage is not a sufficient measurement of success of protection mechanisms
2. Identifying the poor is difficult and requires the consideration of many different dimensions
3. Sufficiency of funding is key to the success of protection mechanisms
4. Allocation formulas are an important part of any exemption system
5. Benefits and target population have to be consistent with available funding
6. Evaluation and monitoring is key to the improvement of an exemption system though extremely scarce



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Lessons and challenges

- Utilization patterns and financial protection provided by LIC are not well documented and there is some disperse evidence that
 - Some card holders do not use health cards due to discrimination at health facilities and stigma
 - Card holders are not adequately financially protected



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Lessons and challenges

National poverty line and cut off points, LIC, Thailand

	1988-89	1993-94	1997-98
National per capita poverty line per month ¹	473	636	911
Cut off point for a single/month	1500	2000	2000

Source: Donaldson, 1999; and Somchai, 1998.

•Eligibility criteria explain leakage

- Income threshold way above national poverty line
- About 50% of the Thai population classifies for LIC
- Convergence due to inflation

- Widespread eligibility was addressed informally



Lessons and challenges

- Income criteria are difficult to implement.
- It was replaced by other more flexible criteria
- Flexibility led to inconsistency in application among locations, within the community screening body
- *“The 1990 village card-allocation committee used different criteria from those of the health worker, The committee based their judgments of card eligibility on how much money each villager had loaned from the Bank for Agriculture.. The larger the debt the more likely they would be granted a card. The health worker simply based her judgment on a criterion that anybody owning more than 10 rai of rice filed would not be eligible...” (Gilson, 1998)*



Lessons and challenges

- The poor do not always ask by themselves to be identified and aggressive “supply driven” mechanisms of information dissemination may be necessary
- Member composition of screening bodies has to be adjusted to reach a balance of skills and powers



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Lessons and challenges

- Exemptions given were not fully compensated
- Creates incentives to give lower quality care to card holders
- Funding should reflect expected outlays



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Lessons and Challenges

- Thailand achieved increasing equity in allocation formulas



Lessons and challenges

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- Sufficiency of funding is key to the success of protection mechanisms
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- **Benefits and target population have to be consistent with available funding**
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Lessons and challenges

- In Thailand the following factors coexisted
 - An eligibility criteria encompassing almost 50% of the total population
 - A lot of uncompensated care
 - Possibly some discrimination against card holding patients
 - No defined benefits package
- What should be done?
 - Increase funding?
 - Reduce target population?
 - Limit benefits?



Lessons and challenges

- High coverage and low leakage is not a sufficient measurement of success of protection mechanisms
- Identifying the poor is difficult and requires the consideration of many different dimensions
- Sufficiency of funding is key to the success of protection mechanisms
- Allocation formulas are an important part of any exemption system
- Benefits and target population have to be consistent with available funding
- **Although evaluation and monitoring is key to the improvement of an exemption system, it is lacking**



Lessons and challenges

- Throughout, there has been no systematic evaluation of performance, i.e.,:
 - Coverage and leakage
 - Effective protection (access and financial protection)
 - Identification process, its costs, and other potential problems



Lessons and challenges

- LIC is one of the most successful exemption systems among all cases reviewed here
- A surprising end of story: LIC has been replaced by an even more ambitious policy called 30 baht policy, whereby all uninsured can access health care by paying \$0.70 per event.

