

Universal Health Coverage: Thailand experience

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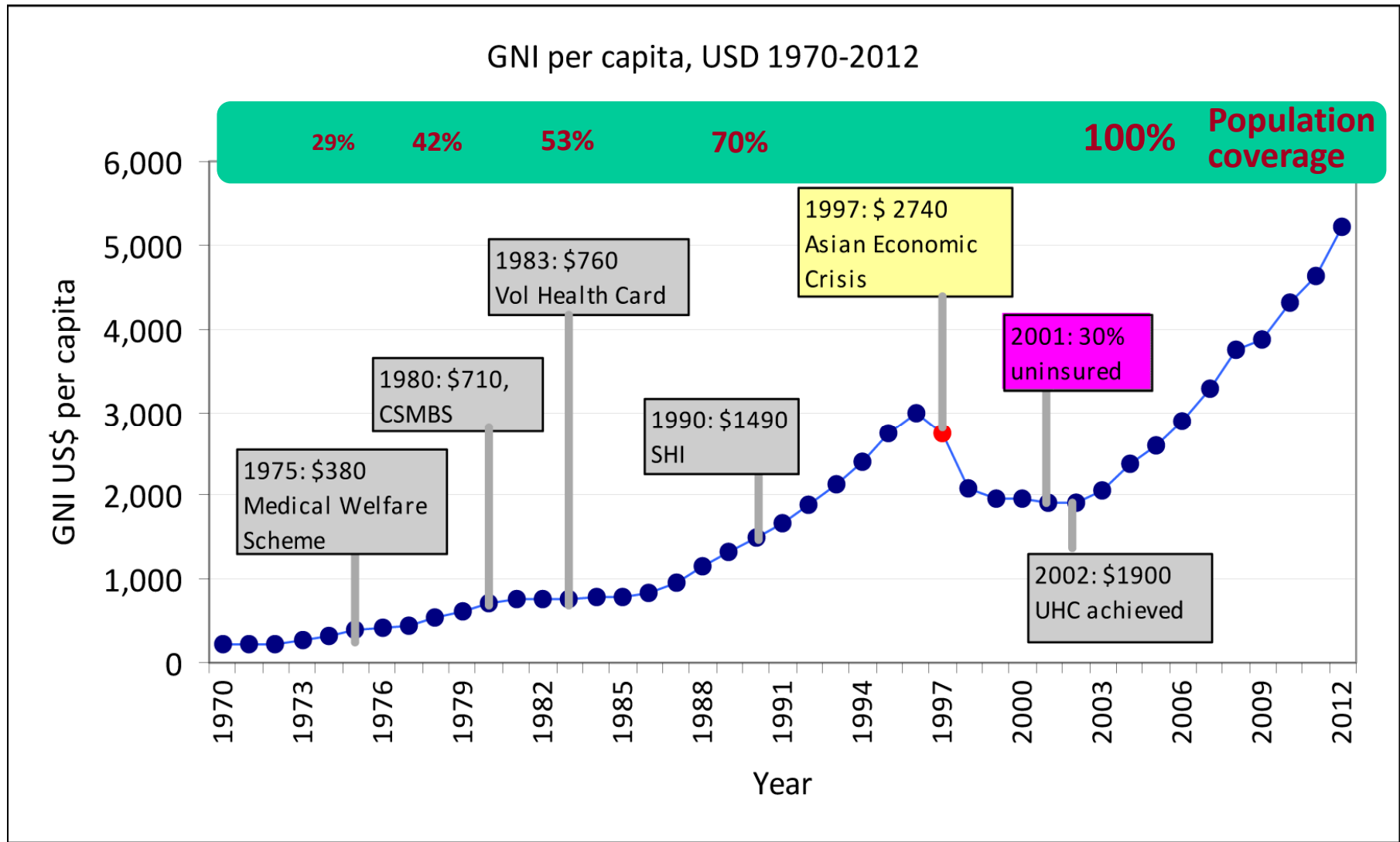
Yokohama, Japan

ASEAN-Japan 15 July 2017

Statement of the Minister of Public Health, Thailand

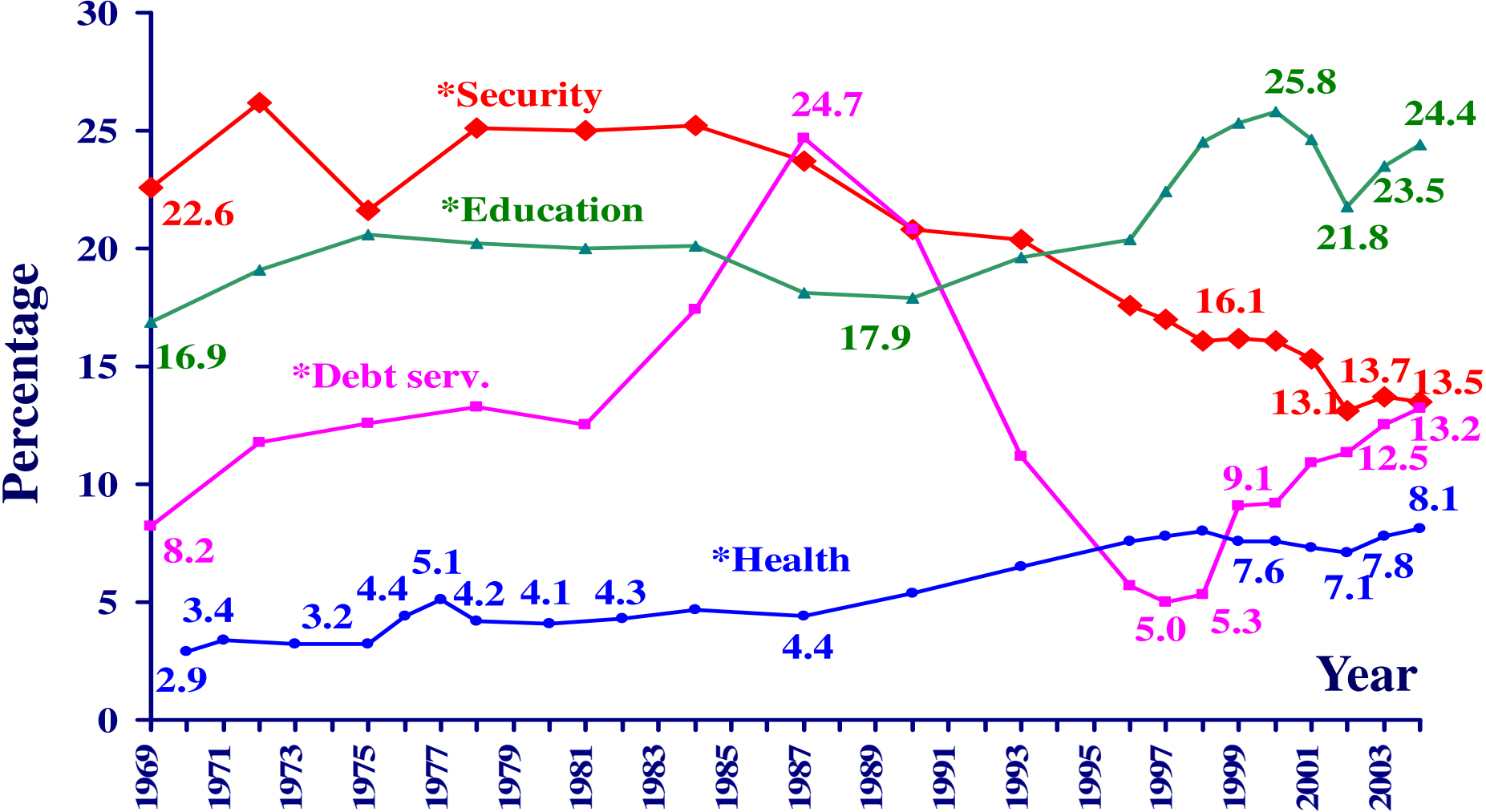
1. With strong political commitment, UHC can be started and achieved at low level of income
2. Peace and sustained economic growth mobilized 'more money for health'
3. Universal access to good quality essential health services is the real goal
4. Strong capacity on health system and policy research
5. Participatory governance systems ensures real ownership

1. UHC can be started and achieved at low to middle income level



2. Peace and sustained economic growth mobilized 'more money for health'

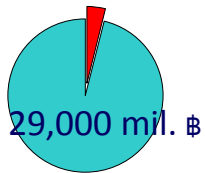
From security and debt service budget to health



Source: Bureau of Budget; Dr.Suwit's presentation 30 Sept 2011

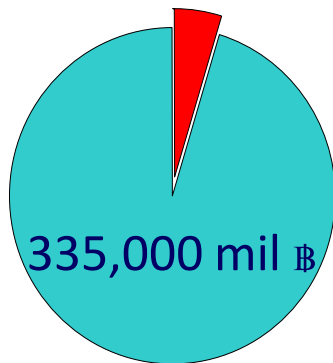
More budget to health

986.6 mil. ₪
(3.4%)



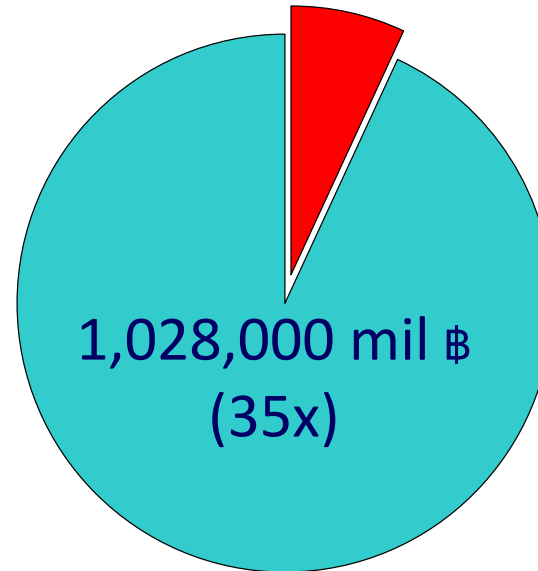
1972

16,225.1 mil. ₪
(4.8%)



1990

77,720.7 mil. ₪ (78x)
(8.1%)



2004

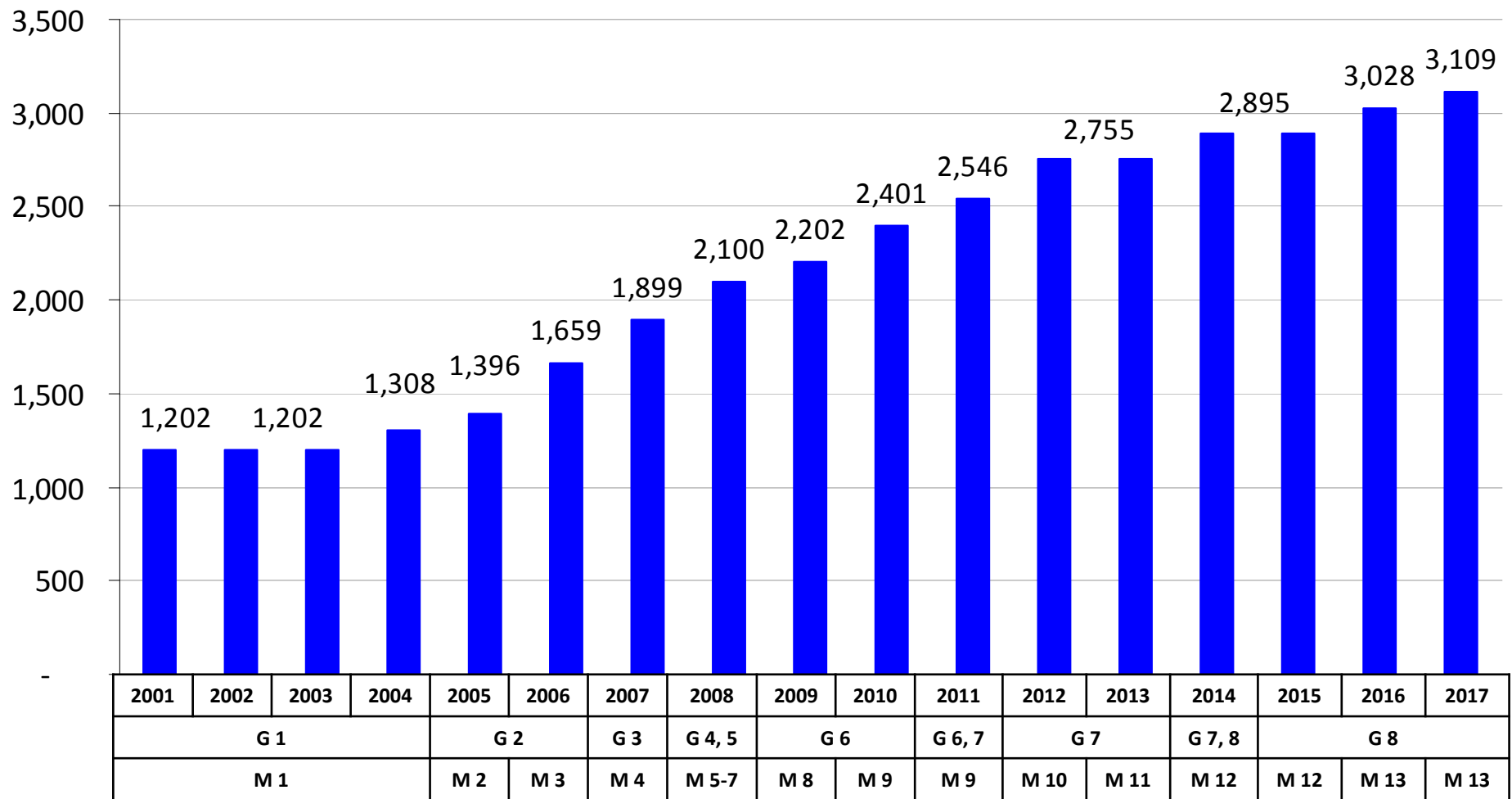
2011 Budget
for health rose
to 13% of
government
budget

 Government budget

 Budget for health

Continued political commitment to UC Scheme: Budget, Baht per capita, by Regime 2002-2017

8 governments, 13 Health Ministers, 11 Permanent Secretaries

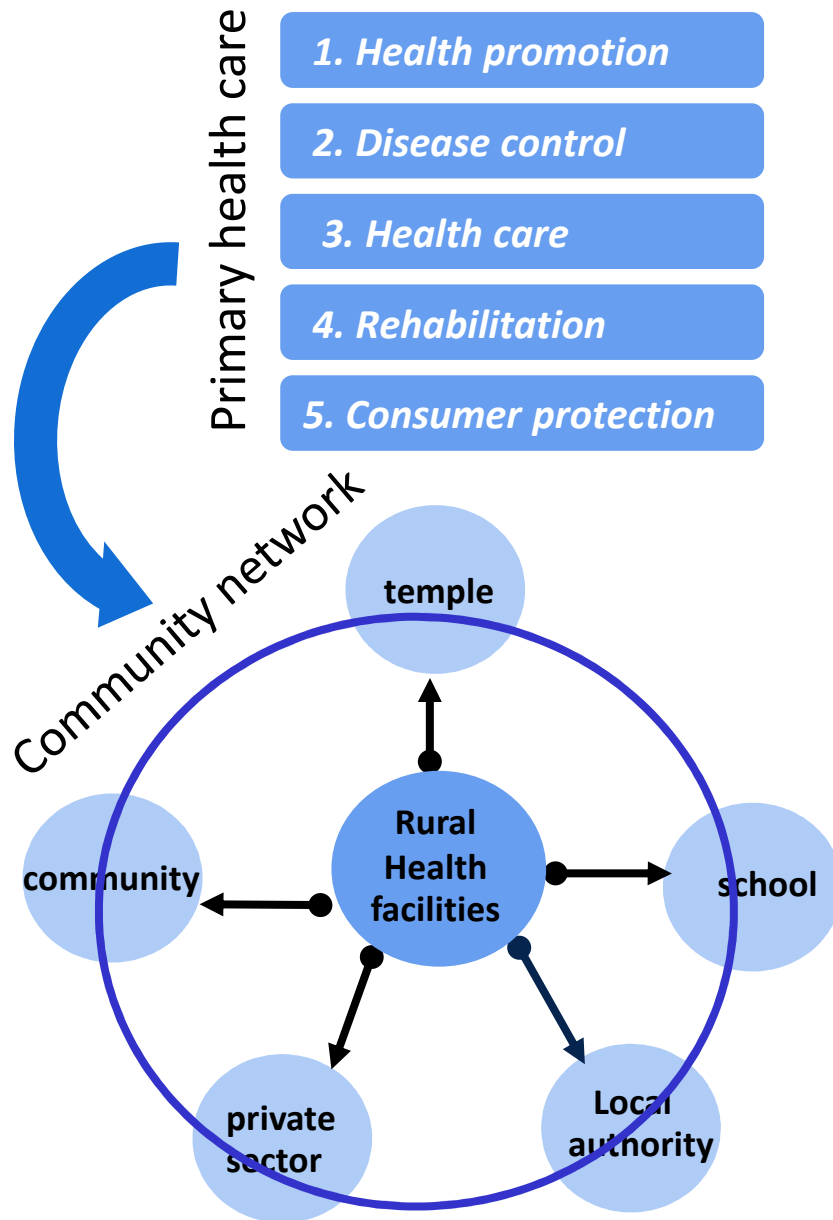


3. Universal access to good quality essential health services is the real goal

- Free but inaccessible health services and/or poor quality is not UHC.
- Thai's UHC focuses on Primary Health Care.
- Evolution of rural health systems since before UHC
 - 780 district hospitals: one district hospital per district
 - 9,777 health centers: one health center per rural commune
- Rapid increase in HRH training, i.e., doctors, nurses, voluntary health volunteers, etc, through *“rural recruitment, local training and hometown placement”* and compulsory public work for graduates with adequate motivation and incentives;

District health system: hub for pro-poor outcomes

The Lancet 2013;381:2118-33.

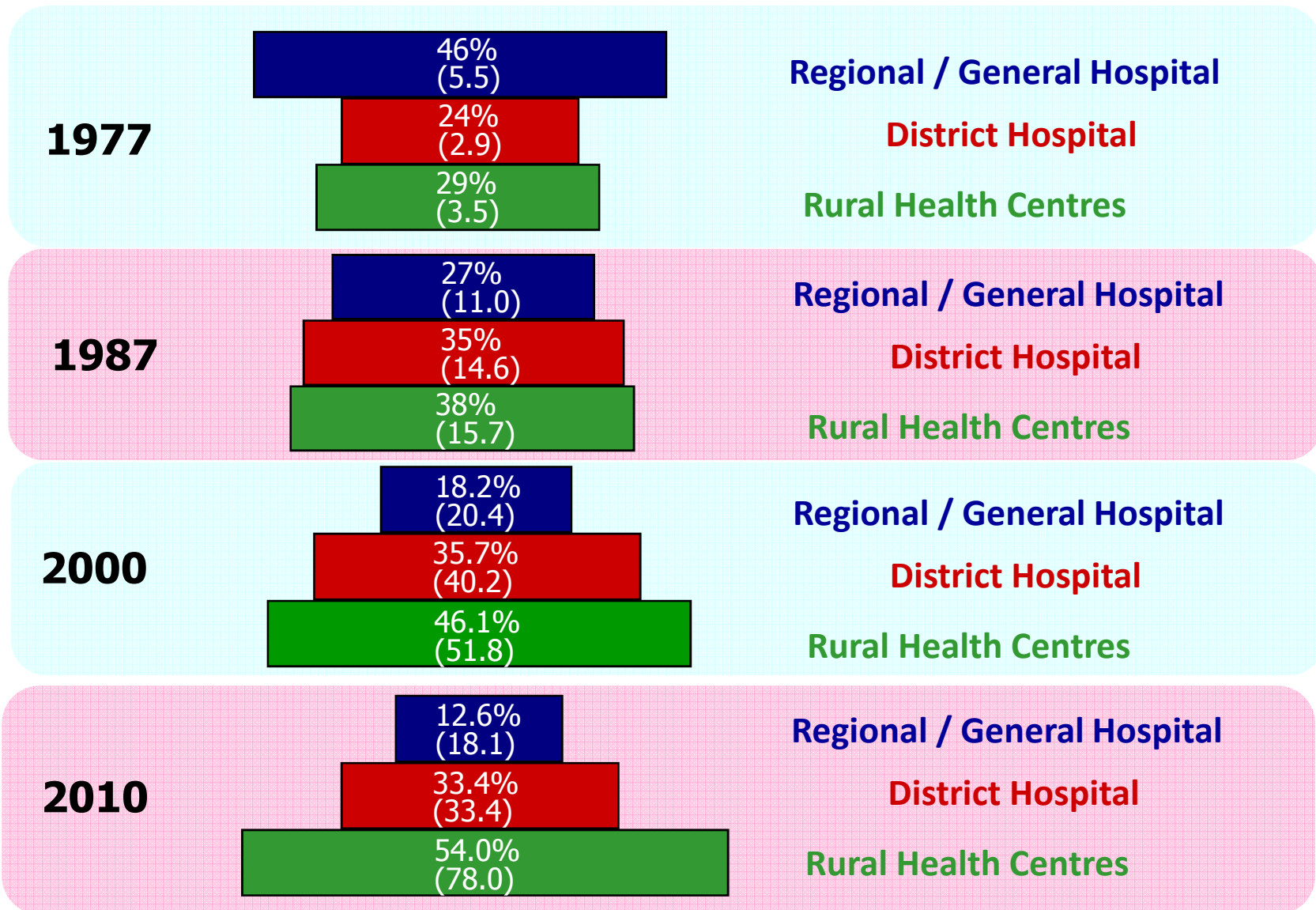


Rural health centers with 3-6 nurses and paramedics cover 2,000-5,000 population



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

4. Strong capacity on health system and policy research

- Home grown technical capacities
 - Designing and implementing UC scheme
 - Provider payment methods: capitation, DRGs, fee schedule
 - IT to support UHC
 - Medical audit
 - Priority setting using many tools, including health technology assessment, budget impacts, supply side readiness,
 - Monitoring progress of UHC
 - Population coverage using citizen ID of CRVS; everyone is count
 - Service coverage -> effective coverage of 6 conditions: HIV, TB, cervical cancer, DM, Hypertension, cerebrovascular disease
 - Financial risk protection: catastrophic and medical impoverishment

UC Scheme 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.

New interventions assessed for service coverage

Contribution by IHPP and HITAP

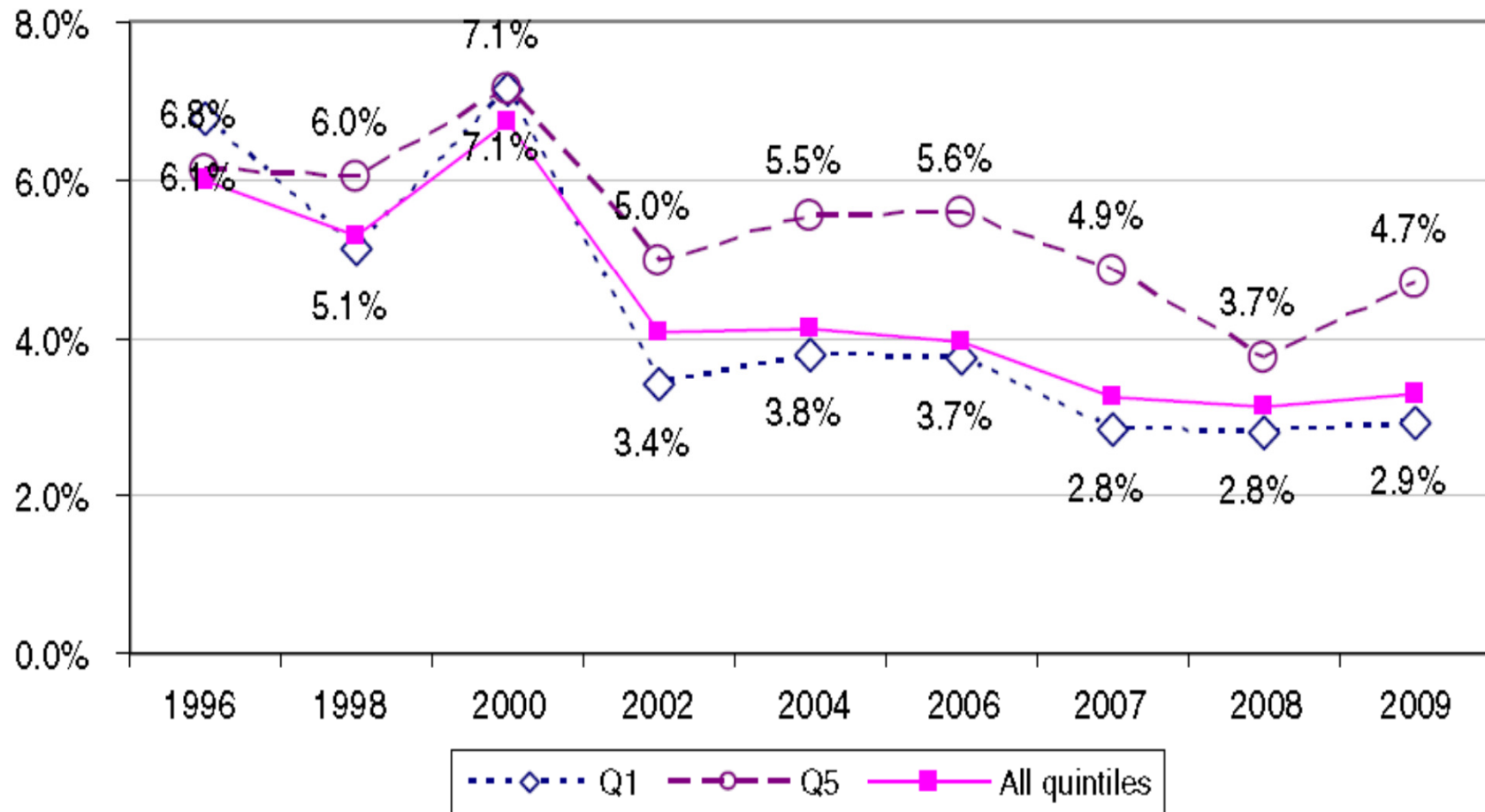
Interventions (Indication)	Cost-effectiveness	Budget impact	UC Scheme coverage
Lamivudine (Chronic hepatitis B)	Cost-saving	Low	Yes
Cyclophosphamide + azathioprine (Severe lupus nephritis)	Cost-saving	Low	Yes
Peg-interferon alpha 2a + ribavirin (Chronic hepatitis C)	Cost-effective (ICER=86,600*)	High	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: * Threshold: ICER = 160,000 ThaiBaht per QALY

Source: UC Benefit package project

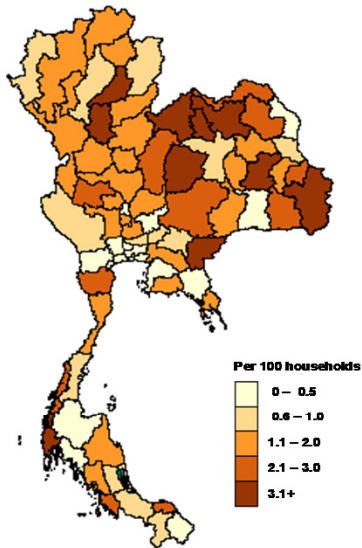
Incidence of catastrophic health spending

>10% of household expenditure, before and after UC Scheme in 2002

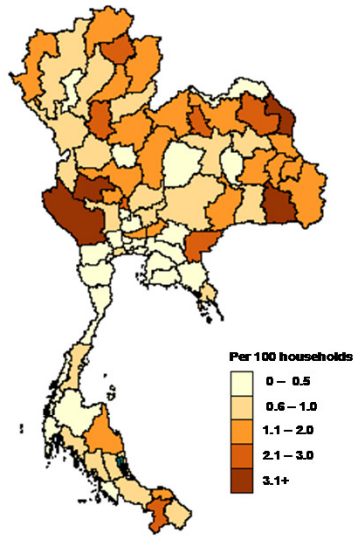


[Health Research Policy and Systems 2013;11:25](#)

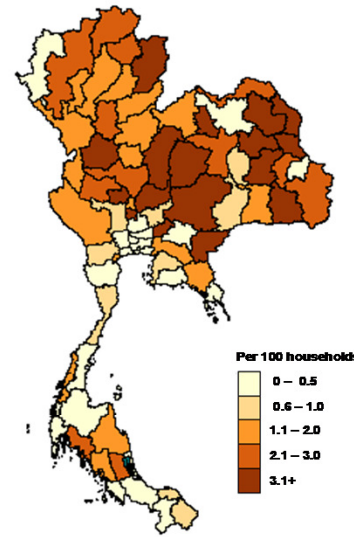
Sub-national health impoverishment 1996 to 2008



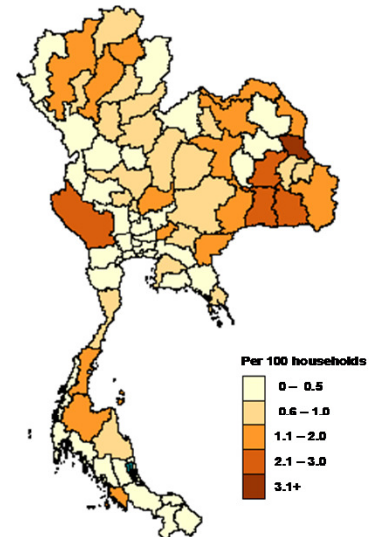
1996



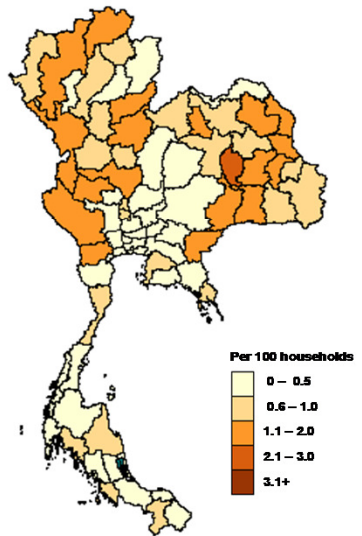
1998



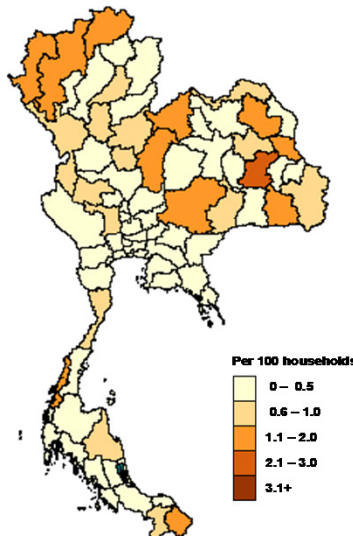
2000



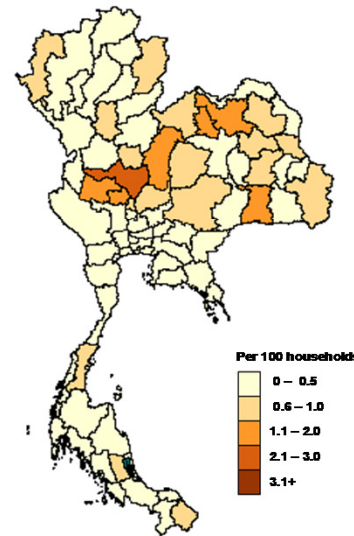
2002



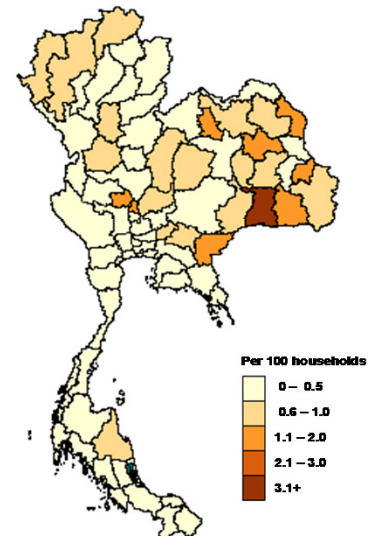
2004



2006



2007



2008

5. Participatory governance systems ensures real ownership

- Voices of people
 - Board of UC scheme: 5 seats from civil society (out of 30), chaired by the Minister of Health
 - satisfaction survey of providers and patients
 - Call Center 1330 of UC Scheme
 - Annual public hearing at the national level, regional level and now extend to provincial level

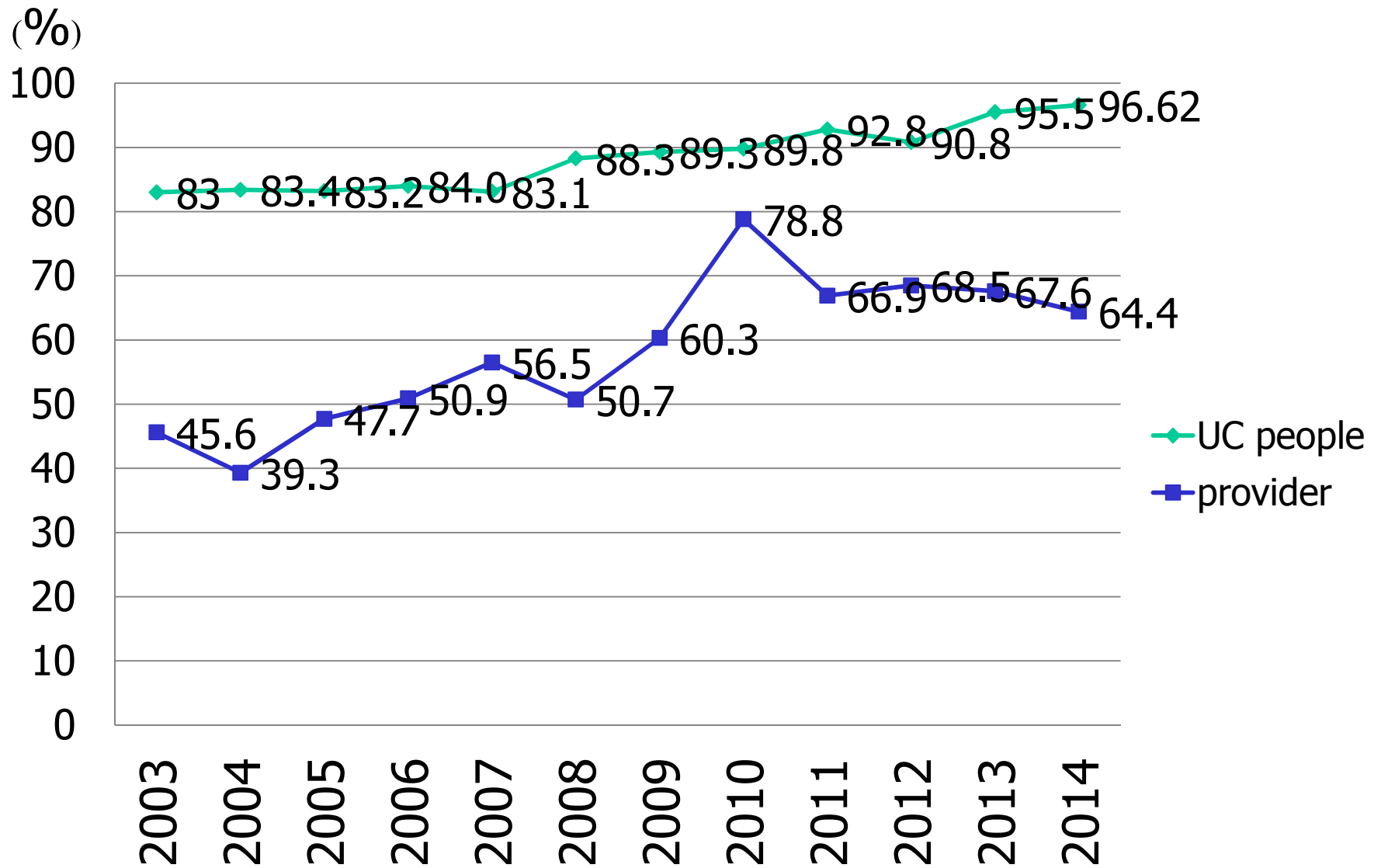


Call Center 1330 of UC Scheme



Public hearing of UC Scheme

Satisfaction of UC beneficiaries & health care providers

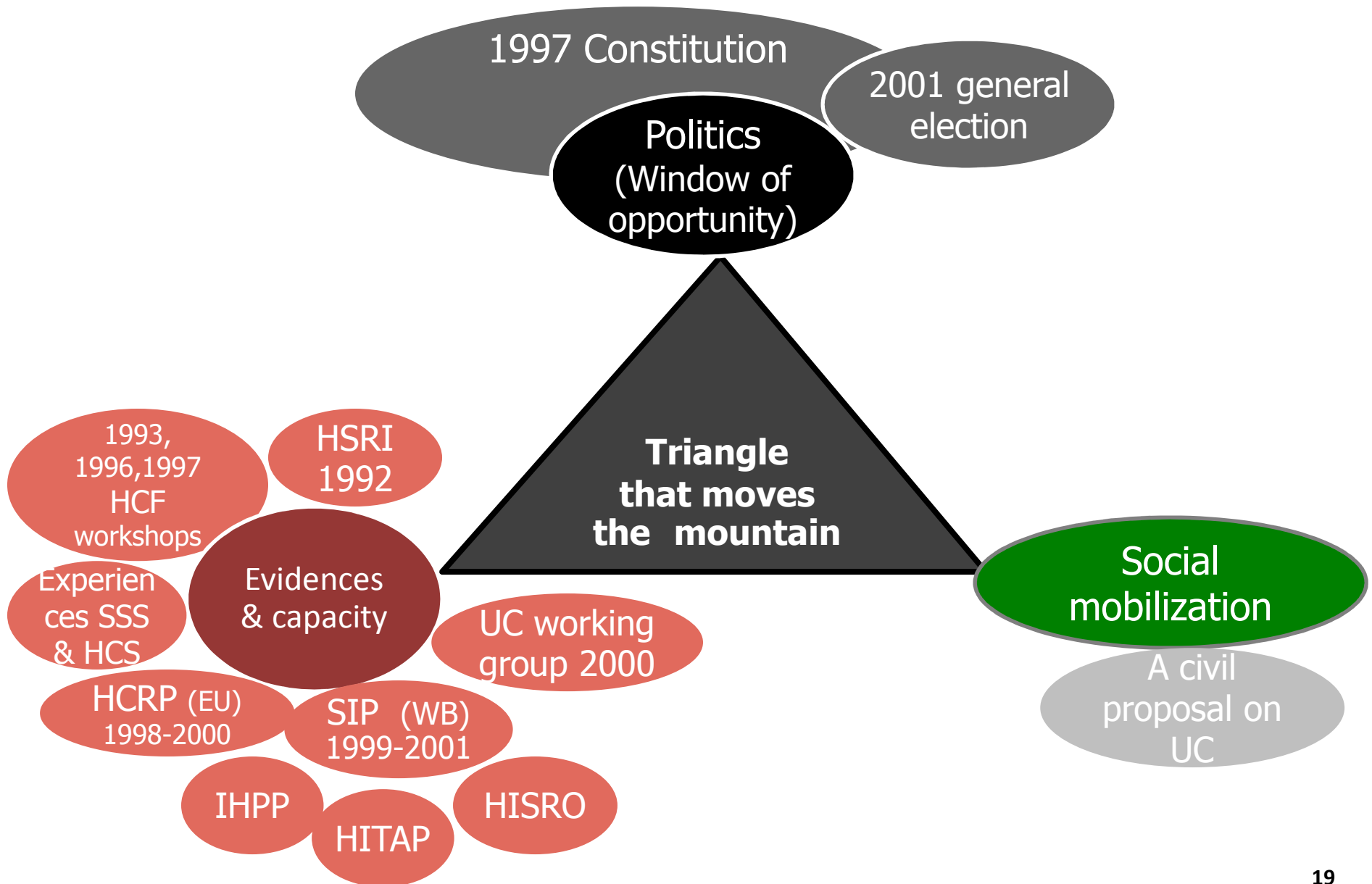


Source: NHSO

Summary

- UHC is context specific – learn from others and adapt but not copied
- Political and financial commitment is the key factors – on both health systems development and financial protection
- Ensuring equitable access to and good quality of health care services is as important as the financial protection
- The success of UHC depends much on the spirit of committed health workers not only money
- National capacity for evidence based policy is really needed

Situations that lead to reform



Thank you for your attention