HEALTH EQUITY AND FINANCIAL PROTECTION IN ASIA

POLICY BRIEF

MAKING GOOD ON THE PROMISE OF UNIVERSAL COVERAGE IN THAILAND

Prior to 2002, health insurance systems in Thailand were characterised by fragmentation, duplication and incomplete coverage. The Universal Coverage Scheme was introduced in 2002 with the aim of providing access to comprehensive healthcare for all Thais not covered through formal employment-based health insurance. This policy brief provides the background, and assesses the impact.

THAILAND – A PROVING GROUND FOR COST-EFFECTIVE UNIVERSAL COVERAGE?

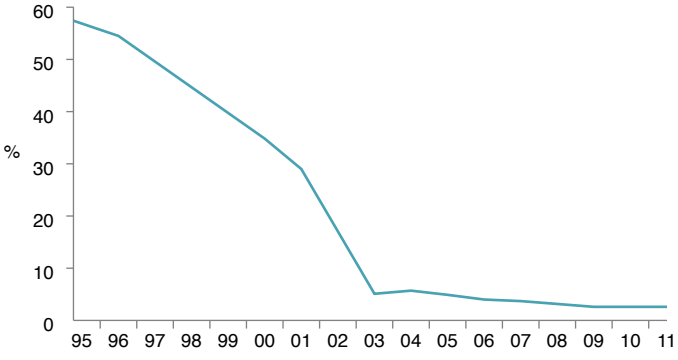
Ever more countries are proclaiming the goal of universal health coverage – comprehensive, effective and affordable healthcare for all. The World Health Organization (WHO) also champions the cause and maintains that its pursuit is feasible everywhere. Yet, sceptics may doubt whether a middle-income, let alone a low-income, country with a narrow tax base can realistically hope to insure its entire population against the cost of most treatments without substantial cost sharing.

Thailand provides perhaps the best example of whether it is indeed feasible to deliver, and not merely promise, universal coverage on a very limited budget. Since 2002, all Thai citizens not insured through formal sector employment have been entitled to comprehensive curative and preventive care through a scheme that initially charged a copayment of less than US $1 per treatment, and later dropped even this, and had an annual budget of only $30 per enrollee.

The insurance expansion was accompanied by supply side measures intended to control costs and deliver cost-effective care: a single public payer with a fixed global budget; capitation for outpatient services and prospective provider payment for inpatient admissions; gatekeeper access to tertiary care; and movement towards a purchaser-provider split. Yet demonstrably, universal and comprehensive coverage cannot be conjured out of thin air. Total health expenditure per capita increased by one sixth in the year of the coverage extension, and then doubled in the following decade but remained below 4 per cent of GDP.

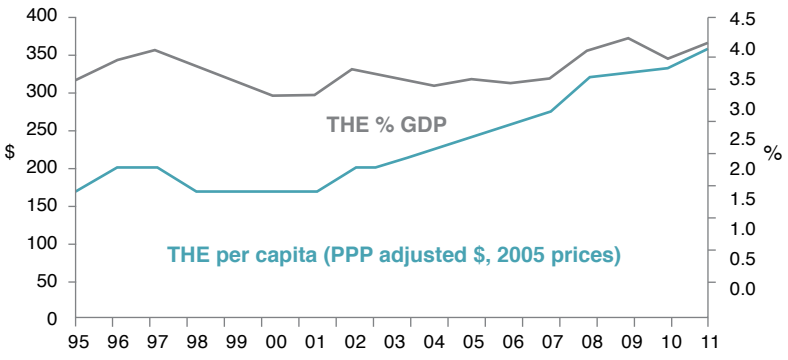
The HEFPA project has examined whether the Thai reform was able to make good on the promise that universal health coverage would raise access to needed medical care and better protect household finances from medical expenses.

UNINSURED, 1995-2011



Source: *Thailand Health* and *Welfare Survey*, various years

TOTAL HEALTH EXPENDITURE (THE), 1995-2011



Source: Thai national health accounts, various years

THE THAI UNIVERSAL COVERAGE-REFORM

DEMAND SIDE

Within one year from April 2001, the 70 per cent of Thai citizens not insured through formal sector employment were given entitlement to comprehensive medical care, including medicines prescribed from an essential drug list and high-cost treatments (eg. open-heart surgery, chemotherapy), at local, mainly public, provider networks. The Universal Coverage Scheme (UCS) raised the percentage of the population covered by some form of health insurance from 71 per cent immediately prior to its introduction, to 95 per cent in 2003. The tax-financed scheme initially charged only 30 Baht ($0.75) per service contact, with exemptions made for the poor, children and the elderly. Even this modest copayment was abolished in 2006 (before being partially reinstated in 2012).

SUPPLY SIDE

The UCS reform accompanied the demand side extension with various supply side measures to maintain cost control and improve spending efficiency. First, citizens register with a Contracting Unit for Primary Care (CUP) consisting of a district hospital and several health centres through which referral to other CUPs and higher level providers is controlled. Second, the UCS operates under a capped global budget fixed by the number of enrollees multiplied by an annually negotiated capitation rate, which has increased by 71 per cent in real terms over 10 years. Third, within the global budget, ambulatory and preventive care budgets are prospectively allocated to CUPs by a capitation formula and inpatient care is paid according to Diagnosis Related Group tariffs. Finally, the 2001 reform initiated movement towards a purchaser-provider split, with the National Health Security Office, which was fully functional by 2006, exercising the purchasing role.

Q WHAT IMPACT DID UNIVERSAL COVERAGE HAVE ON ACCESS AND FINANCIAL PROTECTION?

The HEFPA evaluation indicates that the universal coverage reform reduced the probability of a sick person going without formal ambulatory treatment by 3.2 percentage points (or around one tenth relative to baseline).[1] The reduction in forgone medical care was even larger among the poor, rural and, in particular, elderly populations. Since the poor and the elderly were, in principle, covered before the reform through a targeted scheme, universal entitlement and the budget increase accompanying the reform appear to have made nominal coverage of these groups effective. The UCS also raised the probability of inpatient admission by 1 percentage point (almost one fifth) in its overall target population, with larger increases among the elderly and urban populations. The scheme however did not have a significant impact on inpatient admissions in rural areas.

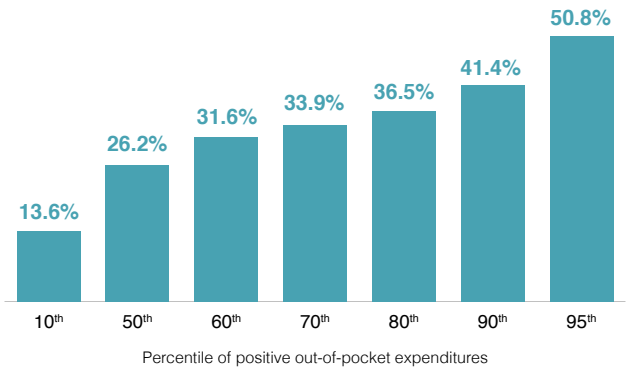
Increased utilisation of public outpatient and inpatient care was achieved without any crowding out of private sector care. Within the public sector, the location of care was shifted from provincial to district hospitals consistent with the reform assigning a gatekeeper role to a provider network consisting of the district hospital and surrounding health centres. The likelihood that the highest level of ambulatory care was received at a health centre fell in favour of treatment at a district hospital, which may be due to the increased affordability of the latter.

Universal coverage also greatly improved financial protection against medical expenditure risks. It reduced average household out-of-pocket (OOP) medical spending by one third.[1] Household spending on ambulatory care and on medicines was cut by one quarter and almost two fifths respectively. There was no overall impact on average spending on inpatient treatment. This results from the offsetting effects of a rise in the propensity to make any payment for inpatient care, reflecting its greater affordability, and a one third decrease in the amount paid among those incurring expenses.

The reform was particularly successful in reducing exposure to the risk of incurring extremely high medical expenses that could have devastating, impoverishing consequences. The share of Thai households incurring so-called 'catastrophic payments' – namely OOP spending exceeding 10 per cent of the household budget – was decreased from 5.8 per cent immediately before the reform to 3.8 per cent. While spending at the 10th percentile of the distribution of (positive) medical expenditures was reduced by a significant but relatively modest 14 per cent, spending at the middle of the distribution fell by over a quarter and at the very top of the distribution (i.e. the 95th percentile) it was reduced by half. The proportion of households impoverished by medical expenses is also likely to have fallen substantially.[2]

These findings confirm that the promise of universal coverage was brought to fruition in Thailand. It gave citizens greater access to treatment when they were taken ill, and better protected them from the burden that medical care can impose on household finances.

REDUCTION IN OUT-OF-POCKET EXPENDITURE AT PERCENTILES DUE TO UCS

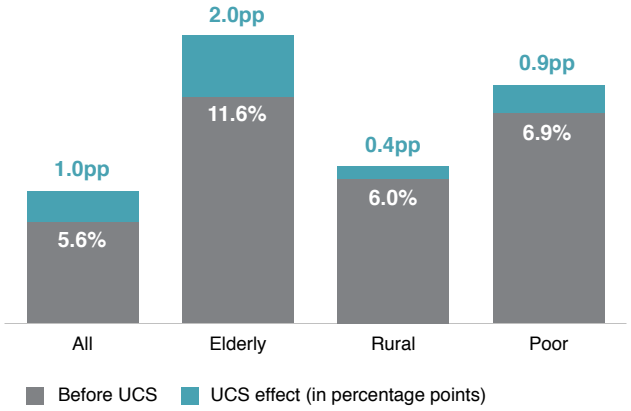


HOW THE FINDINGS WERE OBTAINED

The impact of the UCS reform was determined by comparing the change in healthcare utilisation (and household medical expenditure) – between the periods before and after the reform – for population groups to whom coverage was extended through the UCS, to the corresponding changes for public sector workers and their dependents whose insurance coverage did not change. This difference-in-differences method reveals the effect of the reform, provided that in its absence, the healthcare utilisation (and medical spending) of the population that was covered by the UCS would have changed to the same degree as experienced by public sector workers. Under this assumption, one subtracts from the observed change in healthcare utilisation (and spending) the change that would have occurred in any case, to thereby reveal the specific change induced by the reform.

REDUCED PROBABILITY OF FORGOING TREATMENT WHEN SICK DUE TO UCS (IN PERCENTAGE POINTS)

PROBABILITY OF ADMISSION TO PUBLIC HOSPITAL



REMAINING AND EMERGING CHALLENGES TO UNIVERSALITY

While the Thai universal coverage reform has been successful, it has nevertheless left some healthcare problems unaddressed, and has done little to avoid others arising. The extension of coverage did not eradicate geographic differences in access to healthcare. While it greatly improved access to ambulatory care in rural settings, the impact on inpatient treatment in these locations was more muted. This may be partly attributable to the failure of the reform to realise its ambition of redistributing medical manpower to hitherto understaffed areas. An attempt to tie finance for salaries to population size met with fierce resistance from the more generously staffed urban and central areas and was consequently repealed.

Inequity continues to exist not only across locality but also between healthcare schemes. Despite the gradually increasing UCS budget, the spending gap compared to the public employee scheme is large and widening. Per capita spending for the latter was about five times that of the UCS in 2010. While there is no clear evidence to prove it, the large financing gap may very well generate clinically significant differences in healthcare quality. The distribution of healthcare is generally pro-poor in Thailand, even after taking the greater medical need of the poor into account, but better-off do make greater use outpatient care at tertiary hospitals.[3,4] Potentially, this could serve to undermine support for the UCS, should it come to be seen as a poor man's service from which the slightly better off prefer to opt out.

Affordability is perhaps the major challenge to universal coverage. The accelerating budget of the public employee scheme is a major contributor to the mounting pressure on government health spending and a priority on the current Thai healthcare reform agenda. At the same time, the UCS spending increase has raised concerns about its financial sustainability and brought ideas of cost sharing back to the policy debate.

The Thai experience proves that effective universal coverage can be delivered on a limited budget. However, achieving this goal is contingent upon a variety of factors: previous investment in facilities and manpower; careful design of the health system architecture to provide incentives for cost-effectiveness; and a sufficiently healthy economy to provide the additional resources that a major expansion of coverage will inevitably require.

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PROJECT IDENTITY

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- **World Bank Development Research Group** http://econ.worldbank.org/

FURTHER INFORMATION

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