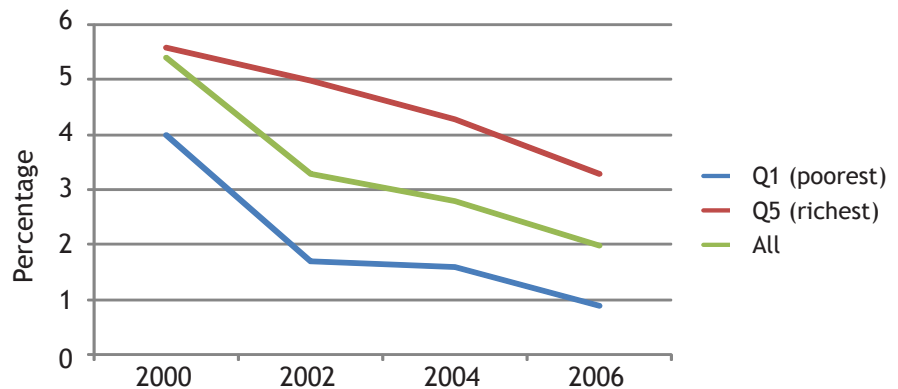


## BACKGROUND

Thailand achieved universal coverage in access to health care in 2002. Since then, there has been a dramatic reduction in the prevalence of catastrophic health expenditures reflecting the capacity of the main public health insurance schemes to protect their members from financial risks owing to medical care costs' [see Figure 1].

This policy brief draws on evidence from a recent study of the Social Health Insurance (SHI) and Universal Coverage (UC) schemes. It identifies the key features of these schemes which have contributed to the reduction in catastrophic expenditures.

Figure 1: Incidence of catastrophic health expenditure in Thailand exceeding 10% of total household income (2000-2006)



Source: The impact of universal coverage on equity in health care finance and financial risk protection in Thailand.

## METHODS USED

Qualitative approaches were used, including document reviews and in-depth interviews conducted with three groups of stakeholders: purchasers, providers and patients.

- In-depth interviews with key informants from National Health Security Office (NHSO) for the UC scheme, and Social Security Office for SHI.
- In-depth interviews with key informants from public and private SHI and UC contractor providers in Samutsakhon province located near Bangkok.
- Several interviews with 65 patients being treated for diabetes or cancer, who were covered by either UC or SHI schemes and treated in the public and private sectors.



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The interviews were conducted at patients' houses. Information was provided from both patients and their families.

## MAIN FEATURES OF INSURANCE SCHEMES IN THAILAND

The table below highlights some of the main features of three insurance schemes available in Thailand.

	Type of insurance scheme		
	Social Health Insurance	Universal Coverage Scheme	Civil Servant Medical Benefit Scheme
<b>Legal framework</b>	Social Security Act enacted 1990, implemented April 1991	Implemented May 2001. National Health Security Act enacted, Nov. 2002	Royal Decree 1980
<b>Population eligible</b>	Private sector employees (excluding dependants)	The population not covered by SHI and CSMBS	Govt employees + dependants (parents, spouse and up to 2 children age <20)
<b>% of population</b>	16%	75%	9%
<b>Financing source</b>	Equal contributions from employer, employee and govt.	General tax	General tax, non-contributory scheme
<b>Purchasing agency</b>	Social Security Office, Ministry of Labour	National Health Security Office (Independent public agency)	Comptroller Generals Department, Ministry of Finance
<b>Mode of provider payment</b>	Capitation for inclusive outpatient and inpatient services	Capitation for outpatient and global budget plus DRG for inpatients	Fee for service, direct disbursement to mostly public providers
<b>Access to service</b>	Registered public and private competing contractors	Registered contractor provider, notably district health system	Free choice of providers, no registration required

Note: Only the Social Health Insurance and Universal Coverage Schemes were compared in the research.

Source: <sup>2</sup>

### SOCIAL HEALTH INSURANCE: PIONEER IN RISK PROTECTION AND PREDECESSOR OF UNIVERSAL COVERAGE SCHEME

Since its creation in 1990, SHI has had the explicit aim of protecting its members from the financial risk of illness. Two key features of the system are its comprehensive benefit package and its method of paying health care providers. SHI uses a capitation payment (a fixed amount per person enrolled with a particular provider), which is inclusive of outpatient service costs. It also provides an additional payment to providers based on a fee schedule for high cost services.

SHI members and their families are therefore well protected from financial catastrophe caused by use of these costly services including cancer treatment, anti-retroviral treatment (ART) and renal replacement therapy (RRT). SHI is the predecessor of the UC scheme and shares a number of design features, in particular the close-end provider payment contract model and benefit package design.

### UNIVERSAL COVERAGE SCHEME: PROVIDER PAYMENT DESIGN FOR BETTER FINANCIAL PROTECTION

One key difference between the schemes is that the UC scheme separates provider payment for outpatient and inpatient services: outpatient services are paid through a capitation payment, while inpatient services are paid for using diagnosis-related groups (DRGs) together with a global budget. One risk of having the SHI capitation payment include outpatient care is that providers may treat potentially high cost cases that should be hospitalised in lower-cost outpatient departments. They do this to increase their profit margin, but such actions lead to worse health outcomes.

This distorted provider behaviour and the consequent welfare loss, may encourage patients to seek care and pay for services out-of-pocket elsewhere, exposing them to greater financial risk. The provider payment design of UC scheme reduces this incentive, and in doing so supports a greater degree of financial risk protection. In light of

these distorted incentives, SHI is considering revising its provider payment methods and adopting those used in the UC scheme.

## BENEFIT PACKAGE DESIGN: INCLUSION OF HIGH COST SERVICES

The purchasing agencies for the UC and SHI schemes, NHSO and SSO, have no explicit policy statements on financial risk protection other than the NHSO commitment to provide equitable access to health care for all population groups. Nonetheless, both purchasers have taken explicit policy and implementation steps to extend their benefit package, from the current comprehensive coverage, to include high cost services that are potentially catastrophic for households. In some cases these services have been shown to be cost-effective (for example, ART, included in the benefit package from 2003)<sup>3</sup>.

However, in other cases, the dominant criterion has been the need to protect households from financial catastrophe. This is the case for the inclusion of renal replacement therapy (in 2007). A study of the impact of RRT on households showed that it can have devastating effects<sup>4</sup>; while at the same time it has been shown not

to meet conventional cost-effectiveness thresholds<sup>5</sup> and also to have substantial long term budget implications<sup>6</sup>. A further criterion influencing the decision was the achievement of equity across public insurance schemes. SHI and the Civil Servants Medical Benefits Scheme (also publicly funded) both fully cover their members for RRT.



Both outpatient and inpatient services are covered by public health insurance schemes. Patients can be admitted in the registered public and private hospitals.

## WHAT FACTORS OF THE POLICY ENVIRONMENT ENABLED THIS POLICY DEVELOPMENT?

### CAPACITY TO GENERATE EVIDENCE TO INFORM DECISION-MAKING

One key feature that enabled the UC scheme to be successfully implemented was the presence of institutional capacity to generate country-specific evidence, together with continuous interaction between researchers and partners outside NHSO and policy opportunists within the NHSO. These features of the Thai policy environment help to support the translation of evidence into effective policy decisions.

### CAPACITY OF PURCHASING ORGANISATIONS

A second enabling factor is the implementation capacity within the UC purchasing organisation - the NHSO. For example, the centrally managed Diseases Management Initiative was able to translate programme design into adequate funding, effective purchasing of medical services, monitoring and continued assessment to improve the health outcomes of UC members. Most of the senior NHSO staff have public health and medical backgrounds and hands-on experience implementing various health programmes. This is in contrast to SSO, which sits within the Ministry of Labour and whose staff do not have strong medical or public health skills.

### EVIDENCE OF SUCCESSFUL RISK PROTECTION - FEW BARRIERS TO ACCESS

Evidence from cancer and diabetes patients clearly indicates the absence of barriers to access and use of health services, suggesting that the measures outlined above have been successful in protecting households from financial risk. Referrals to high cost care are adequate, although there are some psychosocial problems for the cancer cases for which households sought alternative care or services outside the contractor providers and incurred cost.

Household payment for direct costs at the contractor providers is very minimal. However, chronic illnesses such as diabetes and cancer have major indirect financial implications for households where patients are unable to work, and caregivers may have to stop work to provide care for their family members at home. Transportation costs impose an additional burden on both patients and care givers.



## CONCLUSIONS

The combination of deepening coverage from the comprehensive package to include high cost services, and a provider payment system which reduces the incentives for providers to avoid high cost patients, appear to have been key factors in ensuring that UC and SHI members are protected from the risk of financial catastrophe due to health care payments.

This predominance of the policy objectives of financial risk protection and equity across schemes is illustrated by the recent decision to extend coverage to include RRT, an intervention that does not pass the conventional cost-effectiveness threshold, but which has been shown to have an impoverishing impact on households. Having a clear policy direction on financial risk protection, a comprehensive benefit package, and an active purchasing function based on evidence and clinical monitoring capacities, provide an important foundation for successful financial risk protection.



Regardless of age, gender and economic difference, every patient can access health services without experiencing direct financial barriers. This photo shows a diabetic clinic in a public provincial hospital.

## References

1. Limwattananon S, Tangcharoensathien V, and Prakongsai P. Catastrophic and poverty impacts of health payments: results from national household surveys in Thailand. *Bulletin of the World Health Organization* 2007; 85: 600-6.
2. Prakongsai P, Limwattananon S, and Tangcharoensathien V. The Equity impact of the universal coverage policy: lessons from Thailand. In Dov Chernichovsky, and Kara Hanson, eds. *Innovations in health system finance in developing and transitional economies*, 57-81. London: Emerald Group Publishing Limited, 2009.
3. Revenga A, Over M, Masaki E, Peerapatanapokin W, Gold J, Tangcharoensathien V, and Thanprasertsuk S. The Economics of effective AIDS treatment: evaluating policy options for Thailand. 1st ed. Washington, DC : World Bank, 2006
4. Prakongsai P, Palmer, N, Uay-Trakul P, Tangcharoensathien V, and Mills, A. The Implications of benefit package design: the impact on poor Thai households of excluding renal replacement therapy. *Journal of International Development* 2009; 21: 291-308.
5. Teerawattananon Y, Mugford M, and Tangcharoensathien V. Economic evaluation of palliative management versus peritoneal dialysis and hemodialysis for end-stage-renal disease: evidence for coverage decisions in Thailand. *Value in Health* 2007; 10: 61-72.
6. Thailand: health care for all, at a price. *Bulletin of the World Health Organization* 2010; 88: 84-5

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