

INNOVATIVE HEALTHCARE FINANCING MECHANISMS

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of Sustainable Healthcare”**

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Health Care Financing :
Goals and Methods

Case of Thailand

Historical development of health care system in Thailand

Year	Health Infrastructure	Year	HCF
1945		1945	User fees-Informal exemption
		1954	Establishment of prepayment schemes 1st Social Security Act
1962-1976	1-3rd NHP Provincial hospitals	1974 1975 1978	Work Related HI Free Care for the Poor First Private Health Insurance
1977-1986	4th -5th NHP District hospitals, Health centers	1980	Civil Servant Medical Benefit Scheme
		1983	CHF
		1990	Expansion of prepayment schemes Social Security Scheme
		1993	TAI
		1994	Expansion; MWS, SSS, VHC LIC—MWS, CHI---PVHI
		1998	Reform payment, cost control
		2001 2008	UHC Emergency Medical Act
		Remaining	SSS, CSMBS, UHC

Challenges

Although Thailand has achieved universal coverage more than a decade ago, big challenges remain.

These include:

- how to include foreign migrant workers into the healthcare system;
- how to reduce inequities in benefit packages across the existing schemes;
- how to ensure sufficient and highly-trained human resources in health to meet current shortages; and
- **what are the evolving financial mechanism** that can be used to better serve the population?

Sustainable Financing and Reform of National Health Insurance System in Thailand

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Introduction

- The three main health insurance schemes (CSMBS, SSS and UCS) in Thailand are markedly different in terms of management, financing (including subsidies by the government), payment mechanisms and benefits.

Objectives

- To review and analyze the situation of national health insurance in other comparable economies.
- To analyze the situation of existing schemes, quantitatively and qualitatively, to assess the pros and cons from the perspectives of stakeholder representatives and otherwise related parties and elicit their views on alternatives for sustainable health care financing in Thailand.

Findings

- The literature review suggests that cost containment mechanisms have been put in place for all the economies included in this study.
- Most economies employ cost sharing arrangements while ensuring social protection
- the most common form of social protection is the exclusion of vulnerable groups (e.g. children, elders and the poor). Some economies impose an upper ceiling on the extent of cost sharing, specifically payment by end-users at the point of service delivery.
- Annual caps on cost sharing should be implemented in order to avoid catastrophic payments and protect people financially.

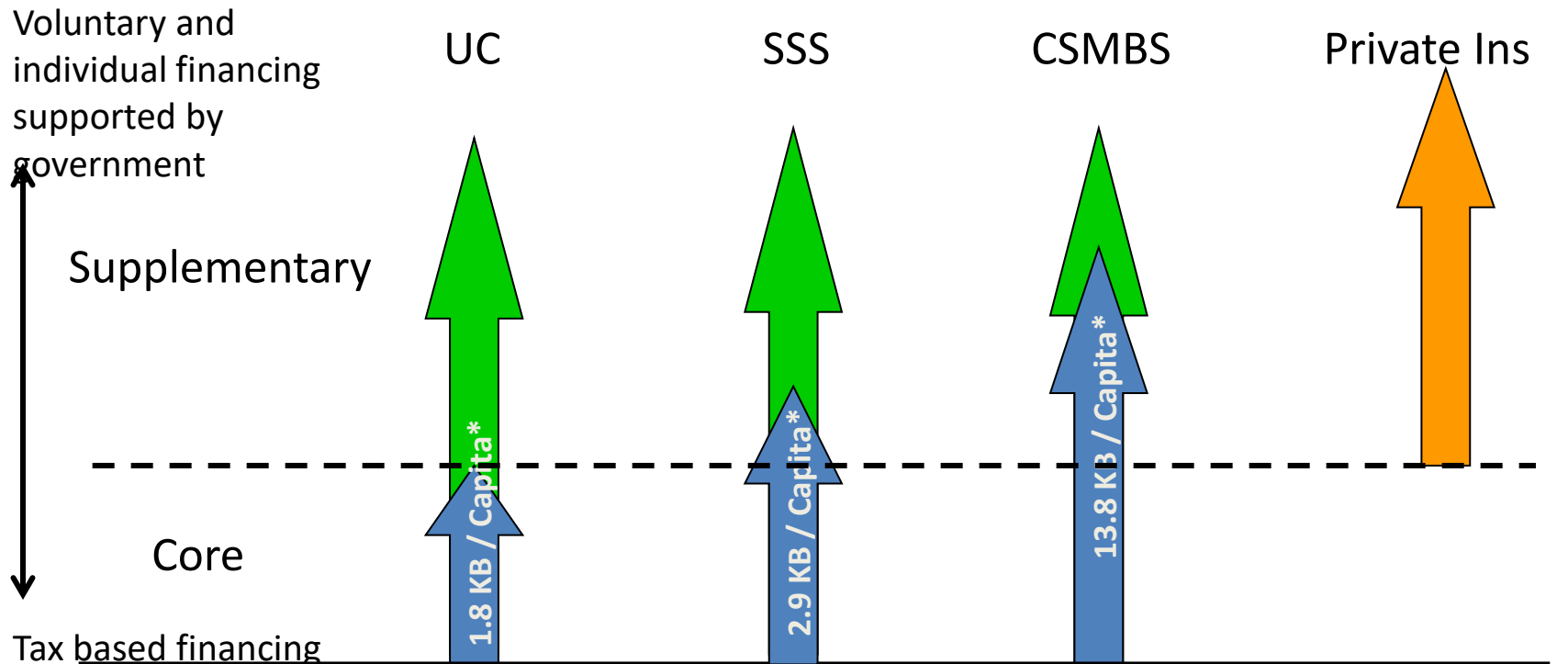
Four options are proposed.

- First, the same benefit packages (of the three existing schemes) are kept intact but wider sources of fund will be sought after.
- Second, the same benefit packages are kept intact but instead of having the government look for more funding, patients need to co-pay.
- Third, the existing packages are replaced with new ones that separate between what is known as a core and a supplementary package and with some co-payment by patients.
- Finally, all aspects of the existing schemes are kept intact but with a better, more efficient management in general and with a more thorough collection of cost data at the hospital level.

Despite no consensus among the stakeholders, some common points emerge.

- 1) the lack of cost data at the hospital level, which consequently casts doubt on whether the existing budget suffices;
- 2) the fact that hospitals face open-ended benefit packages, albeit constrained by closed-end budgeting;
- 3) the prevalence of consumer moral hazard that, owing possibly to the abandonment of the 30-baht co-payment, leads to overutilization of medical care by patients and a strain on the financial position of providers;
- 4) the fact that any introduction of co-insurance or co-payment could affect the accessibility of care, particularly among poor and unhealthy beneficiaries and, therefore, a balance between an attempt to reduce medical care utilization and one to maintain accessibility needs to be well struck; and
- 5) the potential structure of the existing schemes in the future and whether economies of scale would result, given the recently proposed idea to harmonize the three schemes.

Payment Options in the Case of Offering Core and Supplementary Packages



- Major public schemes
- Voluntary public insurance scheme
- Private insurance scheme

--- Beginning Supplementary Data in 2010
*

Voluntary and individual financing supported by government

Harmonization of Public Schemes

Private Ins

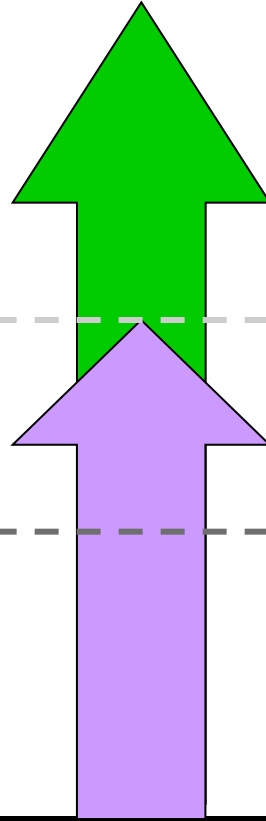


Supplementary



Core

Tax based financing



Harmonization of major public schemes



Voluntary public insurance scheme



Private insurance scheme



Future Supplementary

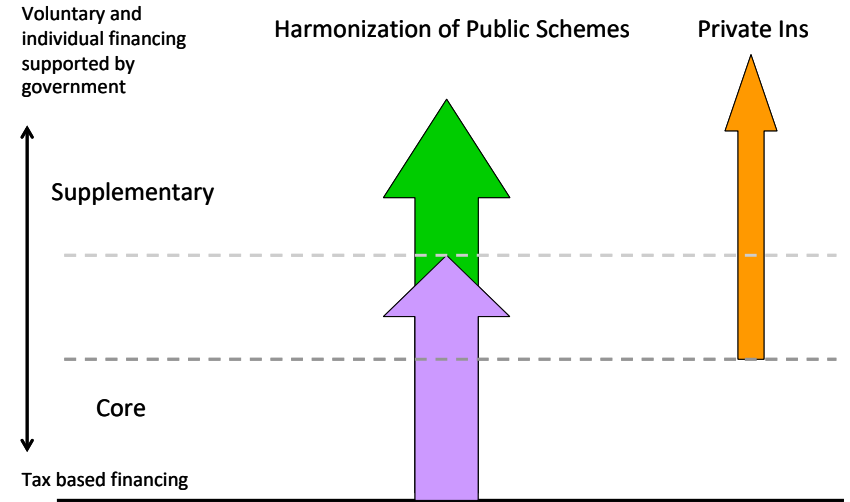
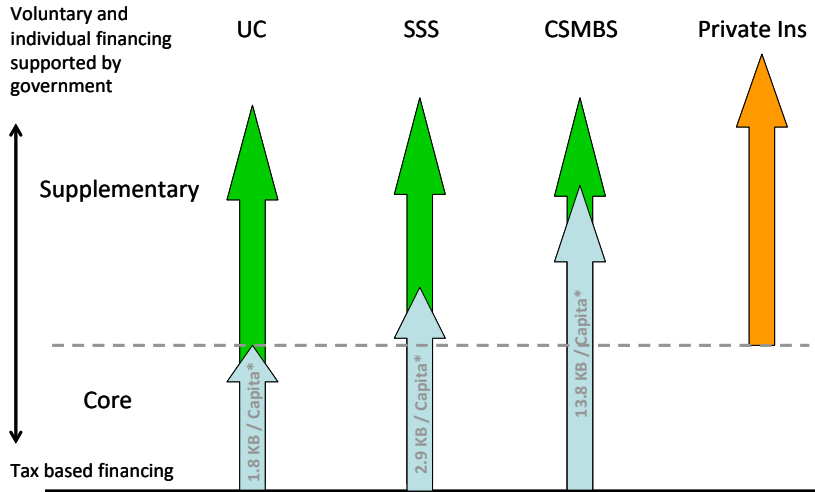


Beginning Supplementary

At Present



In the Future



- Major public schemes
- Voluntary public insurance scheme
- Private insurance scheme
- Beginning Supplementary
- * Data in 2010

- Harmonization of major public schemes
- Voluntary public insurance scheme
- Private insurance scheme
- Future Supplementary
- Beginning Supplementary

- Proposed options that require more government spending therefore might not be feasible in the short run.
- The introduction of cost sharing (Option 2), in the form of co-payment and coinsurance, while ensuring financial risk protection, is preferred in the short run. Granted that hospitals have *cost consciousness*

- In the long run, however, the provision of the core and the supplementary package (Option 3) would be ideal.
- Pre-conditions exist before this option may be implemented.
 - First, GDP should rise to the extent that the government would be able to collect enough revenues (taxes) to finance the core package.
 - Second, the core package should be comprehensive and eliminate the possibility of catastrophic payments.
 - Third, people should be made aware of the concept of a health insurance at the community level.

- What is not in the core package, the supplementary or complementary package, would be paid for by patients with some risk-pooling in the form of a health insurance.

- Risk-pooling for the supplementary package could be
 - 1) to purchase a private health insurance,
 - 2) to contribute to the public health insurance funds (keeping the existing three funds) and
 - 3) to contribute to a National Health Fund.
 - UCS beneficiaries purchase insurance for the supplementary package from a newly established public health insurance fund.
 - SSS and CSMBS on the other hand can choose to purchase insurance for the supplementary package from the new Fund or subscribe to the packages offered by their own schemes.

Conclusion

- In conclusion, this research proposes that in the short run, Option 2, where co-payment is introduced, is preferred while in the longer run, Option 3, with the distinction between the core and the supplementary packages, is preferred, given that the preconditions are met. Bearing in mind the limitations of the study, results in this research should be received with caution.

References

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Thank you