ISSUE PAPER

January 2016

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Embedding Equity in Universal Health Coverage Schemes: Lessons learned from Thailand

A collaborative work between International Health Policy Program (IHPP), Thailand and UNDP

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One of the key challenges for achieving health coverage that is truly universal is equity – yet this important aspect is often neglected. Investing in policies and systems that explicitly address the needs of the most marginalized and excluded is essential to the success of universal health coverage (UHC). This Issue Paper highlights experience from Thailand in embedding equity in UHC, and provides lessons to promote policies that 'leave no one behind'. It is based on a forthcoming publication by the United Nations Development Programme (UNDP): *The Journey of Universal Access to Antiretroviral Treatment in Thailand*, which examines efforts to pursue universal access to treatment for people living with HIV and features various equity-oriented policies and mechanisms.

KEY MESSAGES

- Marginalized people and communities face additional barriers to accessing services, such as stigma, discrimination and punitive legal environments. Without specific attention to their unique needs and circumstances, they could be left out of development gains including UHC. This is a key gap that has not received adequate attention in UHC policy discussions.
- An explicit focus on equity for the excluded and most vulnerable populations in society is critical for the success of UHC and for realizing the principle of 'leaving no one behind,' which underlies the Sustainable Development Goals (SDGs). This includes persons with disabilities, sexual and gender minorities, people living with HIV, and stateless and undocumented migrants, among others.
- Thailand has demonstrated that UHC can be designed and implemented with a strong sense of social justice and social accountability towards marginalized and vulnerable populations. Thailand's experience and innovative approaches can provide examples for other countries on incorporating equity and social justice as part of efforts towards achieving UHC.
- As part of UHC efforts, Thailand has introduced a health coverage scheme for stateless people and undocumented migrants working and living in the country. Thailand also has unique policies to facilitate service provision for people living with HIV, as well as to enable the participation of marginalized communities in UHC decision-making processes.
- In partnership with the government, communities and UN agencies, UNDP supports countries to address their unique needs and equity in UHC policy discussions, capacity development of health service providers, and enabling legal environment. It leverages its experience in the governance of HIV response with particular focus on the marginalized such as people/women living with HIV, men who have sex with men, and transgender persons.

EMBEDDED EQUITY: PROGRESSIVE REALIZATION OF UHC IN THAILAND

Equity is embedded and practiced in Thailand's health policies, where policies and programmes were deliberately designed in favour of the poor, the rural population and the most vulnerable who are often excluded from social and economic development.

Since 1975, a gradual extension of financial risk protection, using a piecemeal approach, has been applied targeting different population groups[1]. The publicly financed Medical Welfare Scheme, free at point of service, for the low income households was initiated and later extended to cover vulnerable groups such as the elderly, children aged under 12 years and persons with disabilities. Through the 1980 Decree, government employees and their dependants were covered by a publicly funded welfare scheme named the Civil Servant Medical Benefit Scheme (CSMBS). The Social Health Insurance (SHI) scheme, financed through a payroll tax covered the private sector employees through legislation under the 1990 Social Security Act. In 1984, the non-poor informal sector who are not eligible for the Medical Welfare Scheme were covered by a Community Based Health Insurance (CBHI) scheme funded by low cost premium contributions. This later was transformed to a publicly subsidized voluntary health insurance scheme where the government subsidized half of the premium.

In 2002, Thailand reached full population coverage. Beneficiaries in the Medical Welfare Schemes, beneficiaries under the CBHI and the uninsured 30 percent of the population, were combined and covered by a new Universal Coverage Scheme (UCS). The UCS was financed from general taxation, the most progressive source of finance as the rich pay a larger share of their income to taxes than do the poor.

UNIVERSAL COVERAGE SCHEME (UCS): PRO-EQUITY DESIGN AND IMPLEMENTATION

The benefit package for the UCS was to harmonize across two other public health insurance schemes, the CSMBS and SHI. All schemes fully offered comprehensive packages with the application of a negative list concept. This means all services and interventions were covered except a few explicit lists such as cosmetic surgery and other unproven effective interventions. Medicine includes all items listed in the National Essential Drug List, which was guided by cost effectiveness evidence. The comprehensive benefit package and free at point of service results in a high level of financial risk protection for citizens, especially the poor who cannot afford to pay or copay at the point of service.

It is the extensive geographical coverage of district health systems (DHS) and referral services to provincial hospitals that contribute to equitable access to diagnosis and treatment by all affected individuals. This fosters heath equity as the poor access to these services without financial barriers. Apart from good health outcomes[2], the incidence of catastrophic health expenditure in both rich and poor households has declined[3]. Pro-poor utilization results in pro-poor government health budget subsidies, as measured by the benefit incidence [4],[5].

Antiretroviral therapy (ART), initially excluded from the UCS benefit package due to its high cost, became universal in 2003. This was achieved as a result of local production of triple medicines by the Government Pharmaceutical Organization at affordable price, as well as because of strong voices by the community of affected people. The cost of ART was made affordable by the government, around US$300 per patient year. Other associated services such as laboratory costs and treatment of clinical complications from ART were also fully covered.

Additionally, various policies and mechanisms were instituted to ensure the provision and use of available services by people living with HIV, who were, and still are in some cases, highly stigmatized and discriminated against. For example, once registered in the ART systems, people living with HIV can use another unique ID number instead of the Citizen ID number to protect confidentiality. They are also allowed to access health care facilities outside their registered locality so that they can avail HIV-related services without the fear of being seen by friends or neighbours. Furthermore, a separate budget dedicated to ART was established under UCS, outside the capitation payment for outpatient services, to incentivize service providers to provide adequate HIV-related services under the capitation-based payment of UCS. ART averts HIV related mortality and improved quality of life of affected individuals, who are among the most vulnerable

in the Thai society[6]. Lives saved results in improved economic livelihood of families and prevents young children from becoming orphans.

Equity prevailed when it came to a decision on high cost dialysis. At the 2001 UCS inception, renal replacement therapy (RRT) for patients suffering from end stage renal disease (ESRD) was excluded, due mainly to its high cost[7]. Large gaps of inequity was intolerant by policy makers; CSMBS and SHI fully covers RRT for their members, while less affluent UCS patients having to pay for RRT services face catastrophic health spending or partial dialysis, often ending up with mortality leaving a huge debt behind or forcing the sale of assets to cover expensive dialysis bills[8]. With pressure from the ESRD patient group, political decisions were made to bring about universal access to RRT, based on equity across the three public insurance schemes and the right to health services as endorsed by the 2007 Constitution. Despite the fact that RRT was proven cost ineffective in technical evaluations, the decision to include it in the UCS benefit package clearly reflects equity, rights and social justice considerations for the most vulnerable in the Thai UHC policy. Recognizing cost ineffective RRT, early detection and prolongation of Chronic Kidney Diseases in progressing towards ESRD was fully funded by the UCS.

The Medical Welfare Scheme covers the low income households regardless of nationality[9]. After UCS, the legal interpretation of "Thai citizen" in the 2002 National Health Security Act as individuals of Thai nationality had negative consequences for stateless people. With pressure from civil society, lawyer and humanitarian activists, the Cabinet in 2010 launched "Health Insurance for People with Citizenship Problems" whereby a separate annual budget was approved to facilitate access to health services among this group, while in parallel accelerating citizenship approval. Not only is the extension of health coverage to stateless people an equity-oriented policy, it also provides financial support to border health care facilities to maintain their services for other vulnerable rural Thai people[10].

The sizable populations of documented and undocumented migrant workers engaged in 'three D work' (dirty, dangerous and demeaning) and their families are covered by annual premiums financed by the voluntary health insurance scheme, managed by the Ministry of Public Health. This aims to expand coverage and access to services for this group. The scheme relieves them from out of pocket payment when ill. The benefit package is very close to that of the UCS.

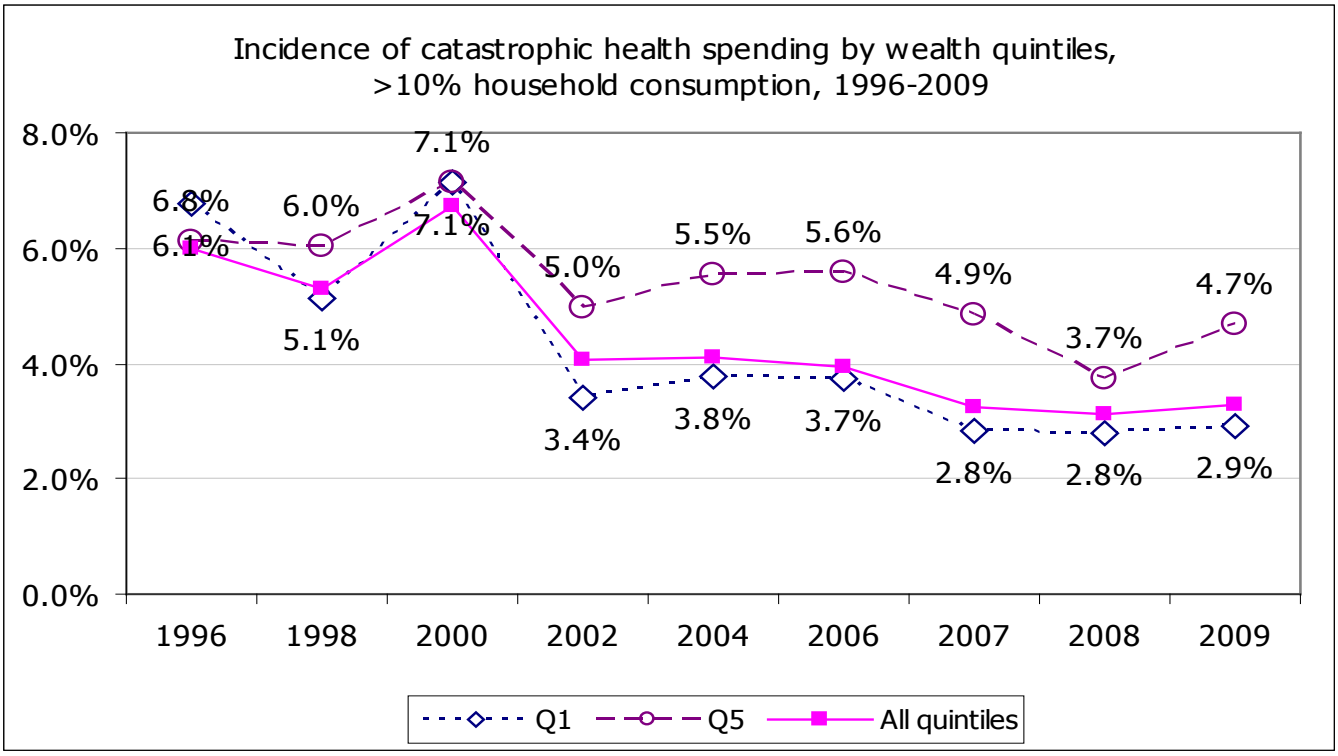
The governing body of the UCS, the National Health Security board consists of 30 board members. It was chaired by the Minister of Public Health, central and local government ex-officios, experts and provider representatives, and four Civil Society Organization (CSO) representatives also play an active role on the Board, ensuring the voices of citizens are heard and decisions are made in the public interest. The inclusiveness of CSO constituencies in the governing body of the UCS has proven critical in safeguarding public interests, and therefore highlighted as a good governance practice.

EMPIRICAL EVIDENCES: EQUITY AND FINANCIAL RISK PROTECTION

The dominant general tax financed scheme of UCS and CSMBS results in progressive financial incidence, where the rich pay a higher proportion of their income on personal income taxes than the poor. Evidence from the Health and Welfare Survey which is regularly conducted by the National Statistical Office (NSO) shows that the use of health services is preferentially in favour of the poor[4]. The "close to client" DHS, easily accessed by mostly poor rural populations due to geographical proximity, is the major hub in implementing UCS with pro-poor and equity outcomes.

Improved financial risk protection was achieved, as reflected by the very low and decreasing trend of incidence of catastrophic health expenditure[11],[12]. A Socioeconomic Survey conducted by NSO shows that average household health spending declined during the post-UCS period in the poorest and richest quintiles[13] (see Figure 1). An external assessment confirms good UCS outcomes[12].

Figure 1: Incidence of catastrophic health expenditure prior to UC (1996-2000) and after UC (2002-2009), national averages



Note: catastrophic health expenditure refers to household spending on health that exceeds 10% of total household consumption expenditure
Source: Computed from SES, conducted by the National Statistical Office

FEATURES CONTRIBUTING TO HEALTH EQUITY AND FINANCIAL RISK PROTECTION

It is the implicit ideology among Ministry of Public Health predecessors during the 1970s, well before the 1978 Alma Ata Declaration, to adhere to the principle of "good enough for the most, not the excellence for a few"[2]. This means, for example, that super-tertiary care is the best for a few urban elites who can easily access but primary health care delivered by DHS is good for the vast majority with proper referral backup. This ideology led to a three decade investment of DHS, the main platform for successful UCS implementation.

The option of a basic minimum package was defeated and the decision was in favour of a comprehensive package. Expansion to cover high cost and catastrophic illnesses boosts financial risk protection such as ART, RRT and chemo and radiation therapy for cancers. These high cost services are not "unfunded mandates" as they are fully funded by annual budgets, though within fiscal space for health. Health expenditure increased from 10.4 percent of total government budget in 2001 to 17 percent in 2013[14].

Despite political conflicts in the last 14 years, UCS flourished across 8 rival governments, 7 prime ministers, and 13 health ministers[15]. The success was achieved through the tacit approach of the "Triangle that Moves the Mountain"[16], an analogy referring to a triangle of three synergistic efforts to overcome complex challenges. The three synergies in this case being: a) the political engagement and commitment; b) guided by evidence; and c) the role of civic movements and social mobilization.

CONCLUDING REMARKS

Thailand has demonstrated that the UCS design was guided by the principle of social justice, equity and social accountability towards the socially-marginalized and most vulnerable populations. Furthermore, Thailand has demonstrated that an extensive geographical coverage of district health systems (DHS) is the UCS implementation platform leading to a pro-poor, pro-equity outcome. It has led to desirable results such as improving health of all, particularly the most vulnerable, and reducing health impoverishment, thereby significantly contributing to robust, inclusive and resilient national economic and social development of Thailand.

Without specific attention to the unique needs and circumstances of the excluded and most vulnerable who face additional barriers such as stigma, discrimination and punitive legal environment, they could be further left behind from development gains including UHC. This is a key gap that has not received adequate attention in recent UHC policy discourse.

Thailand's experience and innovative equity-oriented approaches can guide and encourage countries to give greater attention to equity and social justice as an ethical imperative in guiding their progressive realization of UHC, and even towards other Sustainable Development Goals underpinned by the principle of 'leaving no one behind'.

By illustrating Thailand's pro-equity approach, this Issue Paper reflects UNDP's commitment to supporting countries to address the challenges, needs, and rights of the excluded and most vulnerable populations. Examples of UNDP's work in this area are illustrated below.

UNDP's support related to UHC with focus on equity, social justice and excluded populations

UNDP supports countries to address equity considerations, corresponding capacity development and governance systems in UHC efforts with specific focus on the most marginalized and vulnerable. This is a key gap in UHC policy discussions today, which needs to be addressed early on if countries are to pursue universal health coverage that is truly effective and inclusive, and that 'leaves no one behind'.

UNDP has substantial experience and long engagement in addressing equity, rights and unique needs and circumstances of marginalized populations in the context of supporting countries to develop effective HIV responses.

They include people/women living with HIV, sexual minorities (men who have sex with men, transgender people), sex workers and migrants. These marginalized groups, in comparison with other vulnerable populations, face additional barriers such as stigma, discrimination, breach of confidentiality and punitive legal environments.

These additional barriers discourage the marginalized from accessing HIV-related information and services including HIV treatment even when they are widely available and free of charge. UHC efforts may risk such non-utilization of available services by the excluded and most vulnerable unless these barriers are appropriately addressed and acted upon at the policy and community levels.

The following are examples of UNDP's equity-oriented and marginalized-focused work on UHC/health system strengthening in Asia and the Pacific region:

- Documentation and regional capacity building workshops on HIV-sensitive policies and mechanisms under Thailand's UHC, in partnership with Thailand's International Cooperation Agency, the National Health Security Office, and the Ministry of Public Health.
- Development and implementation of training modules to sensitize health care providers on unique circumstances and needs of transgender people, men who have sex with men (and their female intimate partners), in partnership with the World Health Organization.

- Development of systems to record, monitor, and address rights violations and challenges such as service denial and harassment faced by sexual minorities and other marginalized populations under Indonesia's UHC, in partnership with Indonesia's National Human Rights Institution.
- Documentation of rights violations faced by women living with and affected by HIV at health care settings, and development of training modules to sensitize policy makers and health care providers on the subject.
- Development of capacity and legal frameworks to address the policy incoherence in relation to the rights of inventors, international human rights law, trade rules and public health objectives including increased access to medicines, vaccines, diagnostics and medical devices, in partnership with other UN agencies.

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