Global, Regional, and Thailand Movements on Universal Health Coverage and the Important of Quality Health Services

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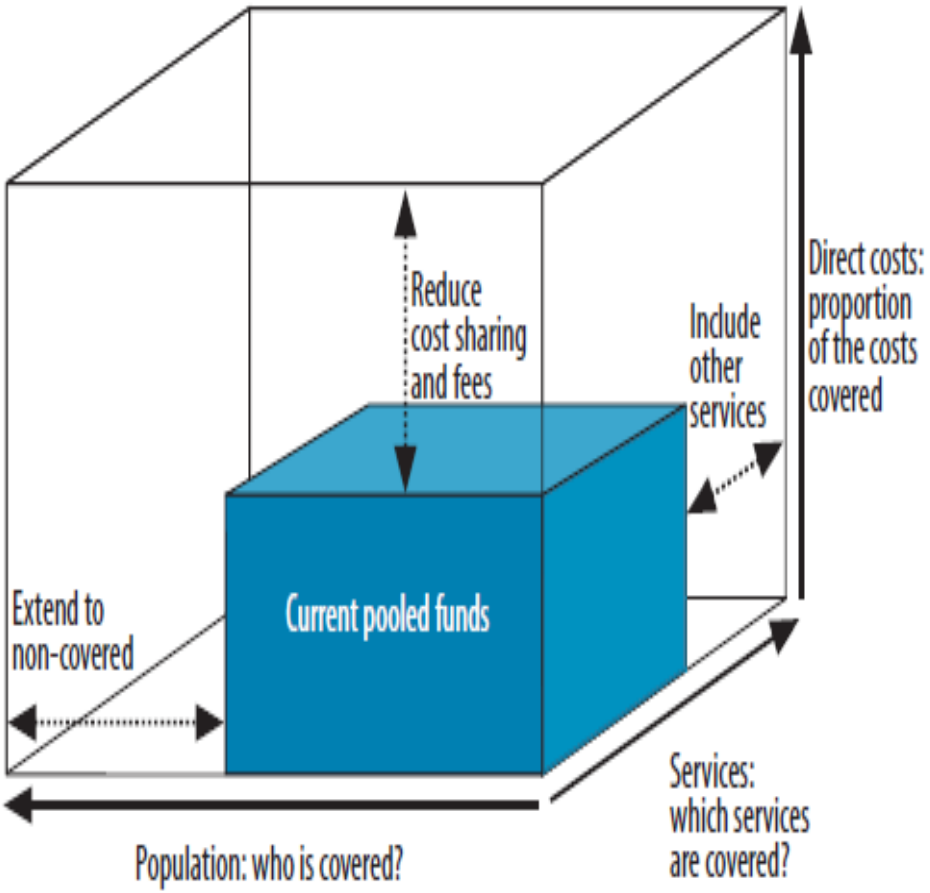
The Universal Health Coverage

- Universal **access** to **quality comprehensive** (promotion, prevention, treatment, rehabilitation and palliative care) **essential** health services and technologies, **without financial barriers**
- Free but *low quality health services* is not UHC
- Three dimensions to target on Who, What and How much to cover in the UHC in each country?

Thai UC – three dimensions of UC cube

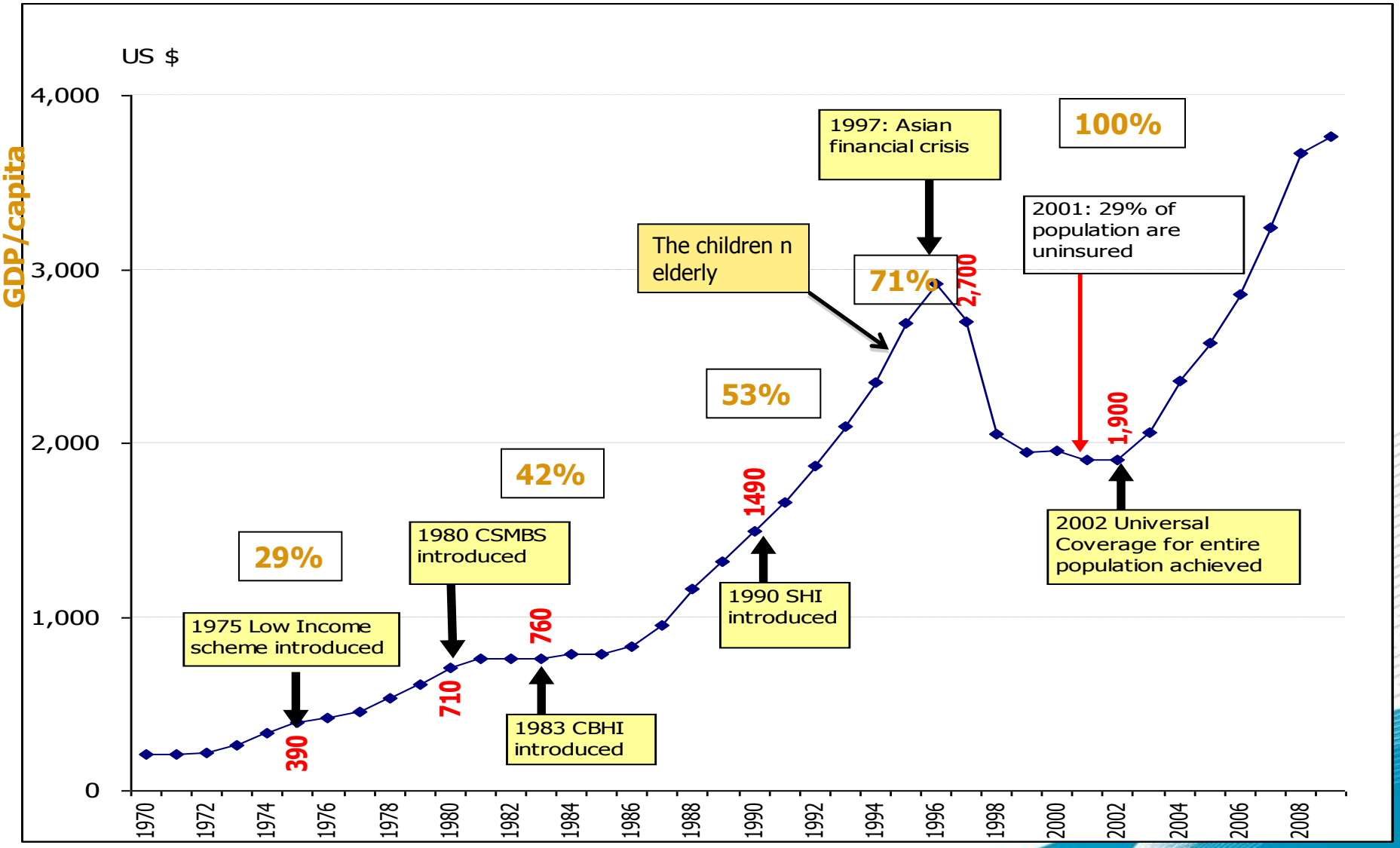


- X axis: Who is covered?
  - Universal (100%) Coverage by 3 public schemes
- Y axis: Proportion of the costs covered?
  - Total health cost
  - Low incidence of catastrophic health expenditure and medical impoverishment
- Z axis: Which services are covered?
  - Essential comprehensive services and drugs
  - High cost services are covered e.g. Renal Replacement Therapy, chemotherapy, ARVs

UHC is feasible and sustainable

- UHC can be started and achieved **at low level of income – don't wait until you are rich**
- UHC is effective for **poverty reduction**
- Fiscal spaces and innovative financing are possible for **additional resources** mobilization
- Mechanisms are there to ensure **quality**, value for money, sustainable financing and meeting the emerging challenges

UHC can be started and achieved at low level of income – Economic Crisis is an opportunity not a threat



Paths Towards Universal Health Coverage

- 1963 – Civil servants medical benefits scheme 9%
- 1975 – Free medical care for the low income +20%

- 1978 - 91 ***- Extensive rural health systems development***

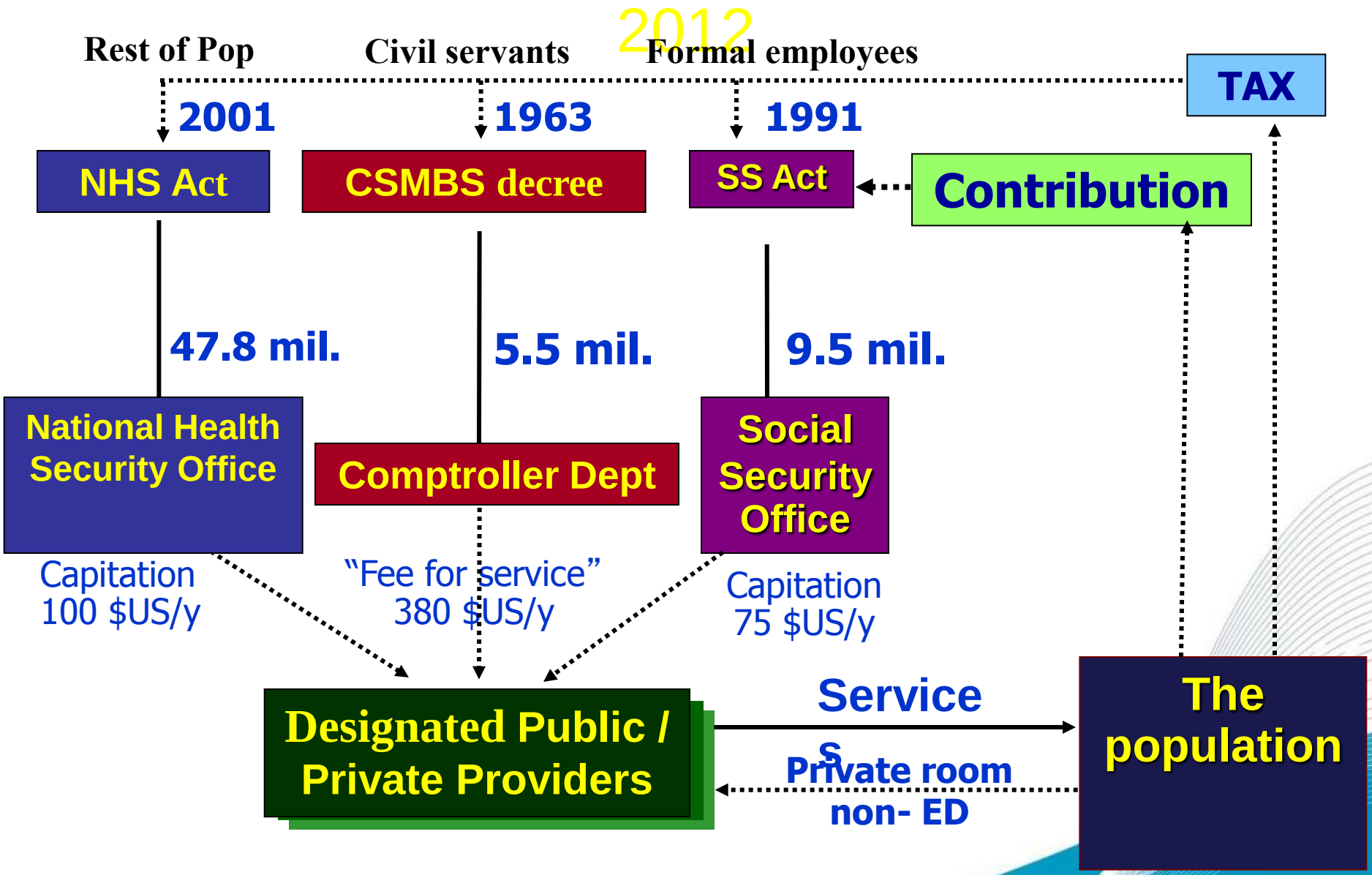
- 1990 - Voluntary public HI (health card) +13%
- 1992 - Compulsory Social Security HI +11%
- 1993 - Free med care for children +16%
- 1995 - Free med care for elderly +6%
- ***2000 – Total health insurance = 71 %***
- ***2001 - Universal HI –*** *30 Baht co-pay per visit*
- *2003 - Universal Access to ARVs*
- *2006 - Free care for all –* ***no co-payment***
- *2008 – RRT and Flu vaccine coverage*

30 years of gradual coverage to Universal Health Insurance

"One of the success factor: Don't listen to the IGOs"

Suwit Wibulpolprasert, MoPH, Thailand

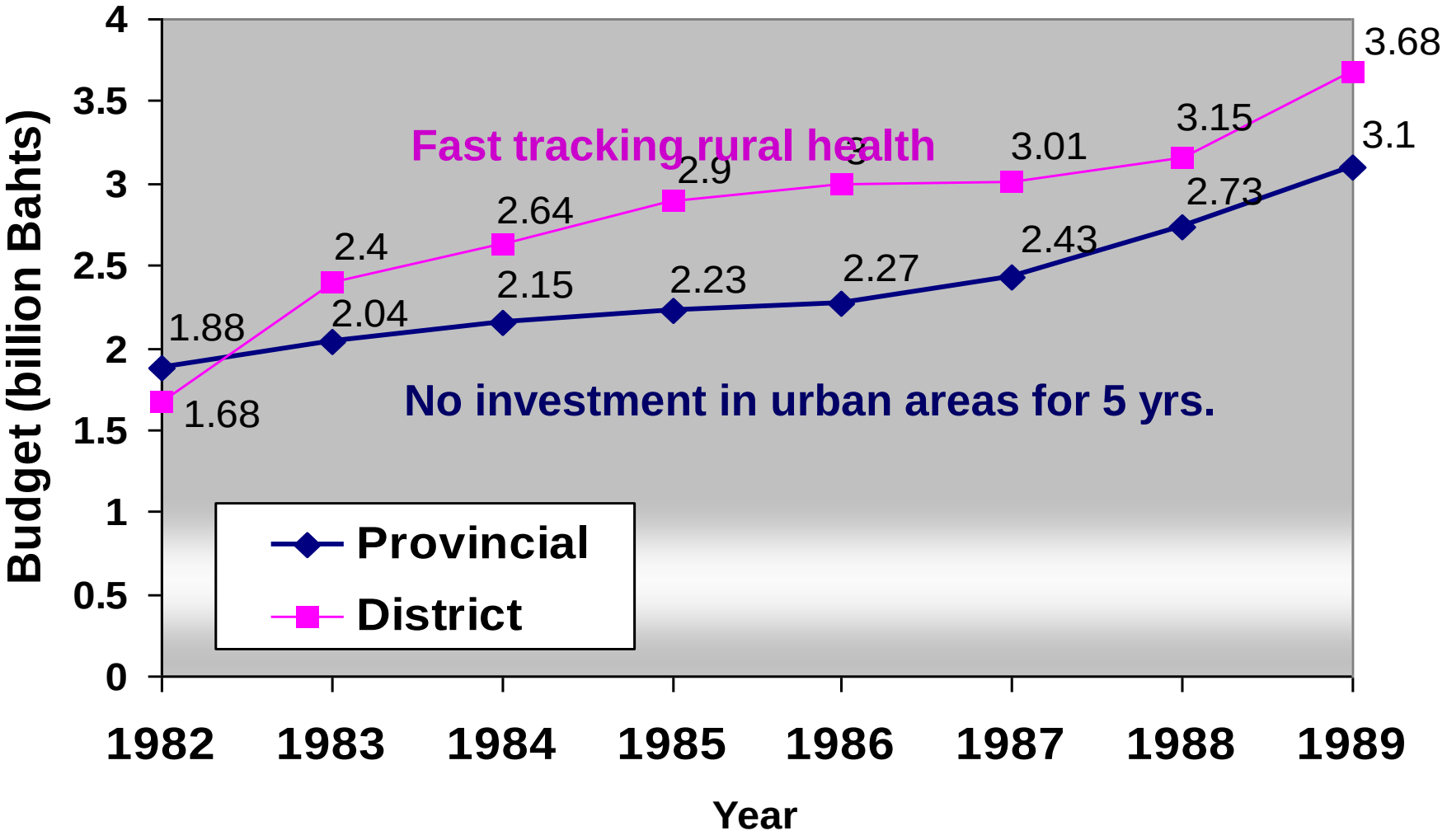
Three schemes for Universal Health Insurance



Ensuring availability of quality health services

- Extensive expansion of rural health services in early 80s **– in spite of economic crisis**
- How? – Budget shifting - **Freeze** new capital investment in urban health facilities for 5 years and reallocate to rural health facilities.
- Extensive production of motivated Rural Health Workers with **compulsory public services and incentives**
- Establishment of **Hospital Accreditation Institute**

Building up quality rural health facilities - Reallocation of budget to rural facilities and HRH



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Adequate and appropriately manned rural health facilitieis

Rural health centers with 3-6 nurses n CHWs cover 2,000-5,000 population

Extensive production of appropriate cadres and motivated health personnel with mandatory public works and adequate support are essential.

Rural community hospital with 2-8 doctors cover 30-100,000 population

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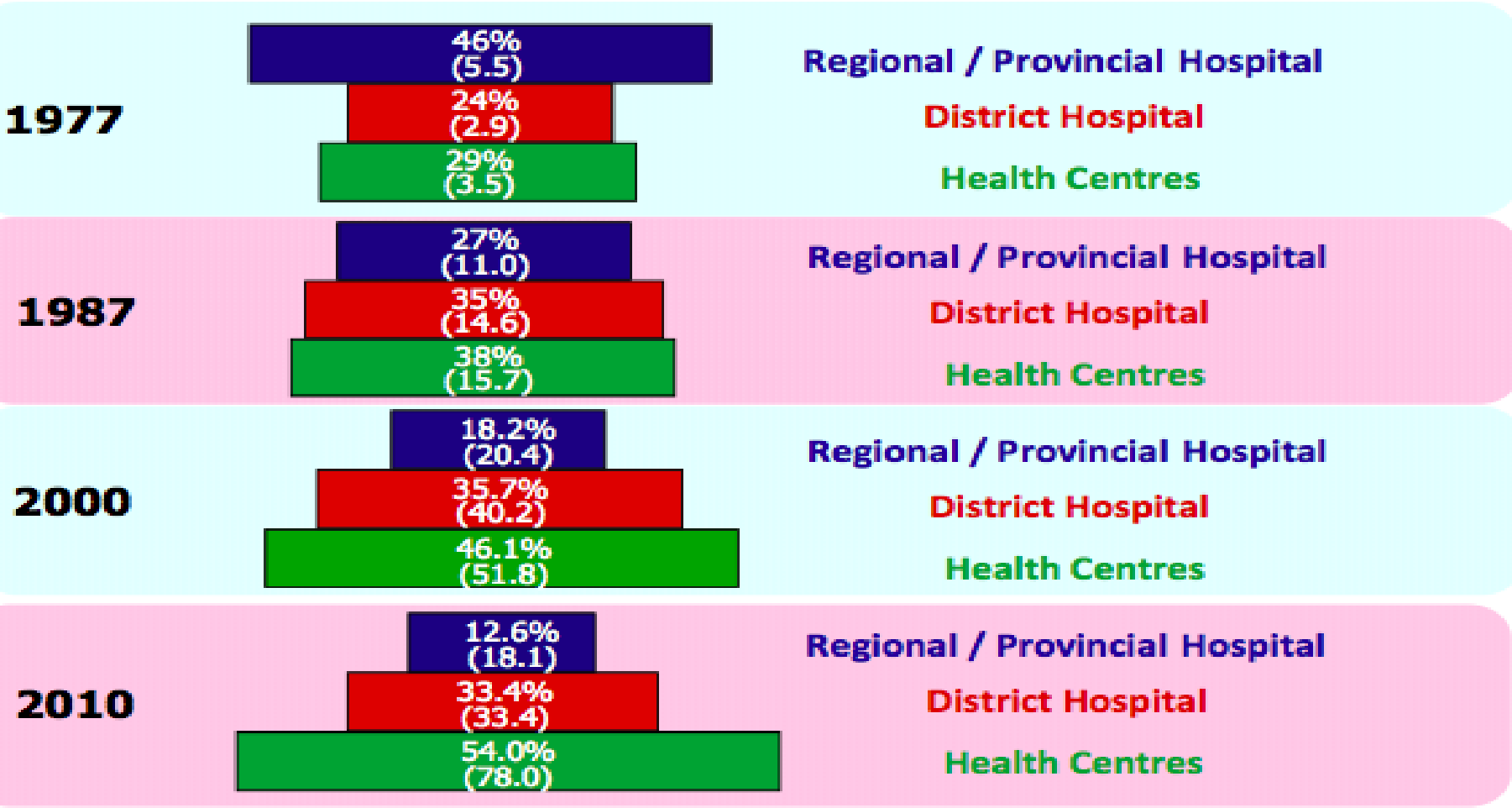
From reverse to upright triangle: PHC utilization (OP visits)

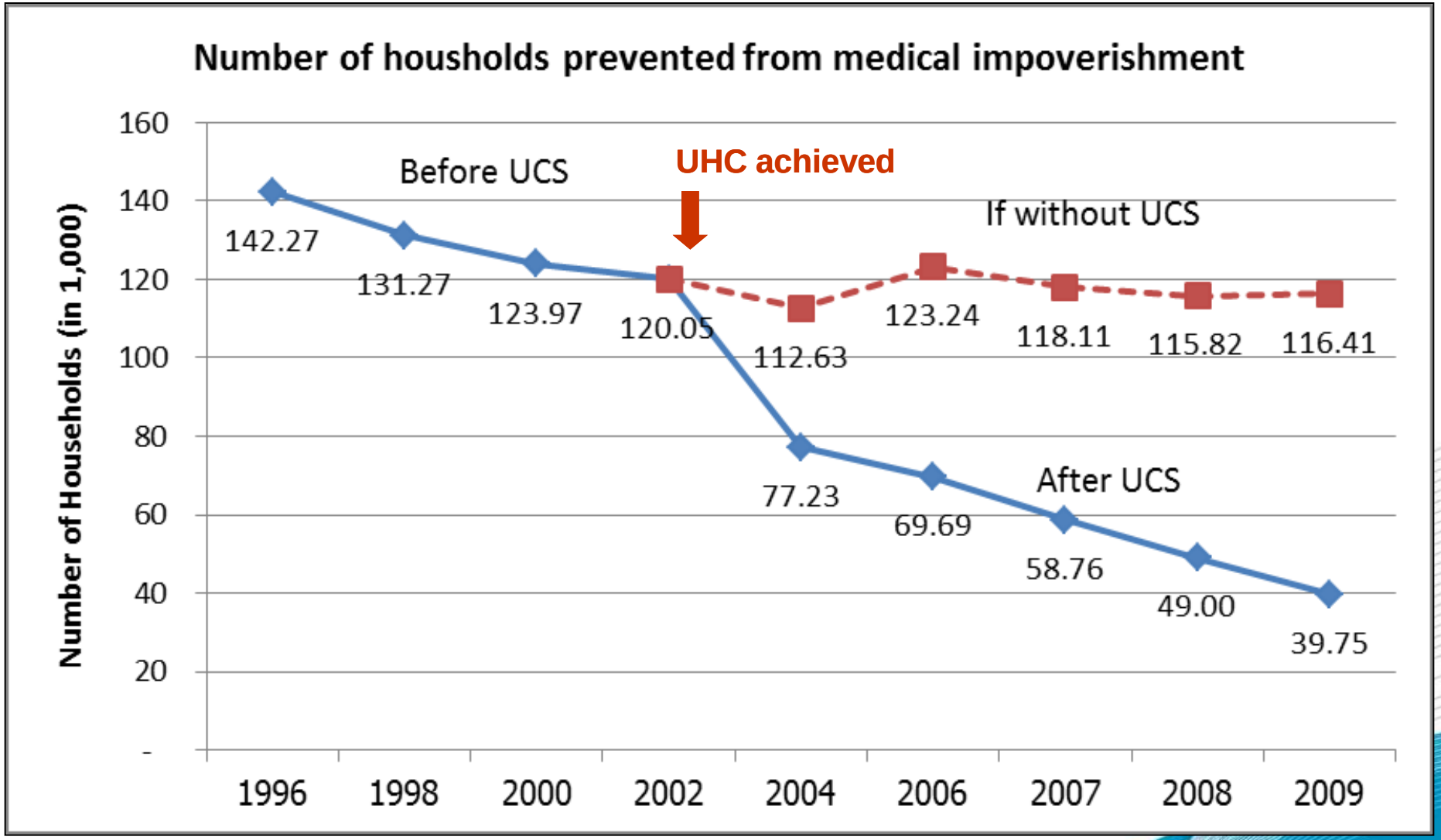
Changes in out-patient utilization:
primary secondary and tertiary 1977-2010



Note: (number of OP visits in million)

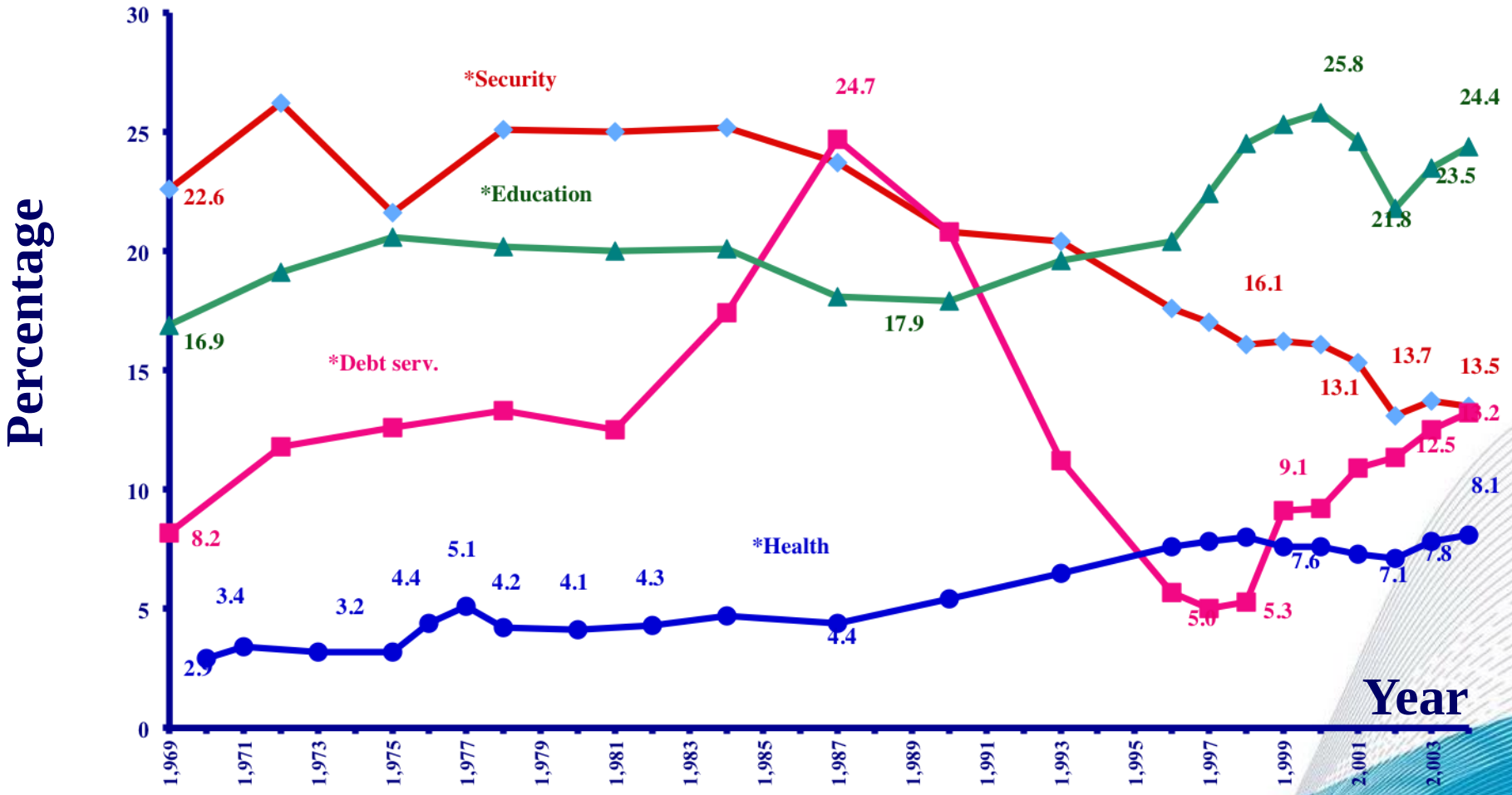
Source: Suwit's presentation on 30 Sep 2011 and updated 2010 data

UHC is effective for poverty reduction



Source: Viroj Tangcharoensathien

Fiscal Space to health from peace and economic growth



Source: Bureau of Budget

Mechanism to ensure Better Value for Money and Cost Control for Sustainable Financing

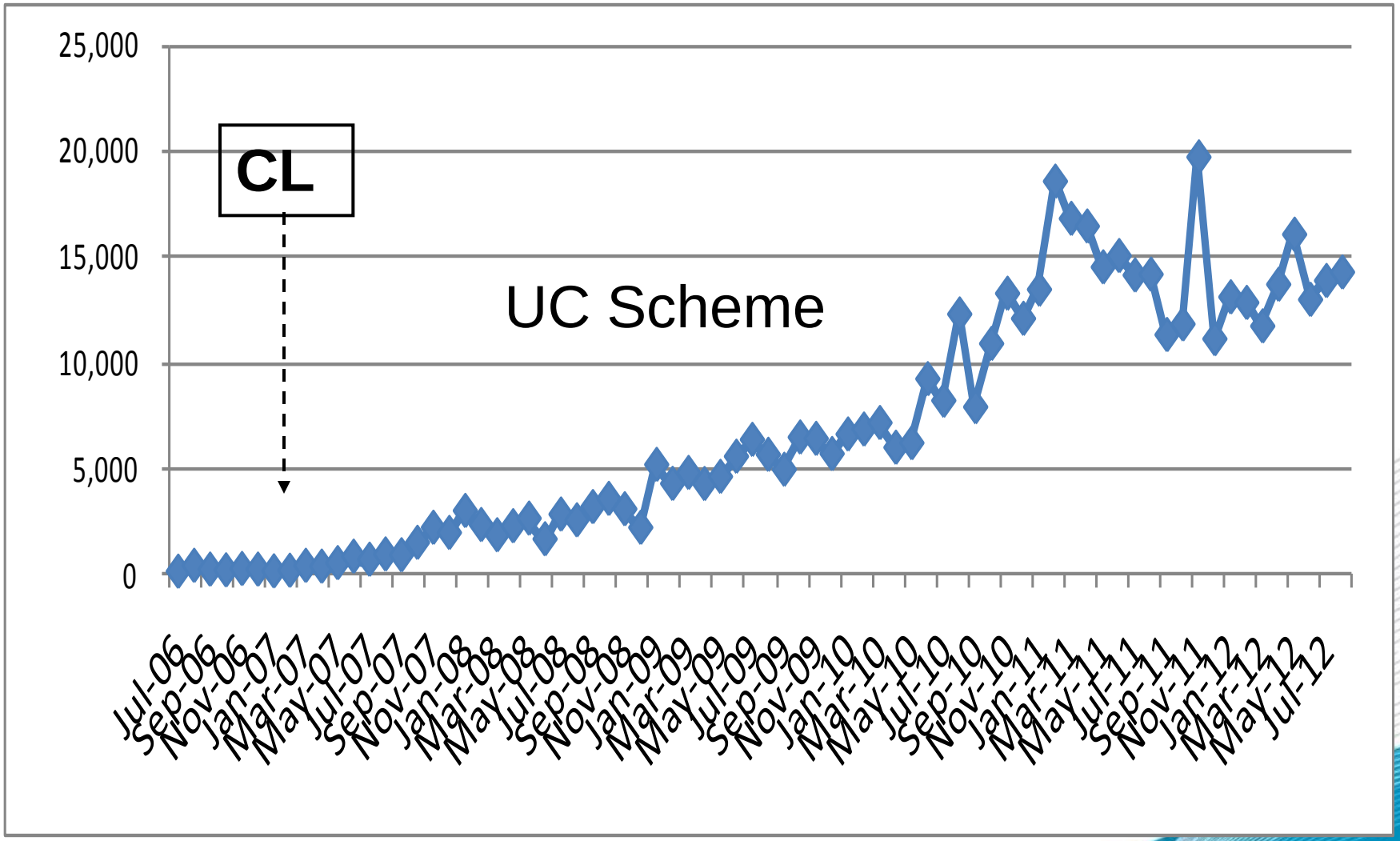
- **20%** of UC budget to P&P & community H fund
- Health Intervention and Technology Assessment to ensure ‘value for money”
- Strategic purchasing – Central purchasing w VMI and TRIPs flexibilities – ***internal fiscal space***
- **Close end capitation** budget with mixed payment mechanisms and PC gate keeper
- ***Improve quality of health services – HA+++***

Central purchasing and bargaining of drug and instrument

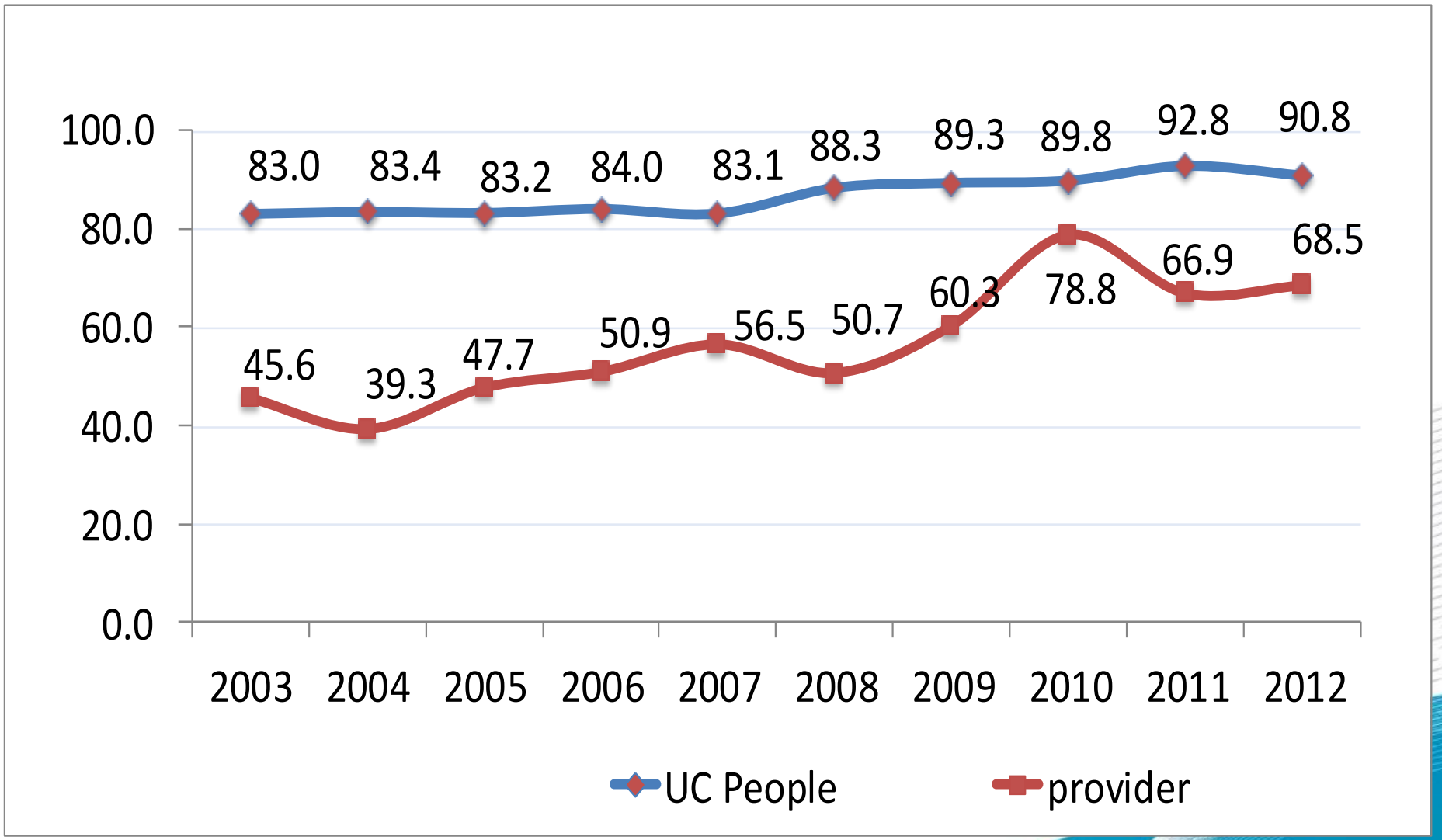
Items	Unit cost (Baht)			Saving (Baht)
	Before	After	Number (unit)	
1.Instrument				
Folding lens	4,000	2,800	64,100	76,920,000
Unfolding lens	4,000	700	7,197	23,750,1o0
Balloon stent	20,000	10,000	26,655	266,550,000
Coronary stent	30,000	5,000	10,575	264,375,000
Drug elutent stent	85,000	17,000	33,794	2,297,992,000
DES Alloy stent	55,000	25,000	343	10,290,000
2. Drug (sample)				
ARV (AZT 300 mg caps.)	1201.22	891.23	47,000	14,569,530
ARV (EFV 600 mg tabs.)	304.89	149.51	400,000	62,152,000
ARV (LPV/RTV 200/50 mg (CL)	2139.82	1481.91	170,000	111,844,700
Botulinum toxin type A 100 IU	10,750.00	7977.74	946	2,622,557.96
Docetaxel 80 mg inj	25654.32	4716.26	2,700	56,532,747.31
IVIG 5% 100 ml	9,649.62	5,479	19,200	80,075,904
Peg-interferon alpha	11,000	3,150	77,000	604,450,000
Influenza vaccine	200	150.28	643,319	31,985,820
Erythropoietin	671	229	1,634,239	722,333,638
CAPD fluid	200	105	19,095,657	1,814,087,415
Saving				**6,440,531,412.27**

From: NHSO 2012

Rate of use of Lopinavir/Ritonavir (200/50mg)



Satisfaction of UC beneficiaries & providers



The regional and global movements on UHC

- Countries with UHC - Brunei, China, Japan, Korea, Malaysia, Singapore, Sri Lanka, Thailand, Brazil, Mexico, Costa Rica, Chile, Cuba
- Asian countries committed - India, Indonesia, Laos PDR, Maldives, Philippines, Vietnam, South Africa
- Joint Statement ASEAN plus three HMM – July 12
- UNGA resolution on UHC - December 2012
- UHC in the post 2015 and SDGs and ECOSOC 13

The UNGA resolution on UHC

- Include UHC in the discussion on the post 2015 development agenda
- ECOSOC consider UHC as part of its 2013 work programs with WHO n WB – July 3rd 2013
- Continue consultation on UHC and possibility of a HLM in UNGA **– indicators and targets of UHC developed by WHO and WB in September 2013**
- UNSG and UN agencies to give high priority to UHC

The Role of Countries to move UHC

- Target UHC and move concretely and actively to achieve it thru both **HSS and HI development**
- Global advocacy movement – to put UHC as the post 2015 and the Sustainable Development Goals
- Capacity building (INNE) thru Knowledge management – the Japan-WB trust fund on UHC, the Joint Learning Network (JLN), the ASEAN plus three UHC networks, the AAAH, the HTAsiaLink, and the **Thai CAP UHC program**