DCP3 Volume 6, Chapter 15 Supplement: Financing Cancer Care and Control in Thailand

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The Royal Thai Government has prioritized chronic disease care and control alongside universal health coverage through innovative health financing and service delivery mechanisms. These initiatives are in part driven by the country’s shifting epidemiological profile. As of 2008, non-communicable diseases (NCDs) accounted for approximately 71% of total mortality in Thailand (1). An estimated 12% of all deaths in the same year were attributed to cancer (1). The burden of NCDs on Thailand’s population and health system is illustrated by the substantial increase in hospitalization rates due to cancer, which grew from 53.8 per 100,000 people in 1985 to 124.4 per 100,000 people in 2006 (2).

Prior to 2002, five disparate insurance schemes served Thailand’s population: the Health Welfare Scheme for the Poor, the Voluntary Health Card scheme, the Civil Servants Medical Benefits Scheme (CSMBS), the Social Security Scheme (SSS) for the formal sector, and private insurance (3). Yet due to inequalities in government funding for each of these programs, health and access inequities largely persisted. Moreover, approximately 30% of the population in 2001 remained uninsured (3). In 2002, the government passed the National Health Security Act, establishing the Universal Coverage Scheme (UCS) in place of the Health Welfare and Voluntary Health Card schemes to extend coverage to uninsured cohorts largely working in the informal sector (3).

Today, the general tax-funded UCS covers approximately 76% of the population, while the CSMBS covers an estimated 7% and the Worker Compensation Scheme and SSS together cover 15% (4). The National Health and Security Office (NHSO) oversees the UCS and centrally purchases services from public and some private providers (5). Beneficiaries enroll in the UCS at contracted units for primary care (CUP), which serve as gate keepers for secondary and tertiary hospitals (6). The NHSO pays CUPs through capitated payments, and utilizes a global budget with Diagnostic Related Groups (DRGs) for inpatient secondary and tertiary care (6). For select preventative services with low utilization rates such as cervical cancer screening, the NHSO offers additional fee-for-service payments to providers in order to incentivize demand (5).

The depth of the compulsory UCS includes inpatient and outpatient services, such as free prescription medicines, ambulatory care, hospitalization, disease prevention, and health promotion. The UCS covers such cancer treatments as radiotherapy and chemotherapy, as well as surgeries and critical care for emergency patients (3). Personal prevention and health promotion activities funded by the UCS are available to all Thai citizens, regardless of whether they are enrolled in the UCS (7).

Prior to the introduction of the UCS, drug costs constituted the largest proportion of out-of-pocket expenditures (6). By covering outpatient care and medicines, the UCS has apparently
reduced this financial burden. As of 2006, copayments for services covered through the UCS were abolished (7). After the establishment of the UCS, a shift toward generic medicines was observed (6). The government’s commitment to increase access to medicines is apparent in its usage of compulsory licenses drugs to treat cardiovascular diseases and cancers as well as anti-retroviral therapies (4). In January 2008, the Royal Thai Government issued compulsory licenses for four cancer medications: letrozole, docetaxel, erlotinib, and imatinib (8). Preliminary evaluations of the scheme five years after inception demonstrate rises in hospital sales of chronic disease medications associated with primary care, including diabetes, blood pressure, and cholesterol drugs. In this same period, drugs for such conditions as cancers, which require secondary and tertiary care, did not show a significant increase. This trend is potentially due to disincentives to refer patients under capitated provider payment for outpatient care (6). More research on the effects of the provider payment mechanisms on provision of services, particularly for chronic conditions, in Thailand should be conducted.

In addition, in attempt to improve the quality of primary care facilities across urban and rural settings, the universal coverage scheme prompted increases in seats for medical students as well as monetary incentives for doctors to practice in rural settings (4).

The government has prioritized NCD control in its path toward universal health coverage. The Ministry of Public Health (MoPH) is responsible for the design and execution of national public health policies. Within the Ministry of Public Health (MoPH)’s Department of Disease Control is the Bureau of Non-Communicable Diseases. This bureau, established in 2003, has launched several initiatives to reduce risk factors for NCDs and improve early detection, including a Comprehensive Tobacco Control Program, Comprehensive Alcohol Control Program, nutrition programs, cervical cancer screening programs, and self breast examination promotion initiatives (2). The bureau’s Strategic Planning Framework (2008-2011) includes strategies that emphasize community level NCD prevention, surveillance, and control efforts, as well as plans to improve networks among providers to facilitate integration across services (2).

The NHSO has aimed to incorporate local governments as stakeholders in health promotion and prevention initiatives. The NHSO allocates 37.5 Baht per capita to the Tambon Health Insurance Fund (THIF) for promotion and prevention activities. These funds are funneled to local governments, which manage community level initiatives. Depending on its financial status, the local government must match 10%, 20% or 50% of the THIF’s contribution (9).

The Thai Health Promotion Foundation (ThaiHealth), founded in 2001, is a particularly innovative approach to improving public health in low and middle income countries. The foundation is funded through a 2% “sin” tax on tobacco and alcohol, and spends approximately US$ 100 million on health promotion activities each year (10). ThaiHealth is an independent state agency which adopts a socio-cultural model of health, and focuses on the following issues: tobacco control, alcohol control, road accidents, physical exercise, and diet, among other risk factors for NCDs (9). ThaiHealth adopts a comprehensive approach to health promotion, through research and knowledge sharing, behavioral interventions, social mobilization, and advocacy efforts (11). The foundation aims to strengthen and coordinate existing organizations and infrastructure (9). Particularly strong are Thailand’s tobacco control initiatives, many of which are financed through ThaiHealth and the NHSO. Several new institutions, such as the
National Tobacco Control Committee, advocate for smoking bans in public places and pictorial warnings on cigarette packages (9). Thailand ranks as one of the highest countries in the world in achieving WHO’s MPOWER framework for comprehensive tobacco control, with systems in place to monitor tobacco use, a national quitline to support tobacco cessation, and systematic legislation on smoke-free environments, along with the tobacco taxation regime. More wide-ranging bans on tobacco advertising and promotion are still needed, along with strong enforcement (WHO 2013). However, as a result of these proactive efforts, the prevalence of regular smoking among men has decreased from 45.9% in 2003-2004 to 38.7% in 2008-2009 (5).

However, comprehensive cancer care and control in Thailand has not yet been achieved. Screening programs for both breast and cervical cancer reach only a small proportion of the population (5). The MoPH has provided Pap smears for over 40 years, and introduced VIA and cryotherapy in the last decade. Additional cervical cancer screening programs are financed by the NHSO’s universal coverage funds (12). These NHSO initiatives support provision of pap smears for women 30-60 years of age, and VIA for women 30-45 years of age (13). Despite these services, pap smear and VIA coverage rates in 2005 remained low, at an estimated 11% and 8% respectively. In 2008, the MoPH attempted to scale up the cervical cancer screening program to reach 80% of the target population through a 116-day campaign. However, these efforts were deemed unsuccessful, as the policies did not address fundamental challenges such as flaws in existing operational guidelines (12). Moreover, some beneficiaries still pay out of pocket because they go around CUP gatekeepers and instead access private pharmacies and clinics for self-prescribed or uncovered treatments (14).

Along with the depth and breadth of coverage under the UCS, a private market for health care continues to thrive, particularly in urban areas of Thailand. Private expenditures on health as a percent of total health expenditures have declined over time since the introduction of the UCS, replaced by increases in government health expenditure (15). Within private spending, purchases of private health insurance have increased, with declines in out-of-pocket spending (15).

These trends suggest that the private market has grown more organized over time in a parallel trend to developments in the UCS. However, private expenditures may still have a detrimental effect on the financial health of patients. Catastrophic expenditures continue to be linked to utilization of private health services and paying out-of-pocket, with particular risk for catastrophic expenditures occurring among households caring for a member with and chronic disease or hospitalization (16, 17). It is not clear whether health care consumers are supplementing gaps in coverage or in quality of care through seeking private health care. It is also not clear what the effects of private health care provision, which tends to be concentrated in urban area, are for health equity (18). There has been substantial research interest in the effects of the UCS on the Thai health system, but the effects of private sector are not well understood, particularly with respect to access to and use of chronic care.

Thailand has made significant strides in improving access to health promotion, prevention, and treatment services through innovative health financing mechanisms; however, further research
must be completed to elucidate whether the Thai population truly accesses services across the cancer care and control continuum.

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