Funding health promotion and prevention - the Thai experience

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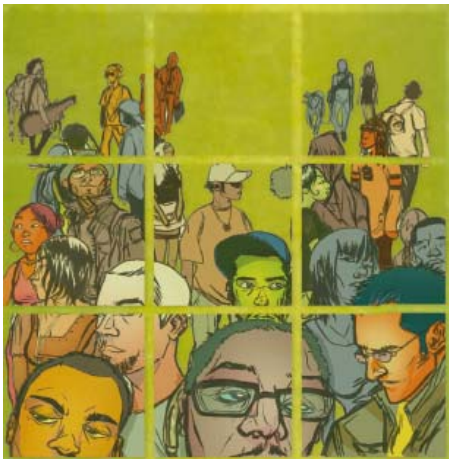
HEALTH SYSTEMS FINANCING
The path to universal coverage

World Health Organization



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1 Background

Health promotion, disease prevention and public health programmes are recognized as cost-effective interventions. Because they are public goods with significant external benefits, they are provided free of charge to the Thai population, and are historically funded by general tax revenue and supply side financing to Ministry of Public Health (MOPH) health facilities.

This short paper describes the transition of health promotion and disease prevention funding from supply to demand side financing, and the additional role played by sin-taxes in funding broad based, civil society movements in Thailand, the intention being to draw lessons which may be beneficial to international audiences.

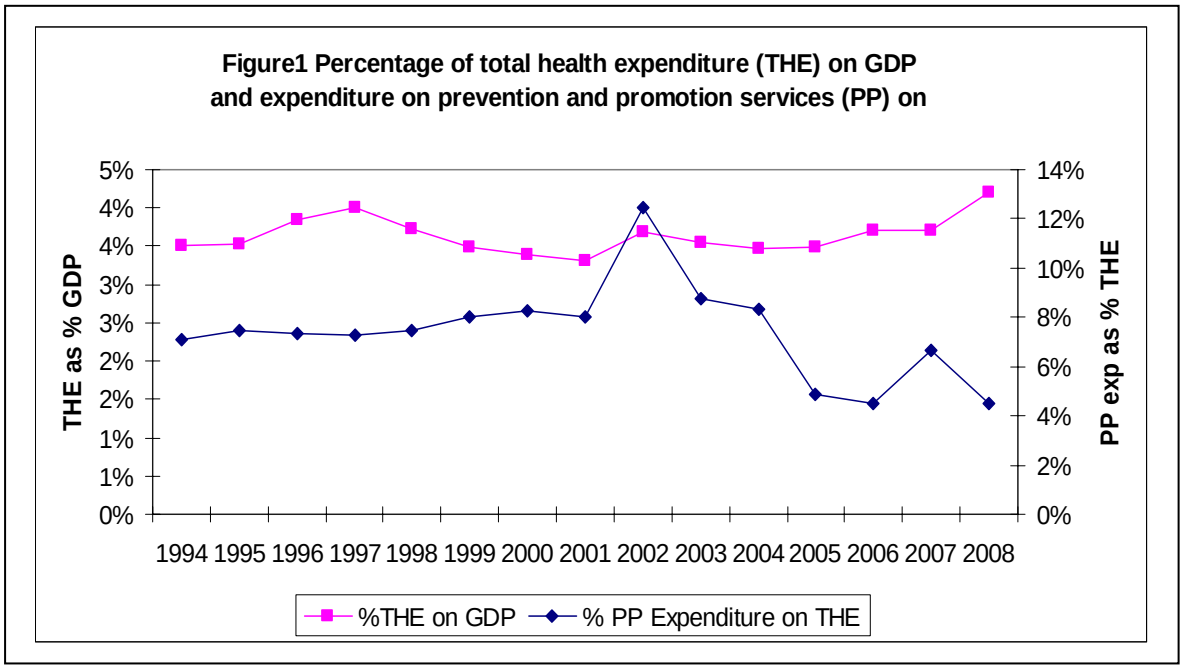
2 Funding clinical health promotion and preventive services

With the introduction of the Universal Coverage (UC) scheme in 2001, personal prevention and promotion services were transferred to and funded by the UC scheme, and managed by the National Health Security Office (NHSO). Public health programs remained under MOPH management and some were transferred to local governments. The UC budgets for prevention and promotion services are directly allocated from NHSO as central purchasing to a public and private contractor network of providers. A typical network for rural areas is a district health system consisting of the district hospitals and 10-12 health centres, each covering some 5,000 people.

NHSO applies capitation for the purchasing of a defined set of prevention and health promotion services; capitation is estimated using activity-based costing for these defined services. However, some services apply a fee-for-service model based on an agreed fee schedule, or bonus payments for services where demand is estimated to be inadequate as with cervical screening and other targeted screening services; payment is based on the number of services rendered.

Providing universal coverage has increased demand for curative services, particularly among those previously uninsured; substantial increase in service utilization of outpatient and inpatient care and other high cost services such as dialysis for renal failure patients and cataract surgery has been observed [1 2]. The substantial increase in curative service utilization resulted in an increase in health care cost while the proportion of expenditure on prevention and promotion services, including public health programs, declined (see Figure 1).

Figure 1 Total Health Expenditure (%GDP) and expenditure on prevention and promotion (% THE) 1994 to 2008



***Source**: Thai working group on National Health Account*

3 The role of "sin tax"

In 2001, just before the introduction of the UC policy, the Thai Health Promotion Fund (THPF) was established by Law as an independent public agency, managed by a governing board chaired by the Prime Minister. Using the "sin tax" principle for financing health promotion, a 2% additional surcharge on tobacco and alcohol was earmarked for the Fund [3].

THPF budgets derived from sin-taxes significantly increased from 1.592 billion Baht in 2002 to 2.859 billion Baht in 2009. The mission of THPF is to empower civil society and promote the well-being of the citizens by acting as a funding catalyst to support programs and actions that change social values, lifestyles, and environments in ways that are conducive to better health. The main portfolios are broad based civil society campaigns on tobacco, traffic accident, alcohol, healthy life style, active living and obesity, sexuality and HIV/AIDS prevention.

THPF addresses various social determinants of health, and broad based community and civil society movements; it also plays a supplementary role to the current clinical prevention and promotion services funded by the NHSO.

4 Innovation: local government involvement in health promotion

Another innovation worth mentioning is the establishment of a sub-district fund for prevention and promotion services named the Tambon[1] Health Insurance Fund (THIF). The THIF was initiated by the NHSO and aims to increase awareness and involvement of local governments and communities in health promotion and prevention activities, particularly where these benefit hard-to-reach groups within communities. The burden of disease in these groups is dominated by chronic non-communicable diseases [4] which are difficult to tackle without inter-sectoral cooperation by concerned organizations and ownership by the communities.

All local governments were invited to participate in the THIF initiative on a voluntary basis and a matching fund from them is required. NHSO earmarks 37.5 Baht per capita to the THIF for prevention and promotion services, while local governments are obliged to match 10%, 20%, or 50% to the budget according to fiscal capacity.

The fund is managed by a committee comprised of representatives from local government, community leaders and health workers. The numbers of local governments setting up THIF increased dramatically from 869 in 2006-7 to 2,677 and 3,933 in 2008 and 2009 respectively for a total of 7,851 Tambon. Fifty percent of local governments had a THIF in 2009.

Early evaluation of THIF shows that it may raise public awareness and cooperation in tackling health problems[5], but its effectiveness remains unclear.

5 Achievements

A decline in the number of regular smokers, particularly among men, has been observed, with male regular smokers declining from 45.9% in 2003-4 to 38.7% in 2008-9 (Table 1). The decline in smoking is attributable to various tobacco control initiatives undertaken in Thailand over the past two decades [6]. The prevalence of metabolic syndrome shows different patterns. There was a slight decline for hypertension, for example, a constant trend for diabetes and an increasing trend for hyperlipidemia.

Access to screening for cervical and breast cancer (two major causes of disease among women) has slightly increased, though the coverage of mammography remains extremely low (Table 1). The proportion of early stage cervical cancer, carcinoma in situ, remains relatively low despite increased

[1] Tambon is sub-district entity, covering 5,000 population

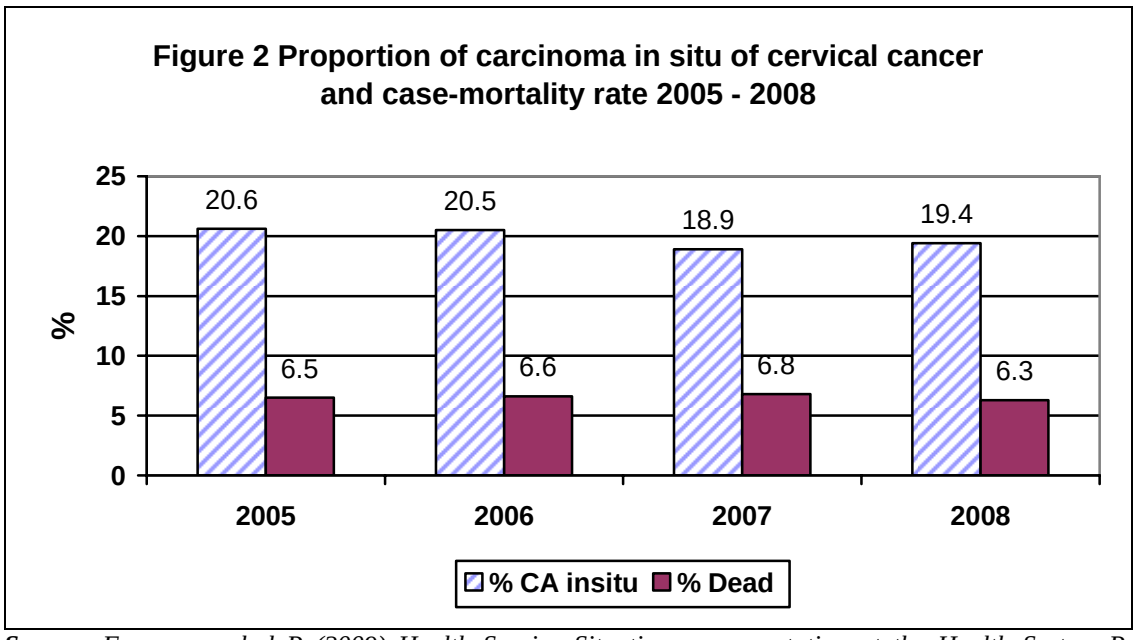
screening coverage and results in constant case mortality (Figure 2). This indicates that the effectiveness of the cervical cancer screening program needs further improvement.

Table 1 Prevalence of crucial risk factors and access to screening programs

	NHES3 (2003-4)	NHES4 (2008-9)
Regular smoking (%) among those aged 15 and above		
Male	45.9	38.7
Female	2.3	2.1
Prevalence (%) of hypertension (Systolic BP>=140 or Diastolic BP>=90 mm)	22.1	21.4
Prevalence (%) of Pre-diabetes (FBG 100-125 mg/dl)	12.9	10.7
Prevalence (%) of diabetes (FBG>126 mg/dl)	6.9	6.9
Prevalence (%) of hypercholesterolemia (Cholesterol >240 mg/dl)	15.5	19.4
Access to screening programs		
% Women aged 15-59 having pap smear within two previous year	32.4	42.5
%Women aged 15-59 having breast examination by health workers	22.7	29.2 (17.9*)
% Women aged 15-59 having mammogram		
.In the previous year	1.7	2.5
Ever	2.2	1.9

Source: *National Health Examination Survey (NHES) 2003-4 and 2008-9* [7, 8]

* having breast examination by health worker in previous year



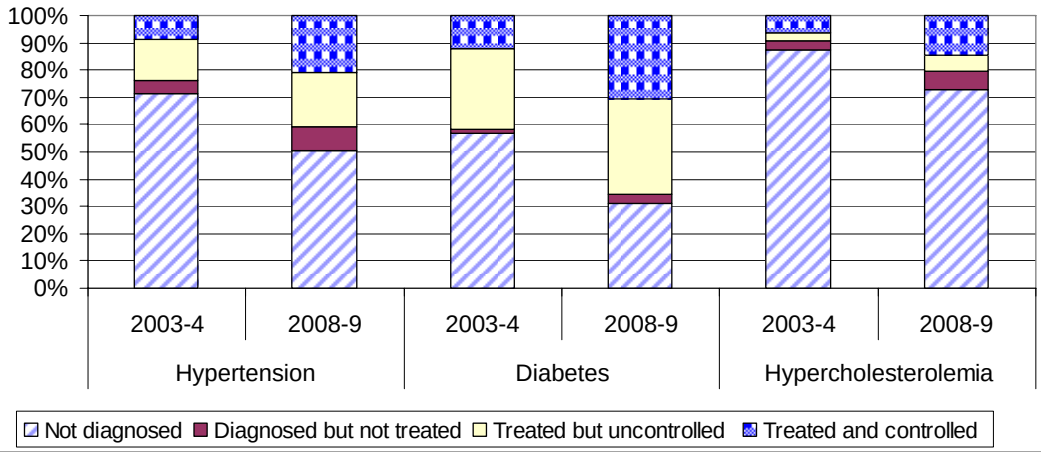
Source: *Faramnuayphol P (2009) Health Service Situation, a presentation at the Health System Research Institute.*

Access to screening for hypertension and diabetes has increased as indicated by a decline in patients with hypertension and diabetes reporting 'not diagnosed' (see Figure 3). People with hypertension but no access to screening declined from 71% in 2003-4 to 55% in 2008-9; while the proportion of

diabetics with no access to screening fell from 57% to 31% over the same period. People with hypercholesterolemia, but no access to screening, declined from 87% to 73%.

Improvement in the proportion of 'treated and controlled' for these three conditions was observed, but the effective coverage was still unsatisfactory. Treated and controlled hypertension and diabetes increased from 9% to 21% and from 12% to 31% respectively.

Figure 3 Access to screening of hypertension, diabetes, hypercholesterolemia and output of treatment



Source: *National Health Examination Survey 2003-4 and 2008-9*

6 Challenges

Having reviewed the situation with regard to the financing of health promotion and disease prevention, we observe a number of challenges.

In the light of increased demand for curative care, there is a consistent reduction in the proportion of total expenditure going to prevention and promotion. Also the UC scheme budget funds the purchase of clinical preventive and health promotion services rather than addressing primary preventions or other social determinants of chronic non-communicable diseases.

There is a lack of public awareness and demand for health promotion and prevention services. Financing and purchasing alone cannot increase coverage for these services. Other innovative interventions should be devised.

The current demographic and epidemiological transition forces us to recognize that intersectoral actions are essential to tackle the increasing proportion of chronic non-communicable diseases. It is necessary to reorient health workers from their direct service provider role to an inter-sectoral 'facilitator' function and the appropriate competency must be strengthened among different cadres of health workers.

Under the current decentralized framework, good governance and effective collaboration is essential, particularly with regard to the roles and missions of each partner, MOPH, NHSO, THPF, local governments, THIF and other related organizations, for the effective implementation of health promotion and prevention and public health programs.

References

[1] Vasavid, C., Tisayaticom, K., Patcharanarumol, W., and Tangcharoensathien, V. (2004) Impact of universal health care coverage on Thais households. Chapter 6 in Tangcharoensathien, V. and Jongudomsuk, P. (eds.) From Policy to Implementation: Historical event during 2001-2004 of Universal Coverage in Thailand. Nonthaburi, National Health Security Office.

[2] National Health Security Office (2008) the 2008 Annual Report on Universal Coverage Scheme. Nonthaburi, National Security Office (in Thai).

[3] Tangcharoensathien V., Prakongsai P., Patcharanarumol W., Limwattananon S., and Buasai S. Innovative financing of health promotion. In Kris Heggenhougen, and Stella Quah, eds. International encyclopedia public health, 624-638. San Diego : Academic Press, 2008.

[4] The Thai Working Group on Burden of Disease and Injuries (2007) Report on Burden of Disease and Injuries among Thai Populations in 2004. Nonthaburi, International Health Policy Program.

[5] Wongkongkathep, S., Prakongsai, P., Wongkongkathep, S, et al (2009) Evaluation on Capacity and Effectiveness of Tambol Health Insurance Funds. Nonthaburi, Ministry of Public Health.

[6] Supawongse, C. and Buasai, S. (1997) The evolution of tobacco consumption control in Thailand. Health System Research Journal 5(3): 25-26.

[7] Porapakham, Y. and Bunyaratapun, P. (Eds) (2006) The Third National Health Examination Survey, 2003-4. Nonthaburi, Health System Research Insitute.

[8] Aekpalakorn, W. et al (2010) Preliminary report on the Fourth National Health Examination Survey, 2008-9. the National Health Examination Survey Office, Health System Research Institute.