# Thailand: progressive UHC

- HS context: public dominant role of service provision
- Two strand policy approaches
  - Supply side strengthening
    - 3 decade (1970-2000) investment on supply side: full geographical coverage of close-to-client service: District health system development (DH+HC) with tertiary care backup in all provinces
    - Mandatory rural services of all health related graduates since 1972 to date.
  - Financial risk protection extension: application of targeting
    - The poor households: tax financed welfare scheme, 1975
    - Public employees: tax financed welfare scheme, 1980
    - Private employees: payroll tax financed social health insurance, 1991
    - Non-poor Informal sector: CBHI 1984 → public subsidized voluntary health insurance 1994
    - Universal Coverage Scheme: tax financed for all remaining citizens who are not public or private employees, 2001 when GNI per capita was 1,900 US$

# Thailand: pro-poor outcome and why?

- Empirical evidence,
  - Pro-poor utilization and pro-poor benefit incidence [BMC PH 2012, 12 (Suppl 1) : S6]
  - Low incidence of catastrophic health spending and health impoverishment [Bulletin of WHO 2007; 85:600–606].
  - THE, 3.3% GDP (2001) → 4.6% GDP (2013)
    - Public 1.9% GDP (2001) → 3.7% GDP (2013)
- Contributing factors
  - District health systems: the contractor provider network.
    - Easy access by vast majority of rural poor UCS members,
    - Facilitate chronic NCD treatment with good outcome
  - Comprehensive benefit package, free at point of services
    - Deepening coverage to high cost catastrophic conditions: Renal replacement therapy, ART, chemotherapy further boosts financial risk protection
    - Closed end payment support financial viability for comprehensive large package