Thailand's health ambitions pay off

With political will and public health vision, Thailand is making essential health services available to all its citizens free of charge. Suwit Wibulpolprasert talks to Fiona Fleck.

Courtesy of Suwit Wibulpolprasert

Suwit Wibulpolprasert

Suwit Wibulpolprasert – a rural general practitioner turned public health policy-maker – is one of the architects of Thailand's acclaimed Universal Coverage Scheme. After completing his medical studies at Mahidol University, he began his career directing four rural district hospitals from 1977 to 1985. After that, he held a series of public health posts including as a director in the Thai Food and Drug Administration and from 1995 to 1998 as chief medical officer. In 2000, he became deputy permanent secretary for global health and held senior health ministry posts until 2013. He has often represented Thailand internationally, in the Executive Board of the World Health Organization, the Global Fund to fight AIDS, Tuberculosis and Malaria, and he is a member of many international and regional expert committees.

Q: Thailand has a long tradition of investing in public health, why?

A: Over the last decades, we have built and maintained leadership among health professionals with a strong sense of public commitment. At medical and public health schools in our country, we learn the teachings of Prince Mahidol. His Royal Highness, the father of our King, is considered the father of modern medicine and public health in Thailand. He taught us to "put public interests first and self-interest second." He said: "I don't want you to be only a doctor, I also want you to be a man." Health professionals learn his teachings by heart. Every seven years we have a national medical education conference and in 1982 it adopted a resolution that medical gradates should be four things: skilled clinicians so that they can work more or less alone in rural hospitals; good teachers as they must train community health workers and volunteers; good managers as they must manage district hospitals; and good supporters of primary health care.

Q: Thailand is one of the first developing countries to make major progress towards universal health coverage. Why did it pursue this goal in the midst of economic crises?

A: The drive towards universal health coverage came hand-in-hand with democracy. After the student revolt against the military government in 1973 and our first democratic elections in 1975, the new government made health services available free of charge to the poor. We then started to improve health insurance coverage for people with low-incomes, the formally employed, children and the elderly. It took us from 1975 to the year 2000, to move from zero to 71% of the population covered by health insurance. Then, in the 2000 election, one of the parties promised to move from 71% to 100% – full coverage – if elected. Within a year of their victory, we closed the 29% gap and on 1 January 2002 the whole population was covered. This was largely thanks to the late Dr Sanguan Nitayaramphong, the first secretary-general of Thailand's National Health Security Office, who worked tirelessly to persuade politicians and the public to embrace universal health coverage. He is considered the "Father of universal health coverage in Thailand."

Q: How did Thailand achieve 71% coverage in spite of the financial crises of the 1980s and 1990s?

A: When the government started to provide free health care to the poor in 1975, we soon found that service access was poor because there weren't enough rural health facilities. In the spirit of the times – of primary health care and health for all – our government started to construct more district hospitals in rural areas. In 1981, annual GDP was about US$ 390 per capita, we were a low-income country facing economic downturn. We had to negotiate an International Monetary Fund loan and had a zero growth budget for five years. Despite this, our government took the courageous decision to continue expanding the rural health infrastructure.

Q: How?

A: The government froze all new capital investment in urban hospitals from 1982 to 1986 and invested these funds in building rural district hospitals and health centres as well as mass training and employment of doctors and community health workers. Before this, the health ministry budget for these districts was lower than in urban provinces. After 1982, it was higher, and this trend continues today. We established a compulsory "public work" placement of three years for medical graduates and four years for nursing graduates. We strengthened primary health care by recruiting and training volunteers in villages across the country. Today, we have about one million volunteers. So our government put us on the path to universal health coverage by investing in the rural health infrastructure.

Q: Why was health policy a vote winner in the 2000 general election?

A: People wanted to have access to essential health services of good quality without facing financial ruin. A group of public health leaders, especially Dr Sanguan, tried to sell this policy to all the political parties before the 2000 election. Polls commissioned by the Thai Rak Thai party showed a popular demand for universal health coverage, so they put it in their manifesto. The other parties didn't dare do this, but this was one of the policies that led to a landslide victory. Thailand's economy was weak following the 1997 economic crisis, when annual GDP per capita fell from nearly US$ 3000 to US$ 1900 in 2001. So, in our experience, economic crisis is a good opportunity for health because when people have less money they appreciate universal health coverage.

Q: How did the government deliver on that promise?

A: Two experts – one from the World Bank and one from the World Health Organization (WHO) – prepared a report on the macroeconomic implications of implementing universal health coverage in Thailand. As deputy permanent secretary in the health ministry, I was the first full-time programme director of the Universal Coverage Scheme. The experts came to my office in 2001 and presented me with their very nice, evidence-based report and asked me to tell my minister and prime minister not to go ahead with their plans, warning that this would bankrupt our health systems and possibly even the economy. What could I do? I didn't dare say this to my minister or prime minister because this was the main policy that won them the election. Thanks to the experts' warning, we were careful with the implementation of the Universal Coverage Scheme and kept tight budget control. We realized that financing was important, but not the main thing. The success factors for universal health coverage were political commitment and leadership, the public commitment of the health workers and our ability to generate evidence for rational implementation while maintaining tight budget control and improving quality.

Q: How do you achieve "rational implementation" and decide which of the bewildering new and expensive health technology options to provide through the Universal Coverage Scheme?

A: By the beginning of 2002, the whole population was covered by health insurance, as planned, but the benefit package for each citizen excluded a few expensive treatments for HIV and some cancers. Dialysis and organ transplants were also excluded. After that, we gradually expanded the benefit package based on scientific evidence. In 2003, we added antiretrovirals (ARVs), with initial funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and from 2006, we covered the cost by ourselves. In 2007, we expanded coverage for dialysis, which costs US$ 200 million, 3–4% of the Universal Coverage Scheme budget.

Q: How did Thailand cover these costs alone?

A: To improve access to drugs, we issued compulsory licences in 2006–7 for two second-line ARV drugs, one blood thinning drug for coronary heart disease and, later, for three anti-cancer drugs, based on the TRIPs agreement (Agreement on Trade-Related Aspects of Intellectual Property Rights). For example, access to the second-line ARV, lopinavir-ritonavir, increased by more than 30 times. We have not issued further compulsory licences partly because of pressure from countries where some of these pharmaceutical companies are based, but also because some of the new drugs were included in the benefit package based on assessments by our Health Intervention and Technology Assessment Program (HITAP) and so we cover the costs ourselves, also, because, increasingly, we can get prices down through bulk purchase. For example, we reduced the price of pegylated interferons for hepatitis C from US$ 320 per dose to about US$ 100. In addition, the proportion of the health budget as part of the total government budget increased from 4% in the 1980s to 14% today.

Q: Why did you decide not to include the human papillomavirus (HPV) vaccine for the prevention of cervical cancer in the benefit package?

A: As mentioned, our health technology agency, HITAP, does assessments that policy-makers can use when deciding which new health technologies (vaccines, drugs, diagnostics and devices) to include in the benefit package. For the HPV vaccine, the market price was US$ 150 per dose. When HITAP did the initial analysis and found a cost–effective price of less than US$ 60 per dose, we were offered the vaccine at that price. At the same time, we expanded screening from 30% to 75% coverage. With high HPV vaccine coverage, the price at which the vaccine would be cost–effective was US$ 6 per dose, so the vaccine company proposed this price. Further HITAP analysis showed that if a booster were required, the cost–effective price would be US$ 3 and if two booster doses were needed, it would be US$ 1. That is why we still hesitate to include it in the benefit package. Recently, the Strategic Advisory Group of Experts on immunization (SAGE) recommended a reduction in the number of HPV vaccine doses from three to two and GAVI has negotiated the price down to less than US$ 4, so we will review our assessment. Health technology assessment is a vital asset for all countries moving towards universal health coverage. This is now widely recognized and in May this year, the World Health Assembly approved a resolution proposed by the Maldives and other countries to increase the capacity of WHO's Member States to do health technology assessment.

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Q: How do you achieve quality of services, a major challenge for universal health coverage?

A: About 20 years ago, we started working on hospital accreditation by building up the commitment of health personnel to improve the quality of care. Every year our national hospital accreditation event is attended by nearly 10 000 people. It's become a huge community of practice in our country. Our medical schools are also committed. The most prestigious medical school, Siriraj, has been giving an annual Outstanding Rural Doctor award for more than 40 years. The winner gives a keynote address to motivate medical graduates and lecturers.

Q: What are the main challenges for Thailand's Universal Coverage Scheme?

A: The civil servant medical benefit scheme provides better benefits than the social security and the universal coverage schemes. We are working towards harmonization or unification of the three schemes. Another challenge is that coverage is not complete for some services. For example, coverage of the acrylic-based dentures was less than 10% in 2012. Finally, we still have almost one million stateless people and around three to four million illegal migrant workers, who are not covered by the three schemes. We have been trying to develop health insurance for them. It is thanks to the dedication of our health workers that these people receive essential services irrespective of their ability to pay. ■