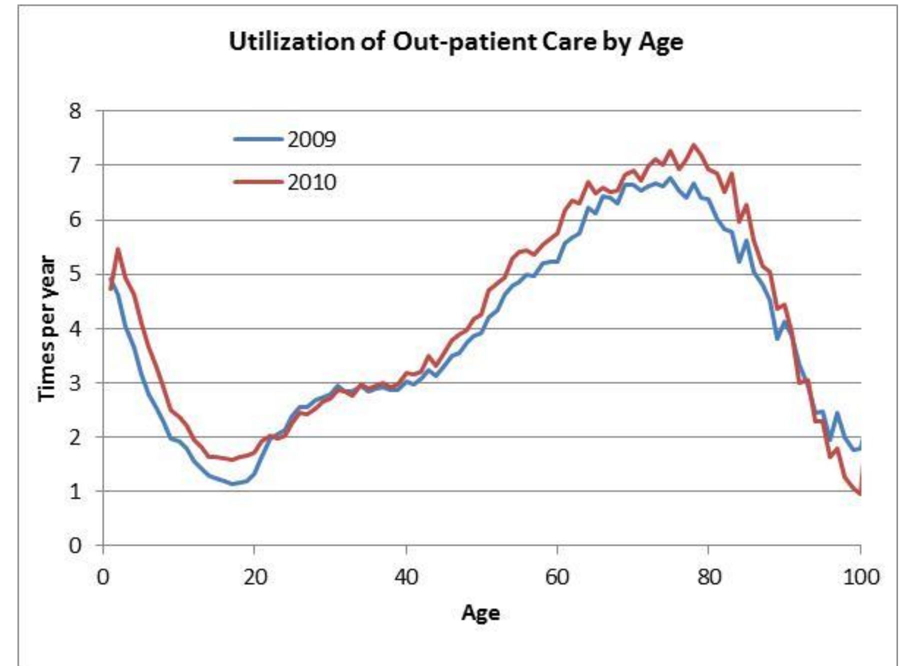
Closing the Health Gaps for the Elderly: Promoting Health Equity and Social Inclusion in Thailand

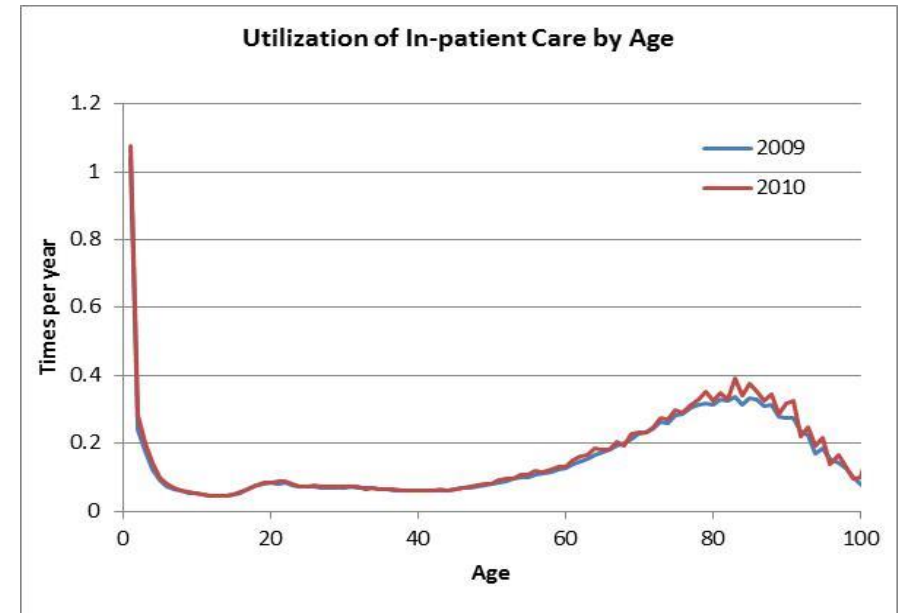
Sutayut Osornprasop

Human Development Specialist, World Bank

Background and rationale

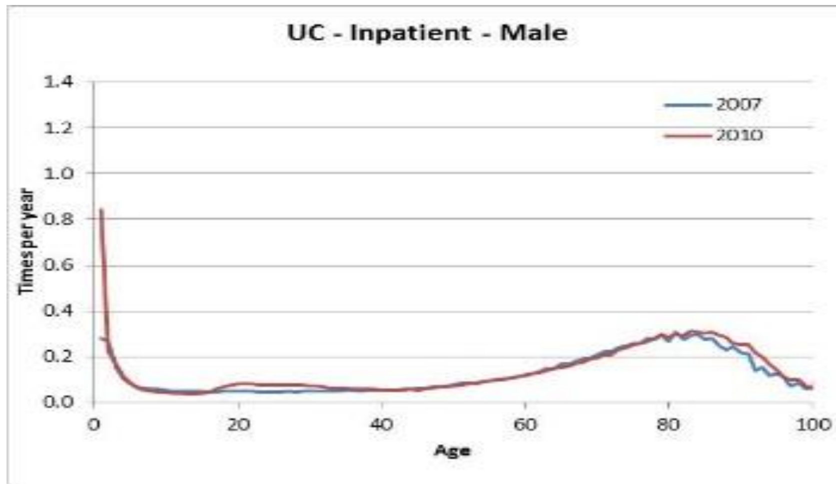
- Today, 100% of Thai citizens are statistically covered by one of the publicly-managed health insurance schemes
  - broadened access to health services
  - contributed to higher and more equitable patterns of utilization
  - helped reduce the financial burden and risk of impoverishment associated with health care costs.
- However, recent data show that there are still gaps in health utilization and financial protection.

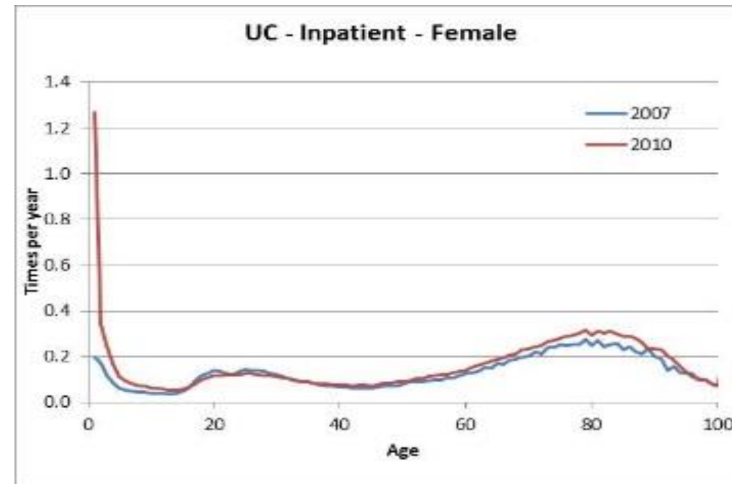


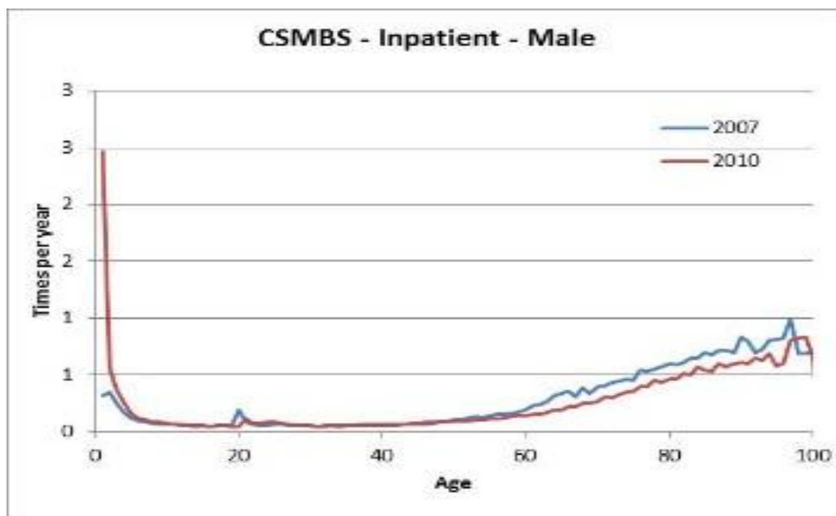


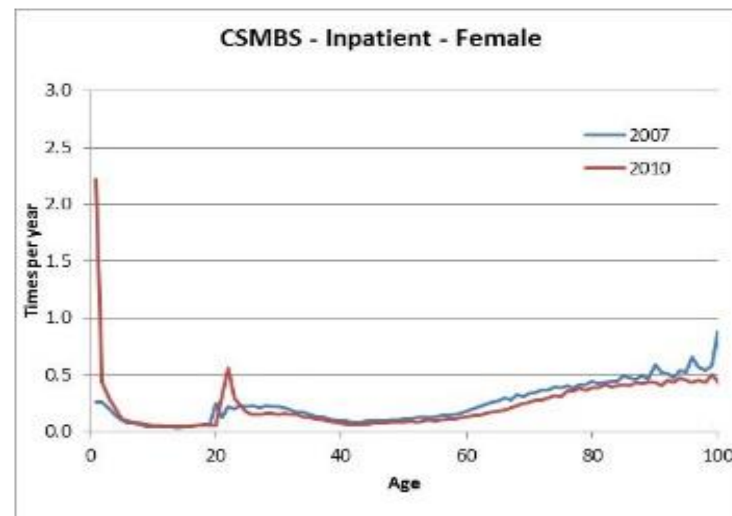
Source: HISRO

- Breakdowns of utilization by schemes indicate major disparity in utilization of in-patient care by schemes.





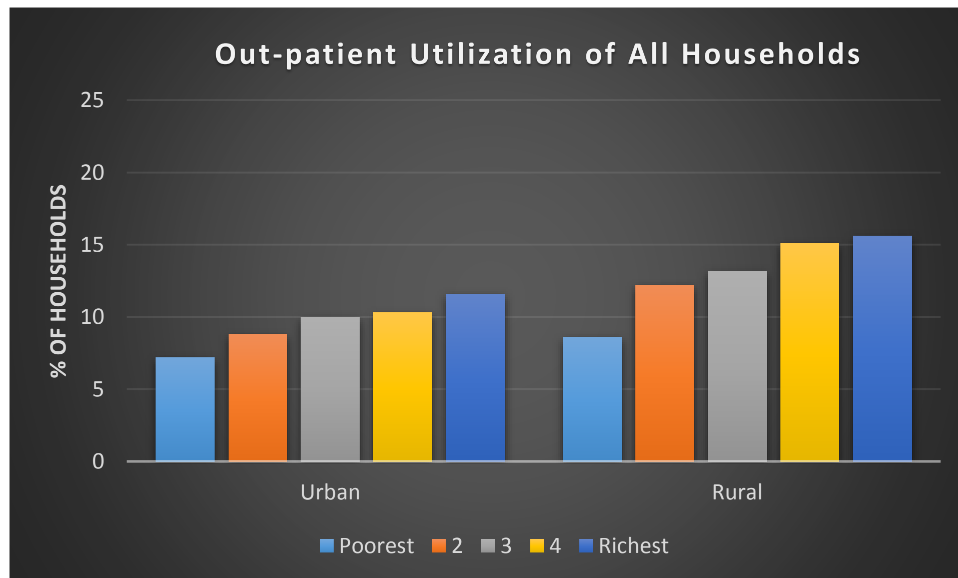


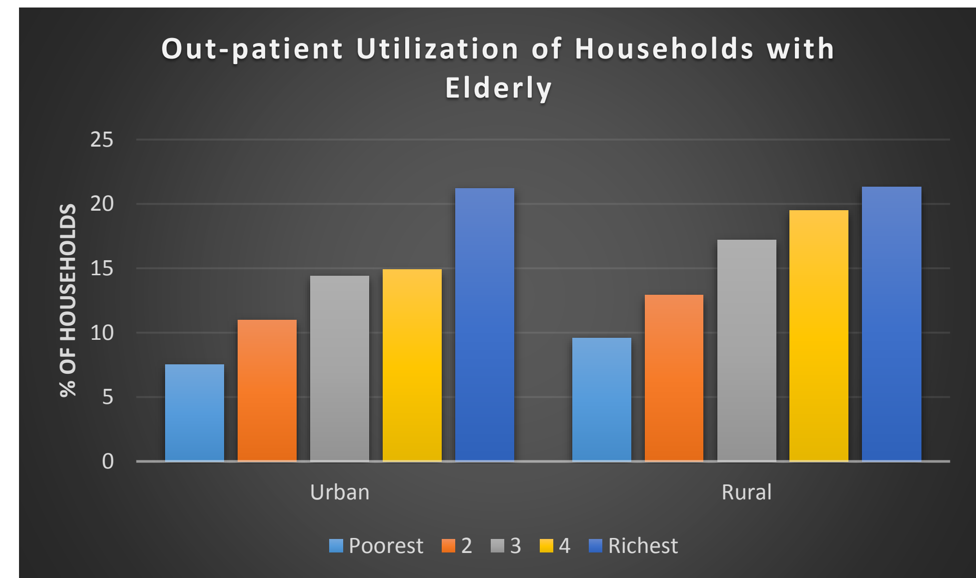


Source: HISRO

- These findings raise several important questions:
  - Why did the utilization of out-patient care by UC members drop after the age of 75, while the elderly people are more likely to have higher health care needs when they are older?
  - Why did utilization of in-patient care services by UC patients drop after the age of 82 while that of CSMBS patients continue to rise?
  - Were there problems with access to health care among the eldest old group under UC?
  - Given that the UC members generally comprise population with lower socio-economic status (compared with CSMBS and SSS), it is important to raise some questions on financial protection among the elderly members of the UC scheme, particularly among the elderly poor?
    - What are the key causes of OOP in health among the poorer elderly?
    - To what extent that these OOP pose barriers to accessing and utilization of health services among the poorer elderly?

- The objective of this study is to identify the gaps of accessing universal health coverage scheme's care system by the elderly population, focusing on utilization and financial protection aspects.
  - Conducted small-scale area-based qualitative case studies, focusing on elderly UC members who live in selected urban and rural areas in 4 different geographical regions of Thailand (797 participants)
  - Conducted quantitative analyses from SES

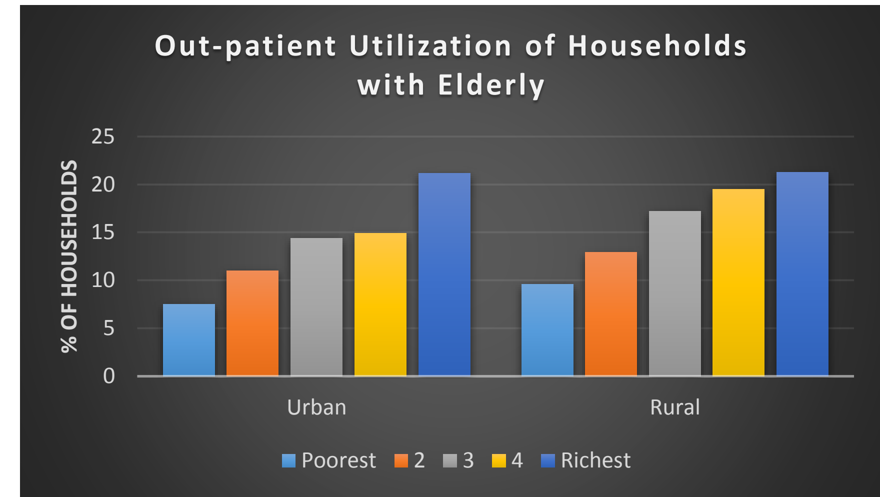


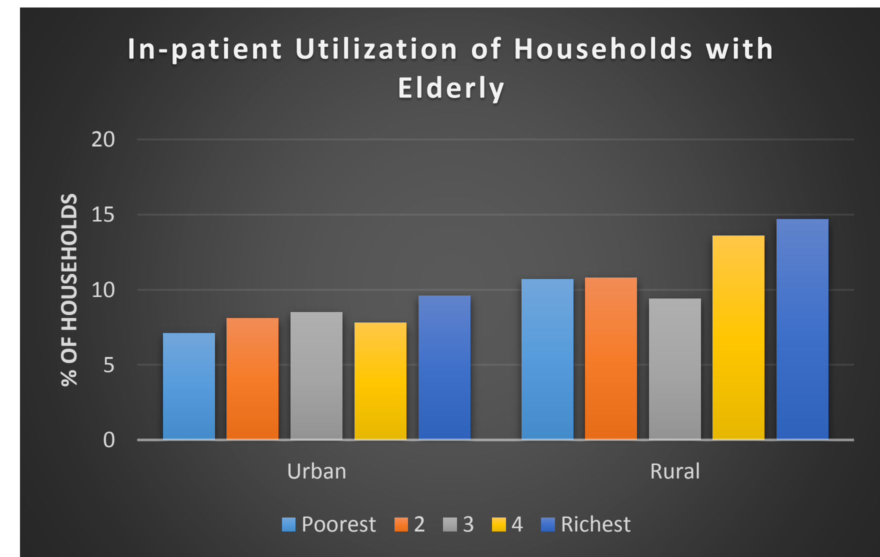


Key Findings on Utilization of Health Services

1. There are gaps in utilization of OP and IP services among households with elderly members from the poorer and richer quintiles in both urban and rural areas.

- The gap is largest in utilization of OP services

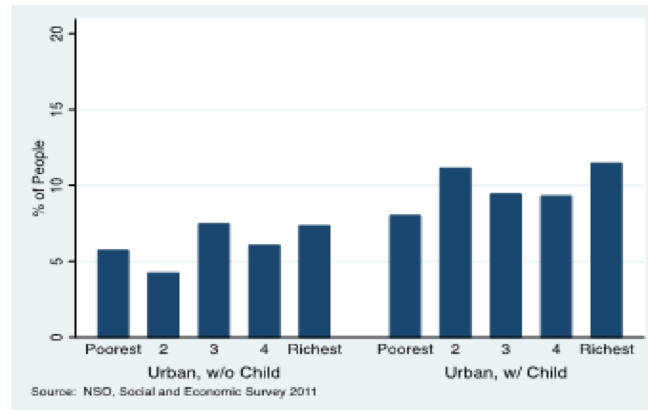




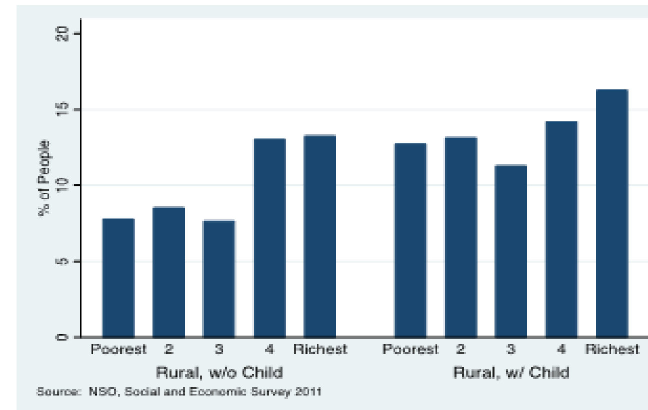
- Poor elderly who do not live with adult children are most vulnerable and have more probability to not being able to access health care services when needed.

Household Inpatient Admission Rates for Elderly (60+)

Urban



Rural



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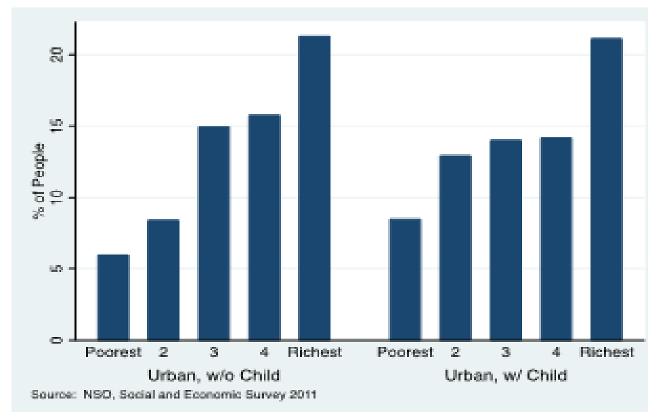
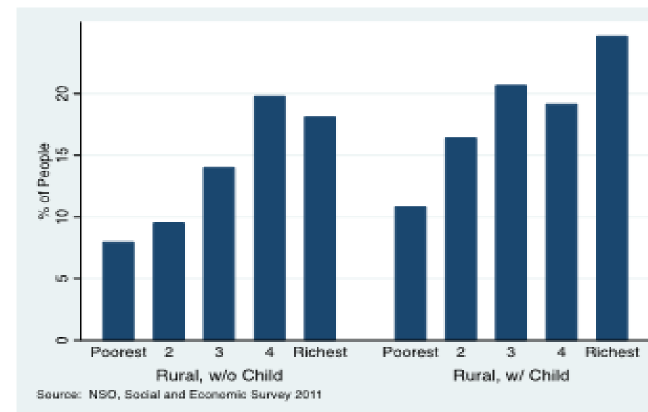
Urban



Rural



2. Per the qualitative assessment, 43% of elderly interviewees were fully satisfied with health services under UC, and did not encounter any key barriers to utilization.

- Of those who have identified barriers to utilization:
  - "long waiting time" is the top barrier for urban elderly
  - "long distance to a health facility" is the top barrier for rural elderly

3. Among frail and bed-ridden elderly interviewees, the key barrier to accessing health services is the unavailability of caretakers/relatives and transportation to bring them to health facilities

- greater effects on elderly interviewees who do not live with adult children, who live in rural areas, and who are females, particularly widows.

4. Trend that utilization of OP increases as people grow older but frequency decreases after age 75-80

- Dependence on availability of caretakers and relatives to bring the elderly patients to a health facility.
- Cataracts appears to be the most common disease that affects mobility of the elderly people and make them dependent of relatives and caretakers
- Change of health-seeking behaviors after having been living and receiving treatments for NCDs for 10-15 years
- Do not want to bother relatives

5. Lack of public and affordable transportation is the most important barrier to accessing health services among the elderly in rural areas

- A large number of elderly interviewees who do not have access to public buses identify that the cost of renting private vehicles is a major impediment for their accessing health services
- This is a major problem even in areas close to Bangkok

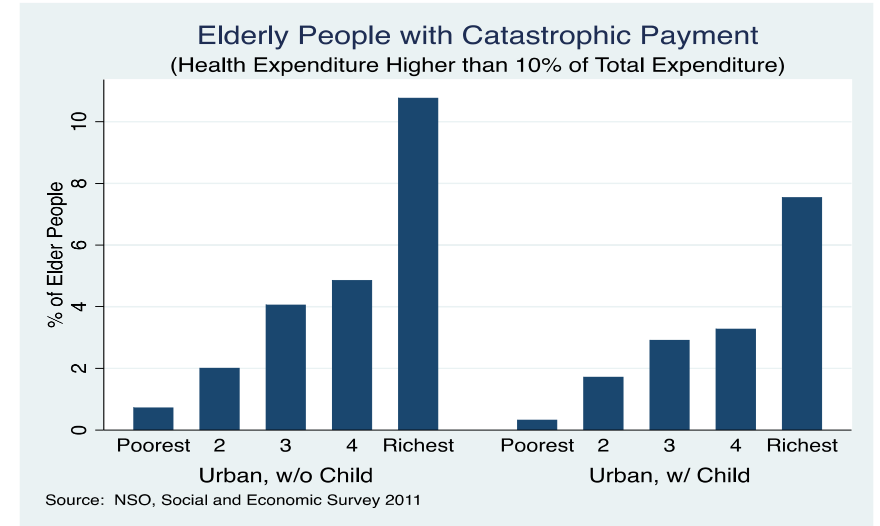
Key findings on financial protection

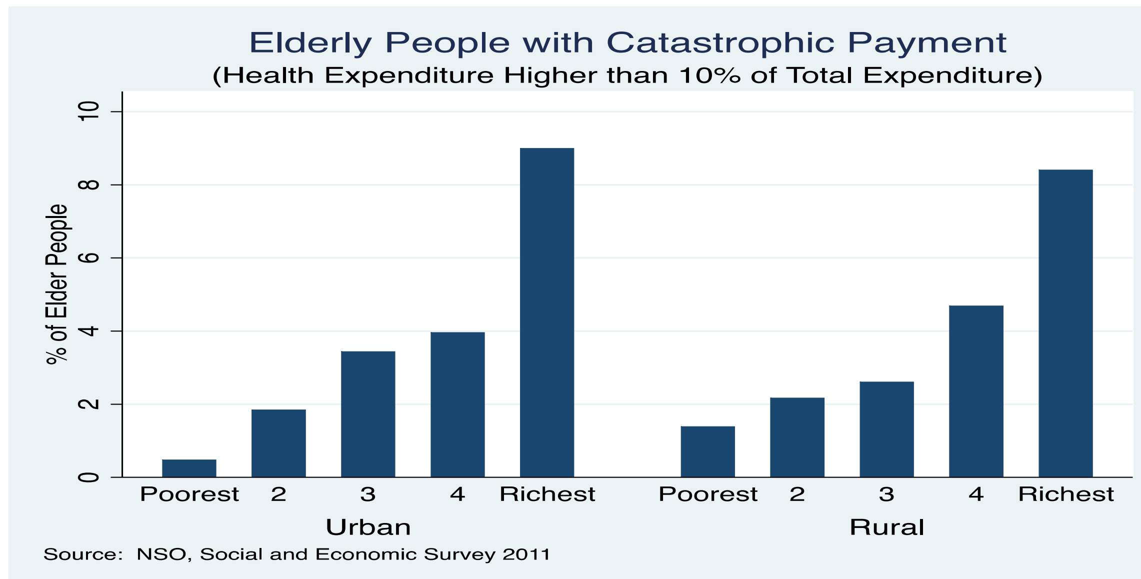
1. Incidence of catastrophic health expenditures among the two poorest quintiles of elderly people is about 1% and 2% respectively

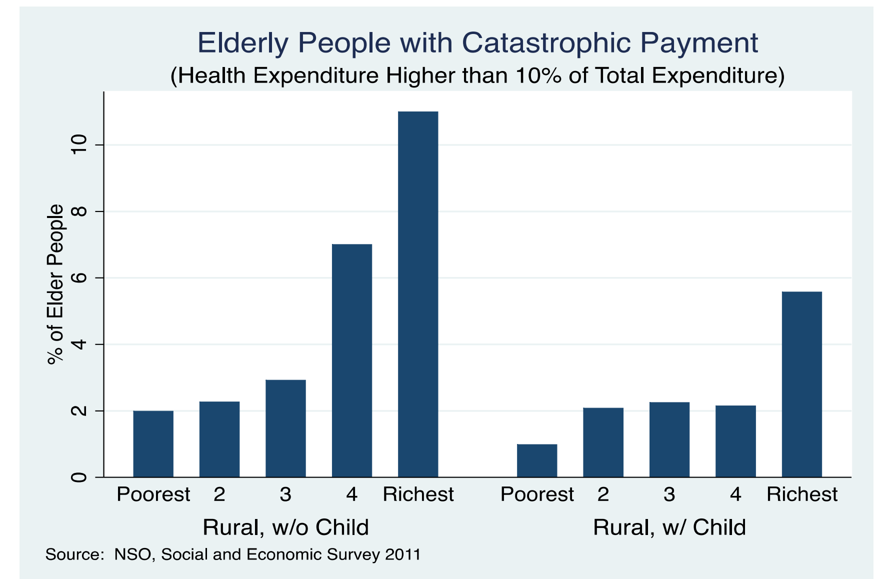
- UC scheme providing financial protection to the poor, or
- "foregone" care – that some poor elderly individuals may not access health care services when needed
  - partly supported by SES 2011 - there are gaps in utilization of OP and IP services among households with elderly members from the poorer and richer quintiles in both urban and rural areas, and that the gap is largest in OP services utilization
  - lack of caretakers to help bring poor elderly to receive health services when needed

2. Higher incidence of catastrophic health expenditures among households with elderly who live in rural areas

- Elderly living with adult children across all wealth quintiles have lower catastrophic health expenditures







- Although less than half of those surveyed under SES 2011 paid OOP, significant number of poor households with elderly still need to pay the costs of OP and IP care services at publicly run health facilities
- SES does not provide information on transportation costs

Average of health and medical expenditure: SES 2011

Medical and supplies

	Modern medicine	Traditional/herbal medicine	Contraceptives and condom	Vitamins	First-aid kits/medical equipments		TOTAL
Poorest 1	49.4	59.2	51.7	317.6	18.3		62.6
2	73.4	99.7	72.7	336.4	21.1		96.6
3	99.6	183.4	88.8	635.5	35.2		146.6
4	170.8	210.5	110.3	762.6	105.4		212.3
Richest 5	294.9	302.0	147.5	1,566.9	1,121.0		637.5
All	111.3	151.0	82.4	1,005.1	175.9		172.8

Medical services (outpatients)

	Public health centre/hospital	Private clinic/ hospital	Traditional healer/ medical services	Private dental clinic	Optometry services & equipment	Other health services	TOTAL
Poorest 1	375.1	381.6	396.2	356.8			380.6
2	465.7	477.6	293.4	210.9	353.9	760.5	493.3
3	887.0	614.3	378.1	462.2	1,943.0	404.5	703.2
4	2,621.9	1,052.6	730.7	910.9	1,433.7	3,373.6	1,465.0
Richest 5	4,586.0	2,751.5	544.7	4,056.3	3,544.0	10,000.0	3,961.5
All	1,655.6	1,021.9	434.3	1,953.6	2,197.0	4,461.4	1,402.6

Medical services (inpatients)

	Public health centre/hospital	Private clinic/ hospital	Other expense				TOTAL
Poorest 1	213.2	185.6	155.5				188.7
2	162.7	381.4	335.4				351.0
3	468.1	603.4	200.1				424.9
4	825.0	1,129.7	246.2				845.9
Richest 5	1,346.6	3,245.3	519.9				2,183.1
All	555.2	1,295.7	260.2				643.4

3. While the UC's coverage of drugs and treatment is relatively comprehensive, there are key cost items that are not covered by the UC

- Drugs that are not on the essential drug list
- Selected medical equipment for knee/hip replacement
- Hemodialysis for severe chronic renal disease patients (except for those who cannot receive peritoneal dialysis)
- Cost of setting up home-based non-medical accessories for peritoneal dialysis patients
- All cancer therapies that are outside of UC scheme's cancer treatment protocol, e.g. targeted therapy and selected drugs for chemotherapy
- All drugs that treat (or slow down the progress of) dementia group of diseases that include Alzheimer. Dementia affects 7.1% of elderly in the 60-69 age group to 1/3 of the elderly in the 80 and over age group

4. Transportation is a major cost for elderly rural residents to utilize health services (not provided by UC)

Expenditure type	Transportation	Food	Medicines	Carer's expenses
Urban	474	343	1,331	256
Rural	6,004	1,891	1,393	393

- Average transportation cost incurred by elderly rural residents is more than 10 times that of elderly urban residents
- Particularly affect the elderly poor, the elderly who do not live nearby major highways and roads on which public buses operate
- Elderly poor who depended on universal social pension as income alone is the most vulnerable
  - Need to use the monthly allowance to pay for room rent and food, and do not have extra resources to travel to health facilities in time of sickness

- Several elderly poor patients from remote districts who undergo cancer radiotherapy and chemotherapy at tertiary hospitals
- Accommodation and food are also significant cost items for elderly patients who need to travel from rural areas to receive care at higher-level health facilities
- Usually the elderly patients need to bring caretaker(s) along to support them
  - This add up the cost of accessing care – transportation, food, and residence if overnight stay is required

5. Several poor elderly do not have the means to travel to health facilities, as their only income is universal social pension, which is not sufficient to sustain their minimum living expenses – they do not have any money left after spending on food and accommodation, and do not have any savings

- Out of 547 elderly participants of FGDs, 38% indicated their monthly incomes are insufficient to sustain their living standard
- Situation is worse among the oldest old
  - Of 272 elderly participants aged 75 and over, as many as 101 (37%) indicated that the universal social pension is their only income source
- Some geographical disparity from the qualitative study
  - Elderly in North and NE tend to be poorer and dependent on universal social pension and support from relatives
  - Elderly from South and central Thailand on average tend to have higher incomes from continued employment or work in agriculture sector in addition to universal social pension

6. Some LAOs have played an instrumental role in promoting access to health services for the elderly in rural communities

- Several LAOs make available health emergency vans for people in the community free of charge
- Several LAOS also arrange annual health check-ups (in coordination with health promotion hospitals) for the elderly in community
- But, health-related support for the elderly vary significantly from one LAO to another, depending on the interests and priorities set by LAOs’ chief executives and mayors
- What the elderly want from their LAOs?
  - Health emergency van initiative to be expanded into more LAOs
  - Free transportation for the poor to travel to health facilities when sick (not only emergency cases)
  - Providing vehicles to bring elderly people from rural areas to receive OP care services at district or provincial hospitals once a week on a regular basis, as this will help boost health utilization

Recommendations

1. Special attention need to be paid to poor elderly individuals who do not live with adult children, particularly
    - Bed-ridden/ Rural areas/ Chronic illnesses
    - Regular home visits by community health workers and VHVs should be promoted
    - Transportation to health facilities should be provided for the poor when needed

2. Transportation costs to health facilities is the most important obstacle that prevents elderly poor in rural areas to access health care services
    - Health protection programs in countries that are much less developed than Thailand, e.g. Health Equity Funds in Lao PDR and Cambodia, often include support for both health care costs and transportation costs
    - There is no national program that supports transportation costs for the Thai poor to travel to health facilities

- It is important for the government to consider options to support transportation costs to health facilities for the elderly poor in rural areas

3. Cost pressures are building up in the UC system, which may make it challenging for the scheme to expand further benefits universally

4. Can more LAOs play an instrumental role in promoting access to health services for the elderly in rural communities?

5. Should identification and targeting of the poor for benefits that address unmet health-related needs be revisited?

- Since the introduction of UC in 2001, the formal system of targeting the poor has been dismissed
- There are still gaps in UC, ie. transportation costs and certain treatments
- 10% of elderly population are poor
- Once identification and targeting of the poor is conducted, the list could be used by NHSO and a number of social welfares schemes operated by large hospitals
- Benefits go beyond health sector