A Summary of the Roundtable Discussion on How to Hold Partners Accountable in Universal Health Coverage: Wisdom from India and Thailand

Reflections from Thailand

Ms. Orajitt Bumrungskulswat
Director, Bureau of Public & Private Participation, NHSO

UHC Implentation

Ms. Bumrungskulswat outlined the involved multi-stage nature of UHC implementation in Thailand, which passed through phases of community financing and public subsidized voluntary health insurance before the implementation of the comprehensive system. She stressed the importance of political will in the system's development and showed evidence that the system's implementation has resulted in increased health service utilization and low un-met need. This has predictably resulted in increased service-user satisfaction but has surprisingly also resulted in increased provider satisfaction, despite the increased workload.

Accountability

Ms. Bumrungskulswat placed great emphasis on the key role played by the people's movement from the very start, in ensuring both the success and accountability of the UHC. This involvement has included the following:

- The National Health Security Bill was proposed by representatives from the people's movement with 52,772 signatures from members of the public.
- There were five representatives of civil society present on the parliamentary commission which considered the bill.
- The governing bodies of the UHC, the National Health Security Board (NHSB), quality board and sub committees, include representatives from providers, NGOs, consumers, and local government.
- Independent complaint centers operated by civil society organizations have been established.
- The Friendship Support Center ensures patient participation in the healthcare system.
- A no fault compensation fund has been established providing preliminary assistance for patients and service providers.

Foundations

The basis of the success of the UHC has been founded on a strong partnership between all partners; this has required:

- Shared objectives and commitments (a shared agenda).
- Increased dialogue and negotiation.
- Building and maintaining commitment.
- Joint development of policy proposals.

Reflections from India

Ms. Jashodhara Dasgupta
Coordinator SAHAYOG and
Member, High Level Expert Group on Universal Health Coverage in India

Ms Dasgupta's presentation gave an Indian perspective on the work towards Universal Healthcare provision by 2022. She stressed the importance of both answerability, ensuring that individuals are obliged to explain their actions and decisions, and enforceability, the application of sanctions or punishments when those answers are not satisfactory.

She explained that the Indian Health System uses multiple methods to hold individuals to account; horizontal accountability, whereby formal state actors hold one another to account; vertical forms of accountability, in which citizens and their associations play direct roles in holding the powerful to account; and innovatively hybrid accountability mechanisms. These include:

- Community-based monitoring of health entitlements

- Public hearings and public dialogue
- Councils and committees with a space for membership-based organizations of the poor
- Forming participatory health councils at all levels
- Organizing regular health assemblies
- A stronger role for local elected bodies (Panchayats) for convergence on SDH
- Role of CSOs for mobilization, information, monitoring and capacity building
- Formal accountability/grievance redress mechanisms

Ms Dasgupta observed that provider-patient relationships are deeply influenced by the social context in which they are embedded. A key challenge India faces, is ensuring that the poor, who need the Universal healthcare system the most, are able to hold providers to account.

Ms. Orajitt Bumrungskulswat,
National Health Security Office, Thailand

Ms Jashodhara Dasgupta,
High Level Expert Group on UHC in India

Group discussion and information sharing

- Three factors crucial to the success of UHC are:
  1. Political commitment.
  2. Engagement of the economic, academic and government sector for knowledge, information, and support.
  3. The will of civil society to push it forward.

  With those three factors are at the right time and with a favourable setting, it is possible to achieve universal coverage.

- Three main obstacles that may challenge UHC in any country:
  1. Existing authorities which lose power in new or reorganized systems: for example the ministry of public health.
  2. Private hospitals, which lose business with the introduction of UHC.
  3. Pharmaceutical companies, which lose profits as UHC causes cost cutting through group bargaining.

- There are a variety of tools which can help to make government accountable. In India, the 'Right to Information Act' is one effective tool: Every citizen of India is empowered to ask the government to release any information that they wish for a 10 rupee charge; those below the poverty line don't have to pay. A question can be asked in simple language and the government is expected to respond within 30 days.

- The quality of healthcare has to be developed in parallel with the coverage of healthcare. If UHC is introduced but the quality of service is not respected then people will not use it. Thailand has been investing heavily in its health system for the past 20 years shifting the emphasis first to provincial level hospitals, and then district hospitals, and most recently to community health centres at the sub-district level. When the UHC was introduced there was a good working system in place for people to access.

- The UHC should not cover healthcare alone, but should also cover health promotion and prevention. Thailand started another initiative called “the Community Health Promotion Fund”; this is a joint partnership between the National Health Security Office and local government at the sub-district and municipality level. These local partners have to contribute up to 50% of the budget depending on the size of the authority. These funds are used proactively to improve health: the local authorities run screenings and other activities. These local authorities have learnt more about healthcare and have improved community participation. More than half of the executive committees are made up of ordinary members of the community representing five groups, children and youths, women, senior citizens, chronically ill patients, and the disabled. The fund is growing significantly, as is the contribution from local government. This scheme builds the capacity of local people.

- The UHC scheme in Thailand is quite comprehensive; it covers all services, hospitalisation dental care, medicines and operations. Initially it excluded anti-retroviral drugs and dialysis treatments, but after further studies these are now included. The only things still officially excluded are cosmetic surgery and gender reassignment surgery.

- Brazil has an even more comprehensive plan in place with the biggest public transplant programme in the world; ant-retroviral drugs have been covered for a decade; likewise renal schemes and dialysis are also covered. Citizens in Brazil have an official ‘right to health’, where medical services are not accessible individuals can sue to get what the law says they are entitled to have. That can be problematic because not all areas of the country can provide access to all of these services.

- Brazil has 60% private hospitals and they are contracted to provide services to the public sector. Thailand tries to get the private sector involved in providing UHC; in Bangkok more than 200 private clinics provide services under the UHC. In Thailand 80% of all medical providers are in the public sector and just 20% in the private sector. This is opposite to India where 80% of medical providers are in the private sector and 20% in the public sector. The issue of regulation between the public and private sectors raises problems for the provision of UHC.

Reported by

Mr. Alex Dalliston
Ms. Nanoot Mathurapote
Global Partnership Development Programme
National Health Commission Office, Thailand