THAILAND UHC & OVERVIEW

OF THE UNIVERSAL COVERAGE SCHEME OF THE NATIONAL HEALTH SECURITY OFFICE

NHSO
National Health Security Office

THAILAND UHC & OVERVIEW

OF THE UNIVERSAL COVERAGE SCHEME OF THE NATIONAL HEALTH SECURITY OFFICE

NHSO
National Health Security Office

GLOSSARY

CIVIL SERVANT MEDICAL BENEFIT SCHEME (CSMBS)

This refers to the health care benefits for government employees and retirees including their dependents including parents, spouse and not more than three children (less than 20 years old). This scheme is supported by the central budget under the management of the Comptroller General's Department of the Ministry of Finance.

SOCIAL SECURITY SCHEME (SSS)

This refers to insurance which covers medical treatment only for the insured (i.e., not including immediate family members). This insurance is designed for employees of a private company or non-governmental entity. The insurance compensates for medical treatment for an accident, illness, disability, death, as well as for the cost of child delivery. It is a tripartite contribution scheme by the employer, employee, and the government, andis under the management of the Social Security Office (SSO), Ministry of Labor.

UNIVERSAL COVERAGE SCHEME (UCS)

This refers to the health insurance for Thai citizens who are not covered by the CSMBS or SHI schemes. UCS provides benefits which include medical care, health promotion and disease prevention and extend to rehabilitation as well. This scheme is managed by the National Health Security Office (NHSO) with central budget funding. The NHSO is the administrator of the UCS.

CLOSE-ENDED BUDGET

This refers to the specification of budget earmarked for the spending of health services each year in accordance with stated targets. Using a close-ended budget helps to ensure fiscal sustainability, control costs and avoid escalation of costs by stipulating the method of disbursement to the various types of service providers. This is also intended to maximize efficiency of disbursements. At present,close-ended budgeting is used for disbursements to compensate for the cost of health services of the NHSO and the SSO.

AGE-ADJUSTED CAPITATION

This refers to the cost of health care as calculated as a lump sum based on the number of the registered population in the catchment areas. These funds are issued for outpatient care. The per capita cost is adjusted to be in line with the age composition, for which various age groups can differ significantly. For example, young children and the elderly have a larger per capita allocation of budget thanother age groups.

DIAGNOSTIC RELATED GROUPS (DRGS) UNDER GLOBAL BUDGET

This refers to a method of budgeting which the NHSO uses to compensate for health care provider services to in-patients. The costs are calculated by the forecast of the number of services that are calculated as a relative weight adjusted by the length of stay in health services provider (adjusted relative weight: adjRW) and the service cost per adjRW. This uses the financial reporting data of the service unit as a basis for calculation. There are many factors involved, such as the number of in-patient days, the severity of the disease, etc., and whether the payment within the global budget in order to be consistent with the budget received from the government.

TABLE OF CONTENTS

1

INTRODUCTION

The Universal Health Coverage (UHC) scheme aims to create equal access to health for the population.[1] UHC is also part of the Sustainable Development Goals (SDGs) set by the United Nations (UN).[2] Thailand launched its own version of UHC in 2002, after the passing of the National Health Security Act in the same year. The Act calls for all Thai citizens to be covered by one form of government health insurance. There are three main public schemes: The Civil Servant Medical Benefit Scheme (CSMBS); Social Security Scheme (SSS); and the Universal Coverage Scheme (UCS). Each of these schemes is backed by a different law. The CSMBS is a fringe benefit for government employees, first initiated in 1980. The SSS is required by law for all employers and employees, and this first came into force in 1990 as part of the Social Security Act. The UCS began in 2002 as part of the National Health Security Act, and reflects the Thai government view that health insurance is a right of citizenship, with funding coming from the central budget.[3]

Thailand has been recognized globally as a developing country which has succeeded in implementing its UHC scheme.[4] The fact that all Thais have access to standard, essential health care is an important form of financial risk protection for families, and significantly reduces unmet health care need.[5,6]

UCS implementation is one of the key successes of achieving UHC in Thailand. It is important to review the 20 years of the UHC, its founding concepts and vision, the social advocacy that gave rise to it, organizational development, personnel development, financial system development, and sustaining a standard level of health care throughout. The lesson of the UCS is an important case study for analysis, and as a model for other countries to emulate.

CONCEPTS, BACKGROUND AND AIMS OF THE CREATION OF THE UHC SCHEME

UHC means that all people can access essential quality health services which are affordable and are ensured financial protection from these services.[7] UHC has actually become accepted as a basic human right and a means to promote equity and fairness in the health care sector. Importantly, all individuals should obtain health services regardless of ability to pay and not suffer a burden from health spending.

In 1978, UHC, as a basic human right, was first proposed at a global forum in Alma Ata (in the Soviet Union at the time) as part of the International Conference on Primary Health Care. Then, in 2005, UHC was adopted by the World Health Assembly as one of the foundations of sustainable development.[8] At present, achieving UHC is a main goal of improving the health care system in many countries. Indeed, UHC is incorporated into SDG 3.8 (of the SDG targets for 2030).[9]

THAILAND ACHIEVEMENT OF THREE DIMENSIONS OF THE UHC CUBE

Figure 1

Achieving UHC comprises of three core components: population coverage; service coverage; and financial risk protection. These principles are referred to as the UHC Cube (Figure 1). In 2002, Thailand achieved the three components of the UHC Cube with three government health insurance schemes: The CSMBS, the SSS, and the UCS. Thai people could access affordable quality health services as an essential right. The effect of this was to drastically decrease the household financial burden for health services which protected households from catastrophic health expenditure and impoverishment from the medical bills.

X AXIS

POPULATION COVERAGE

POPULATION: WHO IS COVERED?

100% OF POPULATION COVERED BY 3 SCHEMES
[UCS 75%, SSS 15%, CSMBS 10%]

Y AXIS

FINANCIAL PROTECTION

WHAT DO PEOPLE HAVE TO PAY OUT-OF-POCKET?

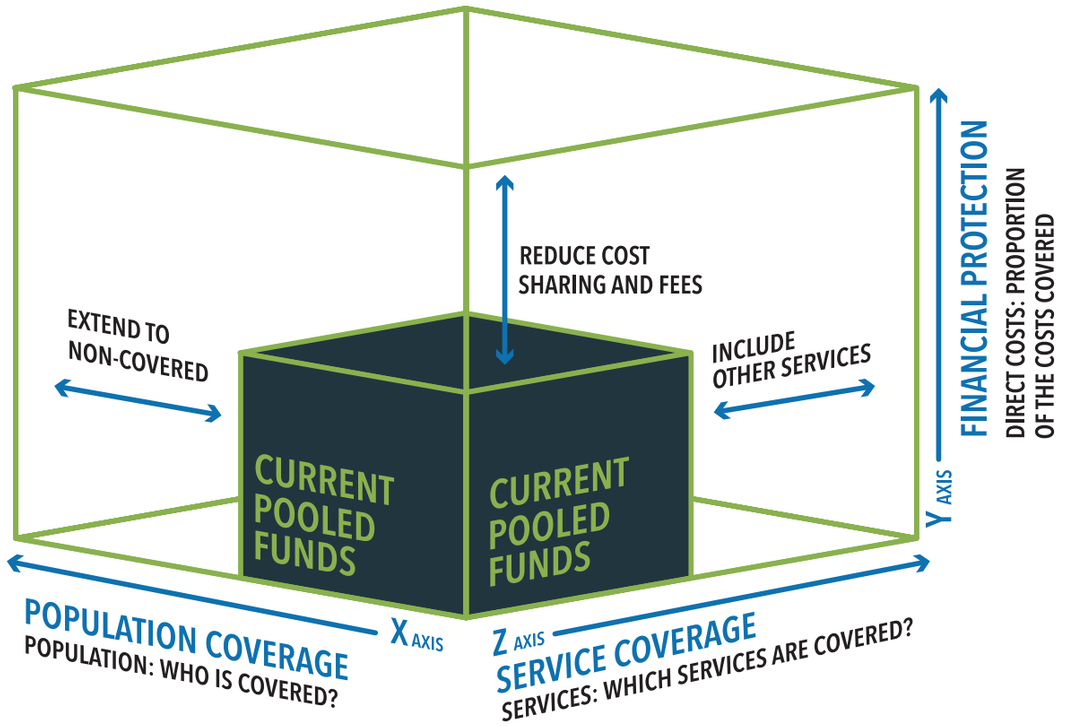
FREE AT POINT OF SERVICES, VERY MINIMUM OOP,
LOW INCIDENCE OF CATASTROPHIC HEALTH EXPENDITURE
AND MEDICAL IMPOVERISHMENT

Z AXIS

SERVICE COVERAGE

SERVICES: WHICH SERVICES ARE COVERED?

COMPREHENSIVE HEALTH SERVICES



HEALTH INSURANCE IN THAILAND

The journey to achieving UHC in Thailand gradually developed over time. The process took about 30 years with a target approach strategy starting by focusing on the lower-income population, and then expanding to include those with special care needs.

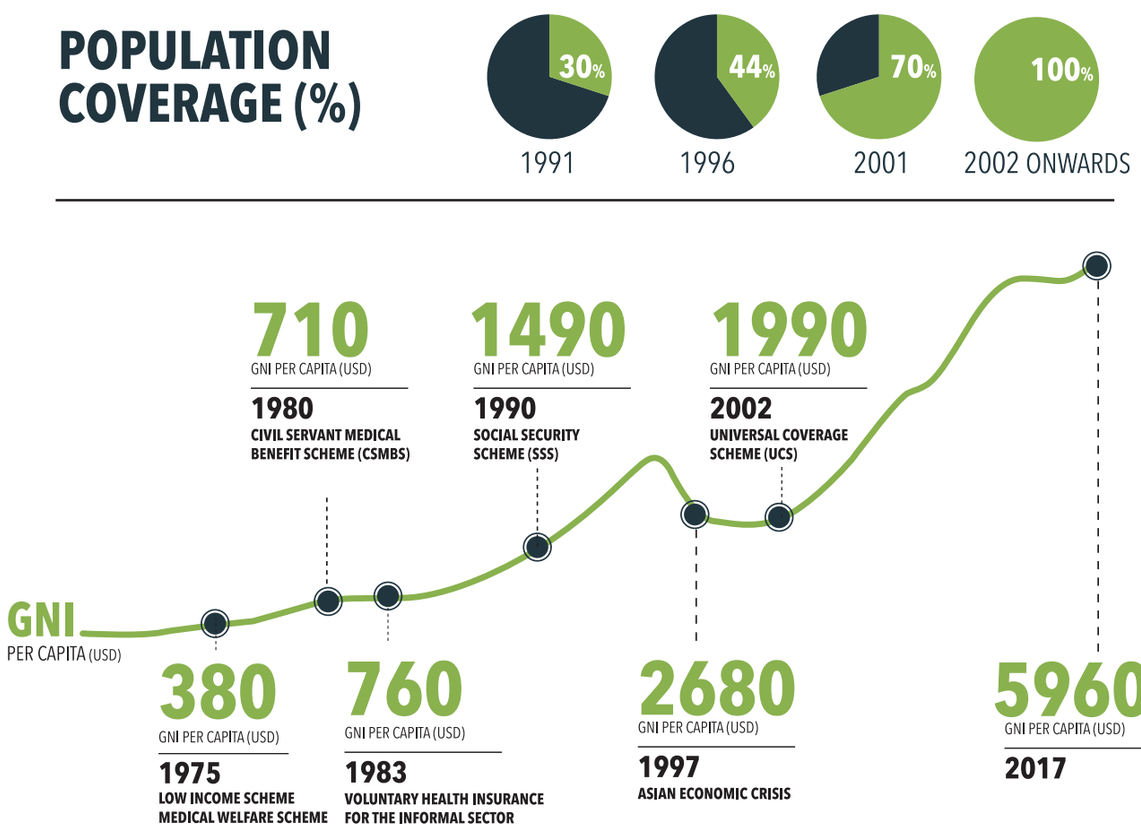
The need to establish health insurance for specific groups of the Thai population was first addressed in the 1974 Thai Constitution. That constitution was enacted by the Parliament in the aftermath of the October 14, 1973 uprising. Article 92 of the 1974 Constitution states the following: "The state should provide medical care to the poor without charge."[10] Since that time, public health insurance has gradually expanded to those outside the formal labor sector, including children, the elderly, and those whom society has a responsibility to care for.[11]

Government employers are automatically enrolled in the CSMBS under the Royal Decree on Health Care Welfare (1980).[12] Workers in the private sector are eligible for SSS coverage under the Social Security Act of 1990. The coverage of SSS was expanded to cover those exposed to hazards, accidental injury, disability, or death in the course of performing their occupation (under the Workmen's Compensation Act of 1994).[11] There is also the Road Accident Victims Protection. Act (1992) for people injured by road traffic accidents. The effect of all this legislation was to extend coverage of health insurance from 30% in 1975 to 70% of the population by 2001.[13] By 2002, all Thais were covered after the introduction of the UCS. Thus, it can be asserted that Thailand can achieve UHC after UCS became a national policy and was implemented.

The Asian economic crisis in 1997 caused Thailand's Gross National Income (GNI) to decline from $2,680 per capita to a low of $1,960 in 2001.[14] Despite facing the economic crisis, Thailand was still able to launch UCS as part of the National Health Security Act of 2002. Since that time, the Thai GNI increased from $1,990 per capita in 2002 to $5,960 in 2017 (Figure 2).

GNI PER CAPITA AND EXPANSION OF HEALTH INSURANCE COVERAGE: 1969-2017

Figure 2



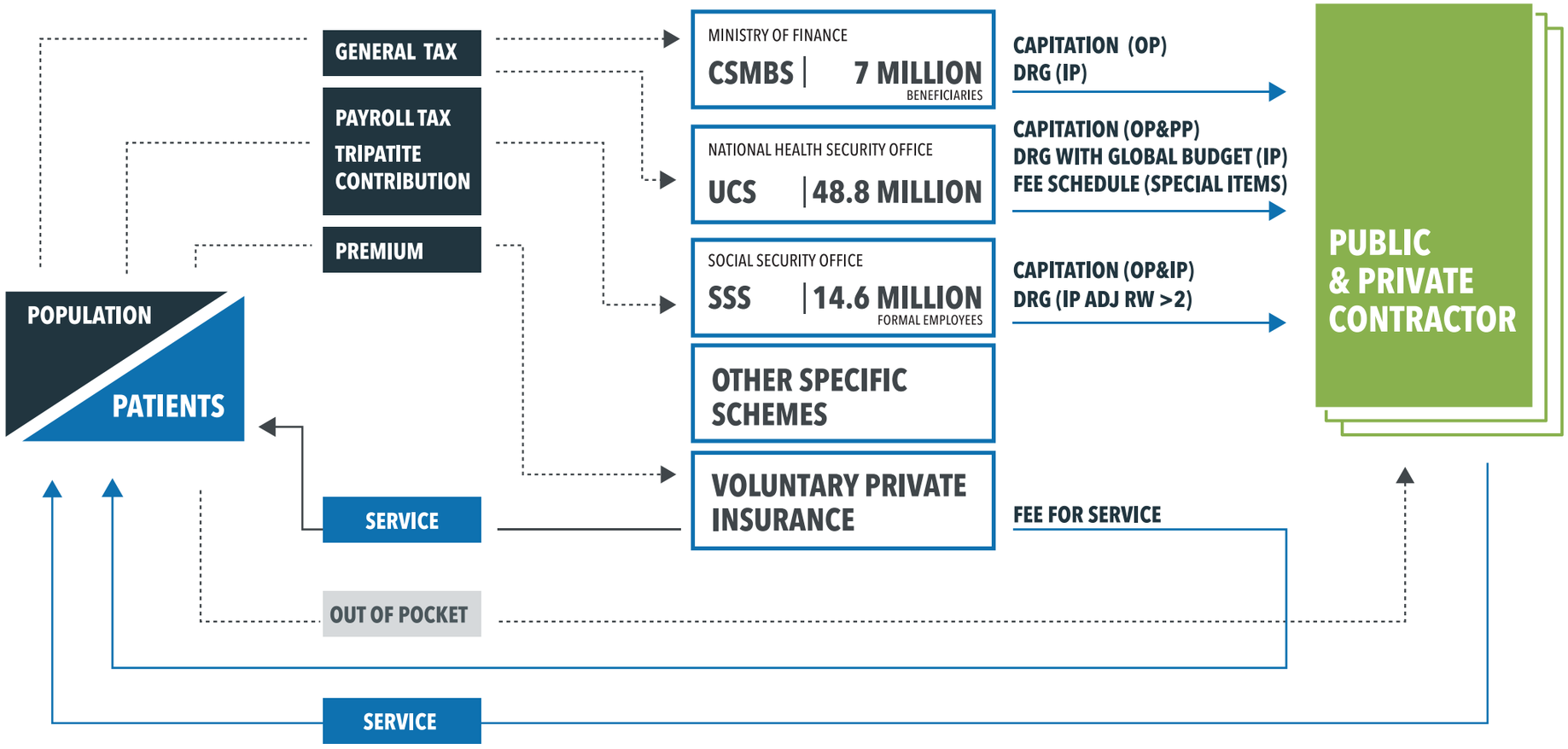
Source: GNI per capita data from the World Bank.https://data.worldbank.org/country/thailand

DIFFERENCES BETWEEN THE CSMBS, SSS AND UCS

Due to segmented development, the three government health insurance schemes have different histories, features, objectives, and administrative management. As of 2018, there were 4.9 million persons enrolled in the CSMBS.[15] Funding for the CSMBS comes from tax revenue, and the scheme is administered by the Comptroller General's Department. The UCS is managed by the National Health Security Office (NHSO),

HEALTH FINANCING AND SERVICE PROVISION IN THAILAND AFTER ACHIEVING UNIVERSAL COVERAGE IN 2002

Figure 3



Source: Thailand Health System in Transition[17]

and covers an estimated 47.1 million persons[15] who were mostly lower-income.[16] The SSS is administered by the SSO, and its funds come from a tripartite contribution (employer, employee and the government). Most of the beneficiaries of the SSS are in the middle- or higher-income groups.[16]

The benefits packages of each of these schemes are not that different, though the methods of disbursements do differ. CSMBS applies a fee-for-service for out-patient services and DRG with open-ended budget for in-patient services. SSO applies capitation for both out-patient services and in-patent services. The DRG system is also implemented for in-patient services, and the adjusted relative weight (the relative weight adjusted with length of stay) is equal or higher than 2. The NHSO applies close-ended budget management and mixed provider methods of paying providers (e.g., capitation for out-patients, DRGs with global budget for in-patient care, and fee schedule in some specific services and other specific conditions which are high-cost). The decision whether to use a type of payment method depends on health care utilization, the availability and distribution of health care infrastructure, health care services, and the health workforce.

In addition to these three government health insurance schemes, individuals with higher income can select to buy voluntary private health insurance. The three government schemes pay the provider directly, while a private health insurance usually pays patients rather than the service provider (Figure 3).

CONCURRENT DEVELOPMENT OF THE SERVICE SYSTEM, PERSONNEL, AND FINANCING

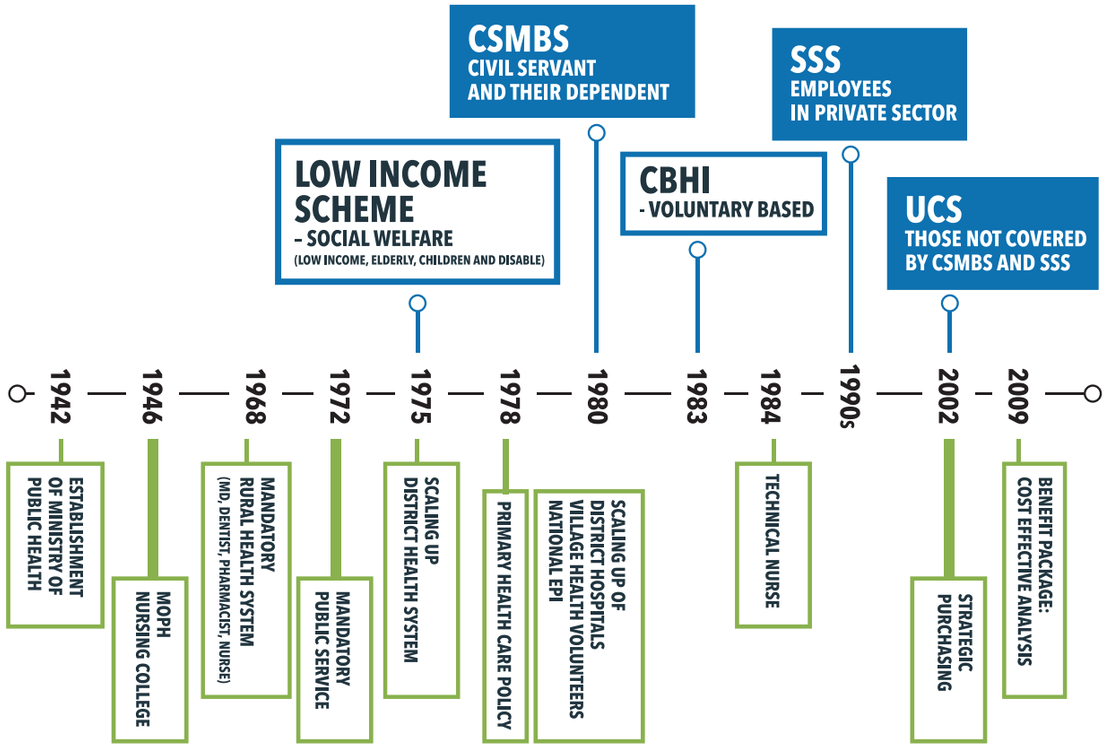
Achieving UHC would not have been possible by only expanding coverage. There had to be a concomitant strengthening and development of infrastructure, service system and health care personnel. In the decade of the 1970s, the Thai health system had begun to expand with a part of the Five-year Economic and Social Development (NESD) Plan. Various policies were promulgated to support these developments, including the National Family Planning Policy (1970), and the Policy for Expanded Immunization (1976). During the 4th Five-year NESD plan, there was significant investmentin infrastructure and construction at the district and Tambon (sub-district) levels, starting in 1977. As a result, Thailand established a district hospital in all districts in Thailand by 1990. A decade of health-center development followed during 1992-2001, resulting in full coverage of health centers in all Tambon by 2010.[3]

IN THE DECADE OF THE 1970s, THE THAI HEALTH SYSTEM HAD BEGUN TO EXPAND WITH A PART OF THE FIVE-YEAR ECONOMIC AND SOCIAL DEVELOPMENT PLAN

The health system at the district level is the backbone of the national health system. In each district, there is one district hospital and a number of health centers for improving access to health services without the burden of transportation cost. This expansion and upgrading was matched by commensurate development of the health personnel by Ministry of Public Health (MOPH). Moreover, the system gained the people's trust from providing services with good quality.

DEVELOPMENT OF THE INFRASTRUCTURE FOR HEALTH CARE AND HEALTH INSURANCE

Figure 4



The health workforce policy calls for an integrated program of recruitment, training, distribution, and retention of these personnel, especially in the rural areas. In 1972, the MOPH introduced a mandatory policy that required new graduates from medical and nursing colleges to first work in rural health care facilities. This policy applied to both public and private training institutions, and was later expanded to include dental and pharmacy graduates. This policy motivated health personnel with financial and non-financial incentives so that services were available 24 hours a day. The MOPH also introduced a program to recruit high school students from remote villages to be able to study to be physicians and nurses. This special program was launched in 1994 with the condition that graduates had to return to their home district to provide health services.

Medical human resource production capacity was expanded by the MOPH with the upgrading of regional hospitals into clinical training centers for special track students in Years 4-6. They study with normal-track students during the first three years of basic science and preclinical courses. The normal track students continue their studies in year 4-6 in the faculty of medicine of their registered university, while students in special tracks are trained in the 37 MOPH clinical training centers.

IN **1972**

THE MOPH INTRODUCED A MANDATORY POLICY THAT REQUIRED NEW GRADUATES FROM MEDICAL AND NURSING COLLEGES TO FIRST WORK IN RURAL HEALTH CARE FACILITIES

Nurses are an important part of Thailand's health system due to their large number, qualifications and wide distribution. They can provide a range of services including public health , patient care, clinical services, etc. There are also in-service training programs to further build the skills of Thai nurses to best meet the demands of the health system. In order to keep up with the demand for nurses, the MOPH has established nursing and midwifery colleges, starting in 1946, which are licensed and certified by the Thai Nurse and Midwifery Council. Since 2002, each graduate must pass a national nursing licensing examination to obatin a license to practice nursing. As part of the nursing competency certification system, all nurses must renew their professional license every five years.

The MOPH has established seven Sirindhorn Colleges of Public Health to provide training for health personnel.[18] Most of this training is in the form of two-year diploma courses, for example in the area of dental public health, community medicine, technical pharmacy, etc. These courses can help to fill gaps where there is rapid expansion of the health system, especially at the district level. Each of these diploma courses is continually being upgraded to keep pace with standards, and the plan is to eventually convert these into bachelor's degree programs.[3] In addition to these educational programs, there is a Thai Traditional Medicine College and an Institute of Medical and Public Health Technology.[18]

THE MOPH ALSO INTRODUCED A PROGRAM TO RECRUIT HIGH SCHOOL STUDENTS FROM REMOTE VILLAGES TO BE ABLE TO STUDY TO BE PHYSICIANS AND NURSES.

WITH THE CONDITION THAT GRADUATES HAD TO RETURN TO THEIR HOME DISTRICT TO PROVIDE HEALTH SERVICES.

LESSONS LEARNED

- The success of Thai UHC was possible because of a solid foundation, including infrastructure readiness, health personnel distribution policy, health system reform and on-going improvement.
- The UCS expanded coverage of health insurance to people who have no health insurance from the government to obtain this basic rights. This was accomplished by a gradual expansion of coverage.If a country's economic system continuously improves, then UHC will be easier to achieve.
- The partial development may result in inequality of access, unequal care, and disparity of rights.

2

NATIONAL HEALTH SECURITY ACT

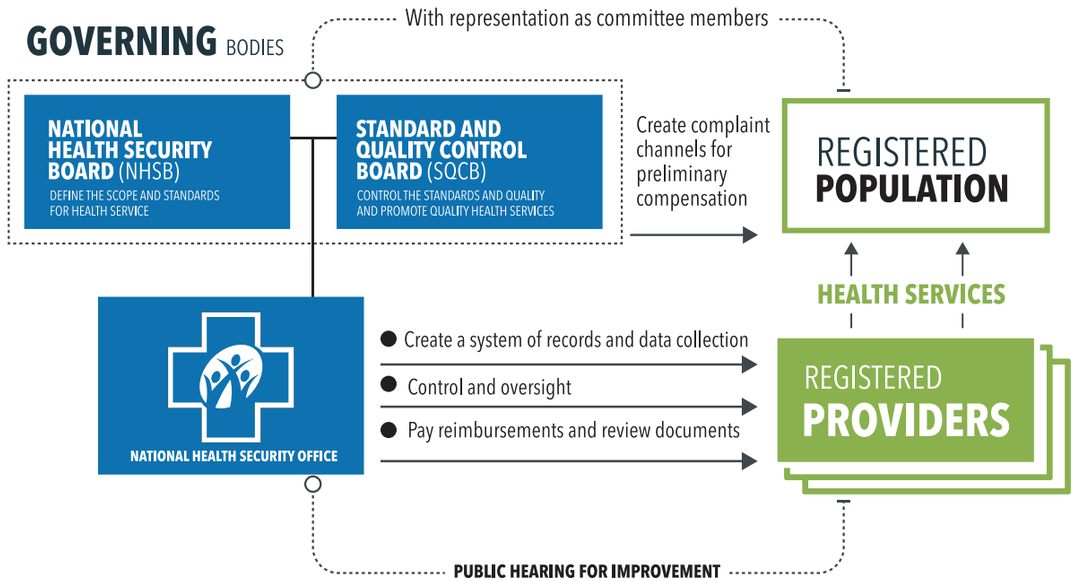
The Thai UCS was only possible due to the advocacy by many partners and sectors. The National Health Security Act of 2002 was the result of a grassroots movement of the people.[19,20] A key aspect of the Act was the creation of a legal mechanism (Figure 5) based on principles of good governance, and governing bodies, to link with health care providers and population who receive health service. The Act emphasizes involvement of the population across all sectors to help improve and refine services to ensure efficient management of the National Health Security Fund in order to deliver the most benefit to all people in accessing quality health services.

GOOD GOVERNANCE

GOVERNING BODIES

ADMINISTRATION OF UNIVERSAL COVERAGE SCHEME BY THE NHSO IN ACCORDANCE WITH THE 2002 ACT

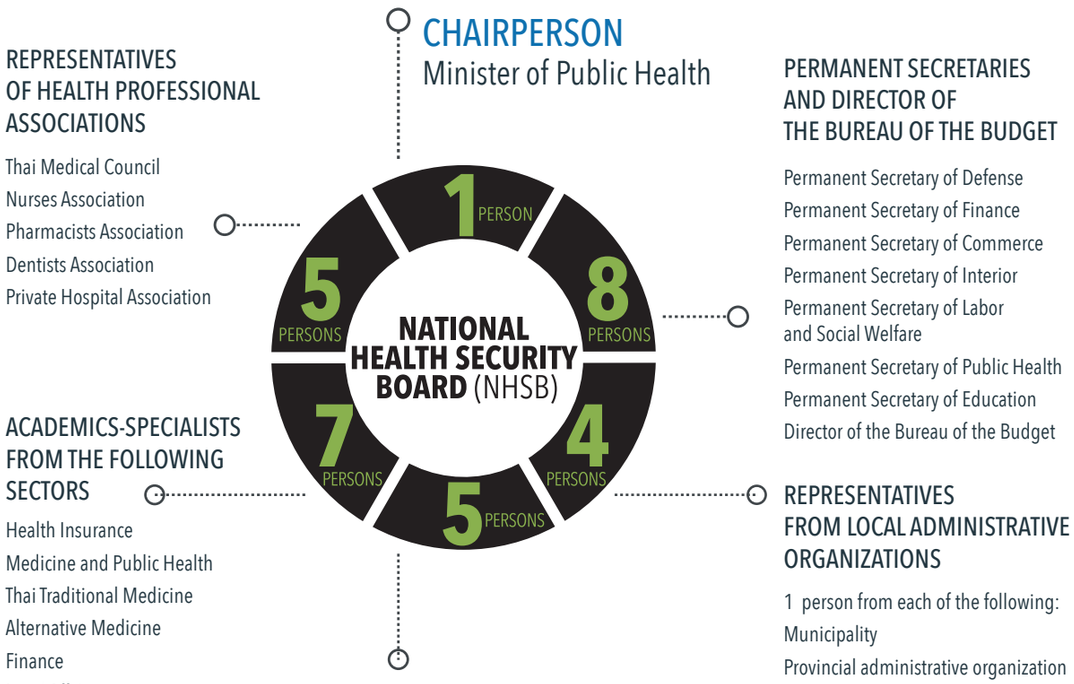
Figure 5



The core governing bodies set in the National Health Security Act (2002) are the National Health Security Board and the Standard and Quality Control Board. The boards are made up of representatives from many sectors as required by law (Figure 6 and 7) in order to set various policies for managing the UCS and operating the NHSO through approval by all relevant stakeholders.

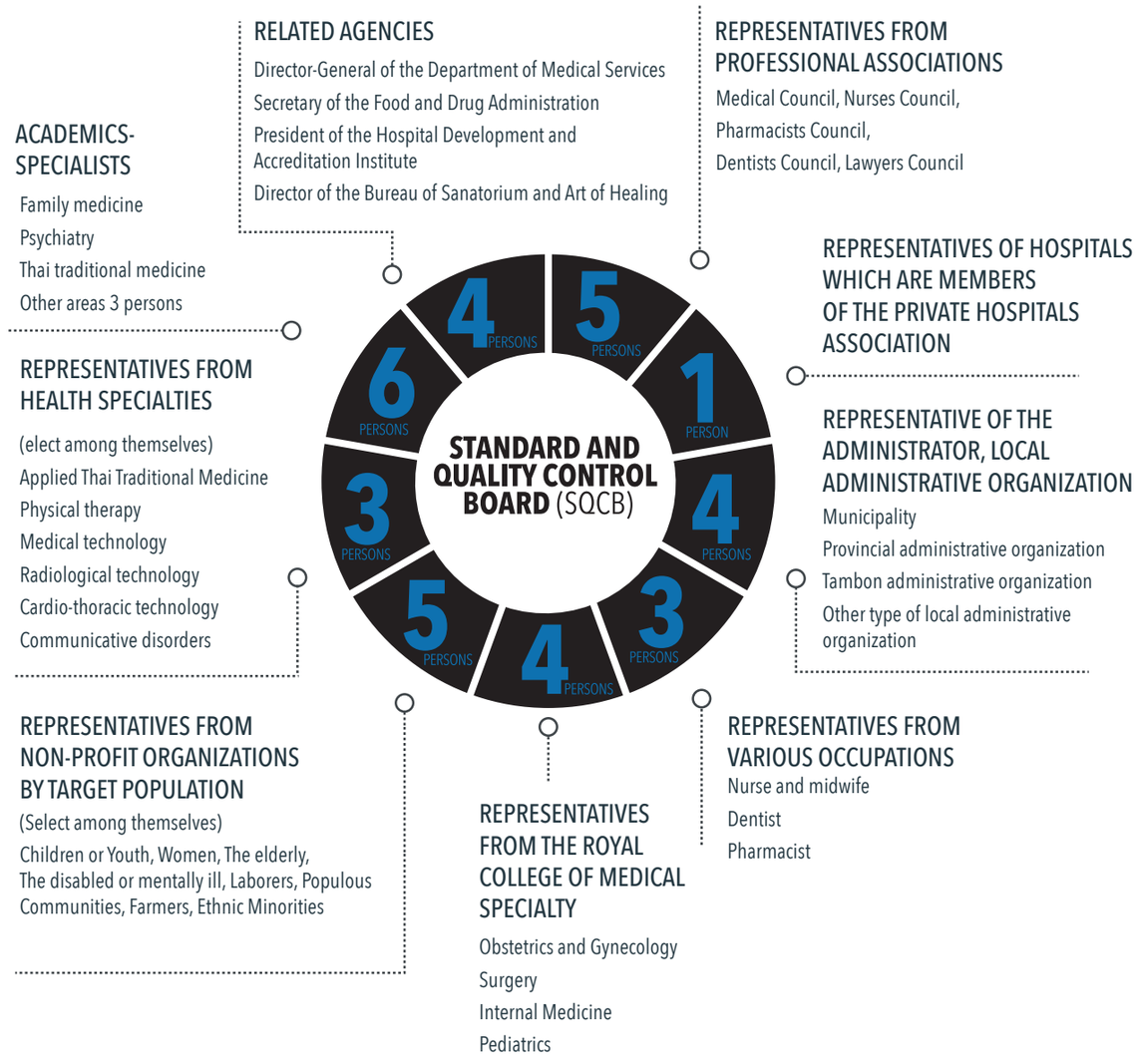
COMPOSITION OF
THE NATIONAL HEALTH SECURITY BOARD

Figure 6



COMPOSITION OF
THE QUALITY AND STANDARD CONTROL BOARD

Figure 7



ADJUSTMENTS BETWEEN SERVICE PROVIDERS AND PURCHASERS

The introduction of the UCS represented a significant change for relevant stakeholders, in particular, the health care providers and purchasers. In the first three years of implementation, the MOPH was still the administrator of the National Health Security Fund. However, since the UCS involved providers that were not under the authority of the MOPH, there were concerns about injustice or inequality on management processes. In addition, because the MOPH oversees the majority of public health care providers in the country, the concept of purchaser-provider split was carried over to the NHSO when it was established. The NHSO took over management of the National Health Security Fund. The purchaser-provider split was conceived to make a clear distinction in management. Nevertheless, in practice, and in the Thai context where most of the services are provided by the public sector, the role of the NHSO is not reallythat of the purchaser (as in the private sector). Instead, the NHSO's role is more as finance facilitator to ensure coverage and efficiency.

This change in administration impacted on the relationship between the providers and purchasers, i.e., from a vertical perspective where the provider specifies the services, to a supply (provider) and demand (purchaser) dynamic. In this framework, the NHSO becomes the purchaser, and the influence of the people is increased. The NHSO also uses financial measures to define the direction of health care providers. This paradigm shift caused confusion and conflict within groups of health care providers in some areas. However, this conflict was more of a systematic dispute rather than an objection to the creation of the NHSO. Thus, there was a period of adjustment and interactive communication to reach a common understanding and consensus of how UCS would work.

LESSONS LEARNED

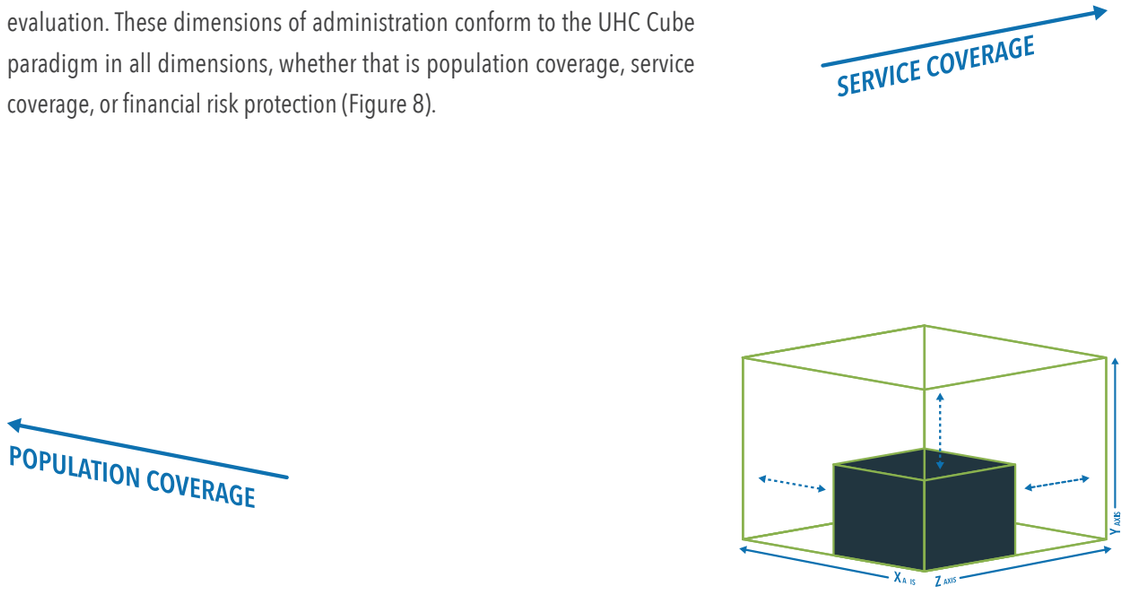
- Developing countries with limited resources can succeed in advocating UHC policy if the health system (service system personnel, and finance) is well-prepared, and there is gradual expansion, both in terms of coverage of the population and benefits.
- For Thailand, the success of the national health insurance policy leading to UHC was achieved by having the right timing to advocate for national policy. There was a collaboration of various sectors, including politicians, civil society and academia.
- The enactment of the National Health Security Act of 2002 was important in determining the policy and role of the NHSO, including any actions taken related to the National Health Security Fund.
- The National Health Security Act (2002) stipulated that the members of the National Health Security Board come from a diverse group of people, including representatives from civil society organizations. Hence, the criteria or policies were approved by all the relevant stakeholders. In this way, good governance can be created by the Act.
- The National Health Security Act (2002) requires hearing the voice of all stakeholders in ways which provide opportunities for people, patients, and health care providers to participate in proposing improvements and developing systems and standards of public health services directly. Such participation creates a sense of ownership which is a key element in the sustainability of the UCS of Thailand.
- Clear legal requirements and emphasis on participation make various rules or policies transparent and which can be verified.
- The transition of the health insurance system should be managed carefully and closely so that those involved have time to adjust and prepare for the change.
- Participation of all relevant sectors plays an important role in reducing conflict from the reform of various aspects of health insurance and/or changed systems.

3

ADMINISTERING THE UCS

The National Health Security Act (2002) stipulates the role of the NHSO in various areas to ensure that the essential health needs of the population are met, that there is equitable access to standard quality health services, and that there is financial risk protection for the patient. Thus, it can be observed that the principal deliverable of the NHSO is the benefits package for the beneficiaries who have the right to access it. Key features of NHSO administration include policy design for the benefits package, budgeting, design and management of the provider payment method, billing and clinical auditing, quality assurance and consumer protection. In order for all these activities to be implemented efficiently, there has to be a system of registering beneficiaries (population registry) and the participating health care providers (provider registry). There also has to be an accurate and auditable system through information for reimbursement for services rendered.

Management of the UCS has to adhere to principles of good governance and participation of all sectors, including key stakeholders (patients and providers) through an efficient system of support. This includes the support of governance/governing bodies, laws and regulations, policy formulation, administration, IT, human resources management, and monitoring and evaluation. These dimensions of administration conform to the UHC Cube paradigm in all dimensions, whether that is population coverage, service coverage, or financial risk protection (Figure 8).

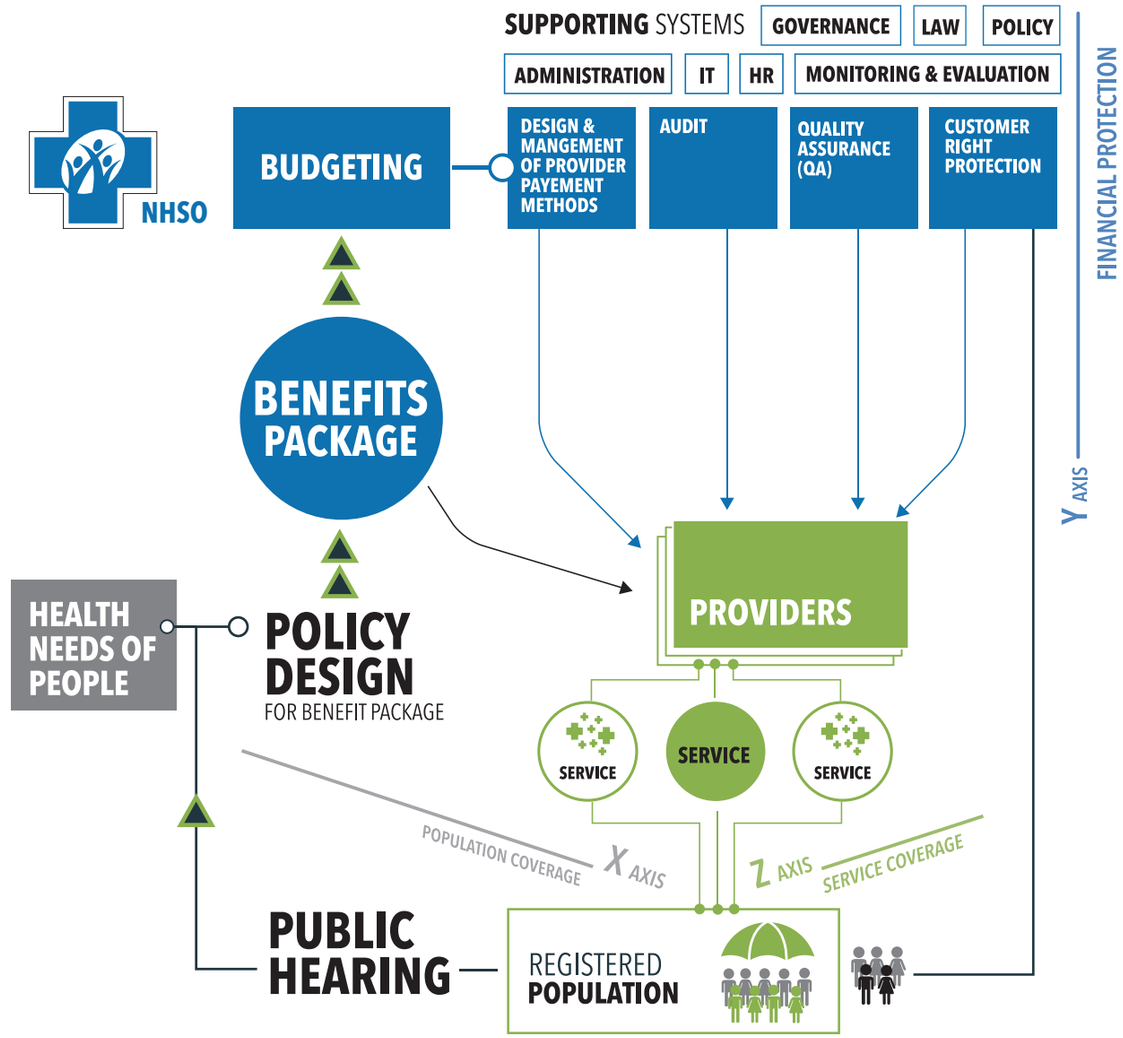


IMPLEMENTATION
OF ACTIVITIES BY THE NHSO

Figure 8

KEY COMPONENT
IN UNIVERSAL COVERAGE SCHEME

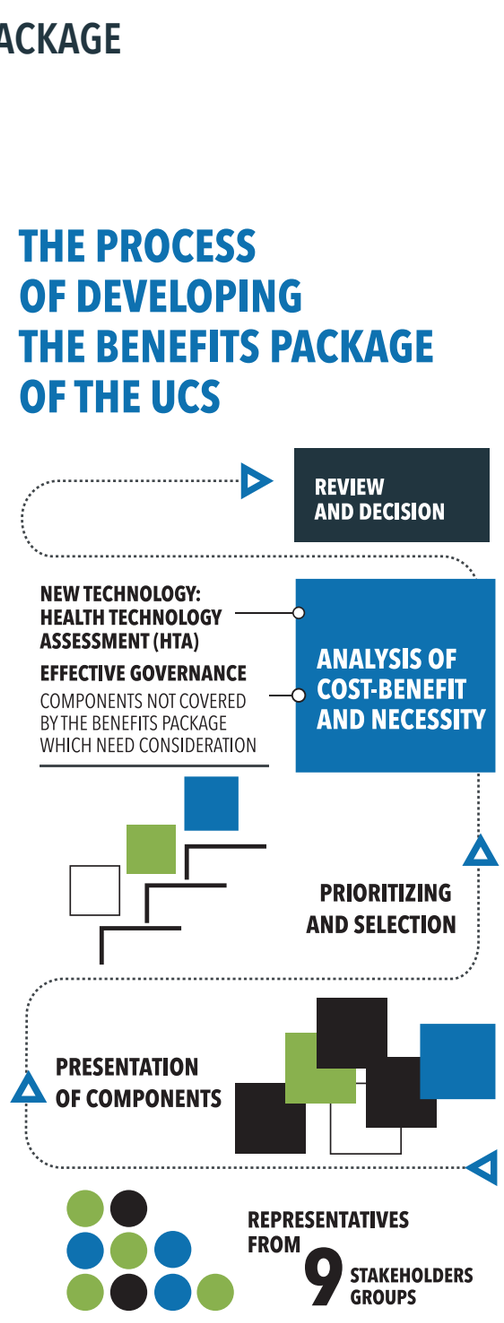
These dimensions of administration conform to the UHC Cube paradigm in all dimensions, whether that is population coverage, service coverage, or financial risk protection.



POLICY DESIGN FOR BENEFITS PACKAGE

According to the National Health Security Act, every person who has the right can receive standard and effective health services that cover essential needs. All health services are covered except for some particular services from the negative list. The process of for-mulating the benefits package starts with an inventory of issues and prioritizing them with various components, assessing the economic evaluation and value/necessity/feasibility of the proposed issues, and then making the appropriate decision (Figure 9). The goal is to achieve continuous improvement of the benefits package, including adding expanding benefits or developing improvements to increase access to services based on existing benefits. There should be protections of access to essential health services and protections for households from financial burden due to medical spending by adhering to the principles of transparency. There should be participation of all stakeholders in all sectors, especially policy makers, represent-atives from civil society/the public, professional councils and various academic departments. Only empirical evidence should be used as the basis for making choices and decisions.

Figure 9



HEALTH SERVICE UTILIZATION

There are three scenarios for accessing benefits under the UCS:

GENERAL CASES

Patients must seek care and be admitted to the service unit for which they are registered as a first step. This service provider is called the contracting unit provider (CUP). The patient may be referred to the other participating hospital in the UCS for further attention if the CUP is not prepared to deliver proper attention or the patient's condition is more complicated than usual.

IN CASE OF AN ACCIDENT OR EMERGENCY

The patient may seek care at the nearest participating service facility in the UCS. There is no limit to the number of times the patient may do this, regardless of whether the provider is public or private.

IN CASE OF AN EMERGENCY CONDITION

The patient may seek care at any health care provider until they are out of danger. Then, the attending provider refers the patient back to the regular service unit or unit which is most prepared to attend to the patient.

In order to increase convenience and options for the beneficiary, patients may submit a request to change their regular service unit, but not in excess of four times per year.

SYSTEM OF REGISTERING BENEFICIARIES (POPULATION REGISTRY) AND SERVICE PROVIDERS (PROVIDER REGISTRY)

There must be continual monitoring and maintenance of the population and provider registries in the UCS, especially the components that rely on IT. The database has to be able to link data on provider and patient. The population registry that is managed by the NHSO and the members of other public health insurance schemes are also linked with the civil registration database of the Bureau of Registration Administration, Department of Provincial Administration, Ministry of Interior. This triangulation of data ensures that errors or duplication are spotted and corrected. The databases need to be continually up-dated to ensure relevance and accuracy, while the provider registry is amended by agreements between the providers and the NHSO.

BUDGETING

The budget of the National Health Security Fund comes from general taxes. The National Health Security Board prepares a budget request to the Cabinet in accordance with Article 39 of the National Health Security Act (2002) for approval before submitting the matter to the Budget Bureau.

Estimating the budget for all UCS members is calculated by the Price and Quantity approach (PQ approach), referencing evidence and empirical data from the database of the beneficiaries, the utilization pattern, and epidemiological data. This process takes into consideration policy directions to address health problems or situations at different times by appointing a subcommittee to set up operational rules and funds management as a preliminary decision-making mechanism before proposing these to the board to consider.

The process of proposing the budget consists of many steps and involves soliciting comments from many stakeholders before the final draft is proposed to the Cabinet by the National Health Security Board (Figure 10). The board has members from a variety of sectors, one of which is a representative from the Budget Bureau. The process is systematic and comprehensive. Thus, the budget that is actually allocated to the fund each year is not much different from the proposed budget. The government specifies the budget for allocation for the UCS under the principle of a close-ended budget for cost-containment.

DESIGN OF THE PROVIDER PAYMENT METHODS

The design of the payment method has to be done in a way that supports the health care providers and motivates them to use funds as efficiently as possible, while maintaining quality standards, and ensuring equal access to services. The design is based on four principles: 1) creating fairness for people and ensuring patient to access health services; 2) increasing effectiveness and quality of health services; 3) ensuring participation of all sectors in joint implementation of national health insurance and public health services; and 4) improving management of National Health Security Fund to ensure efficiency.

The Thai UCS uses a mixed provider payment methods as follows:

1

PROSPECTIVE PAYMENT

Prospective payment uses the capitation method which is adjusted by age and pay with set criteria.

2

RETROSPECTIVE PAYMENT

The provider submits data of services provided in order to receive reimbursement, such as Diagnostic Related Groups (DRGs) for in-patient service, and fee schedule with global budget. Payment by fixed fee per patient is also used by NHSO.

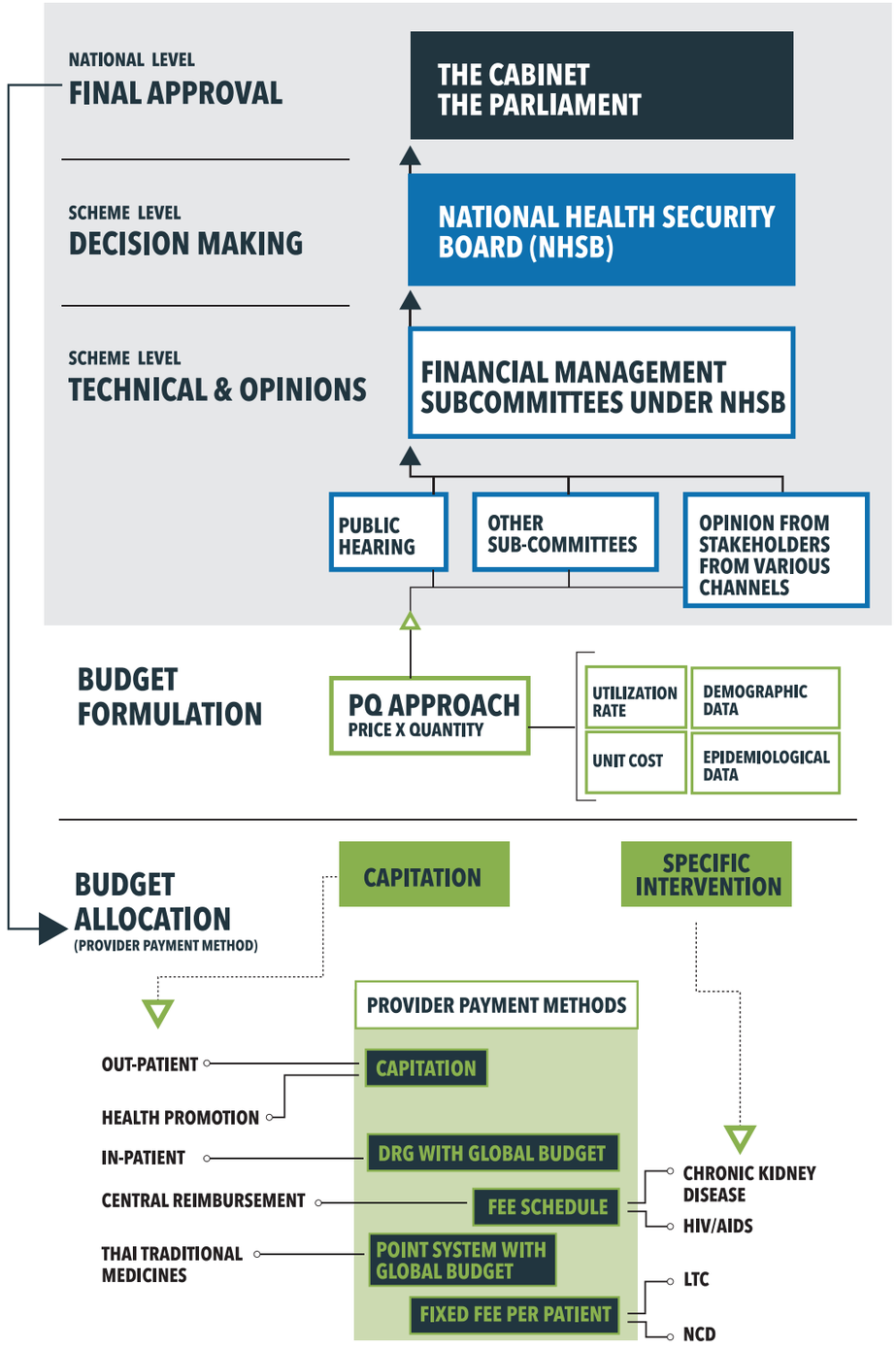
3

PROJECT BASED OR BY CONTRACTING

The service provider is contracted as the sole provider with a given target and clearly specified equipment/supplies.

THE PROCESS OF BUDGETING UP AND DOWN STREAM

Figure 10



MANAGEMENT OF THE PROVIDER PAYMENT METHOD

When defining the design of the provider payment method, the payment process for health care providers must have the required information, which the health care providers must send data to the NHSO. The information includes conditions of reimbursement, data transmission time, compensation processing system, and system to manage the disbursement transaction, including the audit system in order to ensure that the use of funds is efficient, accurate, transparent and auditable. Payment is made by linking electronic transactions to the bank to transfer money to the service unit automatically, with accompanying financial report.

AUDIT

The objective of the medical audit is to insure the efficiency of the National Health Security Fund and reduce delays in reimbursements. The audit process is retrospective and activated after the NHSO has reimbursed the health care providers for services provided. If an audit reveals that the providers received less than is allowed under the law, then the NHSO has to make up the difference. Conversely, if the providers received more reimbursement than is allowed under the law, the NHSO will issue a request for a reverse transfer of the balance. However, health care providers can appeal and request a re-audit if they disagrees with the audit results.[21]

QUALITY ASSURANCE

The National Health Security Act (2002) calls for the establishment of the board controlling the standard and quality of the health services which has the role to control quality and standards of services of health care providers registered in the UCS. This includes a mechanism for patients who feel there has been a violation of standard medical or health practices to file a complaint, which would result in a review, examination and determination whether malpractice had occurred. This includes cases where patients feel they did not receive appropriate convenience in accessing services or in exercising their right to service under the benefits package.

CUSTOMER RIGHT PROTECTION

The NHSO has a legal mandate to protect beneficiaries under the UCS with the principle that all people must have access to standard quality health services and protections of their rights under the law. The NHSO has developed a model for people's rights protections which have three main mechanisms as follows: a Call Center (#1330), the customer services center in health care unit, and the People's Healthy Security Center for receiving complaints. Article 50(5) of the 2002 Act stipulates that this center must be independent from the providers or staff. Hence, beneficiaries can have their rights protected, or file complaints or enquiries directly to the NHSO to that health care providers can improve. The complaint system in each area helps to resolve disputes between the health care provider and a patient who receives some ill effects from the treatment. Consumer protection also receives support from civil society which is one of the main factors behind the sustainability of the UCS . It should be noted that health personnel in the UCS are also protected from false or inaccurate claims of damages when providing health services to the UCS beneficiaries.

MONITORING AND EVALUATION

During the M&E process, there is opportunity to solicit and express opinions about the data. The M&E system collaborates with various sectors through multiple mechanisms. These include Article 26[8] of the Act which pertains to control of the health care providers, and Article 50(5) which refers to the complaint system. There is Article 18[1,13] which emphasizes public hearings and mandates preliminary compensation for patients referred to by Articles 41 and 50[8] for rights protection of UCS beneficiaries, and thereby improves the UCS in the process. The NHSO also has a system of inspections of quality of services, and there is monitoring of access and utilization of in-patient services at various times for some policy implementation on developing the UCS system. There is an annual report of UCS performance which is submitted to the NHSO Board, the Senate, and the Cabinet as required by law. There is dissemination of important knowledge to the public through a variety of channels so that the people can know and access services with quality, standards and safety.

LINKAGE BETWEEN THE DESIGN OF THE ADMINISTRATION OF THE UCS AND THE UHC CUBE

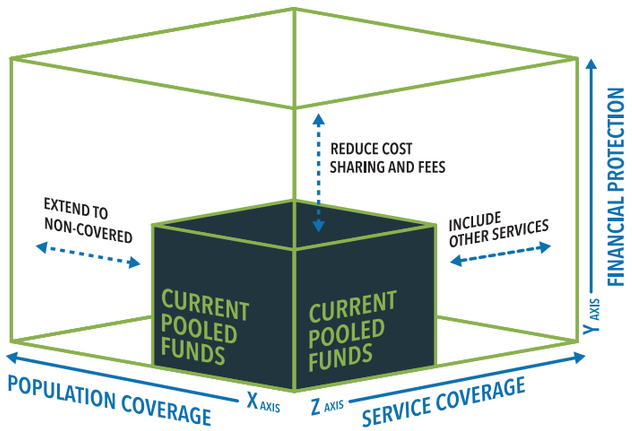
The NHSO has had nearly two decades of operations and implementation of various policies in order to achieve the goal of universal health coverage for the Thai population. This includes expanded coverage of the target beneficiaries (X-axis) through a system of registration and outreach to identify persons who are eligible to enroll in the UCS, improvements to the database so that there is electronic access to real-time information, determining eligibility for UCS, care for a given patient, and a system for complaints and quality control.

The NHSO also protects the beneficiaries from unmanageable health spending for essential health services (Y-axis) by offering a benefits package which is affordable and relevant to the basic needs of the patients. The government has allocated adequate budget to meet these essential needs based on empirical data. There is a systematic procedure for inspections, there is open solicitation of opinions from all sectors, there is a system for reimbursement of health service costs which promotes maximum efficiency in use of funds, and there is continual development of the information system to promote efficient management of the UCS.

The NHSO has improved services (Z-axis) which is reflected by the continuous expansion of the UCS benefits package, and the system of registration to provide standard quality services. These processes ensure coverage of essential services so that the people can enjoy the benefits from UCS (Figure 11).

DEVELOPMENT OF THE UCS IN THE THREE DIMENSIONS OF UNIVERSAL HEALTH COVERAGE

Figure 11



X AXIS

POPULATION COVERAGE

POPULATION: WHO IS COVERED?

- Database system of eligible beneficiaries and rights audit
- Population registry
- Seeking services by the beneficiaries
- Receiving complaints and protection of rights

Y AXIS

FINANCIAL PROTECTION

WHAT DO PEOPLE HAVE TO PAY OUT-OF POCKET?

- Procuring the budget
- Model and method of paying compensation for services
- Clearing House of payments
- Management information system

Z AXIS

SERVICE COVERAGE

SERVICES: WHICH SERVICES ARE COVERED?

- Defining the benefits package
- Registering service facilities
- Services
- Control of quality and standards
- Audit system

LESSONS LEARNED

- In developing countries with limited budgets, using payment methods through a close-ended system is a way of controlling costs and increasing efficiency and sustainability of policy.
- Expanding the benefits package to cover essential services has a direct impact on reducing the health care costs of patients and preventing financial burden in the household due to the medical spending.
- The design of a good system involves defining benefits, reimbursing costs for services that is comprehensive, having a system of referral when needed, and having participation of all sectors. In this way, the UCS will be successful and sustainable.
- A successful UCS has an efficient management information system with regular M&E which uses empirical data based on sound technical principles to support decision-making and policy implementation, so that services and systems have a clear evolution and are auditable.
- There must be a good support system, including electronic data system, and links among the related data bases (e.g., with the civil registration system), to facilitate management and administration so that actions are accurate and auditable.
- The successful UCS will have participation from the related sectors, including the health care providers, the beneficiaries, civil society, etc. This will promote transparency and access to issues or problems in the UCS that need to be addressed. This openness will motivate the private sector service providers to join the UCS. There also needs to be appropriate representation of civil society on the relevant committees, boards and other bodies.

REFERENCES

1. Tangcharoensathien V, Mills A, Palu T. Accelerating health equity: the key role of universal health coverage in the Sustainable Development Goals. BMC Med. Apr 29 2015;13:101.
2. United Nations. Sustainable Development Goals. SDG Indicators 2015; https://unstats.un.org/sdgs/metadata/. Accessed 30 Apr, 2019.
3. Tangcharoensathien V, Witthayapipopsakul W, Panichkriangkrai W, Patcharanarumol W, Mills A. Health systems development in Thailand: a solid platform for successful implementation of universal health coverage. Lancet. Mar 24 2018;391(10126):1205-1223.
4. Jim Yong Kim. Speech by World Bank Group President Jim Yong Kim on Universal Health Coverage in Emerging Economies. 2014; http://www.worldbank.org/en/news/speech/2014/01/14/speech-world-bank-group-president-jim-yong-kim-health-emerging-economies. Accessed 30 Apr, 2019.
5. Thammatacharee N, Tisayaticom K, Suphanchaimat R, et al. Prevalence and profiles of unmet healthcare need in Thailand. BMC Public Health. Oct 30 2012;12:923.
6. Yaowalak Wongwong, Chahida Wiriyathorn, Sasirat Lapthikultham, Warisa Panichkriengkrai, Kanchana Tiyathikom, Walaiporn Phatcharamnumol. Necessity of happiness: Unmet health need in the case of out-patient in-patient and dental services in the Thai population, 2015. Journal of Health System Research. 2017; 11 (2): 182-194
7. World Health Organization. Universal health coverage and health financing. 2019; https://www.who.int/health_financing/universal_coverage_definition/en/. Accessed 1 February, 2019.
8. Abiiro GA, De Allegri M. Universal health coverage from multiple perspectives: a synthesis of conceptual literature and global debates. BMC Int Health Hum Rights. Jul 4 2015;15:17.
9. Sustainable Development Solutions Network (SDSN). Indicators and a monitoring framework for the Sustainable Development Goals: Launching a data revolution 2015. 2015; http://unsdsn.org/wp-content/uploads/2015/05/FINAL-SDSN-Indicator-Report-WEB.pdf. Accessed 1 February, 2019.
10. Viroj Na Ranong. Thai health insurance: the path to UHC. Annual academic conference 2006; 9-10 December 2006; 2006; Ambassador City Jomtien Hotel, Chonburi.
11. Wirot Tangcharoensathien et al. Chapter 8 Health insurance in the country. In: Suwit Wibulphonprasert, ed. 2005-25502551: 379.
12. Comptroller General's Department. CSMBS Manual for 2010 :https://home.kku.ac.th/praudit/law/07_medical_fee/22_Medical_guide_government%20officer_CGD_2553.pdf.
13. Supol Limwattananon and Thaweesakun. Chapter 3 The situation before having UHC in Thailand. In: Surajit Sunthorntham, ed. System health insurance Thailand. Bangkok 2012
14. Data of Thailand: GNI per capita. 2018. https://data.worldbank.org/country/thailand. Accessed 05 October 2018.
15. NHSO . Report about the system. Population registration. Population report classified by area. 2018; https://www.nhso.go.th/FrontEnd/page-contentdetail.aspx?CatID=MTA5NQ==. Accessed 10 April, 2019.
16. Chahida Wiriyatorn, Yaowalak Wongwong, Kanjana Tiyathikom, et al. Using out-patient and in-patient services in various types of medical facilities of the Thai population, 2015. Journal of Health Systems Research. 2017; 11 (2): 155-169.
17. Phongphisut Jongudomsuk, Samrit Srithamrongsawat, Walaiporn Phatcharumarumol, et al. The Kingdom of Thailand health system review = Review of the health system in Thailand . 2015.
18. Praboromarajchanok Institute. Network of Academic Institutions of Public Health and Medical Technology (NSTDA). 2019; http://admission.pi.in.th/admission/index.php/admis/contact. Accessed 24 April, 2019.
19. Racha Puchchun; Naphonat Anupongphat and Gomat Sathiensub. Rural doctors, good governance and health politics. Nonthaburi: Health Systems Research Institute; 2013.
20. Saree Ongsomwang and Rujaree Saeng. Statement: Lessons: Collecting public lists for proposing draft laws The case of 50,000 people entering the name of the National Health Security Act, 2002. MPO; https://ilaw.or.th/node/289.
21. NHSO . Audit. Bangkok: NHSO ; 2019.

ADVISOR

Vichai CHOKEVIVAT
Suwit WIBULPOLPRASERT
Viroj TANGCHAROENSATHIEN
Walaiporn PATCHARANARUMOL

RESEARCHER

Shaheda VIRIYATHORN
Yaowaluk WANWONG
Putthipanya RUEANGSOM
Waritta WANGBUNJONGKUN
Pigunkaew SINAM

EDITORIAL TEAM

Churnrurtai KANCHANACHITRA
Anthony BENNETT
Prateep NAIYANA
Cattleeya KONGSUPAPSIRI
Nipaporn HUABCHAROEN

National Health Security Office