Annual Report 2003

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thailand

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Message from the Chairperson of the National Health Security Board

Sudarat Keyuraphan
Minister of Public Health
Chairperson
National Health Security Board

The National Health Security Office (NHSO) was established in 2002, according to the National Health Security Act of B.E.2545 (2002), as a state agency under the supervision of the Minister of Public Health, responsible for the administration of the Universal Coverage of Health Care Scheme aimed at providing all Thai citizens with quality health care on an equitable basis.

Even though the NHSO was recently established, it has been undertaking its missions very well as required by law. Despite numerous problems and obstacles, in cooperation with various agencies concerned and support from the Royal Thai Government, such problems have been continually resolved, resulting in a high level of people's satisfaction (97% of the people were satisfied with the Universal Coverage of Health Care policy). The NHSO's internal administrative system has also been developed to ensure its efficiency, transparency and accountability.

This "Annual Report for Fiscal Year 2003" is part of NHSO's effort in compiling the results of its operations during the past fiscal year as well as problems/obstacles and experiences in resolving such problems. In addition, this report contains statistics on the administration of the National Health Security Fund which has tens of billions of baht each year, for further study and developing the NHSO to be more transparent and accountable to the public.

On this occasion, I would like to express my appreciation and well wishes to all concerned and request that they all jointly develop the universal health care scheme further in a sustainable manner.

Message from the Chairperson of the Health Service Standard and Quality Control Board

Ueachart Kanchanapitak
Chairperson
Health Service Standard
and Quality Control Board

The Health Service Standard and Quality Control Board has been trying to ensure that 45.97 million Thai citizens are provided with quality health care in accordance with the established standards or to the extent possible.

However, there have been some problems and obstacles in its operations as the 2002 National Health Security Act is quite new, involving a lot of people, health facilities and providers at different levels. All parties have to take time for their practice adjustment, working in cooperation with one another, instead of satisfying only their own interests.

The provision of Universal Coverage of Health Care to all will take a long time and require continuous improvements with full capacity and knowledge of all concerned.

I would like to request that all concerned cooperate in this effort to create the Universal Coverage of Health Care for all Thai citizens.

Message from the Secretary-General of the National Health Security Office

Sanguan Nitayarumphong
Secretary-General
National Health Security Office

Since the National Health Security Act of B.E. 2545 (2002) has been enacted, the rights of all Thai citizens to health care, regardless of sex, age, and socio-economic status, have been protected. Although there are several health insurance schemes with different coverage systems, all have the intention that, as prescribed by law, ultimately all such systems will adjust themselves towards a unified management system with standard services.

At present, the implementation of Universal Coverage of Health Care Scheme could be considered as the beginning of a long journey. An urgent mission after the people have been protected by the system is how to make the people feel more confident in the service quality. Health care providers are a critical factor in determining the success and quality of care.

The NHSO has realized that the Universal Coverage of Health Care Scheme is part of the health system reform process aimed at health prevention and promotion. The NHSO has therefore included health promotion and disease prevention services as part of the benefit package, which would be more intensified in the future.

The NHSO Annual Report for fiscal year 2003 is a compilation of all aspects of the operations of the Universal Coverage of Health Care Scheme after the enactment of the 2002 National Health Security Act. We are hopeful that this report will reflect what really happened during the past period and help stimulate an exchange of ideas beneficial for further policy development.

The Universal Coverage of Health Care Scheme is a system created by Thai citizens and belongs to them all. The scheme will not be sustainable unless there is cooperation from all parties concerned.

I, on behalf of the NHSO, and all our staff are ready to work and make that intention happen and come true.

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Executive Summary

In fiscal year (FY) 2003, 45.97 million people were registered under the Universal Coverage of Heath Care Scheme, accounting for 73.58% of the entire population (62.48 million). Of all the registered people, 42.20 million (91.79%) were registered with 822 health facilities under the Ministry of Public Health (MOPH), 1.96 million (4.26%) with 71 non-MOPH state health facilities, and 1.82 million (3.96%) with 88 private health facilities.

With regard to service utilization of eligible people, there were 115 million outpatient visits with an annual average of 2.52 visits per person - increasing by 11% compared with that for FY 2002 (2.27 visits per person). The average rate of hospitalizations or admissions as inpatients was recorded at 0.087 admission per person per year - increasing by 3% compared with that for FY 2002 (0.085 admission per person per year). And the average rate of referrals of patients for higher level of medical care dropped by 1.31% compared with that for FY 2002, while accident and emergency services increased by 9.47% and 4.25%, respectively.

The public opinion polls conducted by several academic institutions, such as ABAC Poll, the National Statistical Office, and Siripen Supakankunti and colleagues, revealed that most of the people were satisfied with the services whereas some did not exercise their rights due to a lack of confidence in the standard and quality of care. There was also some extent of inequity of resource allocation to health facilities.

Regarding the quality of contracted health facilities, 3.9% of them had been certified by the Institute of Hospital Quality Improvement and Accreditation and 68.4% were in the process of improvement in steps 1 and 2.

In FY 2003, 62,425 inquiries and complaints were received at the NHSO. Of all inquiries and complaints, 92.69% were related to inquiries, whereas 7.37% were about complaints mostly on card issuance and registrations (54.60%), followed by medical treatment (14.90%). Of all the complaints, 80.99% were subject to further actions and 91.08% of the cases that requested interventions could be settled.

A survey on the satisfaction of patients and service providers in FY 2003, on a scale of highest satisfaction of 10, revealed that the average score of people's satisfaction was 8 (standard deviation or SD 1.99). The people needed improvements in providers' manner (41%), quality of care (19%), and more choices in selecting health facilities (9%).The overall satisfaction score given by the provider

reqarding The Universal Coverage of Health Care Sheme was 6.15 (SD 1-80). Their suggestions for the scheme's improverments included a more budget allocation (39.8%) and a benefit package review to meet people's needs (25.6%)

Throughout FY 2003, 86.43% of the budget, which was 31,337,924,300.00 baht (approx. 40 baht = 1 US dollar), was disbursed. Of the total disbursement, 73.65% was for capitation payments covering inpatient/outpatient care and promotive/preventive services; 12.76% was designated for investment activities as well as durable articles and constructions; and 7.03%, 4.52% and 2.04% were for high-cost medical care, accident/emergency care, and vaccines, respectively.

Access to care and care quality remained two major concerns and needed further improvements. Other systems requiring intensive development were the efficiency of registration system, the protection of people's rights, the suitability and coverage, the public participation, the information system, and the management and budget allocation.

รูปเปิด 01

Universal Coverage of Health Care Scheme : System Administration

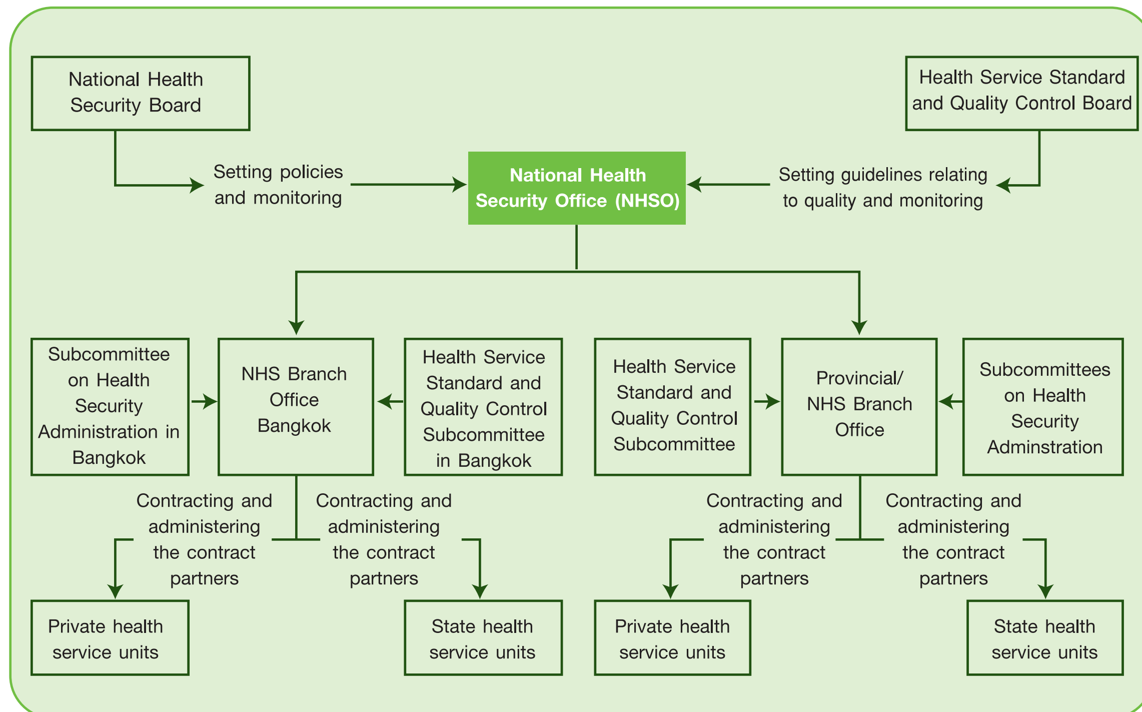
The National Health Security Act of B.E. 2545 (2002) came into force on 19 November 2002. Since then the implementation of the Universal Coverage of Health Care (Universal Health Care or 30-Baht Health Care) Scheme, previously carried out by the Ministry of Public Health, has been transferred to the National Health Security Office (NHSO).

The scheme has been in operation under the NHSO for a little over a year. The policy in FY 2003 was similar to that of FY 2002 but implemented under the new administrative structure.

1. Administrative Structure

According to the 2002 National Health Security Act, the administrative structure of the Universal Coverage of Health Care Scheme comprises three major components, i.e. the National Health Security Board (NHSB), the Health Service Standard and Quality Control Board (SQCB), and the National Health Security Office (NHSO). All the three components are interrelated and supportive of each other (see Figure 1).

Figure 1: Administrative structure of the Universal Coverage of Health Care Scheme, 2003



1.1 National Health Security Board

The National Health Security Board (NHSB) comprised ex officio members and a number of other members who were appointed within 180 days after the 2002 National Health Security Act came into force. However, while the members were being selected, according to the transitory provisions section 67 of the Act, an interim NHSB was appointed, comprising the Minister of Public Health as chairperson, the Permanent Secretary for Public Health as vice-chairperson, and the following as members: the Permanent Secretary for Finance, the Permanent Secretary for Commerce, The Permanent Secretary for Interior, the Permanent Secretary for Labour and Social Welfare, the Permanent Secretary for University Affairs, the Director of the Bureau of the Budget, and five other qualified persons appointed by the Cabinet, four of whom were representatives of consumers.

This Board already transferred its powers and duties to the newly appointed NHSB under section 13 of the NHS Act at its meeting on 19 May 2003. The NHSB has powers and duties under section 18, involving the creation of the Universal Coverage of Health Care Scheme, including the setting up of systems for administration, management, and monitoring and evaluation of the scheme.

1.2 Health Service Standard and Quality Control Board

The Health Service Standard and Quality Control Board (SQCB) comprises ex officio members and a number of appointed members, similar to the appointment of the NHSB. An interim SQCB had to be appointed according to the transitory provisions section 68 of the NHS Act, comprising the Director-General of the Medical Services Department, the Secretary-General of the Food and Drug Administration, the President of the Institute of Hospital Quality Improvement and Accreditation, the Director of the Medical Registration Division, the Secretary-General of the Dental Council, the Secretary-General of the Medical Council, the Secretary-General of the Nursing Council, the Secretary-General of the Pharmacy Council, the President of the Law Society of Thailand, and seven other qualified persons appointed by the Cabinet.

At its first meeting, the President of the Institute of Hospital Quality Improvement and Accreditation (Prof. Dr. Charas Suwanwela) was elected chairperson. The interim SQCB transferred its missions to the newly established SQCB under section 48, which held its first meeting on 4 July 2003 and elected Dr. Ueachart Kanchanapitak as chairperson. The SQCB has powers and duties as prescribed in section 50 of the Act, involving the health care standard and quality control under the Universal Coverage of Health Care Scheme, including the setting up of standard of health care and health care facilities, the protection of people’s rights relating to health, the provision of preliminary financial assistance for the patient when a damage occurs because of service utilization, and the support for public participation.

1.3 National Health Security Office

The National Health Security Office (NHSO) works as a secretariat office of the NHSB and the SQCB, and acts as a system manager in developing the Universal Coverage of Health Care Scheme.

The NHSO is a state agency having a status of a juristic person under the supervision of the Minister of Public Health, charged with powers and duties pursuant to section 26 of the 2002 National Health Security Act.

The National Health Security Board, according to section 25 of the Act, has assigned each of the provincial public health offices (PPHO) as a “branch office” of the NHSO and has established the Bangkok Branch office as a bureau within the NHSO.

2. Benefit Packages for Eligible Persons

The type and scope of health services, which the people are entitled to receive, are those set up in 2002, consisting of curative and rehabilitative care, health promotion and disease prevention services for the individuals and families, and Thai traditional and alternative medical care as recognized by the Medical Registration Committee.

Curative and rehabilitative care	Health promotion and disease prevention services
1. General examination, curative and rehabilitative services 1.1 Medical examination, diagnosis, treatment and rehabilitation until the treatment ends, including alternative medical care as recognized by the Medical Registration Committee. 1.2 Childbirth delivery services, totaling for no more than 2 deliveries. 1.3 Meals and room charges for inpatients in common rooms. 1.4 Dental services: extraction, filling, scaling, plastic-based denture, milk-tooth nerve-cavity treatment, and placement of artificial palate in children with harelip and cleft palate. 1.5 Medicines and medical supplies according to the national essential drug list. 1.6 Referrals for further treatment among health facilities. 2. High-cost medical services, including artificial organs and prostheses (both inside and outside the body), as indicated in the payment criteria set by the NHSB.	1. Having and using personal health record-books in providing individual health care continually. 2. Examination and pre-natal care for pregnant women for health promotion purposes. 3. Services related to child health, child development and nutrition, including immunizations according to the national immunization program. 4. Annual physical checkups for the general public and high-risk groups (according to the Medical Council guidelines for medical checkups of 2000, as recommended by Royal Medical Colleges). 5. Antiretroviral medications for the prevention of mother-to-child transmission of HIV, as indicated in guidelines set by the NHSB. 6. Family planning services. 7. Home visits and home health care. 8. Provision of knowledge about health care for patients at the individual and family levels.

Curative and rehabilitative care	Health promotion and disease prevention services
3. Care for accident and emergency illnesses: any accident or emergency case can go for medical care at any health facility (participating in the scheme) located nearest to the scene; the medical expenses incurred within the first 72 hrs can be reimbursed from the central health insurance fund; after that the contracted unit of care shall cover the costs as indicated in established criteria. (Reimbursements of within 72-hr expenses were abolished in FY 2004)	9. Counseling and support for people's participation in health promotion. 10. Oral health promotion and disease prevention: 10.1 Oral health examination; 10.2 Advice on dental health; 10.3 Fluoride treatment among population groups at risk of dental caries such as children, elders, and patients taking radiation in the head and throat areas; 10.4 Sealant application of dental pits for children under 15 years of age.

The aforementioned benefit packages do not cover the following services:

1. Groups of medical services that are beyond the basic needs such as infertility treatment, artificial fertilization, transgender operation, cosmetic surgery without any medical indications, and excessive examination, diagnosis or treatment without any medical indications.

2. Groups of medical services for which specific budget has been allocated such as mental illness requiring more than 15 days of hospitalization (as inpatient), drug-dependence treatment and rehabilitation as required by law relating to narcotics, and road-traffic accident victims who are entitled to care under the traffic accident insurance law.

3. Other groups of medical services such as the same illness requiring more than 180 days of hospitalization except for the case that requires continuous care due to complications or medical indications, experimental treatment, peritoneal dialysis for the end-stage renal failure, hemodialysis with artificial kidney machine, and organ transplantation.

3. Budgeting and Management Systems

The government allocated the budget to the NHSO for two major components: one for medical services and the other for the management of the scheme.

3.1 Budget for Medical Services

In FY 2003, the government allocated a capitation budget of 1,202.40 baht per person per year for medical care expenses and capital replacement. The budget was classified into 7 categories:

outpatient services, inpatient services, health promotion and disease prevention services, accident and emergency services, high-cost medical services, emergency medical services, and capital replacement. The budget for medical care expenses included personnel costs. All details are presented in Table 1.

Table 1: Capitation budget, FY 2003

Type of service budget	Amount, baht
1. Outpatient services	574
2. Inpatient services	303
3. Health promotion and disease prevention services	175
4. Accident and emergency illness services	25
5. High-cost medical services	32
6. Emergency medical services	10
7. Capital replacement costs	83.4
Total, capitation rate (baht/capita)	**1,202.4**

Guidelines for budgetary management:

1) The allocation of service provision budget was made to the provincial branch offices based on a capitation basis. Further payments to service units were made. Deductions were made at the central level for the purchases of vaccines and the expenses for maternal and child health record-books at 14.76 baht per person. The Department of Disease Control and the Department of Health of the MOPH administered such a budget. The provinces could make a request for such medical supplies and materials from the Department of Disease Control or Regional Disease Control Offices and the Department of Health.

2) The budget for accident or emergency illness services. Previously, beneficiaries of the system had to utilize health services at their registry health facilities. At present, if the illness occurs outside such a province, the medical expenses incurred within the first 72 hours will be reimbursed by the NHSO; the remainder will be claimed from the registry facility.

3) The budget for high-cost medical services. The hospital that provides high-cost medical care for nine categories (announced by the NHSO) can submit high-cost medical bills to the NHSO in accordance with the established procedures.

4) The budget for capital replacement cost. This budget was administered by the central administration for both FYs 2002 and 2003. Allocation criteria have been established to minimize inequity of resource distribution, based on the population in each catchment area. A subcommittee has been set up to support the management of health resources by developing the allocation criteria as shown in Table 2.

Table 2: Management of the investment budget of the Universal Coverage of Heath Care Scheme, FY 2003

Investment budget	Criteria for allocation
For private contracted units of care	Allocation according to the number of registered eligible persons
For specialty or excellence medical centers, and services in remote/border areas, islands, and special localities	Allocation for essential items as determined by the joint committee comprising representatives from the public sector and universities with tertiary medical institutions
For state-run health facilities under MOPH and other government agencies in Bangkok and provinces	Allocation according to the number of registered persons

In FY 2003, the NHSO established the implementation guidelines for the provincial level as follows:

1) The budget for outpatient and inpatient services. The exclusive capitation payment model was implemented nationwide. The budget for outpatient care would be paid to the service unit on a capitation basis. The inpatient care budget would be managed at the provincial level; and health facilities could be reimbursed based on the diagnosis-related groups (DRGs) and global budget principle, i.e. depending on the budget availability for each allocation period.

2) The budget for health promotion and disease prevention services. Payments would be made to the contracted units on a capitation basis or a combination of capitation and results-based principles.

3) Medical expenses for cases referred to another province. The expenses would be claimed from the service unit at which the patient is registered. The claim was made on an actual-cost basis for outpatient care provided by a tertiary care unit, not exceeding 700 baht per visit for the care provided by another level of facility. Each claim for inpatient care could be made on a DRG basis with one relative weight (1RW) that equals 16,000, 14,000 and 10,000 baht for services provided by the facilities under the Ministry of University Affairs (MOUA), non-MOUA tertiary care units, and other care units, respectively.

3.2 Budget for the Operations of the Universal Coverage of Health Care Scheme

This portion of the budget is for use by the NHSO and its branch offices to carry out their missions including the registration of eligible individuals, the assessment of standards of service units

and their network members, the management of contracted units of care, the protection of eligible person's rights, the support for quality development of service units, the monitoring of the scheme operations, and the support for the operations of provincial committees and subcommittees.

4. Service and Quality Control Systems

4.1 Service Units under the Universal Coverage of Health Care Scheme

For FY 2003, service units under the Universal Coverage of Health Care Scheme continued using the procedures developed in FY 2002, i.e. any public or private service unit desiring to join the National Health Security System has to express its interest, indicating the role it wishes to take part. The health facilities are classified into 4 categories as follows:

Category	Description
Category 1	Contracted units of primary care (CUP): a CUP with a certain number of registered residents provides all kinds of specified comprehensive primary medical care.
Category 2	Subcontractors of a CUP: a subcontractor provides part of the services such as outpatient services, health promotion and disease prevention services, as stipulated with its contractual partner.
Category 3	Contracted units of secondary care (CUS) or contracted units of tertiary care (CUT).
Category 4	Units of super tertiary care.

The registration system of health facilities as contracted units of care is as follows:

1) A branch office, which is a local purchaser of health services, will negotiate with health facilities in the locality as to which category each one wishes to participate. The number of participating facilities will be in accordance with the number of residents and their roles, which will be clearly specified and agreed upon.

2) The inspection and certification of the qualifications of health facilities and the registration of health facilities will be announced to the public.

3) The contract will include the terms and conditions about the operations and results or outcomes of the operations.

4.2 Management of Service System

The service provision system emphasizes that the people should utilize a primary care unit (PCU) first. A PCU has been set up in each and every locality so that the people will have access to health care in accordance with the specified standard (i.e. people can reach a PCU within 30 minutes and each PCU covers no more than 10,000 residents). The responsibilities of the PCU include the overseeing of public health on a continual basis, emphasizing individual, family care and comprehensive care encompassing curative, promotive, preventive and rehabilitative services within the service facility and the community, as well as community services that are not individual and family care. Cases beyond the responsibility of the PCU can be referred to a secondary or tertiary unit of care.

Besides, in FY 2003, two committees were established: the Committee on Development of High-level Tertiary Care and the Committee on Networking for Development of Recommendations on Service System Management.

4.3 Service Quality and Standard

In developing the quality and standard of health care units prior to being registered as contracted units under the Universal Coverage of Health Care Scheme, the method of structural standard assessment is applied. In the beginning, the guidelines of the Social Security Office and the Medical Registration Division were adopted. After being registered as a contracted unit of care, the quality development process focuses on helping it to meet the hospital accreditation criteria, by providing budget to agencies involved in health service quality development and inspection.

5. Consumer Protection and Public Participation Systems

The operation for the protection of people's rights was developed according to the principles of the MOPH's former Health Insurance Office. Modifications to the guidelines have been made so that it is more convenient for the people to lodge complaints and to cover all aspects of people's needs. A Health Security Service Center has been set up on the M floor of the Jasmine International Building.

The Center provides hotline services (30 lines of telephone number 1330) and will be developed further as a Call Center, according to the international standards of customer relations management system. Besides, recommendations have been made for setting up a system for helping the people who are damaged by medical treatment. Under the 2002 National Health Security Act, a certain amount of the health security fund (not exceeding 1%) can be set aside to provide compensation for the damaged patients.

6. Support for Public Participation

Several sections of the 2002 National Health Security Act prescribe that the people are to take part in the management of the Universal Coverage of Health Care Scheme. In the beginning, the NHSO organized a number of public hearings to seek opinions on its operations, established networks for public participation, and set up a working group on public participation responsible for developing guidelines for involving people and local organizations in the policy development process.

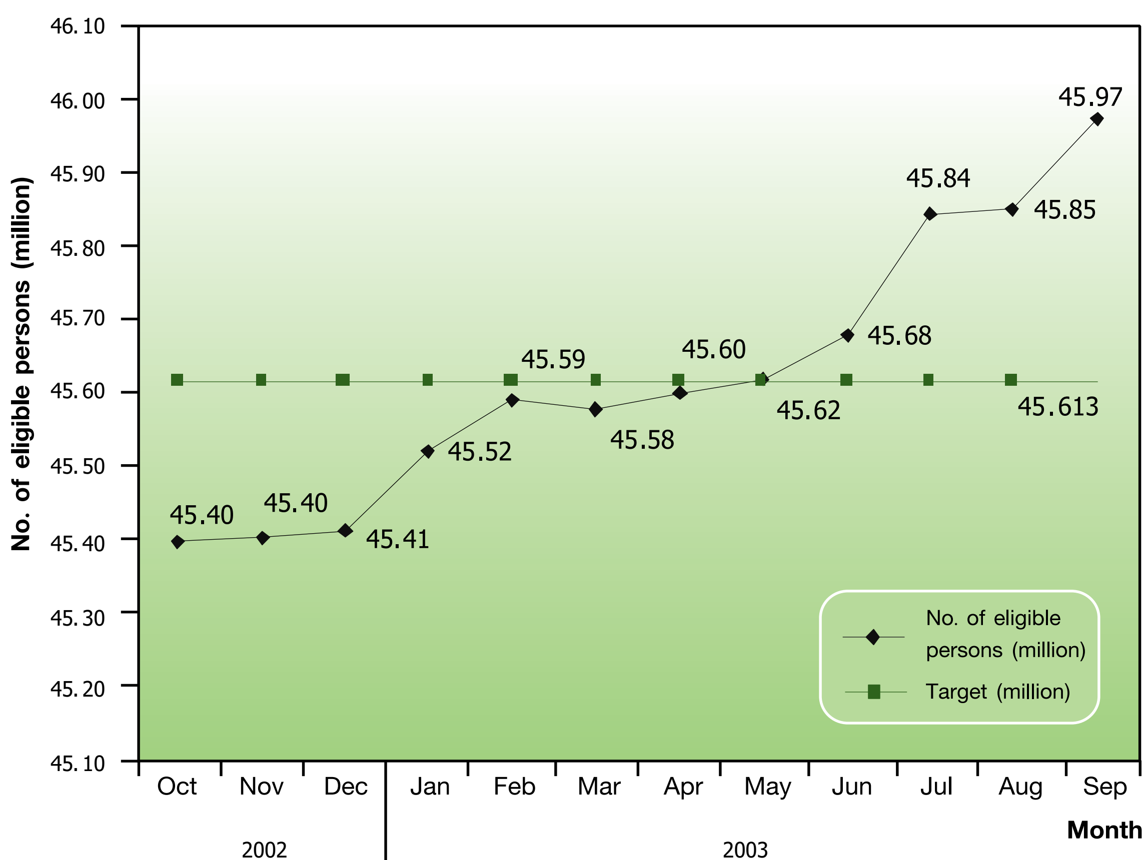
รูปเปิด 02

Achievement of the Universal Coverage of Health Care Scheme

1. Coverage of the Universal Coverage of Health Care Scheme

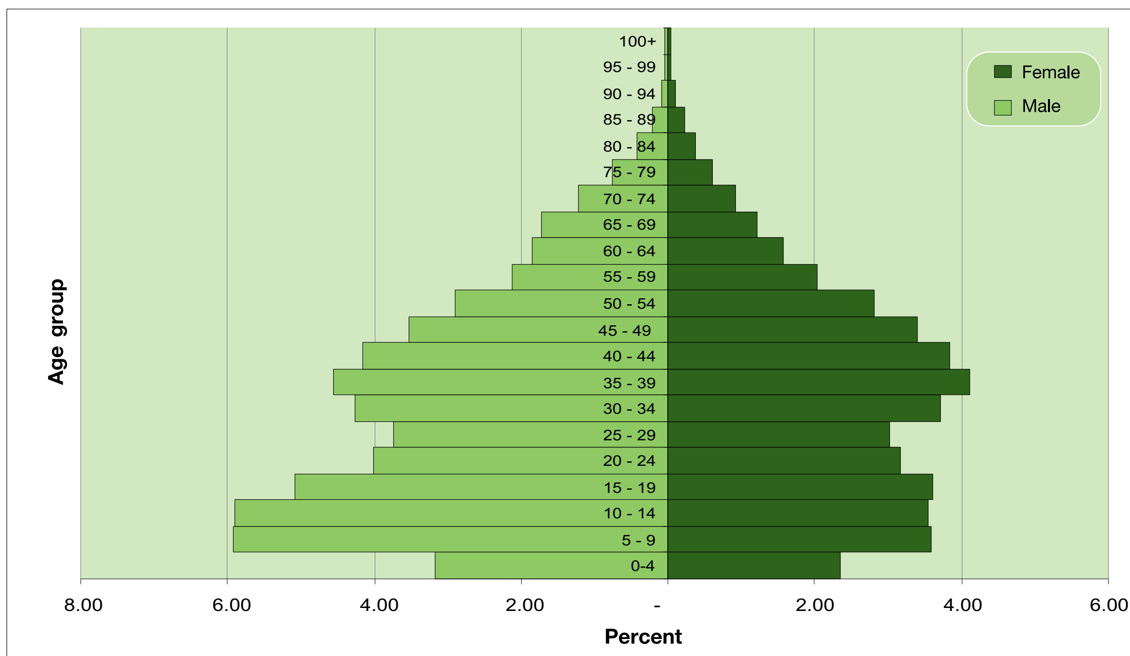
In comparison with the number of registered individuals of 45.40 million in early 2003, it was found that the number had risen to 45.97 million at the end of the fiscal year (30 September 2003) a 1.28% increase or 73.58% of the country's total population (62.48 million). Of all the registered persons, 42.20 million (91.79%) were registered with 822 MOPH health facilities, 1.96 million (4.26%) with 71 non-MOPH state-run health facilities, and 1.82 million (3.96%) with 88 private health facilities.

Figure 2: Number of eligible persons under the Universal Coverage of Health Care Scheme, 2003



Among the registered people, it was found that 26.3% of them were in the population group aged under 15 years, 10.79% over 60 years, 55.74% male, 44.26% female, and the greatest proportion was in age groups 5-9 years and 10-14 years, totaling 19% (see Figure 3).

Figure 3: Age and sex structure of the target population under the Universal Coverage of Health Care Scheme, 30 June 2003



Source: Database of eligible persons' registration for mid-FY 2003 in the National Health Security System as of 30 June 2003.

When comparing the health insurance coverage of Thai citizens in fiscal years 2002 and 2003, a significant increase of 13.69% was noted for the Social Security Scheme as it had expanded to cover all enterprises with one employee or more; and there were additional registrations of eligible persons under the Universal Coverage of Health Care Scheme, resulting in a decline in the number of uninsured or "non-registered eligible" persons (see Table 3). Overall, the coverage of all health security systems increased from 92.48% in FY 2002[1] to 93.01% in FY 2003.

[1] Calculated from the formula: (No. of all registered persons under all systems / total No. of Thai citizens) x 100.

Table 3: Population under various health insurance systems in Thailand, FYs 2002 and 2003

No.	Category of health insurance eligibility	No. of registered persons		Percent Increase/ Decrease
		FY 2002	FY 2003	
1	Social security scheme	7,020,564	7,981,994	13.69
2	Medical benefits for civil servants and state enterprise employees	4,045,406	4,023,992	-0.53
3	Social security scheme and medical benefits for civil servants	100,508	104,055	3.53
4	Social security scheme and medical benefits for politicians	75	66	-12.00
5	Medical benefits for Thai citizens overseas	33,134	32,454	-2.05
6	Medical benefits for politicians	586	596	1.71
7	Medical benefits under the Universal Coverage of Health Care Scheme	45,352,811	45,972,011	1.37
8	Uninsured (non-registered eligible) persons	4,600,780	4,366,355	-5.10
	Total	**61,153,864**	**62,481,523**	**2.17**

Source: Registration database, Bureau of Information Administration, NHSO, 30 September 2003.

In comparison with the population coverage target of 45 million set by the NHSO for 2003, the target was later adjusted upward to 45.613 million (based on the number of citizens actually registered in May 2003). The NHSO had requested an additional budget of 5 billion baht to cover the excess. As of 30 September 2003, the coverage of the universal health care scheme had increased to 45.97 million, which was 0.79% higher than the target.

Problems/Constraints and Resolution Guidelines

At the end of FY 2003, it was found that 4.36 million people were uninsured or non-registered, as their names were in the central database and there was no information to be used for getting them registered with any of the health insurance schemes. The NHSO has actually been trying to resolve such a problem by coordinating with the Bureau of Registration Administration in asking for the addresses of such individuals so that a project can be designed and implemented to cover them all.

Coordination meetings were held with relevant agencies, in order to set up an effective system for registration and service support, such as with the military for conscripts' registration, the Corrections Department for prisoners' registration, the Primary Education Commission and private school teachers

for dependants' registration, the Public Welfare Department for the registration of detainees in observation/ protection centers and welfare institutions, and other agencies.

Regarding duplicative or multiple eligibility, as of 30 September 2003, 0.45% of the eligible persons had such eligibility. Efforts have been made to coordinate with such agencies as the Social Security Office, the Comptroller General's Department, the Bureau of Registration Administration, the House of Representatives, the Senate, the Consular Department, prisons, observation/protection centers, etc. to develop a database for each agency which will eventually minimize the duplications.

2. Health Service Utilization of Eligible Persons

According to the statistics from all service units in FY 2003, it was found that eligible persons under the Universal Coverage of Health Care Scheme had 115 million outpatient visits and 3.98 million inpatient admissions. Relative to the mid-year population, the outpatient utilization rate was 2.52 visits per person per year and the inpatient admission rate was 0.087 admission per person per year (see Table 4).

Table 4: Service utilization of registered persons under the Universal Coverage of Heath Care Scheme, FY 2003

Description		Data from Form 0110 Ror Ngor 5		
		FY 2002	FY 2003	Increase/ Decrease
Service utilization rate (visit or adminission/ person/yr)	Outpatient	2.270	2.520	11.00%
	Inpatient	0.085	0.087	3.00%
No. of persons using service and times, total	Outpatient - million cases	41.396	32.537	-21.40%
	Outpatient - million visits	102.950	115.013	11.71%
	Inpatient - million cases	3.836	3.989	3.97%
	Inpatient - million bed-days	14.930	14.564	-2.45%

Note: The population for mid-year 2002 is 45,292,441 and for mid-year 2003 is 45,961,203.

Sources: 1. Data for FY 2002 from report Form 0110 Ror Ngor 5 as of 10 December 2002 and from a survey on participating hospitals under the Universal Coverage of Health Care Scheme during Oct - Nov 2002, adjusted to 100%[2] for the 84% report completion.

2. Data for FY 2003 from report Form 0110 Ror Ngor 5 as of 7 November 2003, adjusted to 100% for the 82% report completion.

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[2] The data completion rate was calculated from the formula: [(No. of reporting hospitals x No. of months reporting) / (Total No. of participating hospitals x 12 months)] x 100

Besides, for contracted units of care under MOPH, which had to report on service utilization (Form 0110 Ror Ngor 5), 12.87% of all outpatients and 14.73% of all inpatients did not show their rights or entitlements to any health insurance benefit, probably due to the fact that they did not have any health insurance coverage (non-registered persons). Some might be insured under the Universal Coverage of Health Care Scheme but could not exercise any rights or did not want to exercise the right for that particular episode of illness.

The statistics from the surveys on health and welfare of Thai citizens for 2001 and 2003, conducted by the National Statistical Office, showed a 20.1% increase in the annual outpatient utilization rate from 4.101 visits/person in 2001 to 4.926 visits/person in 2003; 72% of which were the visits to health facilities - an increase of 3.7%.

For inpatient care, the annual admission rate increased by 8.8% from 0.076 admission/person in 2001 to 0.083 admission/person in 2003.

The rate of utilization of health insurance eligibility (compliance rate) was 56.6% for outpatient care and 80.9% for inpatient care (see Table 5).

Table 5: Morbidity rates and health service utilization of eligible persons under the Universal Coverage of Heath Care Scheme, FYs 2002 and 2003

	Outpatients			Inpatients		
	FY 2001	FY 2003	Change	FY 2001	FY 2003	Change
Morbidity rate, episodes/person/yr	4.101	4.926	20.1%	0.076	0.083	8.8%
Service selection						
Non-institutional care	30.6%	28.0%	-8.5%			
Institutional care	69.4%	72.0%	3.7%	100.0%	100.0%	
● Public facility	54.8%	57.2%	4.4%	89.0%	90.3%	1.5%
● Private facility	14.6%	14.8%	1.4%	11.0%	9.7%	-11.8%
Rate of utilization of eligibility rights when receiving services (compliance rate)		56.6%			80.9%	

Source: Viroj Tangcharoensathien et al., 2003.

3. Referrals of Patients

For cases requiring referrals, it was found that for 2003 the referral rate dropped by 1.31% compared with that for 2002 (see Table 6).

Table 6: Referrals of patients among health facilities at all levels, FYs 2002 and 2003

Fiscal year	Referral rate (%)	Increase rate (+/- %)
FY 2002	1.32	-1.31
FY 2003	1.30	

Notes: Referral data include referrals at all levels, including within a CUP and outside a CUP. The referral rate is the number of referred cases as a percentage of the total number of all patients.

Due to data limitation in the reporting system, no consideration could be given to the severity and appropriateness of referrals. The survey conducted by the National Statistical Office[3] revealed that a number of severe cases were not referred to the facilities providing higher level of care and a number of higher-level hospitals tended to deny care for such cases. However, the survey showed that only 6.0% and 4.7%, respectively, had ever experienced them.

4. Utilization of Services for Accident/Emergency and High-Cost Care

Between 2002 and 2003, the number of inpatient-care claims for accident and emergency care was 3.3 to 3.4 times higher than that for outpatients, an increase of 6% and 10% for outpatients and inpatients, respectively. For cases with high-cost care, the number of inpatient-care claims was 1.4 times higher than that for outpatients, an increase of 6% and 3% for outpatients and inpatients, respectively (see Table 7).

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[3] National Statistical Office, 2003. Summary of a public opinion survey on National Health Security Scheme (30-baht health care scheme) in 2003.

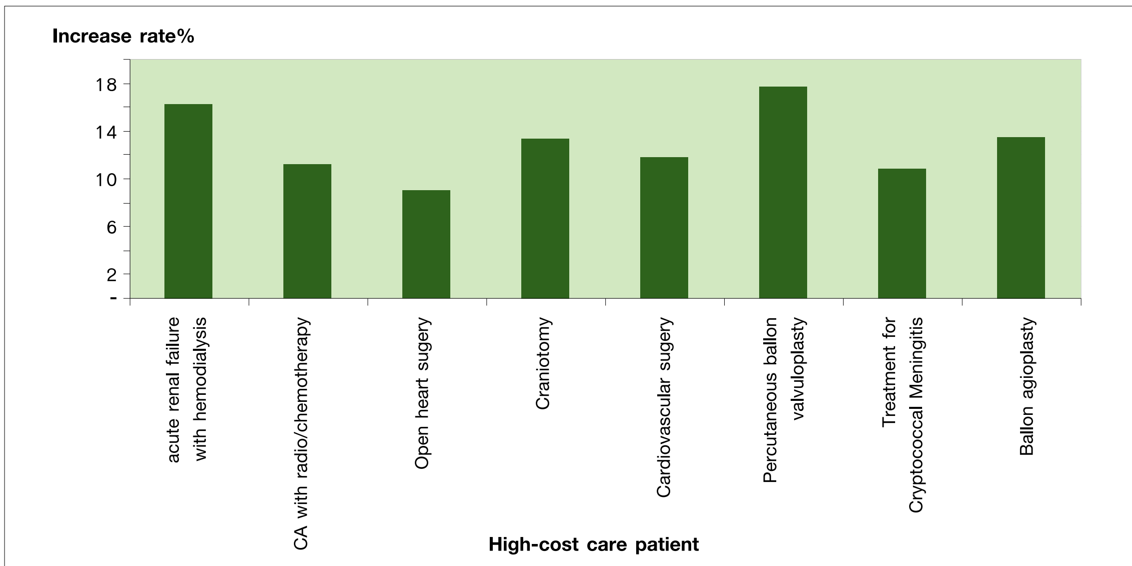
Table 7: Numbers of accident/emergency patients with claims for medical-care expenses, FYs 2002 and 2003

Type of service	FY 2002		FY 2003		Increase,%	
	Outpatients	Inpatients	Outpatients	Inpatients	Outpatients	Inpatients
Accident/ emergency care	30,326	100,583	32,269	111,038	6.41	10.39
High-cost care	64,695	92,869	68,394	95,864	5.72	3.22

Source: Database on medical-care claims, Bureau of Information Administration, NHSO, FYs 2002 and 2003, as of 1 October 2003.

The number of patients with diseases requiring high-cost care increased in all categories of diseases, especially for cardiac-valve repair/replacement with a percutaneous balloon-tipped catheter (valvuloplasty) and for dialysis in acute kidney failure cases, increasing by more than 17%.

Figure 4: Rate of increase in the number of patients with high-cost care, as claimed by hospitals, FYs 2002 and 2003



5. Quality of Medical Care

In FY 2003, the number of contracted units of health care with hospital accreditation certification increased by 3.9%. However, most of the contracted hospitals (68.4%) are still under development process steps 1 and 2 (see Table 8).

Table 8: Status of the service quality development program in the service network of the Universal Coverage of Heath Care Scheme, September 2003

Status of hospital accreditation	Hospitals under MOPH	Hospitals, non-MOPH	Total	Percent
Under development process steps 1 and 2[4]	643	29	672	68.4
Under development process step 3	143	3	146	14.9
Hospital Accreditation-certified	27	11	38	3.9
Data not available	-	125	125	12.8
Total	**813**	**168**	**981**	**100**

Sources: Department of Health Service Support, MOPH, and Institute of Hospital Quality Improvement and Accreditation, September 2003.

Between April and September 2003, the NHSO conducted a preliminary investigation on health facilities that were complained about service quality. The investigation revealed that seven health facilities were suspected of committing offences under sections 57 and 59 of the 2002 National Health Security Act. The cases have been submitted to the Heath Service Standard and Quality Control Board.

The public opinion polls were conducted by several institutions in FY 2003, such as the ABAC Poll of Assumption University[5], the National Statistical Office[6], and Siripen Supakankunti and colleagues[7]. Overall, most of the eligible people were satisfied with the services. Nevertheless, the people who did not exercise their rights felt unconfident in quality of service.

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[4] Development step 1: management for risk management; step 2: continuous quality assurance and quality development; step 3: assessment visit for accreditation purpose.

[5] ABAC-KSC Internet Poll Research Center (ABAC Poll), Assumption University, 2003. Opinions of health care providers on the Universal Coverage of Health Care Scheme: a case study on a sample of health care personnel in 13 participating health facilities nationwide.

[6] National Statistical Office, 2003. Summary of the results of public opinion poll on Universal Coverage of Health Care Scheme (30-baht health care), 2003.

[7] Siripen Supakankunti et al. Executive summary. Public opinions on the Universal Coverage of Health Care Scheme with the co-payment mechanism.

Those who actually utilized the care and were unsatisfied with the services commented that the service and drug qualities were not good enough. The ABAC Poll showed that the first three aspects requiring improvement were the service and manner of health care providers, quality of care, and quality of drugs and equipment.

6. Equity in Receiving Health Care

In consideration of resource distribution, there were geographically considerable discrepancies of hospital beds and physicians (see Table 7). The bed to population ratio was 1:200 for Bangkok, while it was as low as 1:700 for regions 5 and 7, respectively. Similarly, the physician to population ratio was 1:1,077 for Bangkok while the ratios were rather low at 1:6,524 and 1:9,168 respectively for the two regions.

Table 9: Comparison of population and the numbers of beds and physicians in health facilities by health region, FY 2003

Health Region	No. of contracted units of care	Eligible population under the Universal Coverage of Health Care Scheme, 30 June 2003	No. of beds	No. of physicians	Pop:bed ratio	Pop: Physicisan ratio
1	57	2,260,698	5,902	614	383	3,682
2	61	2,145,264	6,378	722	336	2,971
3	71	2,828,662	7,945	868	356	3,259
4	66	2,920,128	8,119	752	360	3,883
5	99	5,721,681	8,088	877	707	6,524
6	118	5,731,497	9,612	1,212	596	4,729
7	101	5,235,202	6,800	571	770	9,168
8	53	2,623,688	4,595	496	571	5,290
9	64	2,860,685	5,630	559	508	5,118
10	91	3,661,266	10,725	1,217	341	3,008
11	81	3,073,624	6,233	588	493	5,227
12	76	3,440,846	6,403	786	537	4,378
Bangkok	45	3,187,962	15,927	2,959	200	1,077
Total	**983**	**45,691,203**	**102,357**	**12,221**	**446**	**3,739**

Sources: 1. Data on the number of physicians were derived from the survey on health resources conducted by the Bureau of Policy and Strategy, 2002, as of 16 July 2003. Overall, the data were 90% complete, except for region 4 (87.9% complete) and Bangkok (55.6% complete).

2. Data on the number of beds were derived from the database from the Bureau of Health Service Network Development for 2000, and the Bureau of Health Facility Standard and Medical Registration for 2001. Overall, the information from hospitals in each region was over 96% complete.

Regarding the services for cases requiring high-cost care diseases such as heart surgery, brain surgery, cancer treatment, etc., a study of the subcommittee on study and monitoring of the Universal Coverage of Health Care Scheme of the Senate[8] revealed that health facilities in the provincial areas

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[8] Subcommittee on research and monitoring of the Universal Coverage of Health Care Scheme, 2003. Report of the Senate Public Health Commission on the follow-up on the operations of the Universal Coverage of Health Care Scheme (30-baht health care) and the operations according to the 2002 National Health Security Act.

had a lower capacity to provide such services than those in Bangkok or the central level. The provincial residents who were ill with any of such diseases were unlikely to receive medical care on a timely basis.

In connection with the equity of health care provision, the ABAC Poll[9] revealed that, even though health care clients were satisfied with the services, the providers gave their opinions that the top-quality care was more likely to be rendered to civil servants, followed by out-of-pocket payers and insured persons under the Social Security System, and the lowest-quality care to the Universal Coverage of Health Care Scheme (30-baht scheme) clients.

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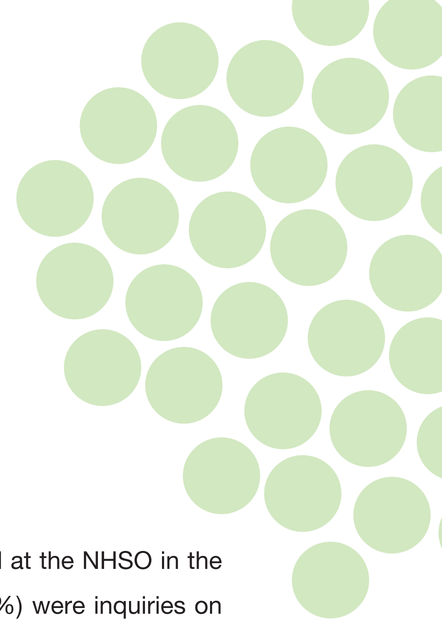
[9] ABAC-KSC Internet Poll Research Center (ABAC Poll), Assumption University, 2003. Opinions of health care providers on the universal coverage of health care system.

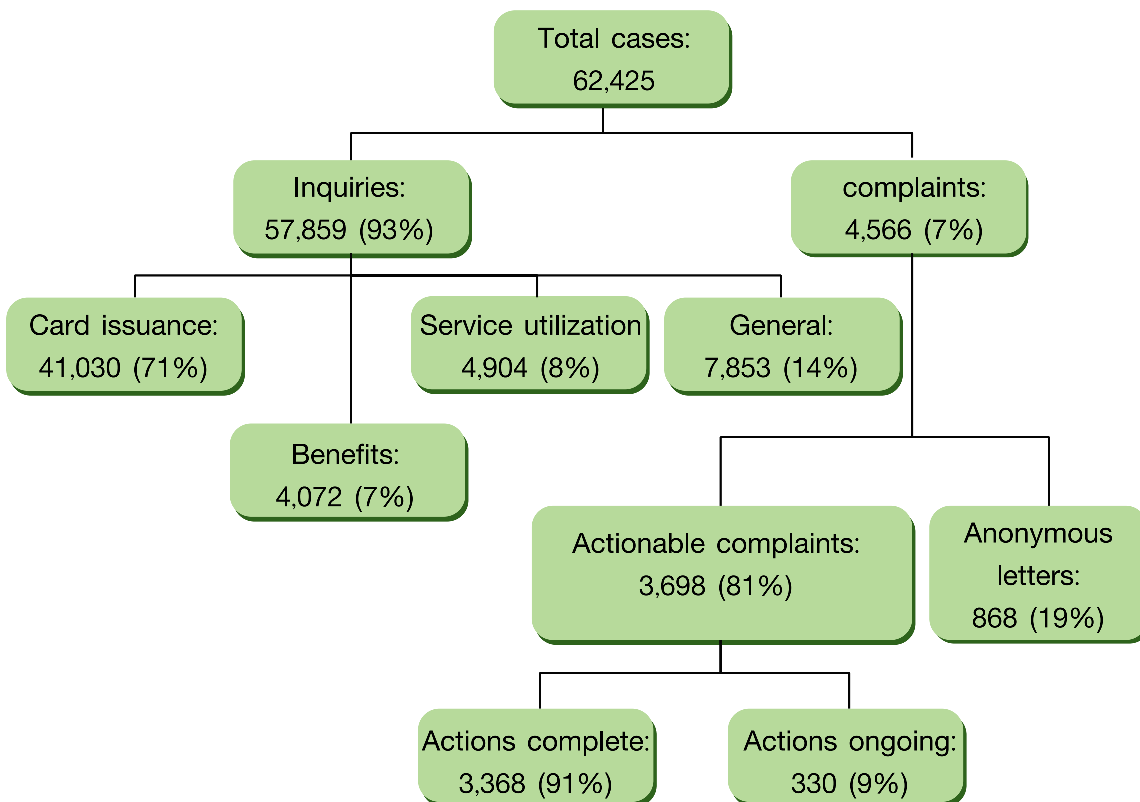
รูปเปิด 03



Acceptance of Complaints and Protection of People's Rights

In FY 2003, 62,425 inquiries and complaints from the people were received at the NHSO in the forms of letters, emails, phone calls, or personal visits. Of all the cases, 57,859 (93%) were inquiries on general issues and 4,566 (7%) were complaints. Among the complaints, 3,698 cases (81%) were on issues that actions could be taken, for 91% of which (3,368 cases) the actions had already been complete (see Figure 5).

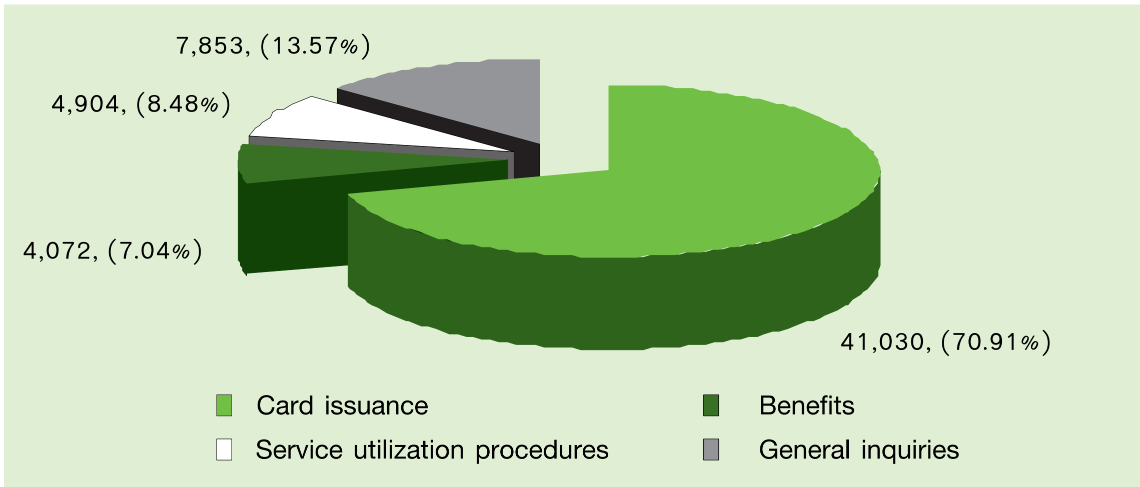
Figure 5: Numbers of public inquiries and complaints sent to NHSO, FY 2003



1. Inquiries

Most of the inquiries were about the steps for card issuance (71%), followed by general issues (14%) and service utilization procedures (8%, see Figure 6).

Figure 6: Number and percentage of inquiries by nature of inquires, FY 2003

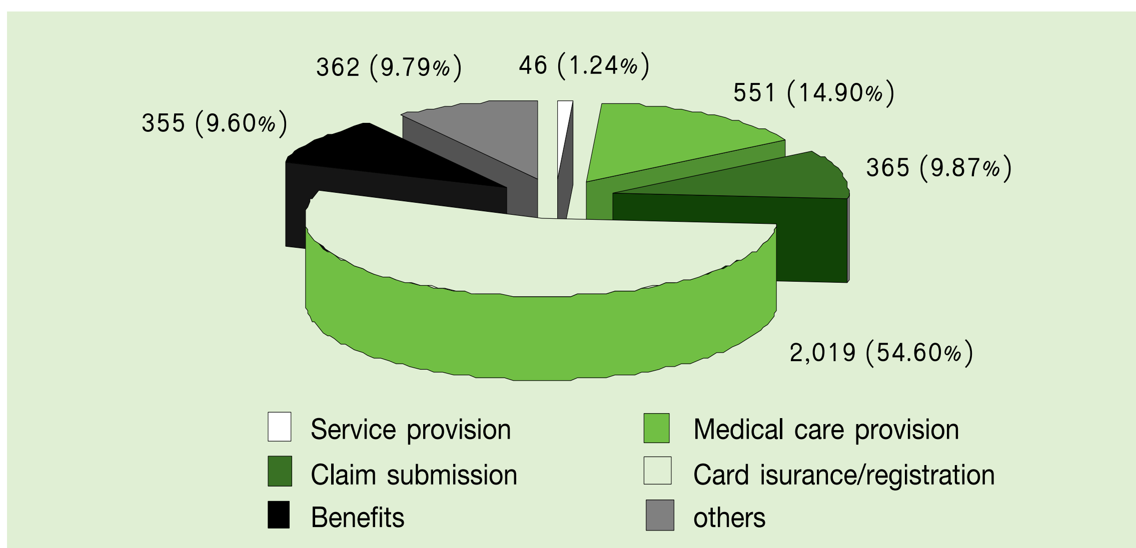


2. Complaints

Of all the 4,566 complaints, 3,698 (80.99%) were actionable cases, of which 3,368 cases or actions (91.08%) had been completed.

Of all the 3,698 actionable complaints, most of them were related to card issuance and registration such as requests for revocation of duplicative eligibilities (54.60%) and complaints about medical care (14%).

Figure 7: Number and percentage of complaints by nature of compliants, FY 2003



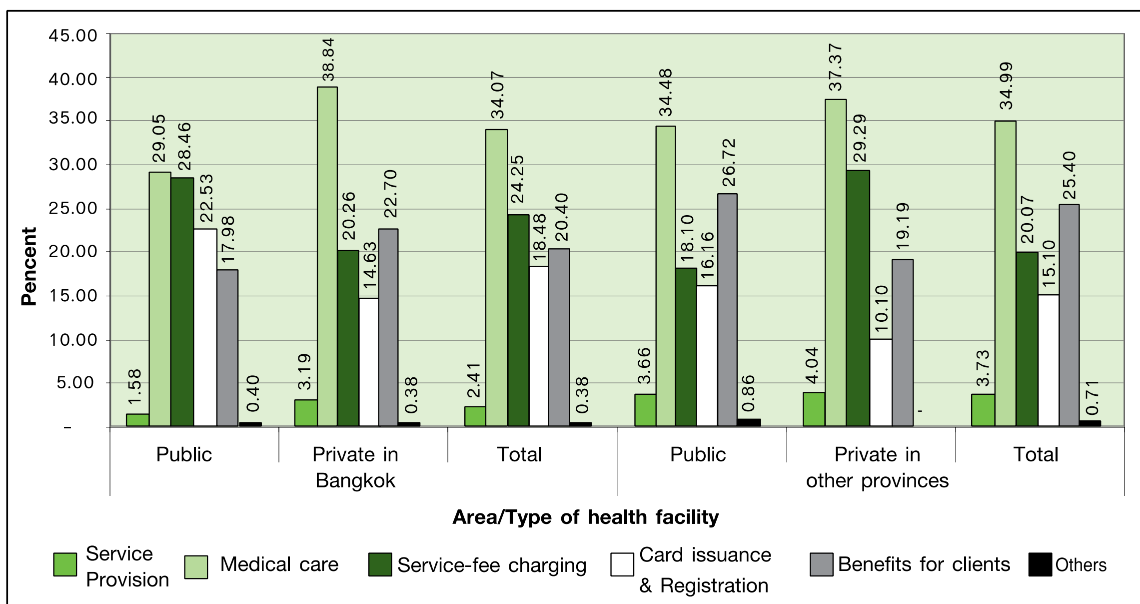
Of all the complaints, 1,602 cases had indicated the names of health facilities, involving 320 health facilities: 253 public and 67 private. And of all the complaints, 1,039 (64.86%) involved health facilities in Bangkok and 563 (34.14%) involved those in other provinces. Details of the complaints considered, most of them were related to medical care, followed by claim submissions (see Table 10).

Table 10: Number of complaints about health facilities by type of facilities, area, and nature of complaints, FY 2003

Area	Service provision	Medical care	Service-fee charging	Card issuance & registration	Benefits for clients	Others	Total
	Number (%)	Number (%)	Number (%)	Number (%)	Number (%)	Number (%)	Number (%)
Bangkok	25 (2.41)	354 (34.07)	252 (24.25)	192 (18.48)	212 (20.40)	4 (0.38)	1,039 (100.00)
Other Provinces	21 (3.73)	197 (34.99)	113 (20.07)	85 (15.10)	143 (25.40)	4 (0.71)	563 (100.00)
Total	46 (2.87)	551 (34.39)	365 (22.78)	277 (17.29)	355 (22.16)	8 (0.50)	1,602 (100.00)

When considering the complaints by area and nature, it was found that, in both Bangkok and provinces, most of the complaints (34.07% and 34.99%, respectively) were related to medical care. In Bangkok, more of such complaints were lodged against private hospitals (38.84%) than against public hospitals (29.05%); and a higher proportion of public hospitals (28.46%) had complaints about service-fee charging, compared with private hospitals (20.26%). But in the other provinces, the proportion of complaints about service-fee charging at private hospitals was higher than that at public hospitals (29.29% vs. 18.10%).

Figure 8: Proportion of complaints by area and type of health facilities, FY 2003



In summary, complaints with identified health facilities mostly were related to medical care and service-fee charging. The NHSO has to create a good understanding among service providers to improve the services and among the clients so that they understand different situations and constraints of health facilities. Besides, the NHSO has revised the guidelines for implementation according to the recommendations from a consultative meeting held in August 2003, which are as follows:

1. There should be complaint handling centers in the civic sector.

2. More channels for accepting complaints should be set up to make it more convenient for the public to access, by setting up such units at the village, subdistrict or Tambon (at Tambon Administration Organization [TAO] offices), district, provincial, and central (NHSO) levels.

3. Provincial private-sector coordinating centers should be set up to accept complaints.

4. Support should be provided for the setting up of a people's rights promotion and protection center organized by the community and run by elected community members.

Regarding the support for people's participation in the monitoring of service units and their network, the recommendations are the following:

1. Formally, the public participation should be as required by law.

2. Informally, each community should have its own committee comprising elected community members, serving as an organization that realizes the importance of health programs, linking the health insurance work to the formal committee, and having learning-process activities at the grassroots level.

With regard to the support for public education system development, aimed at helping them to make decisions on health care seeking, a public relations program should be undertaken to disseminate the information by organizing training sessions and discussion forums, sending out documents, and publicizing the scheme through the mass media.

Therefore, development guidelines have been developed pursuant to the basic information, with the recommendations from public hearings, as follows:

1. Developing the capacity of complaints acceptance centers, in terms of personnel, capability, and technology, so that they can cope with an increasing workload more efficiently.

1.1 Customer-relations system development. Based on the trends in rising numbers of inquiries and complaints, the NHSO has set up a program to handle such matters. A contract is being concluded for the setting up of a Call Center according to the international standards. This is to develop a customer-relations management system so that it can retrieve previous information from the same complainant. The system will have an automatic-answering device for answering frequently asked questions, a modern data collection and processing system, and a call-respondent performance control system. All these mechanisms will make it more convenient and faster for the people to receive services. The results of data processing and analysis will lead to service improvement in a more efficient manner.

1.2 Setting up a coordinating system for seeking a hospital bed for an eligible person with emergency illness and for requesting qualified health facilities to become members of the network for emergency-bed reserves for universal coverage of health care or cardholders. This is to ease the hardship of the people.

1.3 Training of personnel so that they have adequate skills and capability to participate in negotiations more effectively and to have good service attitudes.

1.4 Increasing the number of personnel involved in responding to inquiries/complaints and resolving the problems of people, or contracting out such services to the private sector, particularly those related to providing general information where there is no duplication of effort.

2. Giving importance to the public relations and communication efforts in creating a good understanding among the public and distributing the information as widely as possible about the Universal Coverage of Health Care Scheme.

3. Getting prepared for the development of the standard of the inquiries and complaints acceptance services at the branch offices so that they all have a similar/acceptable standard nationwide. Each of such units must be really able to help the people and serve as a center that creates a good understanding with health care units being complained about, and help such units to improve their operations or help them clarify with the clients in the event of misunderstanding. In so doing, a quality assurance system will have to be established.

4. Coordinating with agencies that are responsible for communicating with various health facilities, particularly those in the private sector, in preventing complaints, and following up on service quality assurance in Bangkok and provinces, since they have a higher proportion of complaints about medical care, compared with other kinds of complaints and those in the public sector.

5. Emphasizing a proactive approach in encouraging the participation from service providers, local administration organizations, and civil society to create a good understanding among parties concerned, which will minimize conflicts and complaints.

6. Getting additional information about the inquiries and complaints in provinces in order to obtain a better picture of the situation.

7. Coordinating with the civic sector in establishing complaints acceptance and information centers in the localities that are ready to help create a good understanding with the public in 2004.

8. Coordinating with the civic sector and community organizations in publicizing and disseminating the information about universal health care.

รูปเปิด 04

Results of Surveys on People's and Service Providers' Opinions

The NHSO contracted the ABAC Poll of Assumption University to conduct a survey on the opinions of the insured and providers in relation to the provision of health care under the Universal Coverage of Health Care Scheme.

The survey on the service users was conducted in 13 provinces, covering a sample 6,087 cardholders in Bangkok Metropolis, Nonthaburi, Chainat, Chachoengsao, Chiang Rai, Lampang, Phitsanulok, Khon Kaen, Maha Sarakham, Nakhon Ratchasima, Nakhon Si Thammarat and Trang.

The survey revealed that the overall average satisfaction score was 8 with a standard deviation of 1.99 on the 1-10 scale (10 representing the highest level of satisfaction); 60.7% of the respondents were readily able to pay more than 30 baht per visit if asked, while 39.9% were unable to do so due to their poverty and they had considered 30 baht as most reasonable according to the government policy.

Of all respondents, 51% appreciated the 30-baht scheme as it had helped cut their medical expenses while 24% believed that the scheme really assisted the poor. However, 41% indicated the necessity of care improvements regarding the providers' behavior when providing care (41%), care quality, quality of drugs and medical equipment (19%), and choices of health facilities (9%).

The survey on the providers' opinions was carried out among a sample of 3,006 respondents in 156 health facilities in Bangkok Metropolis, Nonthaburi, Samut Prakan, Chon Buri, Prachuap Khiri Khan, Phichit, Phitsanulok, Chiang Mai, Roi Et, Ubon Ratchathani, Khon Kaen, Yala and Songkhla. The providers were physicians, dentists, pharmacists, nurses and health officers.

The results showed that the overall satisfaction score was 6.15 with a standard deviation of 1.80. Their suggestions for the scheme's improvements included a more budget allocation (39.8%) and a benefit package review to meet people's needs (25.6%).

With respect to their needs, the adequate remuneration and welfare (52.8%), their capacity and skill development (14.6%), and more health personnel (9.5%) to meet workload were cited.

Major conclusions and recommendations from the two surveys are as follows:

1. The satisfaction levels of the providers and the users were moderate and high, respectively.
2. The providers rated their care quality at a good level while the users considered the quality not as good as that under other insurance schemes.
3. The physicians considered that the scheme had problems which were greater than the concerns of other health personnel.
4. Budget allocation was regarded by the providers as most problematic. The funds allocated to each health facility should be sufficient; and the budget transfer should be timely.
5. Proper management was needed to alleviate the providers' workload, which had increased continuously and became a major cause of their resignation.
6. Primary care facilities as a major entry point of users are capable of reducing patient overcrowding at hospitals but currently need improvements to ensure that the users get good-quality care.
7. The gap between the satisfaction levels of the providers and users should be narrowed to promote better relationships between both groups.

รูปเปิด 05

The Administration of the National Health Security Fund

1. Allocation and Disbursement of the National Health Security Fund (FY 2003)

The total budget for FY 2003 (1 October 2002 - 30 September 2003) was 31,337,924,300 baht composed of the regular budget of 30,476,924,300.00 baht and the subsidy fund of 861,000,000 baht. Of the total budget, 86.43% was designated for capitation payments for inpatient/outpatient care, promotive/preventive services (73.65%), capital investment as well as durable articles and constructions (12.76%), high-cost care (7.03%), accident and emergency services (4.52%), and vaccines (2.04%) as detailed in Table 11.

Table 11: Expenditures of the budget of NHSO, FY 2003

Category of expenditure	Amount expended, baht	Percent
Capitation budget	19,948,408,813.08	73.65
Accident/emergency services	1,223,514,165.93	4.52
High-cost care	1,903,291,071.85	7.03
Capital investment and durable articles	2,474,749,262.19	9.14
Constructions	980,493,179.11	3.62
Vaccines	553,892,429.00	2.04
Total	27,084,348,921.16	100.00

Source: Financial Administration Bureau, National Health Security Office, 30 September 2003.

2. Categories of Expenditures

2.1 Capitation Budget for Inpatient/Outpatient Care and Preventive/Promotive Services

The capitation budget was allocated to contracted units of health care at a rate of 1,037.3 baht per capita (covering staff salaries, less vaccines costs deducted at the central level at 14.7 baht per capita). The first installment was for the expenses incurred during the first four months and was made two months in advance at the amount of 80% of the total capitation budget. The remainder (20%) would be transferred according to the actual number of registered/eligible persons after the registration had been verified for each province.

For contracted units of care in the private sector and under the Thai Red Cross Society, the allocated capitation was at the same rate (1,037.3 baht per capita). The contracted units of care under the MOPH's Office of the Permanent Secretary also received the capitation budget at the same rate less the amount required for salaries and permanent wages as indicated in the FY 2003 Annual Budget Act; the remainder would be transferred to the MOPH for further allocation.

Other contracted units of care (under the Department of Medical Services and other agencies) received a capitation allocation of 578.6 baht per capita.

Table 12: Allocation of capitation budget for outpatient/inpatient care and health promotion services, FY 2003

Parent agency of contracted units of care	Registered population	Allocated budget (baht)	Budget for salary health personal (baht)	Total (baht)
Office of the Permanent Secretary, MOPH	41,269,072	16,914,415,656.98	24,912,620,700.00	41,827,036,356.98
Department of Medical Services, MOPH	676,132	54,668,542.00		54,668,542.00
State-run, non-MOPH agencies	1,969,525	1,035,824,236.00		1,035,824,236.00
Private sector and Red Cross Society	1,776,474	1,943,500,378.10		1,943,500,378.10
Total	**45,691,203**	**19,948,408,813.08**	**24,912,620,700.00**	**44,861,029,513.08**

2.2 Compensation for High-Cost and Accident/Emergency Care

In FY 2003, health care facilities submitted high-cost care claims to the NHSO to get reimbursed for 182,494 cases; of which, 177,378 cases (97%) met the established criteria. Accident/emergency claims of 163,905 cases were submitted but 159,638 were in accordance with the established criteria.

The NHSO had already paid the compensations for 88% and 90% of high-cost care cases and accident/emergency care cases, respectively. The proportions of cases that were rejected and required additional documentation were 2% and 1%, respectively (see Table 13).

Table 13: Payments of compensations for cases with high-cost and accident/emergency care, FY 2003

No.	Description of claim		High-cost care		Accident/emergency	
			Outpatients	Inpatients	Outpatients	Inpatients
1	Total claims submitted	(cases)	75,443	107,051	36,304	127,601
2	Being in accordance with criteria	(cases)	72,109	105,269	35,027	124,611
	Compensations paid	(cases)	63,801	92,350	32,810	110,960
		(percent)	88.48	87.73	93.67	89.05
	Being processed	(cases)	8,308	12,919	2,217	13,651
		(percent)	11.52	12.27	6.33	10.95
3	Denied	(cases)	2,303	1,334	598	2,055
		(percent)	3.05	1.25	1.65	1.61
4	Pending additional documentation	(cases)	1,031	448	679	935
		(percent)	1.37	0.42	1.87	0.73

Note: Data were received from health facilities requesting compensation between 1 October 2002 and 30 September 2003 at the Bureau of Information Administration, discarding the data for 13 Nov 03.

For accident/emergency cases, the total amount claimed was 1,239,051,588.63 baht, but the payable amount was as high as 1,375,912,307.79 baht (111% of the amount claimed). Of the payable amount, 1,026,676,653,79 baht (75%) was paid by the central level (see Table 14).

2.3 Investment Budget

The allocation of investment budget in FY 2003 was a follow-on effort, based on the FY 2002 investment budget commitments. A subcommittee on investment planning was set up to develop the

Table 14: Expenses claimed, expenses payable for the whole case, and expenses paid by the central fund and by the parent agency for cases with high-cost care, FY 2003

Description	High-cost care, baht		Accident/emergency care, baht	
	Outpatient	Inpatient	Outpatient	Inpatient
Total amount claimed	211,639,376.10	2,859,389,350.44	24,006,107.26	1,215,045,481.37
Average per case	2,805.29	26,274.15	661.25	9,522.23
Total payable amount	177,163,028.70	2,378,001,145.57	19,027,368.67	1,356,884,939.12
Average amount per case	2,776.81	25,749.88	579.93	12,228.60
Payable amount in relation to total amount claimed (%)	83.71	83.16	79.26	111.67
Amount paid from the central fund	138,858,187.34	719,963,336.86	14,765,833.82	1,011,910,819.97
Average amount per case	2,176.43	7,796.03	450.04	9,119.60
Amount paid by central fund in relation to payable amount (%)	78.38	30.28	77.60	74.58
Amount paid by regular service units	38,304,841.36	1,658,037,808.71	4,261,534.85	344,974,119.15
Average amount per case	600.38	17,953.85	129.89	3,109.00

Note: Data were received from health facilities requesting compensations between 1 October 2002 and 30 September 2003 at the Bureau of Information Administration, discarding the data for 13 Nov 03.

allocation criteria for FY 2003. As a result, the subcommittee had determined and decided to allocate 1,929,641,589 baht for this purpose; and actually 1,147,744,406 baht (59%) had been transferred to service units (see Table 15).

The operating budget of 1,600 million baht was set for the registration of eligible persons, the development of service standard/quality and accounting system of health facilities, and the management

Table 15: Allocation of investment budget in FY 2003

No.	Parent agency	Investment budget, baht			
		Allocated in FY 2003	Transferred to hospitals	Transferred to Office of Permanent Secretary, MOPH	Balance
1	General investment budget	844,373,217		844,373,217	-
2	Investment budget in non-MOPH public sector	79,051,790			79,051,790
3	Investment budget in private sector				
	- Health regions 1-12	61,843,603	1,375,766		60,467,837
	- Bangkok Metropolis	93,037,536	93,037,536		-
4	Investment budget in tertiary care				
	- Tertiary care for heart disease	68,584,094			68,584,094
	- Tertiary care for cancer	70,127,533			70,127,533
	- Tertiary care for accidents	48,084,059			48,084,059
5	Investment budget in remote, border, island, and special areas	208,957,887		208,957,887	-
6	Narenthorn Center				
	- Emergency medical service fees	273,349,122			273,349,122
	- Disabled persons	182,232,748			182,232,748
	Total	**1,929,641,589**	**94,413,302**	**1,053,331,104**	**781,897,183**

Source: Bureau of Purchasers Development, NHSO.

system of the NHSO and its branch offices.

รูปเปิด 06

Development of the National Health Security Branch Offices

Section 25 of the 2002 National Health Security Act provides that the NHSB has the power to authorize other state agencies or establish branch offices in different localities, based on the needs and cost-effectiveness. The NHS branch offices have been set up in two forms: one is the authorized government agency and the other is the office specifically responsible for purchasing health care.

In FY 2003, according to the NHSO announcement dated 21 January 2003, signed by the Minister of Public Health, each provincial public health office was designated as a branch office of the NHSO and the provincial chief medical officer (PCMO or chief of the provincial public health office) served as the director of the branch office in his/her own jurisdiction.

Each branch office and its director have the duties as assigned by the NHSO or the Secretary-General of the NHSO, according to the NHSO announcement, dated 6 February 2003, as follows:

1. Collecting, compiling and analyzing data relating to health service provision.
2. Managing the registration process and networks of service provision.
3. Making payments for health services to health facilities and health facility networks.
4. Examining claim documentation from service units.
5. Implementing public relations on health facility registration.
6. Monitoring the quality of care provided by the contracted facilities and their networks according to the standards set by the NHSB.
7. Facilitating the submission of complaints from users.
8. Carrying out the operational work for the provincial subcommittees, other subcommittees and working groups relevant to NHSO's activities.
9. Performing duties relevant to other laws, rules, regulations, announcements and other assignments designated as the duties of NHS branch offices, or performing any other tasks assigned by the NHSB, SQCB, or NHSO.

Efforts in the early phases of the development of the branch offices have focused on the operational system, including capacity building and the evaluation system as follows:

1. Personnel development. Efforts were made for developing operational capacity in registration, complaint acceptance, legal affairs, and investigations. Operational manuals were prepared and distributed. Meetings with provincial personnel were organized to inform them of the new policies and operational guidelines. The central coordinators for each region were appointed to work in a coordinated fashion and to resolve problems of the provincial branch offices.

2. Development of personnel management structure of branch offices. Provincial public health offices have been reorganized according to the recent bureaucratic reform, each having one section and four groups, i.e. the general administration section, the strategy development group, the consumer protection group, the technical support group, and the health insurance group.

The health insurance group has 8 officials while its missions are interrelated to those of other groups/section. Each provincial branch office has different personnel management systems. Improvements in task clarity of each group should be made. The branch office should also be able to adapt its management style according to its own strengths, weaknesses and environment.

3. Development of infrastructure and operational systems of branch offices. In connection with the infrastructure, a computerized network has been established to link up with all branch offices in the form of Intranet, in cooperation with the Telephone Organization of Thailand. A leased line has been provided to all branch offices.

The NHSO has developed a registration and eligibility verification system so as to perform its functions in a more efficient and timely manner. An E-claim system and a call center for accepting complaints have been set up and capable of linking the NHSO with all branch offices.

Other development efforts have also been made, for example those relating to legal affairs, regulations, announcements, and rules under the National Health Security Act. In addition, community-friendly clinics under the Bangkok Metropolitan Administration (BMA) have been developed so that the people will have a better access to health services.

4. Development of operational budget payment system for branch offices. The NHSO allocated 450 million baht from the subsidy category as the operating costs of all branch offices in the following proportions:

4.1 30% of the budget equally allocated to each of the branch offices for fixed costs.

4.2 65% of the budget allocated according to the number of registered people (75%) and the number of Primary care units (PCUs) (25%).

4.3 3% of the budget allocated according to the specific problems of each locality by the Office of the Inspector-Generals, MOPH.

4.4 2% of the budget allocated according to the results of each office's operational capability.

5. Evaluation of the operations of branch offices. In assigning duties and functions of the branch offices, the performance standards and criteria are set as follows:

Functions	Performance standards
Registration of eligible persons under the Universal Coverage of Health Care Scheme	- Percentage of the people who do not receive the universal coverage of health care cards (less the number of insured persons under the Social Security System and the Civil Servant Medical Benefits Scheme). - Average time spent on changing the area to be registered with or changing the regular service units.
Assessment of the standards of service units and the network of service units for registration purpose	An assessment is conducted annually; and the service unit that previously passed the assessment is reassessed every year. - Average time spent on the assessment of a service unit (from the date the request for assessment is received). - Service units that pass the reassessment by the Bureau of Service Quality Development, NHSO (the units are randomly selected).
Administration of contracted units of care	- Timeliness and accuracy in transferring the budget to service units. - Operational information systems of service units (completeness, accuracy, reliability, and timeliness).
Protection of eligible persons' rights under the Universal Coverage of Health Care Scheme	- Percentage of the people who know of their eligibility under the Universal Coverage of Health Care Scheme. - Percentage of claims that are acted upon. - Number of activities initiated by the people to support the Universal Coverage of Health Care Scheme.
Support for the development of service unit quality and service networks	- Number of service units that meet or are higher than the set standards.
Support for the operations of provincial subcommittees	- Satisfactions of the provincial subcommittees.
Monitoring and follow-up of the progress in the operations of the Universal Coverage of Health Care Scheme at the provincial level and the coordination with other health programs	- Having an information system for monitoring the progress of planned activities. - Sending reports to NHSO regularly according to the set criteria. - The reports are accurate and reliable. - Having a system for disease investigation and control when there is a patient with any of the diseases under the surveillance system at the service unit or the community.

Due to the restructuring and assignment of the provincial public health offices to serve as branch offices, their roles and functions in this regard have not been properly settled; and thus no comprehensive evaluation has been carried out on their performance.

รูปเปิด 07

The Operations of the National Health Security Office - Bangkok Branch

The Bangkok Branch of the NHSO has been established to take charge of the scheme operation in Bangkok Metropolis. As of 30 September 2003, there were 3.22 million eligible people completing the registration process with 44 contracted health facilities in both public and private sectors in Bangkok.

The high proportion of private facilities in Bangkok is regarded as an advantage in making the coverage more expansive (with regard to registration and care accessibility) if more of such private facilities are contracted. In FY 2003, 26 private facilities were contracted under the scheme.

In FY 2003, the Bangkok Branch of the NHSO performed various activities as follows:

1. Coordinating with health facilities under the Department of Corrections to provide services under the Universal Coverage of Health Care Scheme.

2. Organizing meetings with providers and users to solicit their opinions, which were used for policy and operational development.

3. Cooperating with the BMA's Department of Health which supervises all the health centers in Bangkok and contracting 30 health centers to provide services for the eligible.

4. Increasing people's convenience in registration not only at the facilities but also at other units, e.g. mobile registration units and temporary registration centers at secondary schools, which are located in all districts throughout Bangkok.

5. Emphasizing the utilization of primary care units by setting up a pilot project called the community-friendly clinics project aimed at re-conceptualizing primary care provision in similar orientation, under which 27 private hospitals, 5 nursing homes and 101 clinics took part.

6. Conducting extensive and continuous campaigns on the registration of uninsured people living in Bangkok and for those who were eligible to register in other provinces but wanted to register or re-register in Bangkok for the ease of their accessibility to care.

Although the Bangkok Branch of the NHSO has made a lot of efforts to develop the health security system in Bangkok, a number of obstacles remain as follows:

1. Incomplete networking of information system leading to some restrictions in the registration and claiming processes.
2. The dental services, which are within the benefit package, are largely inaccessible, because some registry facilities do not organize such services for the insured.
3. The application criteria for health facilities to be primary care units or community-friendly clinics remain unclear and impractical in some aspects to some extent.
4. Exaggerated information on service capacity is distributed to the users by some facilities to boost their registration numbers.
5. Contingent decision-makings and uncertain procedures on referred cases by tertiary and super-tertiary hospitals largely situated in Bangkok because of inconsistent regulations relating to case referral performed by many provinces.
6. Temporarily ineligible newborn babies, whose mothers' registry facilities are not in Bangkok, are effectively registered after being enrolled at the facilities.
7. High rates of bed occupancy particularly in referral hospitals are considered as a major deterrence to getting inpatient care on a timely basis.
8. Some particular contracted hospitals with more than 30,000 eligible people neither set up nor contract out external primary care units, resulting in the overcrowding at the registry facility when seeking care, doubtful quality of care, and service inaccessibility.

รูปเปิด 08

Obstacles and Future Development

1. Registration Coverage and Service Utilization

There are currently about four million people requiring examination of their insurance entitlement. The NHSO has investigated their entitlement and make them belong to one type of the existing health insurance schemes.

The long-distance movement of laborers due to their work conditions in some circumstances is an obstacle to using services from their registry facilities, except for emergency care. The NHSO has to develop a policy in response to such a problem in accordance with the intent of the National Health Security Act of 2002 as much as possible.

To boost the effective insurance coverage, the NHSO plans to be more proactive by:

(1) Notifying the local purchasers to get uninsured people registered by giving their names and addresses to the purchasers;

(2) Allowing the insured to register at the facility for their convenience by means of verifying their place of residence instead of their household address;

(3) Conducting extensive campaigns to encourage the eligible people to register;

(4) Reimbursing the facilities in case of emergencies and accidents from the central fund in order to minimize the facilities' effort in cost savings which may harm the patients;

(5) Making it more convenient for service utilization for certain population groups, e.g. war veterans and the disabled who will be able to seek care from any contracted facility that can later get reimbursed from the central fund;

(6) Extending the eligibility to those who have not been registered at any facility to get services in case of accident and emergency;

(7) Making more efforts to get sufficient revenue by illustrating the proper capitation rate so as to support the provision of efficient health care by the facilities.

2. Health Facility Choices and Registration Guidelines

The NHSO has placed very much importance of close-to-home facilities by developing the guidelines for facility registration in compliance with sections 6, 7 and 8 of the National Health Security Act.

The policy guidelines have been revised to achieve practical use of care. The care system areas are then categorized into 5 groups, which have different guidelines for registration. The areas are as follows:

(1) A district not adjacent to another district in which a regional or general hospital is located;

(2) A district adjacent to another district in which a regional or general hospital is located;

(3) A district in which a regional/general hospital or a large non-MOPH hospital is located;

(4) A village located at the border of two adjacent provinces;

(5) Bangkok Metropolis.

The categorized areas stated above are considered for developing the facility registration guidelines to provide convenience of care access and effective comprehensive care for beneficiaries.

In Bangkok, under the "community-friendly clinics" project, more choices are given to the insured as a number of private clinics participate in the project to provide the contracted care.

3. People's Rights Protection

In addition to the Call Center through which people can file complaints, the NHSO under the Health Service Standard and Quality Control Board has established the Provincial Subcommittee (in every province) to take responsibility for people's rights protection. Meanwhile, the NHSO has set up programs for training staff of the provincial branches to promote the protection of people's rights.

Under section 41 of the National Health Security Act, the NHSO has the power to set aside a budget of no more than 1% of the security fund for preliminarily compensating the patients suffering from medical injuries due to either medical negligence or non-medical negligence.

The National Health Security Board has issued the criteria and procedures for making the compensations, which was published in the Government Gazette on 9 June 2003.

The provincial subcommittees have been set up in all provinces to take charge of their duties. After this system has been evaluated, some modifications would be made as appropriate.

4. Benefit Package Development

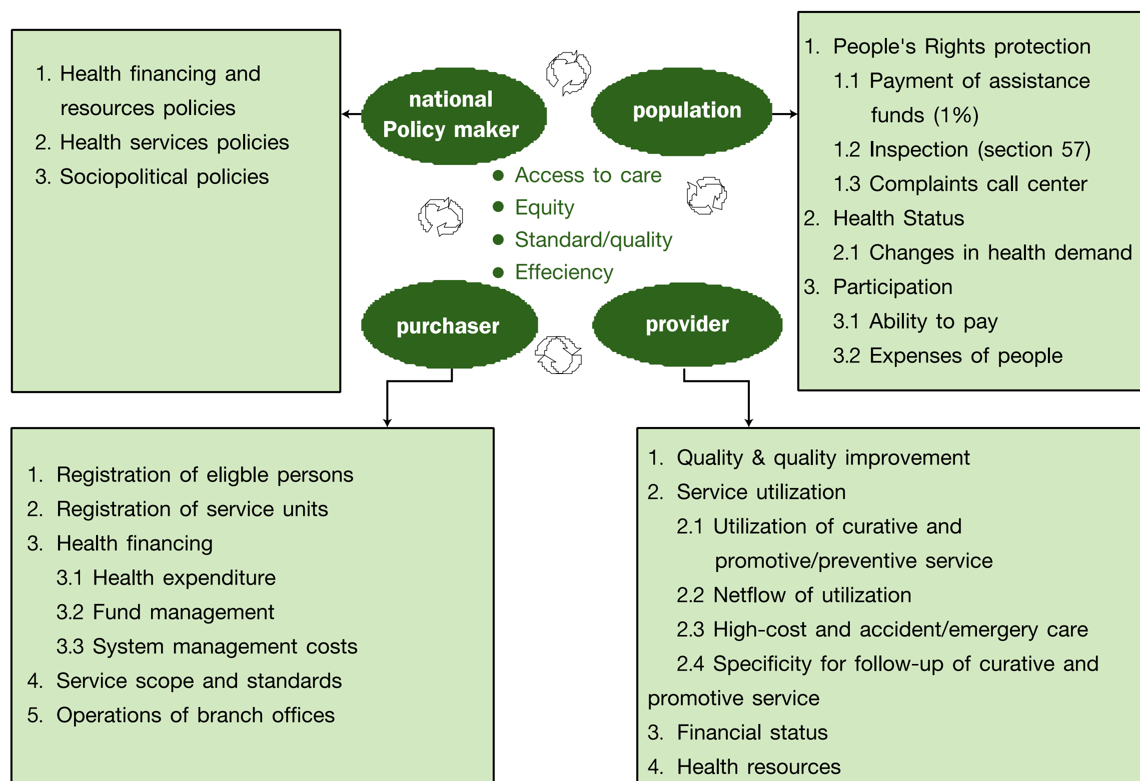
The NHSO reviews the benefit package annually in consultation with representatives from various professional associations in addition to consideration of requests from many civic groups. The review is undertaken with regard to the package's suitability and effective coverage.

5. Information System Development

The NHSO has systematically collected data from health facilities as well as data from various surveys, e.g. the social welfare and health surveys conducted by the National Statistical Office every two years. The forecasts of health status, utilization rates and expenditures are carried out to formulate the policy.

The framework of information system development is illustrated in Figure 9.

Figure 9: Framework for information system development under the Universal Coverage of Health Care Scheme



6. Public Participation

The NHSO has supported public participation processes by organizing meetings with representatives from various civic groups, non-governmental organizations, the NHSB and the SQCB to attain more mutual understandings in relation to the public benefits under the Universal Coverage of Health Care Scheme as well as the development of policy formulation networks, which will work in a more coordinating and harmonious way.