Annual Report 2004

Progress and Achievement

NHSO
NATIONAL HEALTH SECURITY OFFICE

Progress and Achievement

ANNUAL REPORT 2004
UNIVERSAL COVERAGE OF HEALTH CARE SCHEME
IMPLEMENTATION IN FISCAL YEAR 2004
(1 October 2003 - 30 September 2004)

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PREFACE

According to the National Health Security Act B.E. 2545, the National Health Security Office was set up in 2002 aiming to provide universal heath care coverage for all Thai citizens. After a few years of implementation, the Universal Coverage of Health Care Scheme (UC) has been quite successful in achieving its target. The population covered by the UC Scheme increased from 45.3 million people in 2002 to 47.1 million people in 2004. The scheme also got high satisfaction amongst UC beneficiaries. However, there were some problems in the implementation which needed improvement, particularly the financial problem of the scheme. The scheme was struggled with under finance during the first three years; however, the problem has been solved by the government by increasing the per capita budget of the scheme from 2005 onward. All the successes in policy implementation were attributed to good cooperation between all related sectors including civil networks which was a good start of development and sustainability of the UC scheme.

This report is a compilation of policy development and implementation in FY 2004 in addition to its achievements, problems and constraints in its implementation. It is expected that this report will be a good mirror for all related sectors to look back our experiences and synthesise them for further development of the UC Scheme in order to provide effective financial protection and enabling access to good quality of care for the Thai population.

(Dr. Saguan Nittayarampong)

Secretary-General of the National Health Security Office

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ABBREVIATIONS

AE	accident and emergency care
CSMBS	Civil Servant Medical Benefit Scheme
CUP	Contracted Units for Primary Care
DRG	Diagnosis Related Group
EMS	Emergency Medical Services
FY	fiscal year
HC	high cost care
IP	inpatient care
MoPH	Ministry of Public Health
NHSO	National Health Security Office
OP	outpatient care
P&P	prevention and promotion services
PCU	Primary care unit
PHO	Provincial Health Office
SSS	Social Security Scheme
TAI	Traffic Accident Insurance
UC	Universal Coverage of Health Care Scheme

EXECUTIVE SUMMARY

The National Health Security Office was quite successful in implementing the Universal Coverage of Health Care Scheme (UC), particularly in expanding insurance coverage; nearly all Thais were already covered by insurance schemes, and three third of them were covered by the UC. There was increase in access to care and service utilization. The scheme also got high satisfaction level with services provided under the scheme amongst UC beneficiaries. However, major concerns amongst health workers were shortage of health personnel, inadequate funding of the scheme, and increase in workloads.

In FY2004, major policy development and implementation included improving system design and institutional arrangements, increasing physical access by expanding primary care units (PCUs), particularly in urban areas, promoting quality improvement programmes, controlling of quality and service standard, promoting civil involvement, and co-ordination between health insurance schemes.

- The FY2004 per capita budget was increased by 106 Baht from that of FY2003 and adjustment of the per capita budget for outpatient and inpatient care, accident and emergency and high cost care was done according to previous year experiences. Age structure of beneficiaries was taken into account for adjustment of the capitation in allocating the per capita budgets for outpatient and inpatient services. Target payment for specific services was implemented in order to increase access and utilization for patients with cataract patients, with heart disease, and preventing of cervical carcinoma. A regional branch was piloted in Khonkhaen province to coordinate with the Provincial Health Offices (PHOs) in the northeast region.

- In order to increase access to care for beneficiaries in Bangkok and cities and strengthen primary care, 132 clinics, both public and private, were contracted as main contractors to provide outpatient care for registered beneficiaries.

- Quality improvement programmes were promoted for all levels of health care settings: PCUs, hospitals, and excellent centres, in addition to developing health service practice guideline.

- To control quality of services, clinical audit was piloted for treatment of cancer in 8 cancer centres. It was found that patient's records were poorly recorded and variations in practice existed either over or under treatment. It was recommended that a clinical practice guideline for treatment of cancer should be developed in addition to training programme.

- There were 1,490 complaint cases against health facilities, 299 cases about standard of care (Article 57) and 1,191 cases about inconvenience in take-up of UC benefits (Article 59). The majority of complaints were able to proceed for resolution, but 38 cases, mostly about under standard of care provided by health facilities, were sent to the Health Service Standard and Quality Control Board and 9 cases were guilty.

- Civil involvement in implementing the UC Scheme has been promoted by the NHSO in order to provide better knowledge and understanding of their rights and the benefits provided by the UC Scheme. Patient groups were supported by the office to provide information, prevention, and psychological support for patients.

✶ A coordination committee on health insurance development was set up to coordinate development of system design and institutional arrangements between insurance schemes, i.e. benefit package, payment methods, duplication of eligibility, portability of benefit; monitor quality of care and standard of health facilities; develop and share information technology infrastructure, management information system, claim processing, and medical auditing system.

For fund management, the expense for high cost care and no fault liability were only 51.6 and 1.97% of the budgets and the FY2004 budget for Emergency Medical Services (EMS) remain unused. There was delayed in the reimbursement process for high cost care while only cases with adversely affected from medical errors were received financial support, not all those with adverse effects. The unused FY2004 EMS budget was due to remaining unused FY2003 budgets in this category.

Inadequate funding and shortage of staff in health public facilities, particularly in rural areas, were the two major problems in addition to lack of management capacities. The UC Scheme received inadequate funding from the government during the first three years; however, the situation will be improved since the government will increase the per capita budget to 1,396 and 1,510 in FY2005 and FY2006 respectively. Moreover, from FY2005 onward, 21% of salaries of health workers in MoPH facilities will be excluded from the per capita budget; this means there will be more available non-labour operating budget of the scheme for MoPH facilities. Shortage of doctors and appropriate skill staff to provide care in primary care setting was another problem; the situation was worsening when there were more doctors resigned from public to private sector.

Lack of management capacities in performing purchasing functions also limited the success of UC implementation, i.e. lack of effective information system, lack of certain specialists in performing purchasing role, weak monitoring and regulation system. This was partly due to conflict of interests of the Provincial Health Offices (PHOs) who act as provincial branches of the NHSO.

For future development; financial sustainability of the UC Scheme is crucial for its success; therefore, alternative long term financing of the scheme should be considered. Separation of providing and purchasing role and improving management capacities of managers at all levels in purchasing care, financial management, hospital and primary care network management, will enhance insurance functions of the UC Scheme, financial protection and enabling access to care. Harmonization of health insurance schemes will increase equity and efficiency of the Thai health care system.

POLICY DEVELOPMENT AND IMPLEMENTATION

MANAGEMENT OF THE UC FUND

ACHEIVEMENTS OF THE UC SCHEME

PROBLEMS, CONSTRAINTS, AND FUTURE DEVELOPMENT

1. POLICY DEVELOPMENT AND IMPLEMENTATION

In FY2004, there were efforts and movements to improve system design and institutional arrangements of the Universal Coverage of Health Care (UC) Scheme in order to enhance the functions of health insurance, financial protection and enabling access to care for its beneficiaries. Quality of care was another important aspect being emphasized: quality improvement program and controlling on quality and standard of care. In order to get support from the people, the UC Scheme also encouraged civil involvement in its implementation. Co-ordination between health insurance schemes was another strategy employed by the NHSO to harmonize system design and institutional arranqements of these schemes.

1.1 Improving system design and institutional arrangements

There were some efforts to improve system design and institutional arrangements of the scheme as follow:

1.1.1 Benefit package:

In general, there was no change in the benefit package of the Universal Coverage of Health Care Scheme (UC) in FY2004; however, a sub-committee was set up by the National Health Security Board to consider this matter. Some services have been under considering and studying on financial feasibility to be included in the benefit package, i.e. anti retrovirus therapy (ART), peritoneal and haemodialysis for chronic renal failure patients, treatment with growth hormone, and hyperbaric oxygen therapy.

1.1.2 Increase funding and adjustment of the per capita budget

The FY2004 per capita budget of the UC Scheme was increased from that of the FY2003, 1,202, to 1,308 Baht; moreover, the per capita budget for each category was also adjusted as shown in Table 1. Two new categories were added, remote area and no fault liability; the per capita budgets for remote areas and no fault liability were deducted from the per capita budgets for outpatient and inpatient care respectively. The former was set aiming to add on the capitation of those in remote areas.

Table 1 The per capita budget for the UC Scheme in FY2003 and FY2004 (Baht)

Category	FY2003 (%)	FY2004 (%)
Outpatient care (OP)	574 (47.7)	488.18 (37)
Inpatient care (IP)	303 (25.2)	418.36 (32)
Prevention and promotion services (P&P)	175 (14.6)	206 (15.7)
Remote areas		10 (0.8)
High cost care (HC)	32 (2.7)	66.3 (5.1)
Accident and emergency care (AE)	25 (2.1)	19.7 (1.5)
Capital replacement	83.4 (6.9)	85 (6.5)
Emergency medical services (EMS)	10 (0.8)	10 (0.8)
No fault liability		5 (0.4)
Total	**1,202.4 (100)**	**1,308.54 (100)**

→ *Source : The Bureau of Policy and Planning, National Health Security Office*

The budgets allocated to outpatient and inpatient care were adjusted according to service utilization rates and costs of services provided in the previous year. The per capita budget for inpatient care increased from 303 Baht to 418 Baht while that for outpatient care was decreased from 574 Baht to 488 Baht. The per capita budget for high cost care increased from 32 Baht to 66.3 Baht per capita due to the change of payment condition for high cost care. The per capita budget for accident and emergency care was slightly decreased; this was done based on past reimbursement experiences.

1.1.3 Adjustment of capitation

Age structure and remote areas were taken into account in calculating the capitation for outpatient (OP) and inpatient care (IP) in FY2004 while a flat rate capitation was employed for prevention and promotion services. The capitation for OP and IP of those in remote areas was calculated based on 1.2 times of previous expenditure. However, according to the National Health Insurance Act, the National Health Security Office (NHSO) has to allocate the budget for MoPH health facilities through the MoPH for further allocation during the transition phase (FY2003-FY2005)[1].

1.1.4 Payment method

1.1.4.1 Payment for accident and emergency care

A minor change was made for payment for accident and emergency care and high cost care in FY2004. The NHSO was responsible for the full payments of accident and emergency care instead of paying only the first 72 hours incurred costs. The NHSO was also responsible for the full payment of high cost care but paying on Diagnosis Related Group (DRG) basis for inpatient care. However, the payment was made under the global budget; details are presented in chapter 2. Moreover, budget for accident and emergency care was also used to pay services used by those who entitled to the scheme but had not been registered, i.e. new borne.

1.1.4.2 Payment for specific services

In FY2004, the NHSO employed financial incentives strategy to increase access and encourage use of some specific conditions i.e. cataract, heart disease, and cervical carcinoma. The NHSO supported the campaign of "Kaewta Duangjai" (vision and heart). The office reimbursed 1,000 Baht for each Intra-ocular lens replacement (IOL) operation of cataract patients in the campaign. Private non-contracted hospitals were also invited to provide open heart surgery for UC beneficiaries and the office reimbursed up to 100,000 Baht per operation. The NHSO also allocated 115 million Baht to the Department of Medical Services, MoPH, to implement the controlling and prevention of cervical carcinoma. Results showed that there were 13,553 UC beneficiaries received IOL operation, 4,656 for heart surgery, and 1.3 million female UC beneficiaries for Pap smear.

[1] A different formula was employed by the MoPH in allocating the budget. The MoPH separated salaries from the per capita budget and allocated the non-labour per capita budget of 490, 410, and 300 Baht for district, general, and regional hospitals respectively. The budget for remote areas was allocated separately to hospitals in remote areas.

Table 2 Number of beneficiaries receiving intra-ocular lens replacement, open-heart surgery, and pap smear in FY2004.

Type of services	Number of cases
Cataract	13,553
Heart surgery	4,656
Pap smear	1,332,143

→ *Source : NHSO, 30 September 2004*

1.1.5 Establishment of regional branch

Currently, the Provincial Health Offices (PHO) are employed by the NHSO as provincial branches; however, they also govern MoPH hospitals. This conflicting structure limits their effective purchasing role. In order to strengthen the provincial branch offices, the NHSO proposed to establish its own regional branch office to coordinate and support the development and operation of provincial branch offices. In addition, this regional branch office will perform functions which could not be done effectively by provincial branch office i.e. claim process of referral cases and quality accreditation. The first regional branch office was set up in Khonkhaen province as a pilot study in FY2004 to responsible for 19 provincial branch offices in the northeastern region.

1.1.6 Contracting with clinic as main contractor in urban setting

The UC Scheme aims to strengthen primary care; however, due to lack of effective primary care, hospitals have been chosen as contracted units for primary care. In order to promote primary care and ease access to care for UC beneficiaries, particularly in Bangkok, the NHSO invited some private clinics to join the scheme as contracted unit for primary care in FY2004 and also encouraged public hospitals to set up primary care units. There were 89 accredited private clinics joining the scheme in FY2004, and 43 public primary care units. The contracted primary care units received the capitation for outpatient care and prevention and promotion services from the NHSO and provided facility-based and outreach services.

Table 3 Number of contracted networks under the UC Scheme FY2003 and FY2004

Types of contracted networks	FY2003	FY2004
MoPH hospitals	822	818
Non-MoPH hospitals	71	72
Private hospitals	88	73
Private primary care clinic	-	89
MoPH primary care unit	-	3
Non-MoPH primary care unit	-	40
Total	**981**	**1,095**

→ *Source : Bureau of Insurance Information Technology, NHSO, 15 October 2004*

1.2 Promoting quality improvement program

Promoting quality improvement program became an important tool of developing better quality care in FY2004.

1.2.1 Upgrading health centre to meet standard of primary care unit (PCU)

The NHSO had a memorandum of understanding with the Department of Health Service Support, MoPH in upgrading health centres[2] to meet the standard of PCU Development activities included ;

- Developing assessment guideline for PCU accreditation ; this included (1) standard of service provision (community services, integrated care management, continuity of care, and services provided by physician), (2) administrative activities, and (3) technical activities.
- Development and accreditation of PCU plans were developed in all provinces and 300 health workers were trained as trainers in development of PCU.
- Promoting quality improvement in PCU by developing guidelines and assessment tools for accreditation of PCU and accreditation team and network. There were 1,590 PCUs joining this program in FY2004.
- There were 80 PCUs met the standard set by the NHSO and MoPH in 2004.

[2] There are 9,791 health centres located in all Tambons or sub-district areas and responsible for approximately 5,000 people. Services in health centres are provided by paramedical personnel.

1.2.2 Promoting hospital accreditation

The NHSO provided funding to the Institute of Hospital Quality Improvement and Accreditation to assist hospitals in improving service provision and to get accreditation. In FY2004, there were 531 hospitals (54.57%) having risk management system (level 1), 10 hospitals (1.03%) having quality assurance and continuous process of developing their quality, and 100 hospitals (10.28%) passed all criteria. Comparing with information in 2003, only 3.8% or 38 hospitals passed all criteria of hospital accreditation.

Table 4 Number of accredited hospitals in FY2004

Situation	MoPH Hospitals	Public non-MoPH hospitals	Private hospitals	Total (%)
Level 3 (meet all HA criteria)	85	14	1	100 (10.3)
Level 2 (having quality assurance and continuing improvement)	6	0	4	10 (1)
Level 1 (having risk management system)	503	3	25	531 (55)
Under development to level 1	231	67	34	332 (34)
Total	**825**	**84**	**64**	**973 (100)**

→ *Source : The Institute of Hospital Quality Improvement and Accreditation, 30 September 2004*

1.2.3. Promoting quality and standard of excellent centres

The NHSO provided funding to the Department of Health Service Support, MoPH to develop tertiary hospitals to be excellent centres for heart surgery (20 centres), cancer (29 centres) and trauma (28 centres). The activities included;

- Developing master plan of development of excellent centres in terms of structure and human resource
- Developing criteria for registration and accreditation of tertiary hospitals enrolling to be excellent centres
- Developing guideline of development and preparation of heart, cancer and trauma centres.
- Pre-registered assessment
- Evaluation of service provided by these centres in terms of effectiveness and referral
- Developing training course for improving skill and capacity in service provision

1.2.4 Developing Health Service Practice Guideline (HSPG)

The NHSO funded the Health System Research Institute to develop health service practice guideline. By doing so, the national committee was established in composition of experts. The committee aimed to develop practice guideline and database for at least 100 prioritized diseases. However, at the beginning, the practice guideline put forward for practice under the UC Scheme for 20 diseases or conditions.

1.3 Controlling of quality and service standard

1.3.1 Clinical audit

In FY2004, the NHSO selected treatment of cancer for clinical audit. An auditing team comprised of 11 cancer experts assessed clinical practice in 8 cancer centres: the National Cancer Centre, Udonthani hospital, Udonthani Cancer Centre, Khonkhaen hospital, Srinakarin hospital, Chonburi hospital, Chonburi Cancer Centre, and Rachaburi hospital. One hundred and eighty four cancer patient records receiving care within 6 months were sampled. The records of beneficiaries covered by the UC, Civil Servant Medical Benefit Scheme (CSMBS), and Social Security Scheme (SSS) were selected as the proportion of 6:3:1. They found a large number of records poorly recorded, mostly lack of progress notes. Unnecessary investigations e.g. blood test for tumor marker, were found in some cases. In comparison with patients under the CSMBS, the UC patients were more likely to receive chemotherapy in line with standard while the CSMBS patients were more likely to receive treatment over the standard and expensive drugs. For radiation, the waiting list was more than 1-2 months. For hormone therapy, there were both over and under treatment and none of them were checked for hormone receptor before providing hormone. In order to improve quality of cancer care, the auditing team proposed that a clinical practice guideline for cancer treatment should be developed in addition to training program, cancer registration form, and monitoring and evaluation.

1.3.2 Providing information and complaint management

In FY2004, there were 512,969 calls through the hotline number of 1330 asking about obtaining UC card (87.30%), access condition (3.7%), benefit covered (3.6%), calls from providers (3.4%), and others (2%).

There were 14,105 complaint cases of which 13,434 cases (95%) were able to proceed for resolutions. The ratio of complaint cases to number of service uses was 11.23 per 100,000 service uses. There were 1,490 complaint cases against health facilities, 299 cases about standard of care (Article 57) and 1,191 cases about inconvenience in take-up of UC benefits (Article 59). The ratio of complaint on quality of care was 1.25 cases per 100,000 users.

Table 5 Number of Complaints in FY2004

Categories	Numbers	Percent
1. Against health facilities	1,490	10.5
1.1 Standard of care (Article 57)	299	(20)
1.2 Inconvenience in take-up of benefit (Article 59)	1,191	(80)
2. Others	11,944	84.7
2.1 Registration and card issuing	6,950	(58)
2.2 Entitlement	4,167	(35)
2.3 Finding bed for admission	472	(4)
2.4 Others	355	(3)
3. Unnamed card	671	4.7
Total complaints	**14,105**	**100**
Complaints getting resolution	**13,048**	**92.5**

→ *Source : Bureau of Consumer Services, NHSO, 30 October 2004*

The complaint cases in regard to Article 57 and 59 of the National Health Security Act, which were not finalised, 38 cases (2.55%), were to review and present to the Health Service Standard and Quality Control Board. There were mostly about under standard of care provided by health facilities, 26 cases. At the end of FY2004, 21 cases were completely investigated by the Health Service Standard and Quality Control Board, and 9 cases were guilty.

1.4 Promoting civil involvement

Involvement of people and protection of their entitlement were aimed at promoting people's accessibility to good standard care, enhancing self care, providing more alternative services, more responding to community needs and more utilizing local organizations to cooperate in more integrated approach. The implementation programs were as follows:

1.4.1 Establishment of a sub-committee of supporting civil involvement

The sub-committee of supporting civil involvement was set up in FY2003 in accordance with the National Health Security Act. The sub-committee developed vision, goals and strategies for civil involvement on a basis of civil ownership. Each strategy was considered to develop activities to reach the target within 3 - 5 years. They also reviewed 107 projects supporting civil involvement proposed by civil networks. The committee also suggested the NHSO in promoting and supporting civil involvement.

1.4.2 Supporting activities of civil groups

There have been more than 150 existing civil groups incorporating with the NHSO in supporting the UC Scheme such as the HIV/AIDS network, network of people with disabilities, agricultural network, community economy network, network of taxi drivers, and community saving fund network. The NHSO provided training to 1,100 speakers picked from civil organizations and expected to further provide information for specific target groups which might not have been reached by routine information distribution. Some civil networks set up civil co-ordinating centres to provide information to its members, collecting complaints relating to the UC Scheme, and facilitating civil movement to support the UC Scheme. The NHSO already set up 29 co-ordinating centres regarded as a pilot project in regional areas.

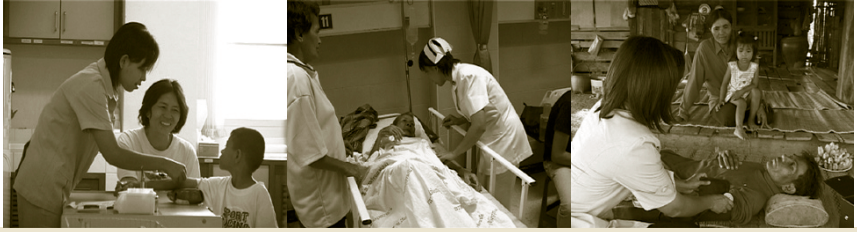
The NHSO also supported creating of patient groups i.e. the network of patients with heart disease and the network of patients with cancer. The networks provided information i.e. self care, prevention, and psychological support for those affected with heart disease/ cancer. The NHSO also coordinated with community radio network for passing health information to communities. There were 700 core coordinators in 7 regional areas and 190 radio operational centres nationwide participating in this program.

1.5 Coordination between health insurance schemes

There are three major health insurance schemes for the Thais which are responsible by different organizations. The General Comptroller Department is responsible for the Civil Servant Medical Benefit Scheme (CSMBS)[3], the Social Security Office is responsible for the Social Security Scheme (SSS)[4], and the NHSO is responsible for the UC Scheme. Seventy five percent of the Thais were covered by the UC scheme in 2004; the numbers of beneficiaries covered by the CSMBS, SSS, and UC were 5, 8, and 47 million people respectively. In order to achieve policy objectives, equity and efficiency, a coordination committee on health insurance development was set up on 19 January 2004, the tasks of the committee include (1) coordinate development and monitor the following issues : benefit package, duplication of eligibility, payment method, standard of care and health facilities, and portability of eligibility, (2) develop information technology infrastructure and management information system together, (3) develop and share claim processing and medical auditing system, (4) share information between schemes on claims, financial reports, claim audit, and medical audit together with setting up privacy protection, and (5) set up a working group to propose policy options and monitor progress.

According to the coordination committee, three working groups were set up in FY2004 : the working group on development of information infrastructure and management information system, the working group on quality and standard of care monitoring, and the working group on development of claim processing. It is expected that through this mechanism could be a channel for harmonization of health insurance schemes.

[3] This is a fringe benefit for civil servants and their dependents (parents and up to two children aged below 18).
[4] This is a compulsory health insurance scheme for workers in formal sector; the contributions come equally from the government, employees, and employers.



2. MANAGEMENT OF THE UC FUND

2.1 Management of the per capita budget

In 2004, the total UC budgets managed by the NHSO were 32,572.86 million Baht[5] and 93% of the budgets were spent at the end of fiscal year (Table 6).

The capitation for outpatient, inpatient, and health prevention and promotion services was directly allocated to contracted hospitals. For MoPH hospitals, procurement and distribution of vaccines was performed by the MoPH so they received the capitation minus by average vaccine cost per capita. Ten Baht per capita of all beneficiaries was allocated to the MoPH to subsidize hospitals in remote areas[6]. In order to get better risk sharing between hospitals and provinces and enabling access to accident, emergency and high cost care, the NHSO managed these budgets at the central office and directly reimbursed hospitals providing these services to its beneficiaries. The capital replacement budget was allocated to contracted hospital by per capita basis, except for public hospitals, details are provided later. The no fault liability budget was managed by the NHSO to pay beneficiaries who were adversely affected from medical care without proof of guilty. It should be noted that none of the budget for medical emergency service system was spent in FY2004 ; this was because there were remaining unused budgets in FY2003[7].

5 This figure did not include salaries of health workers in public facilities.

6 MoPH facilities are the sole providers in rural areas. The higher per diem for health workers in remote areas was the only criteria adopted by the MoPH in allocating this budget in 2004.

7 The Narenthron EMS centre, MoPH is the sole organization who used this budget in FY2002-FY2004.

Table 6 Budgets and expenditures of the UC fund in FY2004 (million Baht in current year price)

Category	Approved budgets	Actual expenses	Percent
Capitation budgets	23,101.37	23,152.191[1]	100.22
Vaccine and Personal Health Profile	455.49	406.65	89.28
Remote areas	460.00	460.00	100.00
Accident and emergency care	906.20	804.44	88.77
High cost care	3,049.80	1,573.98	51.61
Emergency medical service system	460.00	-	-
Capital replacement	3,910.00	3,909.61	99.99
No fault liability	230.00	4.53	1.97
Total	**32,572.86**	**30,311.71**	**93.06**

→ *Source : National Health Security Office, 27 October 2004*

Note : [1]the actual expenses exceeded the approved budgets because the number of registered beneficiaries was greater than what had been planed and approved by the Bureau of Budget so the NHSO forwarded the per capita budget from the high cost budget while waiting for additional budget from the government.

2.1.1 Management of capitation budget

The NHSO paid contracted providers by age differential capitation for curative care (outpatient and inpatient care) and flat rate capitation for prevention and promotion services (P&P services). An inclusive capitation for all personal care was paid to private contracted hospitals while only 60% of the capitation was paid to non-MoPH contracted hospitals[8]. For MOPH facilities, the MoPH acted as agent of MoPH facilities and received the non-labour recurrent budgets (total per capita budgets minus salaries of health workers in MoPH facilities) from the NHSO for further allocation to its facilities. Because change of the registered provider could be done all the year so the NHSO paid contracted providers in advance for two months by employing the previous month accredited registration database and recalibrated the payments by actual registration in each month in the next payment round (every two months).

[8] It was assumed that 40% of the per capita budget was labour cost which already paid by the government.

2.1.2 Management of accident, emergency and high cost care fund

The fund for accident and emergency (AE) and high cost (HC) care was divided into sub categories for financial management purpose according to the global budget received by the fund: A&E outpatient and inpatient, high cost outpatient, inpatient, and medical prostheses and instruments. The available budget in 2004 for each sub-category is shown in Table 6. Reimbursement of outpatient care was done monthly and quarterly for other sub-categories under global budget.[9, 10] Five percent of the budgets of each sub-category was reserved to pay contracted providers at the end of the year for delayed submitting claims, and adjustment of forwarded reimbursements.

Table 7 Available budget for accident and emergency and high cost care

Sub-category	Baht	Baht/ capita
Accident & Emergency care - outpatient (OP AE)	18,400,000	0.4
- inpatient (IP AE)	887,800,000	19.3
High cost care - outpatient (OP HC)	193,200,000	4.2
- inpatient (IP HC)	2,534,600,000	55.1
- medical prostheses and instruments	322,000,000	7.0

→ *Source : Bureau of Claim Administration, NHSO*

9 To facilitate financial flow of hospitals, the NHSO forwarded reimbursements of inpatient care monthly to hospitals by employing the flat rate of 4,000 Baht per weight of DRG and adjusted the payments at the end of each quarter.

10 Hospitals were requested to submit claim information within 30 days after services provided (OP) or discharged (IP); in September 2004, 85% and 78% of OP and IP claims were submitted on the schedule.

2.1.2.1 Reimbursement of accident and emergency care

Services provided to UC beneficiaries who registered outside the province where the hospital is located for treatment of accident and emergency care are met the criteria for reimbursement of this category. There is no limitation of visits for reimbursement of accident injuries, but only up to 2 visits/ year is allowed for emergency care. In 2004, services provided to those who were eligible to the UC Scheme but haven't been registered yet i.e. new borne were also allowed to reimburse from this category.

Reimbursement for outpatient care was done under global budget (point system) ; however, no standard point or fee schedule was set for each service. The actual charges claimed by tertiary hospitals and up to 700 Baht for other hospitals were employed as points in calculating reimbursements in each month; therefore the level of payment in each month varied by the total charges. In general, 95% of outpatient claims met the criteria and were reimbursed in 2004 (Table 8). The total reimbursements were only half of charges claimed by hospitals and average reimbursement per claim was 334 Baht.

Table 8 Claims and reimbursements for accident and emergency care and high cost care in FY2004

Type of hospital	Claim		Reimbursement (% of claim)	
	N	Charges	N	Payments
Accident & Emergency care - Outpatient	52,071	33,541,002	49,687 (95)	16,605,912 (50)
- Inpatient	515,817	2,751,783,839	415,853 (81)	843,241,378 (31)
High cost care - Outpatient	69,439	252,841,727	58,420 (84)	178,799,138 (71)
- Inpatient	148,357	6,369,457,751	139,891 (94)	2,407,865,521 (38)
Medical prostheses and instruments	99,854	594,056,052	89,446 (90)	281,166,729 (47)

→ *Source : Bureau of Claim Administration, NHSO.*

Note : the figures in this Table are different from those in Table 6 ; the figures in this table are based on the accredited claims in fiscal year 2004 for reimbursement at 13 January 2005 while the figure in Table 6 is based on the financial status at 30 September 2004.

Reimbursement for inpatient care was done by employing Diagnosis Related Group (DRG) weighted global budget.[11] The relative weight of each patient was adjusted by the number of hospital days and level of hospital: 1.0 for general hospital, 1.4 for regional hospital, and 1.6 for university hospital.[12] In general, there were 515,817 inpatient cases claimed for this category and 81% of them were reimbursed; average reimbursement per case was 1,955 Baht or 3,134 Baht per weight of DRG.

[11] Based on Thai DRG version 3

[12] The relatively higher weight was given to bigger hospitals because of their relatively higher unit cost of services provided.

2.1.2.2 Reimbursement of high cost care

There are two types of reimbursement for high cost care, fee schedule for specific treatments[13] and inpatients with DRG weight 3 or over. Patients received a specific treatment as outpatient care will be reimbursed monthly by point system under the global budget for high cost outpatient care. For inpatient care, both specific treatments and those with DRG weight 3 or over were reimbursed according to the weights of DRG weighted by length of stay and hospital level as in accident and emergency under global budget for high cost inpatient care.

In general, 84 and 94% of high cost claims for OP and IP respectively were reimbursed. Average reimbursement for outpatient care was 3,061 Baht per case and 3,796 Baht per weight of DRG. The reimbursement-charge ratio of high cost outpatient was nearly double of inpatient care, 71% compared with 37% (Table 8).

2.1.2.3 Reimbursement of medical prostheses and instruments

The point system was adopted to reimburse medical prostheses and instruments, and the standard fee of each item was employed as point. In general, 90% of claims were reimbursed and the reimbursements were 47% of charges.

[13] These include peritoneal and hemo dialysis for acute renal failure (not exceeding 60 days), chemotherapy, radiotherapy, open heart surgery, craniotomy or brain surgery, coronary bypass, percutaneous balloon valvuloplasty, cryptococcal meningitis, brain surgery for epilepsy.

2.1.3 Management of no fault liability fund

The National Health Insurance Act aims to provide financial assistance to UC beneficiaries who were adversely affected from treatment received under the UC Scheme without proof of guilty. The victims can ask for financial support to the provincial committee within 90 days after getting damage. The victims or families would get up to 80,000 Baht in case of dead, 50,000 Baht for loss of organ or disabled and 20,000 Baht for initial support. If the victims or families are not satisfied with the support, they can appeal to the Health Service Standard and Quality Control Board.

There were 85 claims in 2004, 77 claims came from those received treatment from public hospitals, and 8 from those received treatment from private hospitals. Delivery was the major treatment of claims for no fault liability. Seventy three percent of claims (62 cases) were approved and received financial assistance of total 4.53 million Baht from the fund; 42 dead, 9 disabled, and 11 injured and requiring continual treatment. Seventeen cases appealed to the Health Service Standard and Quality Control Board and eleven cases received financial assistance or additional assistance.

2.1.4 Management of capital replacement fund

The objective of this fund is to refurnish or replace current capital investments. Allocation of the fund to private hospitals was done based on solely the number of registered beneficiaries. For public hospitals, there was an agreement in the sub committee of considering capital replacement plan and being approved by the National Health Security Board that 70% of the budgets would be directly allocated to contracted hospitals and 30% of the budgets were allocated to set up excellent centres for cancer, heart disease, and trauma centres.

Table 9 Management of capital replacement fund FY2004

Categories	Approved budgets	Expenses
1) capital replacement MoPH hospitals	2,885,296,372	2,885,296,372
2) capital replacement non-MoPH hospitals	122,005,872	121,902,760
3) capital replacement private hospitals	150,872,195	150,584,668
4) Excellent centre	751,825,561	751,825,561
4.1 cancer	285,693,713	295,273,961
4.2 heart disease	270,657,202	261,080,000
4.3 trauma	195,474,646	195,471,600
Total	**3,910,000,000**	**3,909,609,361**
Percent	**100.00**	**99.99**

→ *Source : Bureau of Developing and Supporting Branch Office, NHSO, 30 September 2004*

2.2 Management of administration budget

In fiscal year 2004, the National Health Security Office received 1,021.323 million Baht for administration. At the end of the fiscal year (30 September 2004), 820.75 million Baht, or 80% were spent out for regulating and supporting development of contracted hospitals, consumer protection and monitoring and evaluation purposes. The budget for regulating and supporting development of contracted hospitals was less spent as compared to others due to the lack of consensus on the role of the NHSO in supporting development of contracted hospitals especially the public ones.

Table 10 Approved budgets and actual expenses on administration in FY2004 (Million Baht)

Activities	approved budgets	actual expenses
1. Regulating and supporting development of contracted hospitals	81.240	15.538
2. Consumer protection	131.632	100.925
3. Monitoring and evaluation	808.451	704.282
Total	**1,021.323**	**820.745**

→ *Source : Bureau of Policy and Planning, NHSO, 30 September 2004*

3. ACHEIVEMENTS OF THE UC SCHEME

3.1 Health Insurance Coverage

At the end of FY2004, of 62.6 million Thai populations, 59.8 million Thais or 95.5% had insurance coverage. The increasing rate of insurance coverage during 2003-2004 was 2.85% and attributable to increase in the number of population and efficiency in the registration. There were 47.1 million, or 75% of the Thais covered by the UC Scheme whereas the uninsured number decreased from 4.4 million to 2.8 million as shown in Table 11. The majority of the uninsured, about one million people, were Bangkok residents. Duplication of health benefits was minimal and mainly between CSMBS and SSS.

Table 11 Health insurance coverage of each scheme in comparison between FY2003 and FY2004

Health Insurance Scheme	FY2003		FY2004	
	Number	%	Number	%
Total coverage	58,115,168	93.01	59,770,365	95.48
Universal Coverage of Health Care Scheme (UC)	45,972,011	73.58	47,099,766	75.24
Social Security Scheme (SSS)	7,981,994	12.77	8,237,686	13.16
Civil Servant Medical Benefit Scheme (CSMBS) or public enterprise's benefits	4,023,992	6.44	4,266,661	6.81
Having both SSS and CSMBS	104,055	0.17	102,253	0.16
Having both SSS and benefits for political officials	66	0.00	67	0.00
Government officials and family living overseas	32,454	0.05	63,269	0.10
Benefits for political officials	596	0.00	663	0.00
Uninsured (under verification of entitlement)	4,366,355	6.99	2,830,302	4.53
Total population	**62,481,523**	**100.00**	**62,600,667**	**100.00**

→ *Source : Bureau of Insurance Information Technology, NHSO, 14 October 2004*

MoPH facilities were major providers under the UC Scheme; they accounted for 75% of contracted facilities and 91% of UC beneficiaries were registered with MoPH facilities. According to expansion of primary care unit as main contractor, the number of non-MoPH and private contractors increased dramatically. However, the average number of beneficiaries registered with non-MoPH facilities and private facilities was much less than that of MoPH facilities, 52,070 for MoPH facilities, 18,571 for non-MoPH facilities, and 13,950 for private facilities.

Table 12 Number of beneficiaries under the UC Scheme by type of registered hospital, FY2003 and FY2004

Types of Facility	FY2003		FY2004	
	facilities	beneficiaries	facilities	beneficiaries
MoPH facilities (%)	822 (84)	42.20 (92)	821 (75)	42.75 (91)
Non-MoPH facilities (%)	71 (7)	1.95 (4)	112 (10)	2.08 (4)
Private facilities (%)	88 (9)	1.82 (4)	162 (15)	2.26 (5)
Total	**981 (100)**	**45.97 (100)**	**1,095 (100)**	**47.09 (100)**

→ *Source : Bureau of Insurance Information Technology, NHSO, 15 October 2004*

3.2 Service Utilization

In FY2004, UC beneficiaries used 119.64 million outpatient visits covered by the scheme with an average utilization rate of 2.54 visits per person per year. The utilization rate of outpatient services increased by 1.08 % compared with that of FY2003. For hospitalization, there were 4.33 million admissions covered by the scheme with an average admission rate of 0.092 admissions per person per year, increased by 5.46% compared to that of FY2003 (Table 13).

Table 13 Service utilization under the UC Scheme, FY2002 - FY2004

Types of Facility		FY2002	FY2003	FY2004
Utilization Rates	OP visits/ person/ year	2.27	2.52	2.54
	IP admissions/ person/ year	0.09	0.087	0.092
Total utilization (in million)	Number of users	41.40	32.54	39.66
	Number of visits	102.95	115.01	119.64
	Number of admissions	3.39	3.99	4.329
	Number of hospital days	14.93	14.53	16.83

→ *Source : Service utilization reports gathered by the NHSO.*

According to the 2004 Health and Welfare surveys conducted by the National Statistical Office, take-up of UC benefits when getting facility-based care was only 53% for outpatient care, and 81% for hospitalization.

3.3 Public satisfaction

The public satisfaction surveys done by ABAC Poll in FY2003 and FY2004 showed generally high satisfaction in relation to services used under the UC Scheme. The level of satisfaction in FY2004 was also higher than that of FY2003 in all aspects, particularly those reporting very satisfied (Table 14). Quality of drugs and time access (service hour and waiting time) were the two aspects getting relatively low satisfaction; 66% and 69% reported very satisfied with quality of drugs and time access respectively.

Table 14 Public satisfaction to health services under the UC policy implementation during FY2003 - FY2004

Categories	FY2003			FY2004		
	Very satisfied	Fairly satisfied	Satisfied*	Very satisfied	Fairly satisfied	Satisfied*
1. services provided by doctors	67.7	23.2	90.9	76.9	16.0	92.9
2. services provided by nurses	62.7	26.7	89.4	71.7	19.5	91.2
3. quality of drugs	55.0	28.3	83.3	65.7	20.9	86.6
4. quality of medical equipments	60.1	25.7	85.8	70.2	20.2	90.4
5. time access	59.5	26.6	86.1	69.4	18.9	88.3
6. physical access	71.3	20.7	92.0	81.7	13.0	94.7
7. results of treatment	62.3	27.9	90.2	72.5	19.3	91.8

→ *Source : Survey by ABAC Poll*

In FY2003, the survey was conducted during 21 May - 30 June 2003

In FY2004, the survey was conducted during 29 April 29 - 30 June 2004

** included those stated very satisfied or fairly satisfied*

3.4 Health personnel's concerns

Major issues of concern relating to the UC Scheme amongst providers were shortage of staff, inadequate funding, and increase in workload. Seventy three percent of health workers stated that they were much or very much concerned about shortage of staff, followed by inadequate funding of the scheme (72%), and increase in workload (69%). Increase in the level of concerns about inadequate funding and increase in workload was also observed during FY2003-FY2004. Over expectation and demanding for care of patients was ranked third in FY2003 amongst providers' concerns, but it was ranked fifth in 2004.

Table 15 Health personnel's concerns relating to the UC Scheme, FY2003 and FY2004

Satisfaction when considering in view of :	FY2003	FY2004
1. shortage of staff	NA	73.3
2. inadequate funding of the scheme	65.5	71.7
3. increase in workload	64.5	69.2
4. remuneration	58.1	62.9
5. patients' expectation and demanding	63.3	62.7
6. complaints	57.1	55.6

→ *Source : ABAC Polls*

Note : the figures represent those stated they were concerned "very much" or "much".

4. PROBLEMS, CONSTRAINTS, AND FUTURE DEVELOPMENT

4.1 Problems and constraints in policy implementation

Although the UC Scheme was quite successful in expanding the coverage of beneficiary registration and enabling access to care for UC beneficiaries, there were number of constraints and problems which limited its success. Some problems were directly related to system design and implementation of the scheme itself while some problems were related to government policy, i.e. entitlement of non-Thai permanent residents, or problem of the health care system, i.e. shortage of health personnel and inequitable distribution of health infrastructure.

4.1.1 Inadequate funding

The UC Scheme had been struggled with inadequate funding since its implementation. The UC per capita budget for FY2002 was underestimated since it was calculated by employing service utilization rate in 1996 without adjustment for changes in age structure and utilization pattern. The under finance of the scheme in later years was mainly due to lack of effective information on service utilization and costs to negotiate with the Bureau of Budget. The scheme received 1,202 Baht per capita in FY2002-FY2003 and 1,308.5 Baht in 2004. Comparing the per capita budget of each year with the actual utilization from the reports and the estimated unit cost of services provided in each level found that the scheme was under financed by 115, 192 and 292 Baht per capita in FY 2002, 2003, and 2004 respectively. Total deficits of the scheme during the first three years of its implementation were 26,957 million Baht. The majority of hospitals remained financially sustainable at the beginning because many of them had reserved revenues gathered from user fee and revenues from other schemes to cross-subsidize the UC Scheme; however, the problem was more evident in the later years. Under finance of the scheme might have some negative implications on access and quality of care provided to its beneficiaries.

Table 16 The UC budgets and estimated expense during FY2002-FY2004

	FY2002	FY2003	FY2004
1. Proposed per capita budget	1,202	1,414	1,447
2. Approved per capita budget	1,202	1,202	1,308
3. Estimated expense per capita under the scheme	1,318	1,394	1,600
4. Difference (2-3)	-115	-192	-292
5. Financial deficits (million Baht)	-5,196	-8,622	-13,139
6. Total deficits during FY2002-FY2004 (million Baht)		-26,957	

→ *Source : Viroj Thangcharoensathien presented in the 2004 Health System Research Institute Annual conference February 2004.*

Currently, the government recognized this problem and agreed to increase the per capita budget of the scheme to 1,396.3 Baht in FY2005 and 1,510.5 Baht in FY2006 plus adjustment for medical inflation and utilization rate in addition to excluding some salaries (21%) of MoPH facilities from the per capita budget[14]. Therefore, the current financial constraints in many MoPH hospitals will be improved soon.

4.1.2 Shortage and inequitable distribution of staff

Providing universal health care coverage increased demand for healthcare resulting in increase in workload for health workers. According to the FY2003 and FY2004 providers' satisfaction surveys conducted by ABAC Poll, providers reported their burden of works increased by 40% after the introduction of the UC Scheme. The situation was worsening by resignation of doctors from public sector; the numbers of doctors resigned from public sector in FY2002 and FY2003 were doubled of that before the UC implementation. Greater burden of work and the low payment in public sector were the two major reasons of those resigned from public to private sector. However, it was not clear to what extent this was attributable to the UC Scheme as there was increase in demand for doctors in private sector according to the growth of the Thai economy.

There were two main underlying problems relating to the health care system affecting the UC Scheme, inadequate supply of health staff (doctor, dentist, pharmacist, and nurse) and the distribution problem. Thailand has relatively low number of staff in relation to its population compared with developed countries. Moreover, the situation was worsening by inequitable distribution of health workers ; they are more concentrated in urban areas and big cities and shortage in rural areas. Due to inequitable distribution of health staff, there was mismatched of resources when the scheme allocated the budget by per capita basis.

It is expected that the situation will be improved in the future; however, it takes time to solve these problems. The MoPH had recognized the problem of shortage of health personnel and had a long term plan to increase the number of doctors and other health professions. The number of doctors has been planed to be double of the current figure within ten years. In addition, the geographical information system (GIS) has been employed by the MoPH to allocate the new graduated health personnel.

[14] The percentage of salaries being included in the per capita budget represented the burden of workload according to the UC Scheme of MoPH facilities. As a result, MoPH facilities will receive more available non-labour operating budget for the UC scheme.

4.1.3 Organizational structure and management capabilities

Currently, the Provincial Health Offices (PHO) act as provincial offices of both the MoPH and NHSO; therefore, there are conflict of interests between purchasing and providing roles and limits their ability to perform the roles. Concerning the problem of inadequate budget of the scheme appeared to let many provinces limited the number of private hospitals and only a limited number of beneficiaries were allocated to private contracted hospitals and limited competition between providers. The conflict of interest also limited monitoring and regulating roles of the PHO.

Lack of management capabilities to perform the new roles of the NHSO and provincial offices was evident, i.e. unclear function of the PHOs and regional branches, weak financial management and information system, weak monitoring and regulating systems, and lack of certain specialised skills to perform the new role.

4.1.4 Eligibility problem of minority groups to get the UC card

According to the National Health Security Act B.E. 2545, permanent residents with Thai nationality and uncovered by other public insurance schemes, i.e. CSMBS or SSS, are eligible to get the UC card. There are some minorities without Thai nationality remain uncovered by any public insurance, i.e. hill tribes, Karen, Mon, refugees, people living in border areas etc. In fact, these people are generally poor and unable to afford health care costs and need exemption. Hospitals in provinces with minorities, i.e. Tak province, have a large number of hill tribes and, usually, have to exempt for those accessing care and unable to afford the fees without compensation while some of them might not access to care. In fact, access to basic essential health care should be the right of all people regardless of their ability to pay[15].

4.1.5 Difference in the benefit package and institutional arrangements of health insurance schemes

There are three major health insurance schemes in Thailand, UC, CSMBS, and SSS, with different benefit package, level of funding, and payment method, in addition to the Traffic Accident Insurance which aims to cover all traffic accident injured patients. Difference in the level of funding and payment method was likely to result in discrimination in service provision, favouring those with better paid, i.e. CSMBS. Together with the under finance of the UC Scheme, UC beneficiaries might be perceived as burden of hospitals as hospitals had to cross-subsidize UC patients with other income sources.

[15] In FY2005, the government agreed to provide basic essential services to all permanent residents i.e. education and health care.

4.2 Future development

4.2.1 Financial sustainability of the scheme

Financial sustainability is a major concern for the UC Scheme so alternatives for long term financing of the UC Scheme is under studying. Currently, the scheme is relied on the government annual budget and negotiation with the Bureau of Budget for the per capita budget has to be done every year. Feasibility study on alternative sources of funding, i.e. sin tax, value added tax, in addition to improving efficiency of the current insurance schemes are undertaken in order to improve financial sustainability of the UC Scheme and controlling health care costs.

4.2.2 Separation of providing and purchasing roles

In order to avoid conflict of interests of provincial branches, the NHSO plans to set up its owned regional branches instead of employing PHO to perform purchasing functions. Currently, the NHSO already have two regional branches in Bangkok and Khonkhaen. The Bangkok branch actually acts as a purchaser while the Khonkhaen branch acts as a coordinator between the NHSO and PHO. The NHSO plan to set up another 11 regional branches in the near future to act as purchasers and each regional branch will be responsible for approximately 5 million UC beneficiaries.

4.2.3 Capacity strengthening

Management capacities of the NHSO and its regional branches in active purchasing role are crucial for the success, i.e. effective management information system, financial management (capitation calculation, adjusted capitation, budgeting), monitoring and regulating. Various problems in UC policy implementation were due to weak capacities of the NHSO and regional branches in purchasing care. Lack of effective financial management information (accounting and service utilization) let the office in weak position to negotiate the per capita budget with the Bureau of Budget and to monitor providers. Strengthening capacity of the national and regional offices to perform purchasing role by setting up effective information system and providing training courses on financial management for managers is urgently needed.

4.2.4 Harmonization of health insurance schemes

Differences in the benefit package, payment methods, and fragmentation of benefits covered by insurance schemes are likely to result in inequity and inefficiency of the Thai health care system. In order to improve equity and efficiency of the system, harmonization of benefit package and payment methods is essential. Assessment of the feasibility of harmonization of insurance schemes and appropriate short and long term policy options will be taken.

Progress and Achievement

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