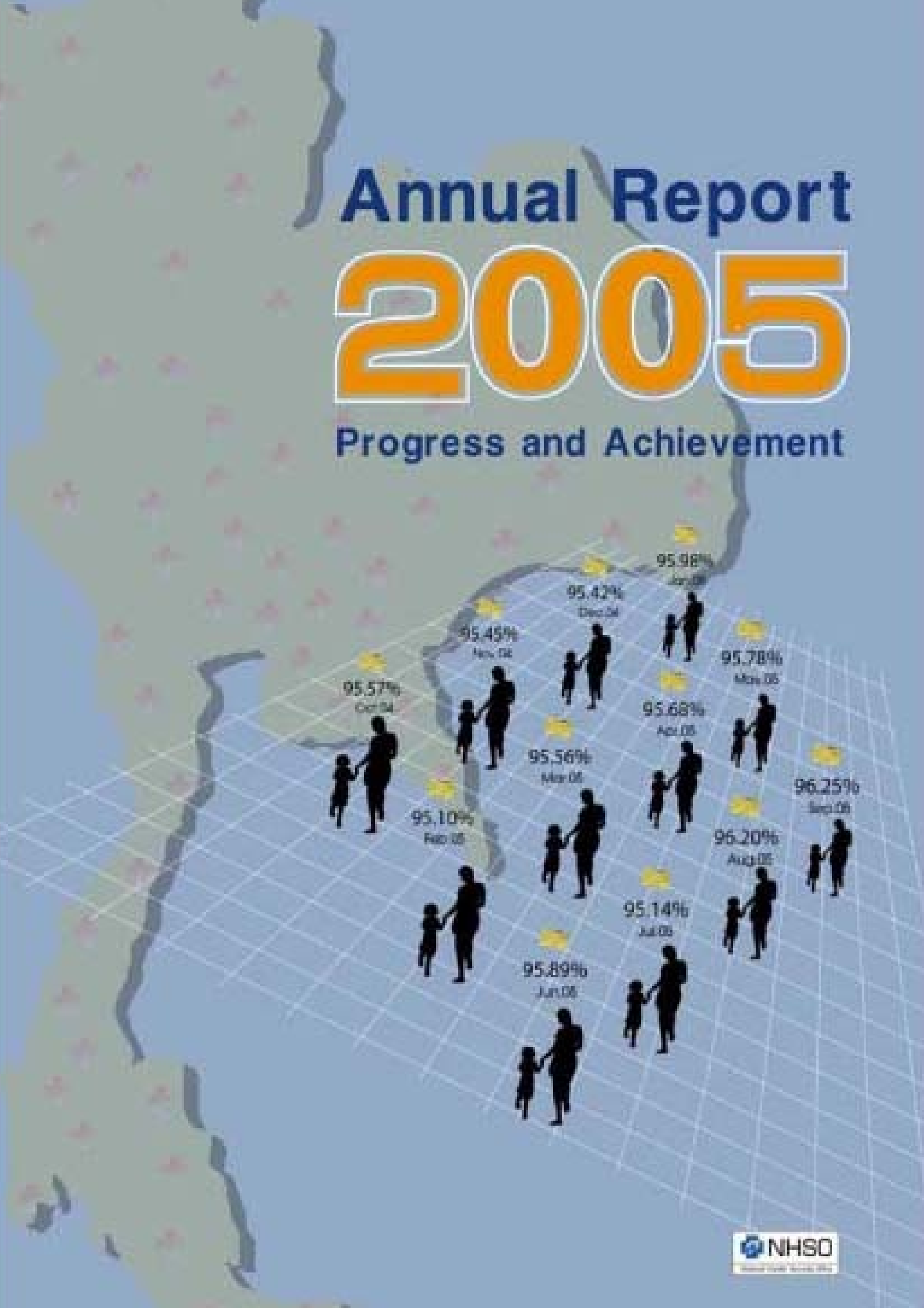
Annual Report 2005

Progress and Achievement



NHSO

Annual Report 2005
Progress and Achievement

NHSO
National Health Security Office

Annual Report 2005

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Progress and Achievement Annual Report 2005

UNIVERSAL COVERAGE OF HEALTH CARE
IMPLEMENTATION IN FISCAL YEAR 2005
(1 October 2004 - 30 September 2005)

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National Health Security Board Chairman's Statement

Universal coverage policy of health care is an important policy of the government. The two strategic goals of the policy are to make all Thais access to care when needed and to prevent Thai households from being in catastrophic situations while faced with high cost care. To reach such goals, more equitable distribution of health facilities and personnel should be promoted in addition to more efficient use of health resources to enhance sustainable health care system. Payment methods of the universal coverage policy are purposively designed for correcting inequitable distribution of health resources and for inducing the health care providers' behavior of using resources more efficiently.

With grateful cooperation from all concerned parties, the universal coverage policy has reached its success and been internationally recognized. Numerous problems relying upon health care system have been alleviated and resolved. Instead of focusing on medical care provision, the policy has been increasingly shifting to health promotion and prevention with its new motto from '30 Baht curing for all illnesses' to '30 Baht keeping Thais from illness'.

This report was produced with its aim of communicating the progress of the universal coverage in 2004/5 and wished to be a historical document of Thailand's medical and public health system in order to help support sharing of the policy understanding.

In this occasion, I would like to give you all best wishes and to thank all parties who have considerably devoted for policy implementation. Lastly, I wish the universal coverage policy to be long lasting and helpful for making health for all Thais.

(Pinij Jarusombat)
Minister of Public Health
Chairman of National Health Security Board, 2004/5

Standard and Quality Control Board Chairman's Statement

At present, nearly all Thais have public health insurance. The policy under the operation of National Health Security Act covers approximately 47 million Thais. For the past 3 years of its operation, there has been increasing improvement on health care system. The scarcity of health resources remains a major concern so does inequitable distribution of health facilities particularly in remote areas; however, the distribution is relatively better than that found in the period prior to the policy commencement. Two key problems challenging the policy implementation and needed improvements are care inaccessibility of some groups and over-work load on providers.

(Uuechart Kanchanapithak)
Chairman of Standard and
Quality Control Board

Statement of Secretary-General

Since the commencement of universal coverage of health care policy, there have been great achievements on public health and medical care system in terms of accessibility including prevention and promotion, ambulatory care, inpatient care, emergency care and high cost care. The better care quality given by both public and private settings has made people more confident in the policy.

To attain the fundamental goals of equitable, sustainable, efficient system with good care quality given under the universal coverage policy, the National Health Security Office has active roles of financing, designing payment criteria to promote more equitable distribution and more efficient use of health resources, and finding ways to give right and sufficient incentives to health care providers.

Great cooperation from wide-ranging parties and sectors has been the most valuable contribution to the policy success so far. I would like to take this opportunity to express thanks to all people who have both physically and mentally devoted for policy success.

(Sanguan Nittayarumphong)
Secretary-General,
National Health Security Office

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Progress of Universal Coverage Implementation

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Progress of Universal Coverage Implementation

Key components illustrating the progress are:

1. Population coverage,
2. Number of service facilities,
3. Service utilization,
4. Care delivery efficiency and care quality,
5. Health promotion program outcomes,
6. Opinions of key stakeholders,
7. Efficiency of fund management.

Insurance Coverage

By September 2005, Thai population stood at 62.81 millions not accounting for those living outside the kingdom and migrant people. 75.37 % (47.34 million) of all Thais were covered by UC scheme while the second and third largest population were insured by Social Security Scheme (8.74 million or 13.92%) and Civil Servant Medical Benefit Scheme (4.14 million or 6.61%) respectively. Overall, 60.45 million Thais or 96.25% were publicly insured. The 2005 coverage number increased by 1.25% compared with that of the 2004 registration. There were however remaining people waiting for their entitlement given (Table 1)

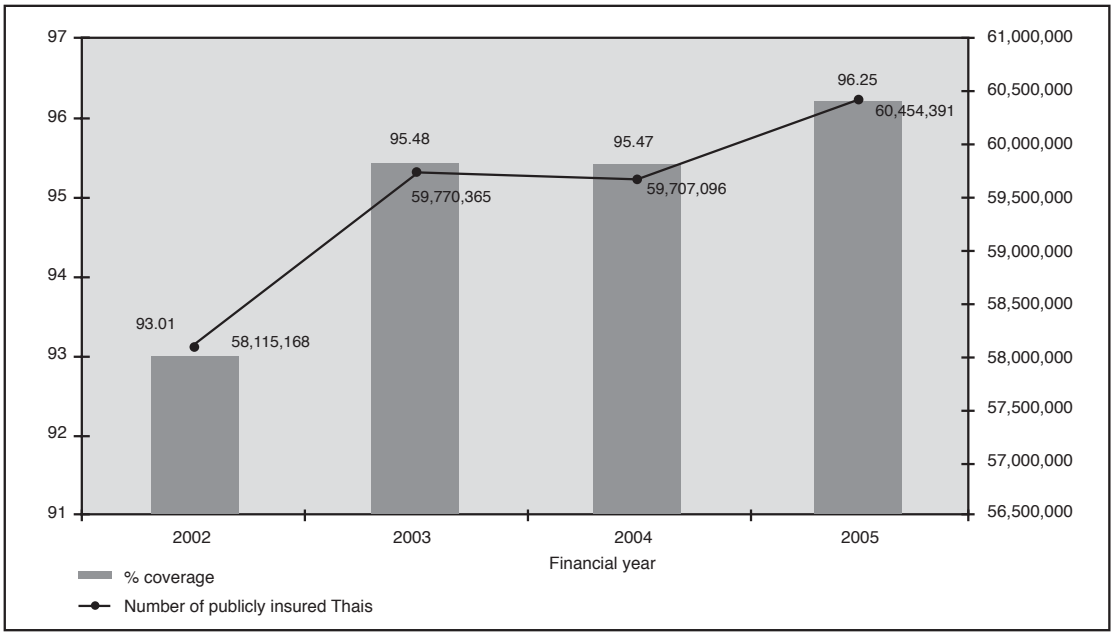
Table 1: Statutory Health Insurance Coverage in Thailand, FY2004 - FY2005

Insurance type	Financial Year		Increase (decrease)%
	2004 Number (%)	2005 Number (%)	
Total population	62,537,397 (100.00)	62,811,354 (100.00)	0.44%
- Universal Coverage Scheme	47,099,766 (75.31)	47,343,401 (75.37)	0.52%
- Social Security Scheme	8,340,006 (13.34)	8,741,658 (13.92)	4.82%
- Civil Servant Medical Benefit Scheme	4,266,661 (6.82)	4,150,924 (6.61)	-2.71%
- Benefits for political employees	663(0.00)	571(0.00)	-13.88%
- Benefits for veterans	-	122,679 (0.20)	-
- Benefits for private teachers	-	95,158 (0.15)	-
- Not yet entitled to any public scheme	2,830,301 (4.53)	2,356,963 (3.75)	-16.72%
Total coverage	59,707,096 (95.47)	60,454,391 (96.25)	1.25%

Remark: Prior to FY2005, benefits for veterans and private teachers were under UC scheme

Source: Bureau of Health Insurance Information Management, NHSO, 13 Oct 2005

Figure 1: Percentage and Number of Public Health Insurance Coverage in Thailand from FY2002 - FY2005



Source: Bureau of Health Insurance Information Technology, NHSO, Oct 2005

The population characteristic of UC scheme was different from that of the average characteristic. Its working age group was lesser in number. 25 % of total UC members were people aged below 15. 12 % and 63 % were people aged more than 60 and 15 - 59 respectively. Female members (51%) were more than male group (49%).

Health Facilities under UC Scheme

Number of contracted facilities and their networks

There were 1,110 contracted facilities under UC. 962 facilities were the hospitals categorized into 825 MOPH hospitals, 63 private hospitals and 74 public facilities. There were 148 primary care facilities mostly private ones (105 units).

Table 2: Number of contracted facilities under UC, FY2004 -FY2005

Facility type	Financial Year		Increase/ (decrease)%
	2004	2005	
Hospital			
- Ministry of Public Health	818	825	0.86
- Public hospitals not under MOPH	74	74	0.00
- Private hospitals	71	63	(11.27)
Total	963	962	(0.10)
Primary care facility			
- MOPH	3	3	0.00
- Public facilities not under MOPH	40	40	0.00
- Private facilities	89	105	17.98
Total	132	148	12.12
Total facilities	1,095	1,110	1.37

Source: Bureau of Health Information Technology, NHSO, Oct 2005

Situation of Primary Care System

A health care centre, the primary care facility under MOPH was mainly responsible for the population number less than 10,000. MOPH's hospitals mostly also acting as primary care facilities took care more than 10,000 population (technical recommendation of 10,000). (Table 3).

Table 3: Number of population per primary care facility in 2004

	Health center	PCU in district hosp.	External PCU contracted by district hosp.	PCU in general / regional hosp.	External PCU contracted by general/ regional hosp.	Public Medical center
Sample size	422	89	22	3	6	7
Population per unit	6,350	11,773	8,730	22,931	11,070	17,428
Standard deviation (SD)	4,679	7,829	3,627	20,874	8,687	16,994

Source: Supatra Srivanichakorn et al., Situation Study of Primary Care Delivery System in 36 Provinces, Aug 2004.

Overall, one primary care unit (PCU) was responsible for about 5,184 people. The units which were in the 2, 3, 4, 7, 8 and12 regions tended to cover higher population (Table 4).

Table 4: Average population number per primary care unit in each region in 2005

Region	The average population number / unit
1	3,920
2	6,988
3	5,781
4	6,285
5	4,105
6	4,891
7	6,338
8	3,903
9	4,956
10	5,258
11	4,728
12	5,805
Average	5,184

Source: Information from provincial health office in 2005, Bureau of Policy and Planning, NHSO

With respect to human resources at PCUs, if compared between before and after UC policy commencement, the number of health personnel at PCUs was on the rise. Nurses were the largest group accountable to this increase.

Table 5: Changing percentage of personnel number at PCUs in 2004 based on the year of UC commencement

	Health center	PCU in district hosp.	External PCU contracted by district hosp.	PCU in general / regional hosp.	External PCU contracted by general/ regional hosp.	Total
Sample size	442	76	17	3	3	577
Proportion of units having reduced personnel number (%)	11.09	14.47	5.88	0.00	33.33	11.61
Not changing (%)	42.53	38.16	35.29	33.33	33.33	41.77
Increasing (%)	46.38	47.37	58.82	66.67	33.33	46.62

Remark: the study not considering physicians, dentists and pharmacists

Care Utilization / morbidity pattern and care accessibility

Utilization of medical and public health services

The total outpatient services were 120.88 millions or 38.21 cases if considering in case number. The OP use rate was 2.56 times / person / year. The total inpatient cases were 4.53 millions with 17.89 million inpatient days. The IP use rate was 0.096 times / person / year. Both use rates of OP and IP care were on the rise (Table 6)

Table 6: Utilization of OP and IP care under UC, FY2002 - FY2005

Service type	Number	2002	2003	2004	2005
OP services	(million people)	41.4	32.54	39.66	38.21
	(million services)	102.95	115.01	119.64	120.88
IP services	(million cases)	3.39	3.99	4.329	4.53
	(million inpatient days)	14.93	14.56	16.83	17.89
Utilization rate	OP (times / pers / yr)	2.27	2.52	2.54	2.56
	IP (times / pers / yr)	0.09	0.087	0.092	0.096

Source: 0110 / 5 report from FY2002 - FY2005

The National Health and Welfare Survey in 2005 found the morbidity rate of the UC members was 23 %. The compliance rate of using OP care was 63.05 % while the rate of IP care was higher at 83.12 %. Compared with the 2004 data, the 2005 OP use rate was lower but higher for IP use rate (72.28 % of OP care rate and 80.29 % of IP care rate in 2004).

Pattern of service use

OP utilization

Most people received the services from health center or public health centers. District hospitals were their second most facilities while the third frequent use took place at pharmacies. The fourth favorite use was private clinic. 49.4 % of UC beneficiaries sought care from health centers. 35.7 % went to district hospitals as opposed to 11.6 % seeking care from general / regional hospitals and private hospitals.

IP utilization

More than 90 % of IP services were delivered by MOPH hospitals among. Among this percentage, more than 50% were from district hospitals. The IP care delivered by MOPH and private hospitals were higher than that of the previous year (Table 7).

Table 7: Percentage of IP Service Use according to Hospital Type, FY2004 - FY2005

	2004	2005	Increase / decrease
District hospitals	55.95	56.09	0.14
Gen / regional hospitals	35.84	36.76	0.92
University hospitals	2.45	2.19	-0.26
Public hospitals (not MOPH's)	3.66	3.21	-0.45
Private / poly clinics	0.10	0.07	-0.03
Private hospitals	1.47	1.63	0.16
Others	0.52	0.04	-0.48

Source: Analysis from the data of National Health and Welfare Survey, National Statistic Office in FY2004 and FY2005

Morbidity pattern

According to the 2005 National Health and Welfare Survey, the most morbidity pattern of UC members was flu followed by headache and muscle pain accounting for 35.92, 6.96 and 6.62 % of all morbidity patterns reported accordingly (Table 8).

Table 8: 10 Most Morbidity patterns of UC Members in FY2005

No.	Morbidity	Percentage
1.	Flu	35.92
2.	Headache	6.96
3.	Muscle pain	6.62
4.	High blood pressure	4.03
5.	Illness related to stomach	3.38
6.	Diabetes mellitus	3.30
7.	Joint pain	3.29
8.	Back pain	2.67
9.	Asthma	2.38
10.	Diarrhea / food poisoning	2.15

Source: Analysis from the National Health and Welfare Survey, National Statistic Office, 2005

The most IP cases of UC members were related with gastro-intestinal and respiratory system. The mostly discharged cases were from baby delivery.

Table 9: 10 Most Hospitalization Cases Reported in DRG Code during FY2003 - FY2005

DRG	Description	2003		2004		2005	
		cases	%	cases	%	Cases	%
6570	Esophagus, gastro-intestinal & mis-cellaneous digestive disease age > 9, no complication	149,222	5.04	176,585	5.15	205,024	4.54
14500	Vaginal Delivery without Complicating Diagnosis	126,692	4.28	164,205	4.79	177,723	3.94
4520	Respiratory infection / inflammation, no Complication	87,649	2.96	99,422	2.9	135,158	2.99
4590	Bronchitis and Asthma, no Complication	81,794	2.76	91,564	2.67	117,088	2.59
14029	Vaginal Delivery with Complicating Operating Room Procedure	71,985	2.43	107,782	3.14	157,779	3.49
6580	Gastroenteritis age < 10, no Complication	68,481	2.31	87,129	2.54	108,736	2.41
3530	Otitis Media and Upper Respiratory Infection, no Complication	62,568	2.11	73,278	2.14	99,658	2.21

DRG	Description	2003		2004		2005	
		cases	%	cases	%	Cases	%
11540	Kidney and urinary tract infection, no Complication	55,515	1.87	61,058	1.78	75,756	1.68
4550	Chronic Obstructive Pulmonary Disease, no Complication	47,013	1.59	48,361	1.41	56,215	1.24
14010	Caesarean Delivery without Complicating Diagnosis	29,727	1	48,250	1.41	63,974	1.42

Source: Analysis from inpatient service data under the UC during FY2003 - FY2005

Accessibility to referral care concerning accident, emergency and high cost care
The proportion of cases referred for OP services from FY2002 to FY2005 was not much fluctuated The highest proportion was reported in FY2004 standing at about 1.86 % of all cases. compared with 1.3% of FY2005.

Additional reimbursement to facilities providing emergency / accidental care and high cost care was made due to UC policy. As a consequence, there has been a rise of reporting such cases during FY2002 to FY2005. In FY2005, the rate of A&E (accidental and emergency care) and high cost care was around 0.09 times / person / year.

In consideration of particular high cost care, the accessibility to PTCA, CATH and BYPASS for AMI (acute myocardial infarction) during FY2003 to FY2005 has been rising (Table 10)

Table 10: Number of cases receiving PTCA, CATH and BYPASS during FY2003 - FY2005

Category	2003	2004	2005
Acute Myocardial Infarction, AMI (cases)	6,882	13,320	16,730.00
The proportion of PTCA, CATH, BYPASS relative to all AMI cases	1.58	3.84	5.14

Source: Analysis from inpatient service information during FY2003 - FY2005

Efficiency of service system and care quality

Due to limited information, three available indicators are presented here, which are the number of cases with rupture appendicitis, caesarian operation and re-admission within 28 days. The inpatient data from FY2002 - FY2003 shows the decreasing incidence of cases with rupture and slight stability from FY2003 - FY2005 (Table 11). The case proportions found in the UC scheme and that of CSMBS (18.04% and 18.17% respectively) were similar.

Table 11: Proportion of UC Cases with Rupture Appendicitis Relative to All Cases with Appendicitis during FY2002 - FY2005

	2002	2003	2004	2005
Cases with appendicitis	49,386	54,568	75,137	83,532
Cases with rupture appendicitis	9,912	9,939	13,707	15,056
%	20.07	18.21	18.24	18.04

Source: Analysis from inpatient service data during FY2002 - FY2005

Caesarian section is considered as an effective indicator reflecting an efficient use of health care resources. The operation must be performed towards medical indications or its associated risks imposeing on the patient. Doing so also reflects inefficient use of resources. Figure 10 shows the rate of caesarian section under the UC system was lower than that of CSMBS. In FY2005, 51.15% of all delivery cases under CSMBS were caesarian section compared with 16.46% of cases found under the UC scheme.

Re-admission within 28 days was taken into consideration for IP care quality. The FY2004 and FY2005 inpatient data was made comparison as shown in Table 12. The comparison does not yield any significant difference.

Table 12: Re-admission Case Number and Rates within 28 days, FY2004 - FY2005

Year	Total IP cases	Readmission patients	Total no of readmission	Readmission rate	Average rate
2547	3,666,199	119,663	166,389	0.045	1.39
2548	4,353,214	143,173	200,581	0.046	1.40

Source: Analysis from inpatient service data, FY2004 - FY2005

The highest rate of re-admission was found in cases with tumor and cancer. The rates of re-admission concerning cases with tumor/cancer, ischemic heart, renal failure, diabetes mellitus, chronic obstructive pulmonary diseases and asthma were relatively lower in FY2005 compared with that of FY2004.

Table 13: Re-admission Rates of Particular Chronic Illness, FY2004 - FY2005

Diseases	2004				2005			
	Cases	Case no of re-admission	%	Re-admission rate (times/case)	Cases	Case no of re-admission	%	Re-admission rate (times/case)
Cancer	1,669	12,339	7.42	7.39	2,197	15,495	7.73	7.05
COPD, Asthma	620	4,591	2.76	7.40	725	5,361	2.67	7.39
Renal failure	100	685	0.41	6.85	99	667	0.33	6.74
Congestive heart failure	65	400	0.24	6.15	91	608	0.30	6.68
Ischemic heart	43	371	0.22	8.63	53	417	0.21	7.87
DM	9	60	0.04	6.67	20	118	0.06	5.90
Hypertension	10	59	0.04	5.90	4	25	0.01	6.25

Source: Analysis from inpatient data under UC system, FY2004 - 2005

Health prevention and promotion

Antenatal / maternal care

During FY2002 - FY2005, antenatal care has been increasingly provided (Table 14). The maternal mortality rate has been reduced correspondingly with the birth death rate. The percentage of infants with low birth weight has also lowered (Table 15).

Table 14: Number of Maternal Care Provision, FY2002 - FY2005

	2002	2003	2004	2005
Antenatal care (cases)	1,175,955	1,281,226	1,357,913	1,716,238
Maternal care (cases)	449,977	413,288	367,378	436,502
Case no with normal delivery	499,210	488,047	462,981	529,956
Case no with abnormal delivery	153,567	152,672	151,386	195,523
No of live birth	647,382	636,469	611,175	721,685

Source: Analysis from 0110 / 5 Report, FY2002 - FY2005

Table 15: Output of Maternal Care Provision, FY2002 - FY2005

Output	2002	2003	2004	2005
Abortion (cases)	36,626	37,344	35,165	35,897
Birth deaths (cases)	5,395	4,250	3,192	3,794
Abortion rate (cases / 1000 pregnancies)	31.00	29.00	26.00	20.92
Birth death rate (cases / 1000 live births)	8.30	6.60	5.20	5.26
% of low birth weight infants (less than 2.5 kg)	na	Na	16.05	11.01
Perinatal mortality rate (cases / 1000 births)	14.25	10.54	9.20	10.46
Maternal mortality rate (cases / 1000 live births)	14.7	13.7	13.3	na

Source: Analysis from 0110 / 5 Report, Bureau Policy and Planning, MOPH

Health promotion for children

Under the implementation of children's health promotion program, health examination and vaccinations have been increasingly given during FY2004 - FY2005 in consistence with their coverage (Table 16).

Table 16: Particular Activities of Children's Health Promotion Program, FY2004 - FY2005

Activity	2004	2005
No of 0-5 year-old children receiving health examination	4,099,352	4,449,298
coverage percentage of 0-5 year-old Children	91.85	94.95
No of DPT vaccine given to 0-5 year- old children	2,138,314	2,769,930
No of BCG vaccine given to 0-5 year-old children	527,982	636,549
No of cases from 6-24 year-old population receiving health examination	3,557,261	5,008,762
coverage percentage of 6-24 year-old population	19.11	27.20
6-24 year-old population receiving MMR vaccine	448,192	526,103

Source: Analysis from 0110 / 5 Report, FY2004 - FY2005

Table 17: Output of Children's Health Promotion Program, FY2002 - FY2005

Output	2002	2003	2004	2005
Infant birth death (cases)	3,907	2,502	2,459	3,794
Infant birth death rate (case no / 1000 live births) (within 7 days after birth)	6.04	3.93	4.02	5.26
Nutrition of 0-5 year-old children				
No of children with poor nutrition (% of all examined)			245,690 (5.99)	320,794 (7.21)
No of children with over nutrition (% of all examined)			110,909 (2.71)	283,865 (6.38)
Nutrition status of 6-24 year-old population				
No of cases with poor nutrition (% of all examined)			282,979 (7.95)	320,059 (6.39)
No of cases with over nutrition (% of all examined)			274,350 (7.71)	184,322 (3.68)

Source: Analysis from 0110 / 5 Report

Health promotion for adults

There has been a rise of promotion measures given to target group aged 25 and over including annual health check-up, family plan consultation, cervical and breast screening programs (Table 18).

Table 18: Outputs of health promotion, FY2002 - FY2005

Output	2002	2003	2004	2005
Number of people aged 25 and over receiving annual check-up (% of coverage)			4,961,600 (12.67)	9,088,171 (22.76)
Number of people with malnutrition (% of people with malnutrition)			156,873 (3.16)	276,280 (3.04)
Number of people with over-nutrition (% of people with over-nutrition)			371,610 (7.49)	689792 (7.59)
Number of people receiving family plan consultation			5,936,779	6,386,617
Number of people receiving cervical screening test (% of coverage for women aged 35 and over)	n/a	1,008,231 (10.56)	1,333,748 (10.02)	1,656,705 (11.02)
Number of people receiving breast screening test (% of coverage for women aged 40 and over)	n/a	n/a	3,690,017 (34.78)	6,623,294 (54.45)

Table 18: Outputs of health promotion, FY2002 - FY2005 (continue)

Output	2002	2003	2004	2005
Number of oral promotion given		4,869,986	4,143,510	4,994,820
Number of people receiving home visit	8,808,476	9,001,988	8,256,473	8,973,769

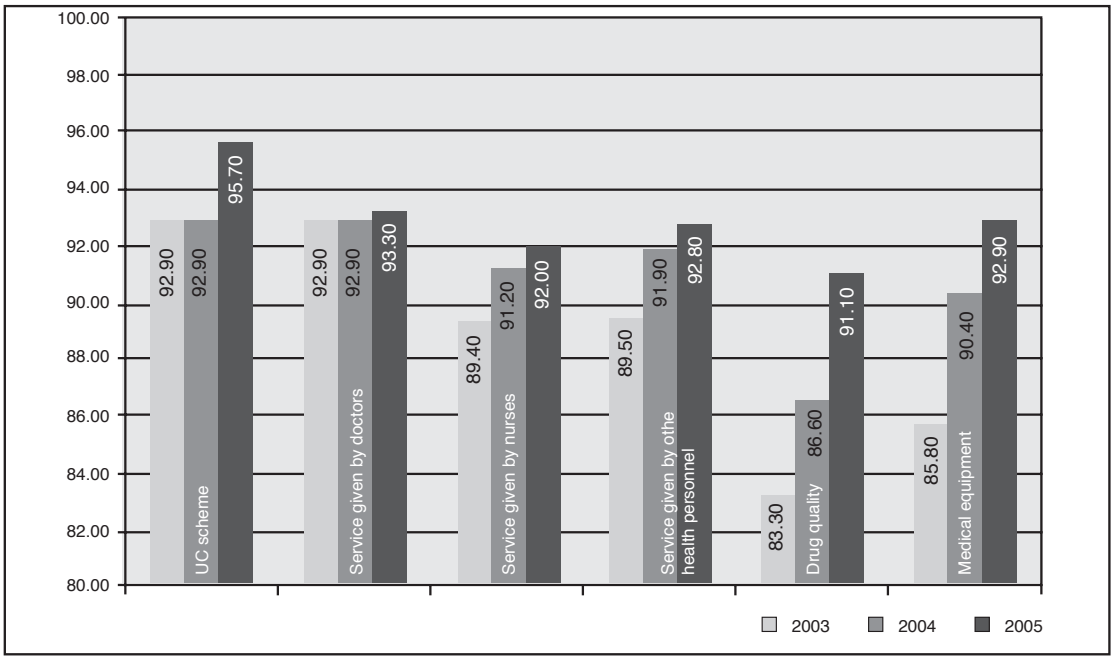
Source: Analysis from 0110 / 5 Report, FY2002 - FY2005

Opinions and attitudes

Users' experience and their needs

The consecutive surveys on users' opinions performed by ABAC Poll during FY2003 - FY2005 yielded increasing satisfaction levels from users towards care quality (personnel, drug quality and medical equipment), convenience and results of care given.

Figure 2: User Satisfaction Levels towards Care Given under UC during FY2003 - FY2005



Source: Survey performed by ABAC Poll, during FY2003 - FY2005

Out of 10 as the total score, the average score given by users was 7.83 (S.D. = 2.054) in the 2005 survey. The first most reason of favoring the UC was the reduction of households' expenditure on health care. The second and third most reasons given were the protection for the poor and ease of access to care. The first most thing needed improvement was long queue while waiting for service consultation or provision. The second and the third were care quality and facility registration which should provide more choices.

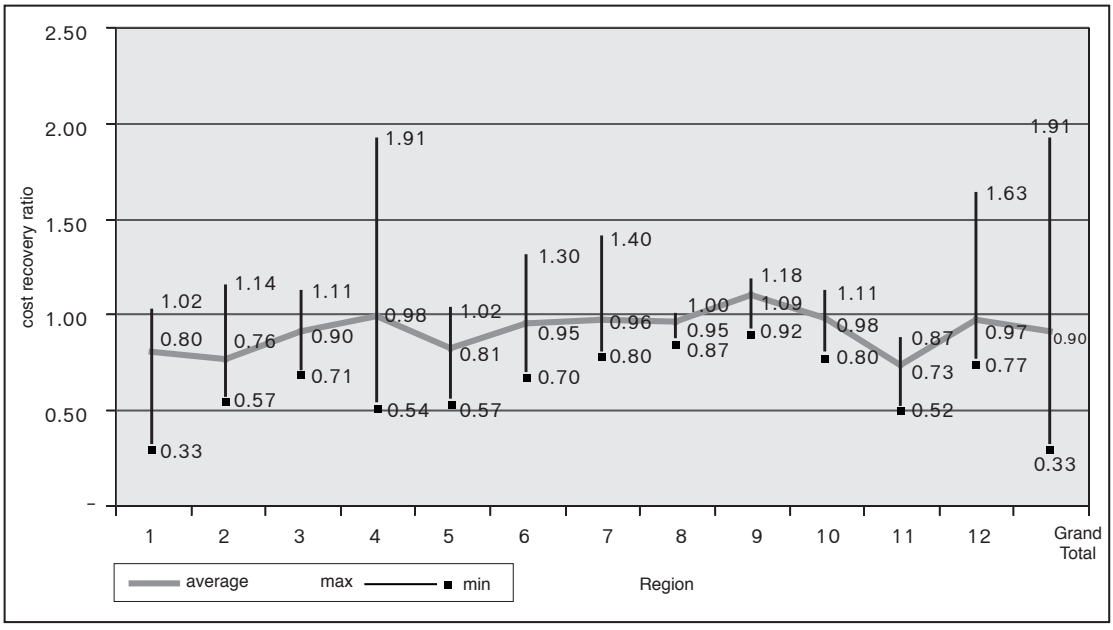
Providers' opinions and their policy recommendation

Out of 10 as the total score, the average score of satisfaction given by the providers was 6.14 in the 2005 survey. If considering the benefits given to population, on average the providers rated 7.54. The lesser score, 5.42 was given when considering the benefits they received. They recommended the first priority to improve the policy be greater budget to recover actual operating costs. The second and the third were improvement of public relations towards population to make them cleary understand the UC and the improvement of incentives for providers to retain in the system.

Efficiency of fund management

The ratios of cost recovery at hospitals were made for this consideration. On account of the report system for UC monitoring and evaluation namely 0110 / 5 Report, the cost recovery ratio of MOPH's hospitals nationwide was on average 0.9. The ratio of the hospitals in the 9th region was greater than 1 (revenue more than cost) contrasting with the lower ratios of other areas.

Figure 3: Ratios of Cost Recovery of MOPH Hospitals in 13 MOPH Regions in FY2005



Source: Analysis from the UC monitoring and evaluation report, 0110 / 5 Report

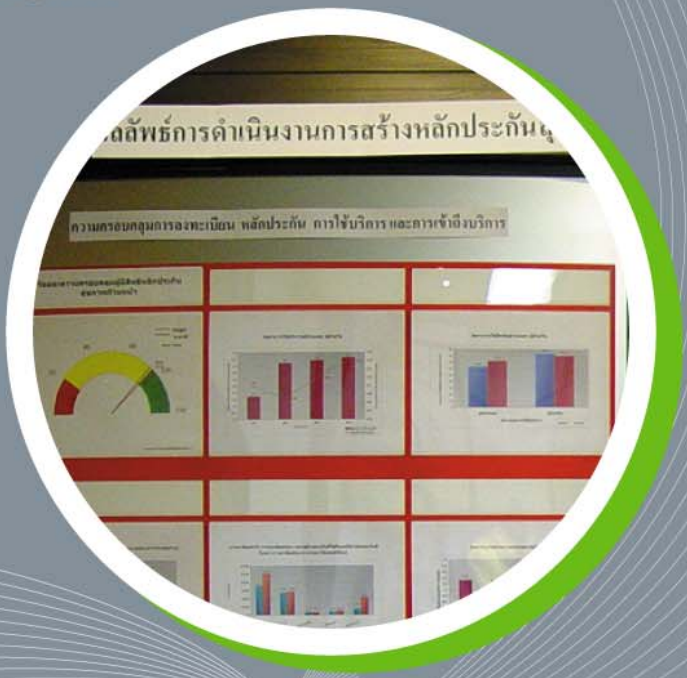
In conclusion, the registration coverage of public health insurance in FY2005 reached 96.25% of which 75.37% were under the universal coverage policy. The registered health facilities accounted for 1,110 facilities increasing by 1.37% relative to that of the previous year. Most primary care clinics at the hospitals were responsible for population over the

determined figure according to the criteria contrary to MOPH health centers mostly having lower registration number.

In FY2005, the service utilization of both OP and IP increased relative to that of FY2003 and FY2004. Most services were given from health centers or public health centers. The second most utilization was found at community hospitals. The referral cases were also found higher relative to that of the previous year. The experienced users rated higher satisfaction level. Particular indicators reflecting care quality and efficiency use of resources should be further developed and closely monitored to make better support for policy decision making.

The greater coverage of prevention and promotion programs was found in FY2005. However, some indicators needed close monitoring including infant birth death, children nutrition, tuberculosis, mental disorder, meningitis and hepatitis B. A greater concern was indicative to the cost recovery ratio of MOPH hospitals which was on average at 0.9. About 73% of the hospitals had higher expenditures than revenues.

Quality Standard and Quality Control for Facilities and their Service Network



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Quality Standard and Quality Control for Facilities and their Service Network

Hospital Accreditation

By the end of September 2005, 967 hospitals met the standard of Hospital Accreditation System. 14% (134 hospitals) had the quality assurance and continuous quality improvement system compared with 10% of FY2004. 5% (48 hospitals) had risk management system (the 2nd step of HA approval) compared with 1% of FY2004. 63% (615 hospitals) was approved for reaching the 1st step of HA approval compared with 54.6% in FY2004. Overall, the approved hospitals against the HA system accounted for 82% (797 hospitals). The remaining of 18% (170 hospitals) was in the process of developing the risk management system. Striking advancement of HA development was found in private hospitals. Their HA achievement jumped from 1.6% in FY2004 to 34.3% in FY2005.

Care Quality of Primary Care Unit

Under a joint program between NHSO and Department of Supporting Health Service Provision, MOPH, 800 health centers had been upgraded to be community health centers in line with MOPH's criteria. 530 health centers (66%) met the criteria whereas the remaining needed continuous improvement and re-evaluation.

Table 19: Assessment on Health Centers against Standard of Community Health Center in FY2005

Region	Target		Assessment result	
	Health centers	District	Criteria met (no of health center)	%
Northern	191	28	134	70
North-Eastern	220	33	171	78
Central	261	51	154	59
Southern	128	28	71	55
Total	800	140	530	66

Source: Department of Supporting Health Service Provision, MOPH, November 2005

Health personnel development for primary care provision

National Health Security Board made an approval of spending 10 million Baht from the FY2005 capital replacement fund to:

1. develop health personnel for primary care provision in line with integrated care approach
2. develop 130 primary care trainers evenly distributed around 12 regions plus one at Bangkok Metropolitan (10 people per region)
3. set up 12 regional training centers
4. train for trainers at provincial and district levels covering 75 provinces at about 1,800 people

Care quality promotion at primary care setting

To support continuous care quality improvement at primary care settings, a continuity of personnel development must be taken. Around 30,000 - 100,000 Baht per facility irrespective of public or private one was given to do so. The progress was as follows;

1. 562 out of 1,451 facilities met the criteria for budget given for personnel development.
2. The qualified facilities assessed themselves against the assessment form given to find gaps needed for personnel development and to help develop quality care improvement projects mostly focusing on chronic care programs (Table 20).

Table 20: Project Types Applied for Care Quality Improvement at Primary Care Settings

	Project type	Central	North	North-east	South	Total	%
1	DM / HT	70	36	63	15	184	32.7
2	Aged and mental care	16	13	16	1	46	8.2
3	Exercise and health promotion	11	4	8	2	25	4.4
4	Thai traditional medicine	14	8	13	2	37	6.6
5	Maternal & child care and nutrition	5	3	6	7	21	3.7
6	Information system	8	2	3	1	14	2.5
7	Community education	27	32	49	15	123	21.9
8	Dengue surveillance	7	2	4	2	15	2.7
9	Environment	2	3	8	1	14	2.5
10	Home visit	8	9	5		22	3.9
11	Activities to support Healthy Thailand Project	5	11	8	2	26	4.6
12	Oral health	1		4	3	8	1.4
13	Youth education	5	1	1	1	8	1.4
14	Cancer screening	3	1	2	3	9	1.6
15	Narcotics	3	1			4	0.7
16	Etc		3	2	1	6	1.1
Total		185	129	192	56	562	100.0

3. Self assessment was focused with technical help from provincial trainers The participated facilities made the reports which were the progress and the final report.
4. Technical forum for facilitating experience sharing either internally or externally provincial level was supported.

Standard and guideline of operation

1. Facility registration

The registered facilities were grouped into the gate keepers, the primary care settings, the joint facilities and the referred facilities in order to support the facility assessment in which different standards for each facility type were used. In addition, the criteria of a referred setting which had a particular specialty, was developed for example heart operation and radiotherapy.

2. Development of health service practice guidelines (HSPG)

NHSO and Health System Research Institute jointly developed health service practice guideline. The progress was the report of Thailand's disease burden and the health service practice guideline of 10 diseases which were community-acquired pneumonia, chronic obstructive pulmonary disease, tuberculosis, hypertension, upper gastro-intestinal bleeding, septic shock, anemia, thalassemia, depression and anxiety.

3. Development of the guideline for caring cases with cancer

The guideline for caring cases with cancer had been developed through professional views, a review of the master development plan of tertiary facility specializing cancer treatment and a review of the claim data for cancer treatment. The guideline constituted the specific guideline of cervical, ovarian, breast, gastro-intestinal, lung, leukemia and lymphoma in child and adult, liver and gall bladder and sinus cancer.

Quality control at health facilities and their network

NHSO had randomly sampled 55 hospitals and 55 primary care facilities to monitor their care quality. The most common problem found at the hospitals was long waiting time at outpatient department. The larger the hospital, the longer the waiting time was. The average waiting time was between 13 - 41 minutes per case. The risk rate of hospital acquired infections was ranged between 0.14 - 1.72. The community hospital was likely to have pharmaceutical errors and errors of recording inpatient service data.

Table 21: Some Quality Indicators of Hospitals Classified into Hospital Types

Indicators	Small community hospital (29 sites)	Medium community hospital (29 sites)	Large hosp (1 site)	Gen / Regional hospitals (4 sites)	Private hospital (4 sites)
Average waiting time (mins)	73	97.59	81	100.20	20.27
Average time of physician consultation (mins)	6.68	8.85	13	6	7.23
Average time of waiting for dental treatment (mins)	41.17	36.88	13	27.75	25.51
Rate of hospital acquired infection (%)	0.79	0.48	0.83	1.72	0.14
Rate of pharmaceutical errors (%) - Prescribing	2.58	0.08	1.43	0.97	0.46
- Preparing	1.34	0.26	1.43	1.47	0.8
- Dispensing	0.22	0.34	1.43	0.06	0.39
- Administering	0.89	0.02	1.43	0.01	0.02
Completeness of medical records - Outpatient records (% of completeness)	71.24	68.42	80.50	74.05	
- Inpatient records (% of completeness)	68.16	55.01	80.50	71.29	76.14

Source: Bureau of Care Quality Development, 2005

Development of indicators for monitoring facilities and their network

NHSO had developed the monitoring indicators determined for pilot use in 5 provinces, Songkhla, Lampang, Lampoon, Tak and Krabi for 1 month. The indicators were later taken for adjustment to develop 24 indicators, 7 for primary care facilities and 17 for hospitals which would be taken up for monitoring in 2006.

Clinical auditing against cancer treatment protocol

Cancer treatment quality assessment

NHSO established a team of cancer treatment quality assessment and selected 8 hospitals aimed for assessment. Their inpatient records related to cancer cases were randomly picked up for review. The assessment found that 86.72% of the assessed hospitals met the criteria of care quality while 81.14% reached the quality criteria of medical recording. The assessment team made the recommendation as follows;

The facility network for cancer treatment should be determined by its treatment capability and geographic coverage

To support continuous care, the standard of medical record should be developed.

The assessment report should be consistent with the practice guideline.

The assessment team should be composed of various provider representatives e.g. from medical council, medical department, physicians from various types of hospitals as well as representatives from Social Security Scheme and Department of Comptroller.

The assessment should be continuously performed.

Care quality assessment for DM and hypertension cases

In FY2005, the care quality for DM and hypertension treatment was assessed in 61 provinces by examining medical records from 647 hospitals totaling 16,401 reports. DM, DM with hypertension and hypertension cases accounted for 22%, 35% and 43% of all examined reports respectively. Incomplete diagnosis, ineffective treatment and under estimation of complications as opposed to practice guideline were found. Around 27% and 36% of DM and hypertension cases were in control of preventing consequent complications for example dyslipidemia and nephropathy (Table 22).

Table 22: Incidence Rates of Complications and Degeneration in DM and Hypertension cases

Complications and degeneration	DM	DM with hypertension	hypertension
Dyslipidemia	16.6	23.7	15.6
Nephropathy	4.3	7.5	2.8
Retinopathy	2.8	3.7	0.5
CVA	1.3	3.7	4.1
IHD	1.8	4.2	4.4
Heart failure	0.8	2.0	1.7
Foot ulcer	3.3	3.1	0.2

Source: Bureau of Care Quality Development, 2005

Table 23: Percentage of DM Cases Receiving Complication according to Hospital Types

Annual check-up for complications	% average of patients receiving check-up	% average					
		Community hospitals	General hospitals.	Regional hospitals	Public hospitals not under MOPH	Medical schools	Private hospitals
Body mass index (BMI)	25.4	25.0	25.3	35.6	15.2	23.2	23.5
Blood examination for average sugar level or accumulated sugar level (HbA1c)	9.2	3.3	21.1	24.2	23.6	62.1	3.0
Retina examination	18.5	12.9	34.5	35.5	13.1	35.8	11.1
Foot ulcer examination	20.9	19.4	25.1	27.0	17.7	20.6	9.8
Urine protein	28.5	25.4	33.9	39.1	39.3	51.7	17.3
Blood lipid	22.4	14.8	33.4	45.5	48.9	66.7	9.0

Source: Bureau of Care Quality Development, 2005

If compared, the care quality of the private and community hospitals was lower than the average (Table 24).

Table 24: Percentage of Hypertension Cases Receiving Complication according to Hospital Types

Annual check-up for complications	% average of patients receiving check-up	% average					
		Community hospitals	General hospitals.	Regional hospitals	Public hospitals not under MOPH	Medical schools	Private hospitals
BMI	20.7	21.4	18.2	25.2	18.4	24.6	21.8
Blood lipid	21.2	14.7	37.2	42.9	49.2	75.1	13.5
Urine protein	24.4	22.4	29.1	34.1	33.5	42.8	14.6
Creatinine	37.6	34.3	45.0	51.7	59.2	77.2	19.2
Blood sugar	62.4	60.8	65.8	66.0	77.8	74.6	54.9
Blood concentration	10.5	8.1	14.3	20.9	21.0	17.0	7.5
Blood potassium	7.3	4.3	13.8	17.5	12.5	30.1	1.4
EKG	19.8	16.9	24.3	29.8	32.4	36.2	15.5

Source: Bureau of Care Quality Development, 2005

Care quality assessment on care for heart diseases
The assessment program was on the process of working with heart specialists to develop the appropriate practice guideline. The components of the guideline would constitute electrophysiology study, percutaneous transvenous mitral commissurotomy (PTMC), percutaneous coronary intervention, percutaneous transluminal intervention and pediatric therapeutic cardiac catheterization requirement.

Complaint on care quality
In FY2005, complaint cases regarding care quality increased by 24.1% (1,502 cases reported in FY2004 and 1,864 cases reported in FY2005). Inconvenience of getting services came first at around 80% followed by the patients not receiving the entitled services, getting charged and the facilities not following the determined standard of practice also on a rise with the rates of 38, 8 and 5% respectively. All the complaint cases had been managed for resolutions. About 1.07% (24 cases) of all cases was left for decisions made by the Board of Standard and Care Quality Control.

Relationship management with health care providers
Main objectives of this program were to create more understanding to universal coverage policy among providers and build greater relationship between the providers and NHSO. In FY2005, there had been several activities as follows;

- Field visits to providers including the southernmost provinces which had insurgencies and the southern provinces where were stricken by Snunami. NHSO was a coordinator for these activities by working with other relevant agencies e.g. MOPH and various professional councils.
- Convening of workshops with providers to discuss on problematic and concerned issues among providers for example conflict resolutions for providers and initial compensation to the medically injured on a basis of no-fault liability.

Civil Involvement / Consumer Protection / Public Relation

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Civil Involvement / Consumer Protection / Public Relation

Civil Involvement

Participation

National Health Security Act 2002 determined civil participation in various forms and on different purposes. In FY2005, several activities supporting participation from several civil groups were:

1. an establishment of 29 coordinating centers as a pilot program in 21 provinces responsible for facilitating communities to give feedback regarding UC scheme implementation and its care delivery as inputs for policy development and making communities more understanding to NHS activities and policy,

2. a development of community facilitators and their network

3. a network creation with community radio stations to broadcast NHS information in 6 regional areas,

4. a facilitation of NHS forums in communities for communication,

5. a network creation with particular societies e.g. cancer society, society of patients with cardio-vascular illness.

Involvement of local government organizations

Article 13 (3), 18 (8) and 47 of National Health Security Act 2005 state the promotion of involvement from local governments for UC development concerning policy development and management, financing, health care delivery and care quality control. In FY2005, 9 provincial administrative organizations, 323 municipalities and 794 sub-district government organizations had been involved.

Involvement of professional bodies

4 professional bodies had been involved which were National Public Health Society, Rural Doctor Society, Rural Dental Society and National Cardio-vascular Association. They all had provided their relevant inputs for developing policy content.

Consumer Protection

Information service and complaint feedback

In FY2005, there were 896,628 information services given including complaint cases. The majority of service was information given through 1330 Call Center accounting for 855,856 cases (95.45 %). There were 1,864 complaint cases relating Art 57 and 59, 25,435 cases (2.84 %) requesting solutions and 13,473 cases (1.50 %) relating health care service.

Table 25 shows a comparison of information types sought by consumers and providers in FY2004 and FY2005. Table 27 illustrates a comparison of complaint types in FY2004 and FY2005.

Table 25: Comparison of Information Types Sought by Consumers and Providers, FY2004 - FY2005

Types of Requested Information	Financial Year				Increase / decrease(%)
	2004		2005		
	No.	%	No.	%	
1. Users	495,582	96.61	831,601	97.17	67.80
1.1 UC card	447,815	87.30	744,610	89.54	
1.2 UC benefits	18,393	3.59	35,512	4.27	
1.3 Right exploitation	19,139	3.73	20,791	2.50	
1.4 Vertical health care Programs	-	-	9,380	1.13	
1.5 Others	10,235	1.99	21,308	2.56	
2. Providers	17,387	3.39	24,255	2.83	39.50
2.1 User right detection	-	-	20,786	85.70	
2.2 Benefits	-	-	1,660	6.84	
2.3 Medical claim	-	-	474	1.95	
2.4 Registration	-	-	839	3.46	
2.5 Others	-	-	496	2.05	
Total	512,969	100	855,856	100	66.84

Table 26: Comparison of Complaint Types, FY2004 - FY2005

Types	Financial Year				Increase / decrease(%)
	2004		2005		
	No.	%	No.	%	
1. Relevant to Art. 57, 59	1,502	11.08	1,864	6.83	24.10
Not receiving the determined benefit	612	40.75	845	45.33	38.07
Being charged	500	33.29	540	28.97	8.00
Facilities not complying the standard	299	19.91	315	16.90	5.35
Receiving inconvenience	91	6.05	164	8.80	80.22
2. Complaints Registration and card issuance	12,057 7,026	88.92 58.27	25,435 15,389	93.17 60.50	110.96 119.03
Given services not as marketed	4,188	34.74	8,335	32.77	99.02
Inpatient bed finding	474	3.93	1,169	4.60	146.62
Vertical care programs	-	-	20	0.08	100
Others	369	3.06	522	2.05	41.46
Total	13,559	100	27,299	100	101.33

A survey was performed on those who had called 1330. 93.71 % of all the sampled (240 people) were satisfied with the call center responders in terms of hospitality. 90 % said the Call Center provided relevant answers and solutions. 81.4% felt most satisfied with the Call Center and 16.7 % felt moderately satisfied leaving only 0.8 % dissatisfied. In regard to survey result on complaint cases, 97.1 % of the sampled (172 people) were satisfied with the hospitality given by the Call Center and 94.7 % felt contented with resolutions given. 73.3 % and 22 % were most satisfied and moderately satisfied respectively with 4.7 % dissatisfied.

In FY2005, NHSO had made various attempts to provide UC information to all relevant stakeholders. The activities are as follows:

1. training and development for community health volunteers with cooperation from Department of Supporting Health Care Delivery, MOPH to help promote UC information distribution
2. publications made for UC information distribution to users, care providers and officials involved in policy implementation
3. public relation in many forms e.g. press tour, press releases, all kinds of medias

Management of National Health Security Fund

Annual Report 2005

Management of National Health Security Fund

Structure of Capitation Budget in 2005 Financial Year

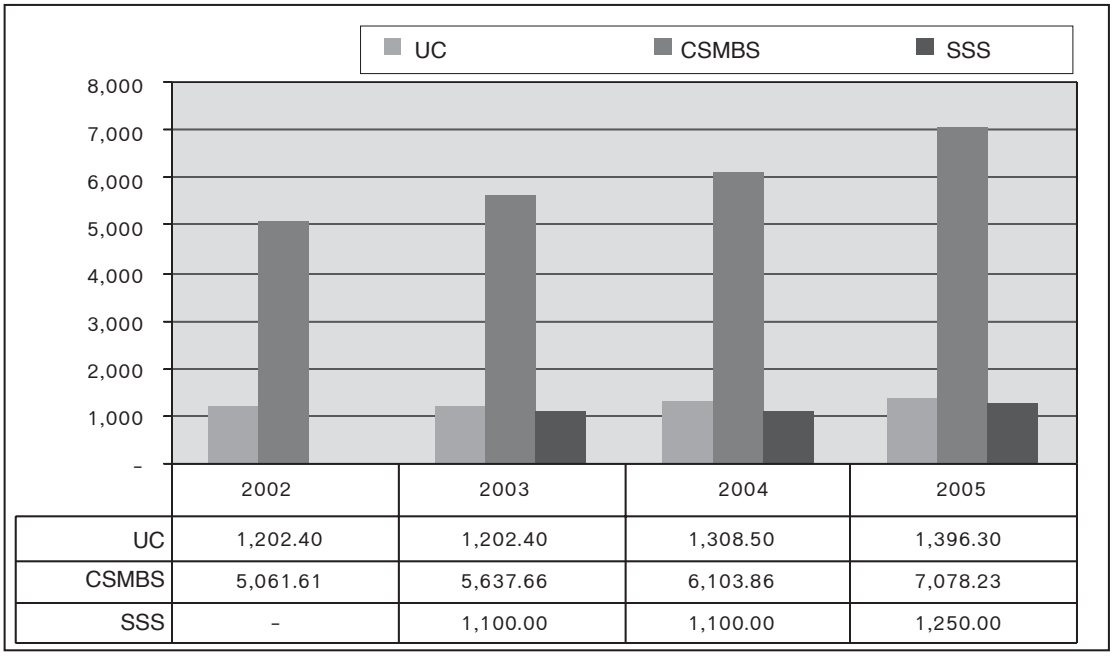
In 2005, the approved capitation rate was 1,396.30 Baht / person for around 47 million people of entitlement. The capitation structure was illustrated in Table 27.

Table 27: Structures of Capitation Budget, FY2003 - FY2005

Component	2003	2004	2005
1. Outpatient service	574	488.2	533.01
2. Inpatient service	303	418.3	435.01
3. Prevention and promotion	175	206	210
4. Accident and Emergency	25	19.7	24.73
4.1 Outpatient service			0.74
4.2 Cases taken place in different control of provincial funds			14.37
4.3 Article 8 entitlement			6.05
4.4 Birth in different control of provincial funds			3.57
5. High cost care	32	66.3	99.48
6. Emergency care	6	10	6
7. Rehabilitative care	4	-	4
8. Capital replacement	83.4	85	76.8
9. Supplementary fund for harsh areas		10	7.07
10. Initial compensation under Art 41		5	0.2
11. Total (Baht / person)	1,202.4	1,308.5	1,396.3
12. Total of OP and IP budget for each provincial Fund	877	906.50	968.02

Despite the growing capitation budget from 2003 to 2005, the capitation rate was lower than the capitation expenditures of CSMBS (4,081 - 7,078 Baht / person / year) and the capitation expenditures of SSS. Even though the SSS capitation rate in 2005 was 1,250 Baht, the SSS had additional expenditure on fees for specialists' consultation, high cost care, emergency care, dental capitation and additional payment if utilization rate was over 15% as determined before.

Figure 4: Comparison of UC capitation budget with that of SSS and expenditure perperson of CSMBS from FY2003 - FY2005



	2002	2003	2004	2005
UC	1,202.40	1,202.40	1,308.50	1,396.30
CSMBS	5,061.61	5,637.66	6,103.86	7,078.23
SSS	-	1,100.00	1,100.00	1,250.00

The 2003 budget had been completely allocated to providers while the 2004 and the 2005 budget had been utilized approximately 96.88% and 97.75% respectively (see Table 30 for budget utilization).

Table 28: Comparison of Budget Utilization Regarding each Budget Component and Financial year, FY2003 - FY2005

Service component	FY2003		FY2004		FY2005	
	budget (million)	% of use	budget (million)	% of use	budget (million)	% of use
1. Capitation (OP + IP + PP)	23,543.12	100	24,082.34	98.93	30,530.79	98.97
2. Accident and emergency care	1,151.50	100	1,014.80	86.17	1,162.31	93.15
3. High cost care	1,473.92	100	3,415.29	87.56	4,675.56	93.88
4. Emergency medical service	460.60	100	460.00	100	282.00	57.99
5. Rehabilitative service	-	-	-	-	188.00	34.52
6. Capital replacement	3,841.40	100	3,910.43	100	3,609.60	100
7. Supplementary fund for harsh areas	-	-	460.00	100	332.29	100
8. Initial compensation under Art 41	-	-	230.00	2.67	9.4	(70.11)
Total	30,470.54	100	33,572.86	96.88	40,789.95	97.75

Budget Management for Prevention and Promotion

In 2005, the prevention and promotion budget was set at 210 Baht / person based on 47 million people totaling 9,870 million Baht. Due to the fact that the two schemes, SSS and CSMBS did not cover prevention and promotion, the UC prevention and promotion budget was then determined for protecting for all Thais. The allocation to a provincial fund took a total provincial population for calculation. In 2005, the prevention and promotion capitation if based on all Thais was 155.68 Baht / person. To ensure service accessibility and practice of economy of scale to some necessary measures and , a portion of the budget was centrally pooled for management. The central management was composed of purchasing particular equipments, drugs or vaccines and the standardization of care provision.

Table 29: Items of Prevention and Promotion under the Central Fund Management

Item	Budget (million)	Management
Vaccines	655.9 (10.35 Bht / pers)	Centrally purchased and distributed by Dept. of Disease Control with continuous reporting of budget use and service utilization
Maternal and child book	7.38 (0.12 Bht / pers)	Managed and distributed by Dept. of Health
Student health book	4.02 (0.06 Bht / pers)	Managed and distributed by Dept. of Health
ARVs under prevention of mother to child transmission (PMCT)	20.54 (0.32 Bht / pers)	Purchased and managed by Dept. of Health with continuous reporting of budget use and service utilization
Norplant (birth control)	26 (0.41 Bht / pers)	Centrally purchased and managed by Dept. of Health
Thallasaemia screening test	49.64 (0.78 Bht / pers)	Equipment and diagnostic reagents purchased and managed by Dept. of Health
TSH (thyroid-stimulating hormone) test	81.5 (1.29 Bht / pers)	Dept. of Medical Science responsible for purchasing test reagents and managing the program
Total	844.98	(13.33 Bht / pers)

The progress of the budget utilization in FY2005 for prevention and promotion is illustrated in Table 30.

Table 30: Budget Utilization for Prevention and Promotion, FY2005

Item	Budget (million)	Budget use (million)	% utilization	Remark
Prevention and promotion	9,870	9,683	98.10	188 million Baht left from previous budget and transferred to use in FY2005 for various programs e.g. care quality development program for reproductive health, prevention for vascular degeneration, iodine supplement for children and student health check-up book
MOPH's programs	845	854	0	81.5 million Baht for Dept. of Medical 107.6 million Baht for Dept. of Health 655.9 million Baht for Dept. of Disease Control
Community prevention and promotion	2,366	2,366	100	
Individual prevention and promotion	6,659	6,472	97.18	- For coverage of UC beneficiaries, 4,991 M Baht allocated to facilities with capitation budget - For coverage of other beneficiaries, 1,668 M Baht was allocated according to these followings; - 420 M allocated to facilities - 729 M determined for vertical programs e.g. children health promotion, denture for the aged, cervical cancer screening test - For harsh areas where program implementation was difficult, 519 M Baht was allocated

Budget Management for Emergency Medical Service (EMS)

The service included pre-hospital or pre-health facility service and patient transportation to facility. Due to the development phase of emergency medical care system, the initial system investment and development was made as follows;

1. development of dispatch center responsible for case coordination

2. development of toxic counseling center by having MOU with Ramathipbadee Hospital to provide the counseling through 1330 Call Center

3. development of first responders with local governments' cooperation expecting one responder per sub-district level

The budget management for EMS had 2 components which were system administration and management and medical expenditures. Table 31 shows the budget structure and its utilization in FY2005.

Table 31: EMS Budget Structure in FY2005

Component	Item	Budget (Bht)	Utilization (Bht)	Remained budget (Bht)
Administration & Management	HR training & development	83,000,000	83,000,000	-
	Administration	22,000,000	22,000,000	-
	Toxic counseling center	6,950,000	6,950,000	-
	Purchase of life saving equipment	15,000,000	15,000,000	-
	EMS system development	100,000,000	100,000,000	-
	EMS training program	10,000,000	10,000,000	-
	Area based meetings	10,639,861	10,553,670	86,191
	Monitoring and evaluation	20,000,000	20,000,000	-
Medical expenditures	Remuneration	299,362,778	213,038,392	86,324,386
	Patient service support (allocation to provincial health fund)	276,000,000	208,523,573	67,476,427
	Central management	23,362,778	4,514,819	18,847,959
	Total	566,952,639	480,542,062	86,410,577

The work progress was as follows;

1. connection between the toxic counseling center and 1330 Call Center had been established and its public relation had been made.

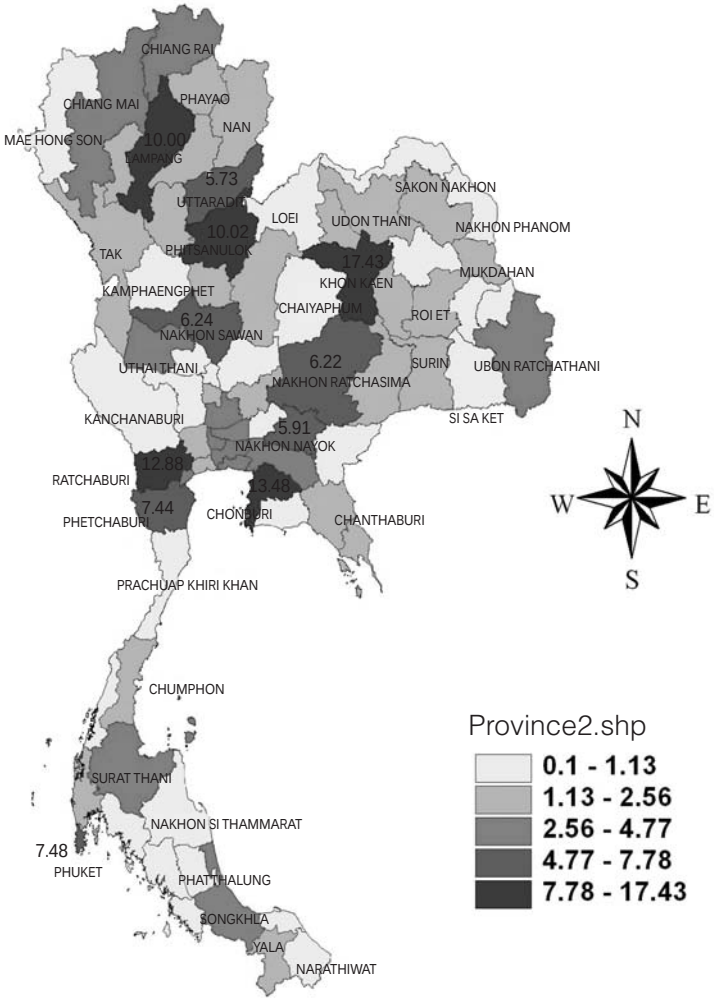
2. 1,500 life saving kits for sub-district level had been purchased and distributed to 1,500 local governments.

3. HR training program for EMS provision had been developed by Narenthorn Center, MOPH under MOU between the Narenthorn and NHSO.

4. a number of regional forums for EMS system development had been convened

The EMS utilization rate in 2005 was 3.24 persons per 1000 population. The five most provinces with high incidence were Konkaen, Chonburi, Rajburi, Pitsanuroke, Lampang accounting for the rate of 17.43, 13.48, 12.88, 10.02 and 10.00 respectively (see Figure 5).

Figure 5: EMS Utilization Concerning Advance Life Support and Basic Life Support, 2005 (Rate: persons / 1000 population)



Source: Analysis from Data of Narenthorn Center, MOPH, 2005

Budget Management for Capital Replacement

The capital replacement budget was 76.8 Bht / person representing 5.5% of total capital budget. This budget was given to both public and private facilities registered under UC policy. The Board had approved the budget structure as follows;

1. Capital replacement for MOPH's facilities = 3,075,300,233 Baht
2. Capital replacement for public facilities not under MOPH = 139,839,149 Baht
3. Capital replacement for private facilities = 157,460,618 Baht
4. Capital replacement for facilities providing special care = 137,000,000 Baht
5. HR development for providing special care = 90,000,000 Baht
6. HR development for providing primary car = 10,000,000 Baht

The progress of budget utilization is shown in Table 33. The budget had already been disbursed around 99.73%.

Table 32: Utilization of Capital Replacement Budget in Each Component in FY2005

Component	Budget (Bht)	Disbursement (Bht)	On process
MOPH's facilities	3,075,300,233	3,075,300,233	-
Public facilities not under MOPH	139,839,149	139,839,149	-
Private facilities	157,460,618	157,460,618	-
Facilities providing special care	137,000,000	137,000,000	-
HR development for providing special care	90,000,000	80,291,094	9,708,906
HR development for providing primary care	10,000,000	10,000,000	-
Total (%)	3,609,600,000 (100)	3,599,891,094 (99.73)	9,708,906 (0.27)

Source: Bureau of Supporting and Developing NHSO Branch, 2005

Budget Management for Compensation under Article 41

The budget was aimed at providing initial compensation to medically injured patients under the UC care provision in compliance with Article 41, National Health Security Act. The budget was centrally pooled. In 2005, the case number of compensation jumped by 30.94% relative to 2004 figure. Death and disability were a majority of cases accounting for 64%. Lost organs and functioning came second at 15%. In practice, not all cases requesting compensation met the compensation criteria (Table 33).

Table 33: Comparison of Medically Injured Cases Receiving Compensation, FY2004 - FY2005

FY	All case requesting	Results from Case Consideration Committee				Cases reviewed by Standard & Quality Control Board (cases)
		Not meeting criteria (cases)	Death/ disab. (cases)	Lost organs/ functioning (cases)	Injuries/ cont. illness (cases)	
2004	99	26	49	11	13	17
2005	320	69	162	40	49	77

Source: Bureau of Legal Affairs, 2005

Budget Management for Rehabilitative Service

The capitation rate for rehabilitative service was 4 Baht / person totaling 188 million Baht. The budget was composed of three management budget portion. 80% of the budget was for medical rehabilitative care, 14% was for purchasing assistive devices under Sirinthorn Institute's management, MOPH and 6% was for training programs benefiting the disabled, care takers and family members. The progress of budget use is illustrated in Table 34.

Table 34: Progress of Budget Use for Rehabilitative Care in FY2005

Component	Budget million	Utilization		Remark
		million	%	
Rehabilitative care	150.4			
- Service remuneration and some assistive devices	110.4	7.6	6.88	
- Screening, disability assessment and registration	30.0	26.2	87.33	
- Delivery system model development	10.0	9.9	99.00	Operating in the facilities as a voluntary project
Purchase of assistive devices by Sirithorn Institute	26.2	26.2	100.00	20.2 million Bht managed by Sirithorn Institute and 6 million Bht made for trial model of coupon system starting from March 05
Training programs for disabled, family members and care takers	11.4	9.6	84.21	Granting disability agencies / organizations

Budget Management for High Cost, Accident and Emergency Care

The budge was managed through direct claim process. Two budget components were aimed at firstly remunerating accident and emergency cases in provinces where the patients were not entitled to and secondly remunerating cases with high cost care. The total budget was 5,837.87 million (Table 35).

Table 35: Budget Structure of High Cost Care, Accident and Emergency Care in FY2005

Component	Bht / pers	Total (Bht)
High cost care - Outpatient care	5.93	278,710,000
- Inpatient care	80.86	3,800,420,000
- Additional remuneration for some IP cases	2.95	138,650,000
- Medical instruments	9.74	457,780,000
Accident and Emergency - Outpatient care	0.74	34,780,000
- Inpatient care	14.37	675,390,000
- Inpatient care for UC members but not registered before	6.05	284,350,000
- Inpatient care for newborn babies	3.57	167,790,000

To make more effective disbursement to providers, NHSO set disbursement duration for each budget component as shown in Table 36.

Table 36: Effective Disbursement Period for High Cost Care, Accident and Emergency Care in FY2005

Component	Disbursement period
Outpatient care (HC and AE)	Monthly
Inpatient care	Quarterly
Instruments / artificial organs (OP and IP)	Quarterly

Since October, 2005, NHSO had determined that a claim report should be reached to NHSO within 30 days since the day of care delivery or the day of discharging the patient so as to facilitate allocation calculation in each remuneration period. It was found that less than 80 % of OP and IP claim reports in 2005 reached NHSO within 30 days (see Figure 28 and 29).

In 2005, there were 1,141,434 claims from providers consisting of 362,215 high cost claims and 779,219 accident and emergency (AE) claims. 96.36 % and 71.76 % of high cost and AE claims were compliant with the payable criteria (Table 37).

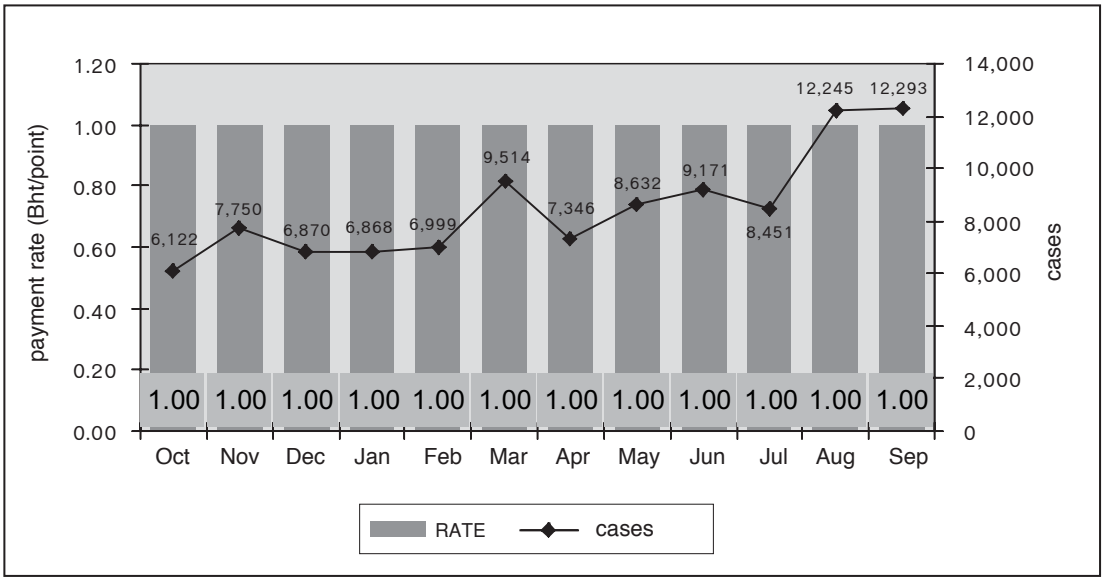
Table 37: Summary of Medical Claims in FY2005

Claim type	No. of facilities making claims	No. of claims	No. of payable claims	% of payable claims
High cost care				
OP care	142	104,017	102,585	98.62
IP care	736	123,419	117,069	94.85
Instruments	747	129,918	126,028	97.00
Supplementary pay for some IP care	253	4,861	3,345	68.81
Accident and emergency				
OP	808	104,434	101,328	97.03
IP	916	203,625	170,624	83.79
IP care for UC members and not registered before	969	97,313	89,861	92.35
Inpatient care for newborn babies	894	373,847	197,332	52.78

Remuneration of High Cost Care

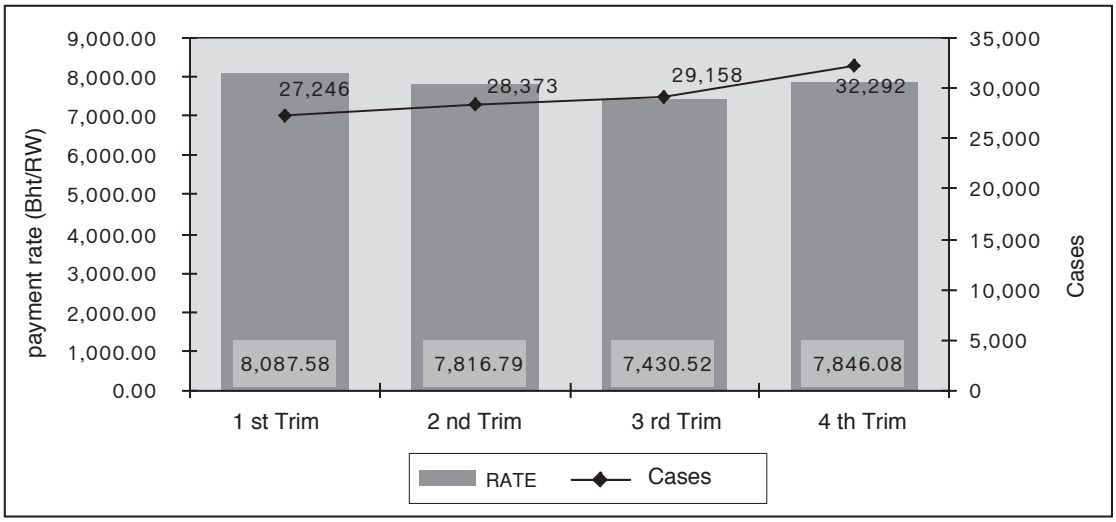
For outpatient care regarded as high cost claim, NHSO paid the facilities on the use of point system with global budget. In FY2005, NHSO had paid 197,968,087.08 Baht (102,261 claims) or 66.29% of total money that the facilities claimed to receive. Figure 6 shows the claim statistic of FY2005 reflecting highest claim amount in terms of value and claim number in the last 2 months of FY in order to clear all claim cases prior to the new FY.

Figure 6: Number of OP-HC Claims and Remuneration Rate from Oct 2004 - Sep 2005



For inpatient care regarded as high cost claim, NHSO paid the facilities by using adjusted relative weight (RW) system based on inpatient days with global budget. In FY2005, NHSO had paid 3,717,148,221.44 Baht (109,069 claim cases). Each trimester had cases ranging between 2.72 - 3.22 thousand cases and had its particular RW payment rate as shown in Figure 7

Figure 7: Number of IP-HC Claims and RW Rate of each Trimester in FY2005



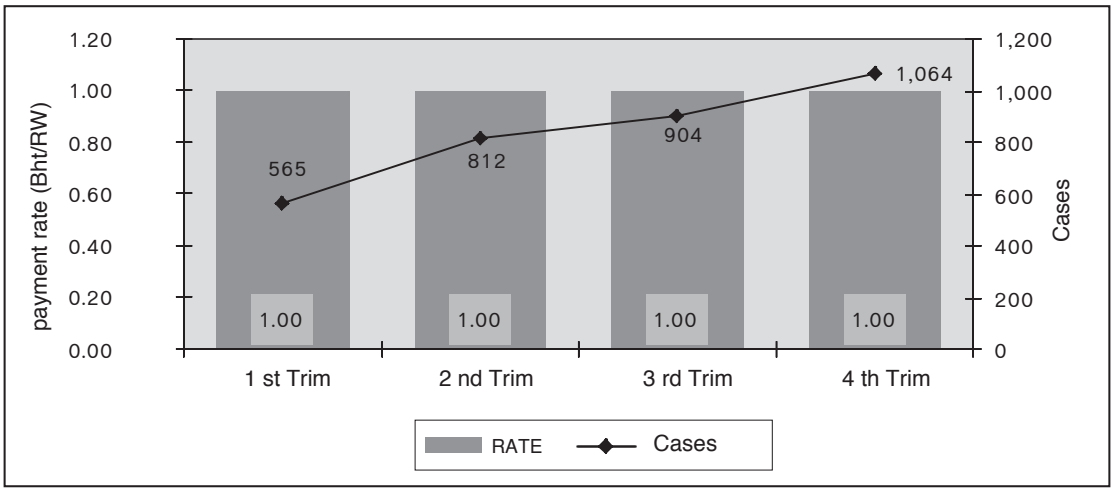
In the beginning of FY2005, the determined rate of payment was 10,300 Baht / RW. However, the actual rate was on average 7,790 Baht / RW or 75.63% of the expected rate. The total payment to the facilities compared with the amount claimed to receive by the facilities was short about 53.28% (Table 38).

Table 38: IP-HC Payment of each Trimester in FY2005

Trim.	Expected amount to claim by facilities (Bht)	Aggregated adj. RWs	Payable adj. RW (Bht/RW)	Total payment (Bht)	% of payment relative to facility expectation
1	1,483,660,257.59	109,119.71	8,087.58	882,513,901.81	59.48
2	1,737,935,786.63	114,528.97	7,816.79	895,249,435.94	51.51
3	1,737,753,755.49	118,857.04	7,430.52	883,169,627.09	50.82
4	2,016,941,868.15	134,616.89	7,846.08	1,056,215,256.60	52.37
Total	6,976,291,667.86	477,122.61	7,790.76	3,717,148,221.44	53.28

Apart from HC care payment, additional payment was made for particular services which were renal dialysis and medication for brain fungal infection in HIV/AIDs patients at the rate of 1 Baht / score. The payment for such cases was 30,495,703 Baht accounting for 3,345 cases (Figure 8).

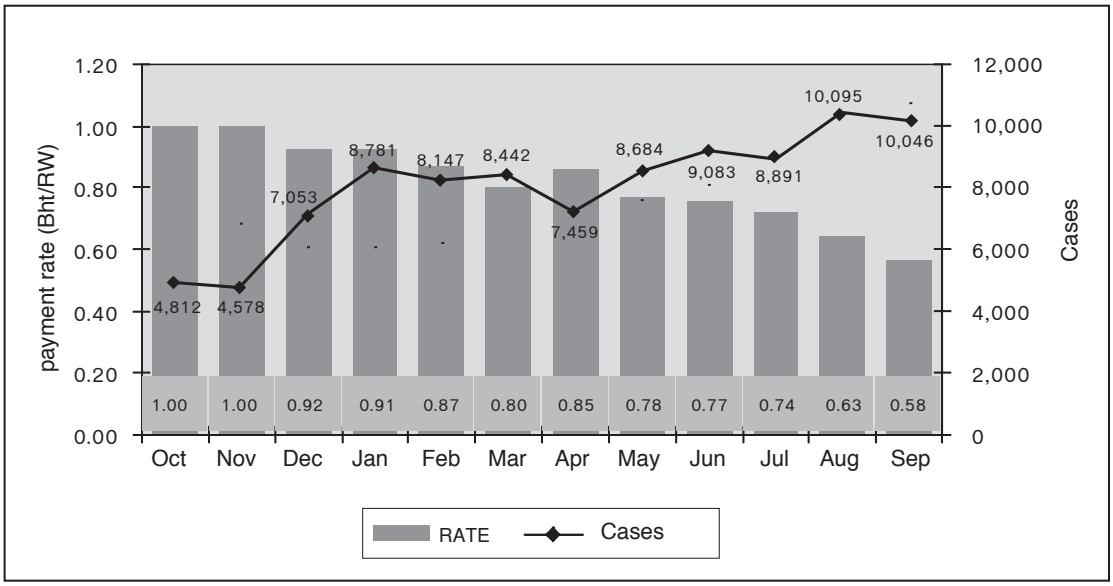
Figure 8: Number of Cases and Payment in Category of IP-HC for Particular Services in FY2005



Remuneration of Accident and Emergency Care

For outpatient care regarded as A&E claims , NHSO had paid the facilities on a basis of the point system with global budget. The payment reached 33,045,876.97 Baht or 60.46% of the amount claimed by the facilities. The average compensation rate was 0.82 Baht / point. The distribution of payment rate in each month is shown in Figure 9.

Figure 9: Number of OP-AE Claims and Payment Rate of each Month in FY2005



For inpatient care regarded as A&E claims, NHSO had paid the facilities on the use of the adjusted relative weight system in which inpatient days were used for adjustment. NHSO had paid 1,023,799,818.62 Baht (170,624 claims). The average payment per RW was 3,381.11 Baht lower than the predetermined 5,050 Baht or 66.59 % of the formerly expected. The compensation only covered 29. 62 % of the written amount the facilities expected to receive. The average IP-AE payment rate was 4,220.83 Baht (36.39 % of the requested amount) while the average of IP care claims for UC members not previously registered and the average rate of IP care claims for newborn babies were 4,144.32 Baht (42.29% of the requested) and 1,676.36 Baht (13.77% of the requested) respectively (Table 39 - 41).

Table 39: IP-AE Care compensation in each Trimester, FY2005

Trim.	No. of claims	Requested claim amount (Bht)	Total Adj.RWs	Payment rate (Bht per adj. RW)	Actual payment (Bht)	%
1	40,184	417,841,050.64	33,766.47	4,405.36	148,753,303.39	35.60
2	41,237	382,621,909.47	34,512.06	4,322.30	149,171,599.37	38.99
3	44,050	403,878,315.70	36,518.05	4,152.26	151,632,571.70	37.54
4	45,153	448,781,474.28	37,744.64	4,029.32	152,085,186.21	33.89
total	170,624	1,653,122,750.09	142,541.22	4,220.83	601,642,660.67	36.39

Table 40: IP Care Compensation for UC members not previously registered in each Trimester, FY2005

Trim.	No. of claims	Requested claim amount (Bht)	Total Adj.RWs	Payment rate (Bht per adj. RW)	Factual payment (Bht)	%
1	19,940	131,725,793.67	13,748.98	4,676.09	64,291,519.93	48.81
2	26,761	173,862,387.78	18,380.59	3,520.27	64,704,733.25	37.22
3	21,624	151,990,723.97	15,008.08	4,267.99	64,054,346.48	42.14
4	21,536	152,002,043.95	15,061.79	4,297.22	64,723,850.71	42.58
total	89,861	609,580,949.37	62,199.44	4,144.32	257,774,450.37	42.29

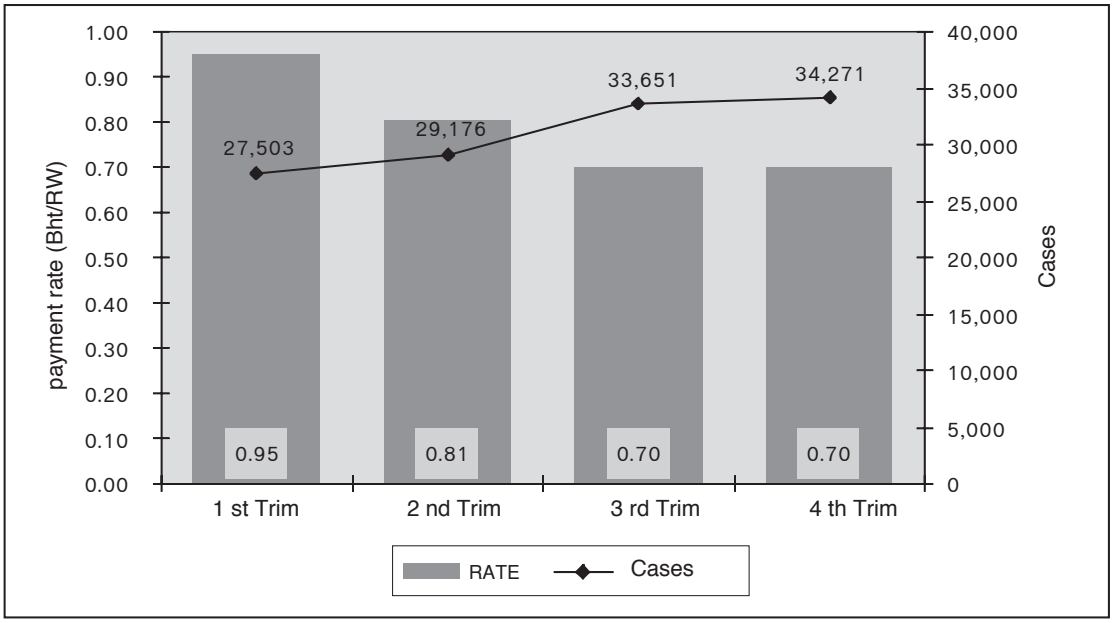
Table 41: IP Care Compensation for Newborn Babies in each Trimester, FY2005

Trim.	No. of claims	Requested claim amount (Bht)	Total Adj.RWs	Payment rate (Bht per adj. RW)	Factual payment (Bht)	%
1	49,651	249,352,641.62	23,881.59	1,668.64	39,849,733.18	15.98
2	49,789	272,655,468.30	23,801.56	1,674.25	39,849,731.92	14.62
3	45,685	310,123,495.16	23,529.70	1,693.59	39,849,662.47	12.85
4	52,207	361,471,451.57	26,846.60	1,669.99	44,833,580.01	12.40
total	197,332	1,193,603,056.65	98,059.46	1,676.36	164,382,707.58	13.77

Budget Management for Medical Instruments and Artificial Organs

NHSO paid the facilities on this provision category through the use of the point system with maximum point ceilings under global budget. Each item had its point ceiling. NHSO had paid 431,154,381.06 Baht for 124,601 claims. The highest claim number was in the last trimester of FY2005. The percentage of price coverage was around 54.01% or 0.79 Baht per point.

Figure 10: Number of Claims and Compensation Rates for Medical Instruments and Artificial Organs in FY2005



Budget Allocation to those Affected by Tsunami

Due to Tsunami in December 2005, the Board approved 100 million Baht for medical and mental services given to the affected. Table 42 shows the budget allocation.

Table 42: Budget Allocation for Services Given to those Affected by Tsunami

Agency	1st allocation	2nd allocation	3rd allocation	4th allocation
Phuket provincial office	10,000,000	500,000		3,629,000
Krabi provincial office	10,000,000	500,000		5,443,000
Pangnga provincial office	20,000,000	1,000,000	4,500,000	7,258,000
Ranong provincial office	5,000,000			1,814,000
Trang provincial office	3,000,000			2,298,000
Satun provincial office	2,000,000			1,088,000
Wachira Phuket Hosp.		500,000		
Krabi hosp.		500,000		
Pangnga hosp.		1,000,000		
Takuapa hosp.		2,500,000		
Suratthanee hosp.		1,000,000		605,000
Maharajnakornsri hosp.		1,000,000		605,000
Haadyai hosp.		200,000		847,000
Songkhlanakarin hosp.		1,000,000		1,210,000
Songkhla hosp.				605,000
Chumporn hosp.		300,000		242,000
Songkhla provincial office				1,110,000
Suratthanee provincial office				968,000
Nakornsrithamarat provincial office				1,110,000
Chumporn provincial office				484,000
Pathalung provincial office				684,000
Total	50,000,000	10,000,000	4,500,000	30,000,000

Source: Bureau of Supporting and Developing Branch Office, Jan 2006

Problems and Direction for Compensation Management

Budget Management

In 2005, 5,838 million Baht or 124.21 Baht / person was set aside for high cost care, accident and emergency care in cases happening in different responsibility of provincial funds where the patients had their entitlement. The calculation of this certain amount was based on the FY2004 utilization statistic yielding the more accurate figure. In addition, the separate budget for services given to UC members not registered before (first time patients) and for services given to new born babies previously covered by AE budget in FY2004 had heightened payment rates for high cost and AE care in FY2005. The separate fund to cover medical instruments and artificial organs also helped increase the DRGs payment rates. .Nevertheless, the higher payment rates remained lower than the predetermined at the beginning of the financial year partly.

In FY2006, more separate funds would be expected to better providers' cost coverage and patients' care accessibility. Due to availability of more funds, the management of budget portfolio would need better information to support actuarial calculation. With respect to claim reporting, in FY2005 around 7 % of total claim reports had been declined to pay in the preliminary review despite payable because of their incomplete recording from providers. An improvement strategy for the next financial year would be a greater emphasis on making training personnel involved in medical recording, reporting and internal reviewing at their facilities.

Service Claim under Article 12, National Health Act, 2002

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Service Claim under Article 12, National Health Act, 2002

Article 12, National Health Security Act states that for injury cases having received services from health facilities under UC scheme. National Health Security Office is legitimate to claim service charges from Traffic Accident Injury Compensation Fund established by Traffic Accident Injury Compensation Act or insurance companies or central insurance company and consequently transfers the compensation to the facilities. In FY2005, NHSO had carried out two projects which were:

1. A pilot project of claiming service charges according to Article 12.
Its main objective is to train relevant hospital officials to understand how to make claim reports effectively. The project had been implemented in Konkaen Hospital, Rajvithee Hospital, Nopparatrajthanee Hospital, Phumipol Adulyadej Hospital, some hospitals in Chiang Mai and Nakhonsawan. While NHSO convened several workshops with Insurance Department, Ministry of Commerce, Central Insurance Company for Traffic Injury Compensation and legal consulting team contracted by NHSO in support of developing a framework of claim process, reviewing all claims and coordinating.

From January to September 2005, 2,492 claims from 60 hospitals had been sent to NHSO accounting for 30,102,215 Baht of which 27,453,675 Baht was determined for compensation from Traffic Injury Compensation Fund. Having claimed to insurance companies responsible for the compensation, NHSO got only 6,711,666 Baht covering 1,308 cases.

A common problem of the development was found in remote hospitals where officials responsible for writing the claims were insufficient and inexperienced. While bigger hospitals with claim experience tended to transfer some cases with difficulty to get claimed to NHSO. Several problems of running the project were insufficient hospital claim reports forms, claim process overloaded with documents which consumed time for review and a lot of vehicles remaining uninsured by Traffic Accident Injury Compensation Act.

2. Hospitals not under the pilot project
NHSO advised these hospitals to claim directly to NHSO later claiming to relevant insurance companies. NHSO deducted the first amount of 15,000 Baht before paying the hospital as it was able to get such payment from Traffic Accident Injury Compensation Fund. In addition, NHSO had given these hospitals consultation and coordinated with Insurance Department on dispute cases.

Problems and development direction

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Problems and development direction

In FY2005 which was the third year of implementing the universal coverage policy, new problems were emerging in addition to the problems which had been perceived prior to the policy commencement and not been resolved. The recent problems were basically resulted from changing demands of population and more complexity of system management.

Insufficient capitation budget

For the past, the capitation budget calculation had been based on results of National Health and Welfare Surveys and various studies of facility unit cost. Adjustments to the calculation were made with the use of information concerning changing patterns of population's service utilization and cost analysis. However, such the calculation approach was restricted to reflect more actual costs usually yielding lower figures than actual ones due to the fact that inputs used for calculation reflected the historical data. In FY2005, numerous factors were utilized for better calculation results (Table 43).

Table 43: Information Source Used for Capitation Calculation, FY2002 - FY2005

Information source	2002	2003	2004	2005
Morbidity data (National Health and Welfare Survey)	1996	2001	2001	2005 (forecast)
Cost analysis data	2000	2001	2002	2005 (using 2003 data for adjustment)

Budget approval

Apart from relative lower capitation rates yielded by the calculation, the capitation budget approved by the government was lower than the calculated figure proposed (Table 44). It was estimated that the health care system accumulated the loss of 32,087 million Baht from FY2002 to FY2005.

Table 44: Comparison of Proposed Capitation Budget with Approved Budget, FY2002 - FY2005

Capitation rate (Bath/person)	2002	2003	2004	2005
Proposed rate	1,202	1,414	1,447	1,510
Recommended rate	1,318	1,394	1,600	1,510
Approved rate	1,202	1,202	1,308	1,396
Difference	115	192	292	114
Difference in total amount (million Baht)	5,196	8,622	13,139	5,130

Source: Viroj Tangcharoensathien, 2005

Management of high cost care

In FY2005, in the beginning, particular high cost services were determined for payment at 10,300 Baht per relative weight higher than the average payment of 5,050 Baht per relative weight. Nevertheless, with respect to global budget given, the actual payment rate was 7,790 Baht per relative weight. To alleviate the unmet costs of high cost care already given, the Board authorized NHSO to shift 295,410,130 Baht as part of the budget determined for EMS to partly supplement the unmet payment. At last, the payment rate of 10,300 Baht per relative weight for high cost care was not fully actualized. To some extent, cost recovery to such care had been materialized. Consequently, the care accessibility had been improved.

Protection of care accessibility to people without nationality

There were approximately 1-2 million people without nationality either living in Thailand for years or being investigated their Thai nationality. Once sick, they received care from the facilities on humanitarian basis without budget support as they were not Thai. The financial subsidization from the UC budget to these people aggravated more difficulty in managing the fund to the providers.

Despite the Board decision on providing financial coverage to these people on January 17, 2005 on the view of their economic contribution for Thailand, the Cabinet deferred such a decision given a reason of burdening the budget.

Effectiveness of budget management for prevention and promotion

The inclusion of budget for prevention and promotion into the capitation payment did not bring about reliable effectiveness of prevention and promotion programs. To boost the effectiveness, NHSO earmarked the budget for such programs and commissioned intermediary agencies e.g. several departments of MOPH to use their specialty to effectively manage the budget. In the meantime, NHSO and the commissioned agencies had to work in partnership to develop information system to enhance more effective decisions on various public health problems in Thailand.