NHSO
Annual Report
Fiscal Year 2014

UHC is a basic right for
All Thai citizens, …

…since we were **born.**

The benefit package included …

- Health promotion services
- Disease prevention services
- Curative care
- Rehabilitation services

… approved by the National Health Security Board.

NHSO

Annual Report

Fiscal Year 2014

NHSO Annual Report 2014

Translated from the Thai version

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NHSO's Vision

"All residents in Thailand
are assured under the Universal Health Coverage"

Message from
the Chair of the National Health Security Board

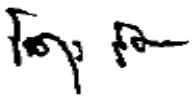
Improving overall quality of life of the population through health system development has been an important policy of Thai government. The policy has been continued to promote in all health dimension including healthcare services especially in primary care development, health personnel, health information, medicines and medical instruments, good governance in health system, and health financing system.

Universal health coverage (UHC) system is one of policies to improve efficiency in health financing and management. Although achieving universal health coverage of Thailand has been internationally recognized as a role model for other developing countries, continuous development and better management for benefit of the citizens and health system as a whole are still be important missions. The key policies to improve quality of life of Thai citizens while also be able to control long-term health expenditure for sustainable health security for the citizens include improving efficiency in administration and resource management, improving accessibility to quality of health care in every level, harmonizing government health insurances, and improving accessibility to healthcare in population who need special attention or who have problem(s) in accessing to basic healthcare as needed.

In FY2014, the National Health Security Board (NHSB) has urged implementation of important policies to improve performance in universal health coverage implementation. The top five important policies are 1) improving efficiency in health security fund management and promoting integrated holistic health services responded to local health need so people can access to health services within their region; 2) harmonizing government health insurances to improve equity and efficiency in health system; 3) promoting benefit package development to introduce new benefit packages in order to promote accessibility and efficiency in health system, e.g., Long-term care for dependent elderly, integrated emergency health service system, primary care development in urban area; 4) promoting consumer rights protection in health security system for beneficiaries other small government health insurance schemes such as government officers of local administration organizations and their dependents; and 5) promoting administrative system development to reduce duplicated processes such as National Clearing House assigned by the government to manage claims and reimbursement transactions for government health insurance schemes.

These achievements are happened because of supports and collaborations from stakeholders and alliances. I would like to thank executives and staffs of the ministry of public health, other related ministries, health facilities and hospitals both government and private, health professional institutes, local administration organizations, civil society, and other related organizations including the NHSO for their involvement in universal health coverage development and their support in the universal health coverage implementation of the government policy. As a result, the citizens are secured, standard quality of care can be accessed; health equity; and benefit package can cover more target groups especially people who have problem(s) in accessing to basic healthcare as needed.

I hope that all stakeholders and alliances will continue their supports, their engagement, and their ownership in universal health coverage implementation for benefits and happiness of the citizen. I also wish you and your family all the best of happiness.



(Prof. Rajata Rajatanavin, M.D.)
Minister of Public Health Ministry
Chair of the National Health Security Board

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

Fiscal year 2014 is the third year after health service challenges had been analyzed and reviewed by the *Health Service Standard and Quality Control Board* (HSQCB) since 2012 when the new members joined the board. This had been done in order to continue duties in promoting health service standard and quality control as authorized by section 50 of the National Health Security Act, B.E. 2545.

During the mid year of 2014, the provincial health offices' role as provincial branch offices of the NHSO has been canceled by the National Health Security Board's resolution. *The Health Service Standard and Quality Control Board* has prepared for the situation to reduce impact to the population and to be able to continue key functions of *the provincial sub-committees on health service standard and quality control* and *the provincial sub-committees to adjudicate complaint for losses from health service according to section 41 of the Act*. As the result, the 76 *provincial sub-committees on health service standard and quality control* had been reorganized to 13 *regional sub-committees on health service standard and quality control*. Official processes to assign members, roles and responsibility in health service standard and quality control of the regional sub-committees had been completed in order to continue the duties. However, the *Health Service Standard and Quality Control Board* (HSQCB) and provincial health office teams have agreed and proposed that roles and responsibilities of *the provincial sub-committees to adjudicate complaint for losses from health service according to section 41 of the Act* in solving problem for health facilities within the province should be continued. The NHSO had submitted the proposed agreement to keep roles and responsibilities of *the provincial sub-committees to adjudicate complaint for losses from health service according to section 41 of the Act* to the Ministry of Public Health (MOPH). After the MOPH had accepted the agreement, the Chief of provincial health office of every province has continued to act as the secretary of *the provincial sub-committees to adjudicate complaint for losses from health service according to section 41 of the Act*. Furthermore, collaboration process between the *regional sub-committees on health service standard and quality control* and *the provincial sub-committees to adjudicate complaint for losses from health service according to section 41 of the Act* within the region has been set up. The *regional sub-committees on health service standard and quality control* will collect results of all the complaints within the region, analyze and summary limitation of health service system, and finally, propose comments and suggestions suitable for health facilities within the region to prevent the problems.

I would like to appreciate great supports from members of the health service standard and quality control board, members of working groups or sub-committees in central, regional, and provincial levels, other related stakeholders, and the national health security office. All great support from stakeholders and alliances has the same goal to benefit to all people living in Thailand.

(Associate Prof. Prasobsri Ungthavorn, M.D.)
Chair of the health service standard and quality control board

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

After the twelve years of universal health coverage implementation in Thailand, the NHSO has collaborated with health alliances including public and private health facilities, civil society, local administration organizations, other health institutes, i.e., the ministry of public health, the Thai Health Foundation, the National Health Commission Office of Thailand, the Healthcare Accreditation Institute (Public Organization), and other academic institutes such as the Health Systems Research Institute (HSRI), the Health Insurance System Research Office (HISRO), the Health Intervention and Technology Assessment Program (HITAP) to develop and to improve the universal health coverage (UHC) in the country. Achievement in UHC of Thailand has been internationally recognized by other countries so Thailand has been a target country to learn the UHC concept for other developing countries not only in Asia but also other regions such as Africa and Middle East region.

Benefit packages of the Universal Coverage Scheme (UCS) have been continued to expand and to improve so that the Thai citizens under the UCS scheme can access to quality of healthcare with financial risk protection. The benefit packages have been expanded to the beneficiaries including kidney transplantation and Hemodialysis in addition to Continuous Ambulatory Peritoneal Dialysis (CAPD) for end-stage kidney failure patient, Anti-retroviral therapy (ART) to HIV/AIDS patients regardless of CD4 cell count, and influenza vaccines to more target groups, i.e., elderly group, risk groups, children age 6 months to 2 year old, health personnel in nursing homes and foster homes.

The NHSO's performance under the supervision of the National Health Security Board in order to promote health service accessibility for the population as needs with equity and dignity concern, to improve effectiveness and quality of health services, to strengthen civil society involvement in universal health coverage and health system has continued to improve during the past decade. As the result, the NHSO has won award as the organization with best working capital management from the ministry of finance for seven consecutive years since FY2008. The award has guaranteed efficiency in financial management of the NHSO since the award is aimed to promote high efficiency of fund managers in financing, operations, responding to stakeholders' needs, and development and management of working capital.

By celebrating the thirteenth anniversary of the NHSO, changing in population structure of Thai people has driven more challenges in universal health coverage management to achieve the missions according to the National Health Security Act B.E. 2545 (A.D. 2002) because Thailand will have to deal not only with more health problems in elderly, chronic diseases, cancers, and more complicated health management but also with other limitations that required extensive collaboration and support from all stakeholders. I hope that all limitations will be solved because all stakeholders are not only doing their jobs but also sharing sense of ownership in the universal health coverage.

(Winai Sawasdivorn, M.D.)
Secretary General of the NHSO

Executive Summary

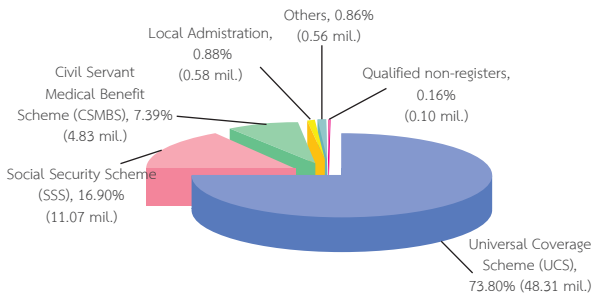
Key target of universal health coverage (UHC) is to have equity in accessing to healthcare as needed for all Thai citizens. Three indicators of the achievement in UHC are increasing in equity of accessibility to quality of healthcare, reducing in household burden on health expenditure, and protecting household from poverty from health expenditure. Performances of universal health coverage implementation in the twelfth year anniversary, in FY2014, are described below:

1. Improving equity in accessibility to healthcare

1.1 Universal health coverage

Universal health coverage for all Thai citizens has been increased from 71.0% in FY2001 to 99.84% in FY2014. The coverage by government health insurance schemes in FY2014 are 73.80% of the UCS, 16.90% of the SSS, and 7.39% of the CSMBS scheme.

Figure 1 Proportion of the government health insurance schemes, FY2014

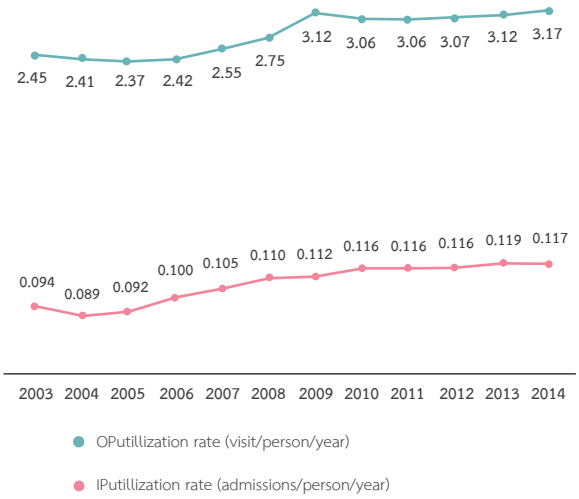


Source: Bureau of Registration Administration, NHSO, September 2014

1.2 Improving accessibility to necessary healthcare and improving quality of healthcare

Indicators to prove that accessibility has been improved are utilization rate of health services not only out-patient and in-patient services but also other complicated and high-cost service. Utilization rate of out-patient services has been increased from 2.45 visits per person per year in FY2003 to 3.17 visits per person per year in FY2014 (29.5% increased). Utilization rate of in-patient services has been increased from 0.094 admissions per person per year in FY2003 to 0.117 admissions per person per year in FY2014 (24.6% increased).

Figure 2 Utilization rate of in-patient and out-patient services in UCS, FY2003- 2014



Source:
1) Out-patient data:
- *FY2003-2009 are from 0110RP5 Report, ministry of public health*
- *FY2010 – 2014 data are from NHSO, FY2014 is estimated from 10 month of services*

2) In-patient data, NHSO, date of data on December 2014

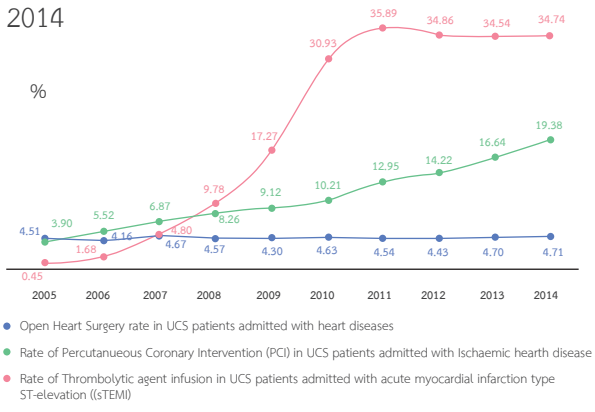
The NHSO has continued to promote quality improvement for its' main contractors and referral hospitals by supporting hospital accreditation (HA) processes. A percentage of accredited main contractors and referral hospitals have continued to increase from only 6.12% in FY2003 to 45.09% in FY2014.

Figure 3 Percentage of UCS registered hospitals classified by level of accreditation, FY2003-2014

Source: The Healthcare Accreditation Institute, FY2014, analyzed by Bureau of Quality and Health Outcome Monitoring, NHSO

Furthermore, it is important to promote accessibility to necessary treatments in high mortality rate disease such as cardio-vascular diseases that have limitation in specialists both in term of quantity and distribution. For example, accessibility rate to key procedures in hearth diseases patients under the UCS has also increased. The accessibility rate to open heart surgery in the patients admitted with heart diseases, to Percutanueous Coronary Intervention (PCI) in the patients admitted with Ischemic heart disease, and to Thrombolytic agent infusion in the patients admitted with acute myocardial infarction type ST-elevation (STEMI) have been dramatically increased since FY2005 as shown in figure 4.

Figure 4 Accessibility rate to heart procedures in heart diseases patients under the UCS, FY2005-2014



Source: In-patient data, NHSO

Most of key performance indices (KPIs) of the UCS fund management in FY2014 are achieved based on the target as described in table 1

Table 1 The NHSO key performance indices in FY2014

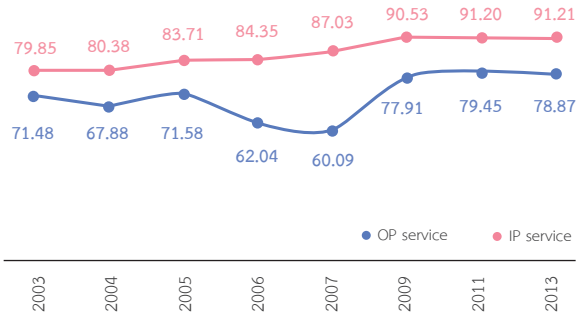
KPIs	Goal (according to budget allocation)	Performance	% of performance
1. HIV/AIDS health service package			
- HIV/AIDS patients received ART	188,000 (cases)	190,342	101.25
2. CKD health service package			
- CKD patients received Renal Replacement Therapy (RRT)	35,429 (cases)	36,519	103.08
3. Health promotion and prevention in chronic diseases (DM and hypertension)			
- secondary prevention in DM and HT patients	2,726,800 (cases)	3,149,023	115.48
4. Rehabilitation			
1) disabled (cases)	1,185,240	1,127,097	95.09
2) instruments for disabled	46,880 (cases)	41,553	88.64
3) rehabilitation services			
- for disabled (visits)	194,985	183,483	94.10
5. Thai traditional medicines			
- Massage, hot compress, herbal stream	3,341,000 (visits)	4,648,944	139.15
- post-partum care (visits)	24,169	35,612	147.35
- registered hospitals having Thai traditional medicine center (units)	590	606	102.71
6. Health promotion and prevention			
- Seasoning influenza vaccines	3,400,000 (cases)	3,179,991	93.53
7. E(2) category drug list (cases)	14,153	12,963	91.51
8. Orphan drug items / cases	20 / 4,790	18 / 5,432	90 / 113.40
9. Compulsory licensing drugs (Clopidogrel)	128,938 (cases)	182,432	141.49

Source: OP and IP services data, NHSO

1.3. Acceptance rate of the citizens when they access to health services

According to health and welfare survey by the National Statistics Office in 2013 analyzed by Prof. Supon Limwattananonta of Khon Kaen University, acceptance rate of the UCS beneficiaries when they access to out-patient and in-patient services has been increased both in out-patient and in-patient services. The results shown in figure 5 found that acceptance rate of out-patient and in-patient services in FY2013 are 78.87% and 91.21%, respectively.

Figure 5 Acceptance rate of out-patient and in-patient services in UCS, FY2003- 2013



Source: Health and welfare survey, National Statistics Office, analyzed by Associate Prof. Supon Limwattananonta of Khon Kaen University

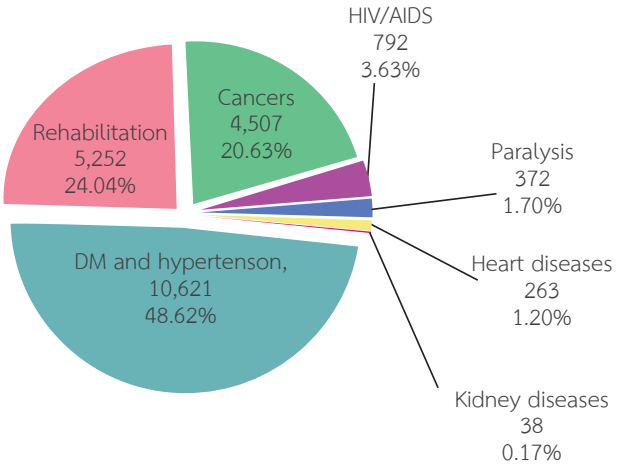
2. Local community participation

The number of local administration offices co-funding in community health security funds has been increased from only 888 sub-districts (or 11.42% of all local administration offices) in FY2006 to 7,759 sub-districts (or 99.78% of all local administration offices) in FY2014. Proportion of funding from local administration offices has been increased from THB616 million (22.03%) in FY2006 to THB990 million (27.36%) in FY2014. Most of health related activities supported by community health security funds classified by types of related diseases of the projects in FY2014 are chronic diseases (DM and Hypertension) (10,621 projects, 48.62%), rehabilitation (5,252 projects, 24.04%), cancers (4,507 projects, 20.63%), and HIV/AIDS (792 projects, 3.63%), respectively as shown in figure 6

3. Consumer Right's Protection

Establishing complaint service centers is one of consumer rights protection mechanism to be a channel that consumers can report complaints about health services through the 1330 hotline, post letters, fax, email, or in-person at the NHSO offices. In FY2014, the number of reported inquiries and complaints is 598,117 cases.

Figure 6 Health related activities supported by community health security funds classified by types of related disease, FY2014



Source: Local administration management data, NHSO

Most of these cases are inquiries (583,260 cases or 97.5%), complaints related to general management (11,029 cases or 1.8%), and complaints related to quality of care (3,8280 cases or 0.7%), respectively.

Complaints concerned quality of care in FY2014 is 3,828 cases; 97.67% of these complaints have been settled within 30 working days. Most of the complaints concerned quality of care in FY2014 are "do not receive service according to their benefit package" (1,341 cases or 35% of all complaints), "inconvenience in health service" (957 cases or 25% of all complaints), "requested for cost of care" (855 cases or 22% of all complaints), and "do not follow standard of care" (675 cases or 18% of all complaints).

The number of application filed for preliminary compensations for losses from health service according to section 41 of the National Health Security Act in FY2014 is 1,638 cases. Most of the applications were applied from consumers (1,112 cases or 83.73%). The amount of preliminary compensations to consumers filed for the losses in FY2004 is THB218.4 millions. Most of approved cases for their losses in FY2014 are deaths or

completed disability (478 cases or 51.3% of all approved cases), injuries (337 cases or 36.2% of all approved cases), and partial disability (116 cases or 12.5% of all approved cases), respectively.

The number of providers filed for compensations from their losses in FY2004 is 526 cases. The amount of preliminary compensations to providers filed for the losses in FY2004 is THB5.20 million. The rate of approved applicants has been increased from 68.75% in FY2004 to 79.85% in FY2014

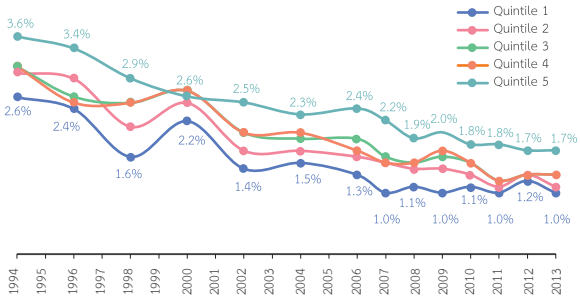
4. Reducing household burden and protecting household from financial disaster and poverty from health expenditure

Reducing household burden and protecting household from financial disaster and poverty from health expenditure is one of indicators to measure achievement in UHC.

When comparing household health expenditure to overall household expenditure classified by income groups, the result found that percentage of health expenditure to the overall household expenditure has continued to reduce in every income group. In the poorest group (quintiles 1), the percentage has been reduced from 2.6% in FY1994 to 1% in FY2013, while the one of the richest group (quintiles 5) has been reduced from 3.7% in FY1994 to 1.7% in FY2013.

When classifying household according to their employment status, i.e., informal / economically inactive group, public formal group of government employees, private formal group of private company employees, and mixed group, the result found that percentage health expenditure to the overall household expenditure of the informal/ economically inactive group has been reduced from 3.3% in FY1994 to 1.4% in FY2013, as shown in figure 8.

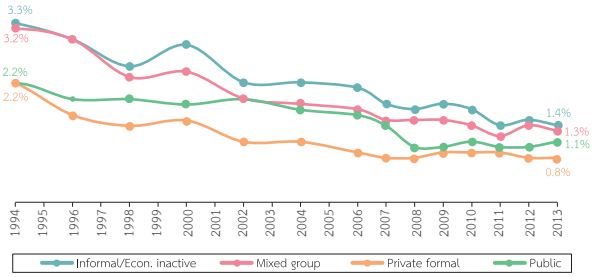
Figure 7 Percentage of household health expenditure to the overall household expenditure classified by income groups, FY1994 – 2013



Source: *Supon Limwattananonta analyzed from Household socio-economic survey of the National Statistics Office, FY1994 - 2013*

Note: *1) The survey has been done by the NSO annually since 2006.*
2) Calculated from health expenditure as a ratio of the overall household expenditure

Figure 8 Percentage of household health expenditure to the overall household expenditure classified by employment status, FY1994 – 2013



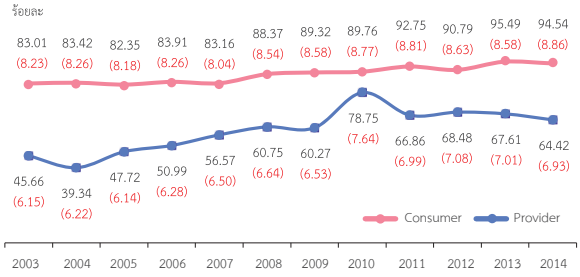
Source: *Health and welfare survey, National Statistics Office (1994-2013), analyzed by Associate Prof. Supon Limwattananonta*

Note: *1) The survey has been done by the NSO annually since 2006.*
2) Calculated from health expenditure as a ratio of the overall household expenditure

5. Satisfaction of consumers and health care providers

The percentage of satisfied consumers and healthcare provider to the UCS scheme at level 6 or more in FY 2014 are 94.54% and 64.42%, respectively.

Figure 9 The percentage of respondents satisfy at level 6 or more and average satisfactory score, FY2003-2014



Source: 1) FY2003-2013: Satisfaction survey report, Academic Network for Community Happiness Observation and Research (ANCHOR), Assumption University of Thailand

2) FY2014: NIDA Poll Center, National Institute of Development Administration

6. Challenges in UHC implementation

1. Improving efficiency in UCS fund management under limited resources: Since cost driver factors both in labor cost and other drivers such as increasing concern on chronic diseases and aging society have been increased, it is important for the UCS scheme to improve its efficiency in fund management.

2. Promoting stakeholder participation in UHC implementation: UHC implementation requires extensive participation and coordination from all stakeholders.

3. Responding to the government policy on harmonization in accident and emergency services of all government health insurance schemes: This required effective tools and mechanisms agreed among stakeholders both public and private organizations.

7. Summary and recommendation for sustain able development

1. To reduce equity between regions—both in health personnel distribution and in service system management—requires the following mechanisms

- Promoting health service networks management on specific services such as high-cost care in cancers, heart diseases, emergency services, and elderly care to reduce burden of the system and to promote seamless referral system within the region
- Reporting performance on accessibility and effectiveness of services between regions to feed back to regional offices
- Promoting decentralized policy and community participation to improve efficiency and effectiveness of health system

2. Supporting collaboration between stakeholders in universal health coverage

Highlight activities in FY2014

▶ Right protection mechanism for the local administrative organization (LAO) under the civil service medical benefit scheme (CSMBS)

In FY2013, The NHSO was assigned by the cabinet to develop claim management system for the employees of the LAO under the CSMBS scheme in order to promote accessibility, equity, and standard quality of care aiming to reduce problem in having to pre-pay for health care cost of the beneficiaries, especially for comprehensive high cost of care and employees of small size of LAO with limited of health benefit fund. The decision that allow the employees of the LAO and their dependents under the CSMBS scheme to exercise their health benefit according to the National Health Security Act (2002) has been legislated in November 2013 to officially effect since October 1, 2013.

The following systems and procedures have been developed or updated in order to support this decision:

1) Registration system and Claim system for health facilities
2) Help-desk system for health care providers
3) Consumer right protection and complaint system
4) Claims and reimbursement system
5) Workshops and channel to collect feedback from health care providers
6) Medical audit system
7) Capacity building for the NHSO regional officers
8) Surveillance and monitoring system
9) Training course on “Direct payment system and other benefits” targeted to registrars officers and employees of the LAO
10) Revised paper claim processes
11) Providing communication channel for news, reports, and information about the LAO health care benefits through a web site at http://portal.nhso.go.th/lgo

Highlight activities in FY2014

Progress report:

1. Enrollment system

1.1. The number of beneficiaries from all 7,851 LAOs enrolled to the system has been increased from 700,716 cases in August 2013 to 702,939 cases in October 2013.

1.2. The number of beneficiaries who registered for direct payment at health facilities (so they do not have to pre-pay for health care cost) has been increased from 418,785 cases or 60% of all enrolled beneficiaries in August 2013 to 426,580 cases or 60.69% of all enrolled beneficiaries in October 2013.

2. Claim and Reimbursement system

2.1. The number of direct payment in FY2014 (on September 28, 2014) is 1,345,957 visits for out-patient services and 67,966 admissions for in-patient services. The total amount of the direct payment is THB2,730,770,736.96.

2.2. The number of paper claims in FY2014 (on September 26, 2014) is 198,301 claims or in amount of THB298,982,863.92. Most of the paper claims are claimed for out-patient services: 196,856 visits or in amount of THB283,337,135.95 (94.77%). The rest of paper claims are claimed for in-patient services: THB15,645,737.97 for 1,445 admissions.

2.3. Total amount of claims for Hemodialysis and Erythropoietin drug in FY2014 (on September 28, 2014) is THB234,953,198.92. The claims for Hemodialysis is THB196,160,684 (83.49%) for 1,408 cases (22 new cases) or 90,980 visits. The rest of claim for Erythropoietin drug is THB38,792,514.92 (16.51%) for 666 cases (2 new cases).

3. Consumer right protection

3.1. The number of enquiries through 1330 hotline of the NHSO during October 1, 2013 to September 25, 2014 regarding to the LAO beneficiaries is 13,316 cases classified by callers as follow:

- Calls from consumers: 7,510 cases (56.40%)
- Calls from registrars of LAO: 4,494 cases (33.75%)
- Calls from health service providers: 1,312 cases (9.85%)

3.2. The number of complaints about inconvenience service is 287 cases.

Increasing efficiency in management of the three main government schemes

I. National Clearing House (NCH) System

The National Health Security Board has assigned the NHSO to act according to the section 26(14) of the national health security Act, B.E. 2545 to be a national clearing house responsible as claim center for other government health insurance schemes such as the local administrative organizations and other small government offices that are voluntary interested to use the service from NHSO. To respond to the new duty, the NHSO has prepared the following activities:

1) Design and develop system and action plan

2) Collaborate and discuss with managers of other health insurance schemes, i.e., Social Security Office (SSO) and the Comptroller General's Department (CGD) to set up guideline for the National Clearing House to be able to function regarding to benefit packages, claim and reimbursement rate, financial transaction, medical audit, standard dataset of health service data of each health insurance scheme, as well as promoting understanding with health care providers.

Progress report:

1) Health service data report
   In FY2014 (ending date September 29, 2014), the number of service data under CSMBS scheme submitted by 859 health facilities through the NCH are 6,920,769 visits of out-patient services and 168,942 admissions of in-patient services.
2) Reimbursement report
   In FY2014 (ending date September 29, 2014), total amount of reimbursement for claims under CSMBS scheme submitted through the NCH are THB5,757.31 million; THB4,185.62 million or 72.70% of the amount is reimbursed for 1,211,045 cases of out-patient services and the rest THB1,571.69 million (27.30%) is reimbursed for 120,743 cases of in-patient services.

II. Harmonizing benefit package for cancer treatments to reduce inequity

After the Office of the National Economic and Social Advisory Council had proposed concept of "Harmonizing benefit package for cancer treatments to reduce inequity" to the secretary of the cabinet, the cabinet has assigned the ministry of public health to be the main organization for other related organizations including the NHSO to perform the following activities:

1) Collaborating with specialists and health providers to prepared academic data for situation analysis and review on health services for cancers
2) Joining workshops and/or discussions about guideline operation for in FY2015, i.e., claims and reimbursement guideline, Cancer registry, health service registration, drug and price list for chemo-therapy and radio-therapy.

3) Collaborated discussions on seven related issues, i.e., public relations, health promotion, disease prevention, screening, palliative care, Cancer registry database, and claims and reimbursement
4) Preparing Memorandum of understanding (MoU) on "Harmonizing benefit package for cancer treatments to reduce inequity" to be signed by the mangers of three government health insurance schemes, i.e., SSO, CGD, and NHSO

III. Harmonizing and promoting a national standard for government health insurance schemes: a case of accident and emergency services on *"When emergency threatened to life occurs, go to the nearby hospital, no question on health insurance"* project (Translated from Thai: "เจ็บป่วยฉุกเฉิน ถึงแก่ชีวิต ไม่ถามสิทธิ ใกล้ที่ไหน ไปที่นั่น")

The project, also called EMCO project, is aimed to protect the citizens in emergency, so they can access to necessary health care at the nearby hospital without questioning on their health insurance scheme and without pre-payment for the care; and, referral system to higher capacity of health care is available as needed. The following activities have been prepared in FY2014:

1) Revising reimbursement rate for in-patient services under the EMCO project to use DRG plus & DRG for emergency version, and developing Pre-authorized system

2) Considering a draft of announcement of the NHSO and CGD

3) Preparing a draft of announcement stated that private health facilities cannot ask for payment from the patients under the EMCO project

Progress report:

Seven out of ten hospitals (69.7%) or 246 from 353 of all private hospitals have submitted service data for claims under the EMCO project to the NHSO. Most of the private hospitals are located in up-country (44.65%), Bangkok (44.44%) and Sub-urban (10.91%), respectively. The total number of submitted health data is 57,562 visits (48,855 cases); 52,366 visits (91%) are in-patient services, the rest of 5,196 visits (9%) are out-patient services. The number of service data qualified for reimbursement is 35,029 cases, or in amount of THB805,093,714.80.

▶ Long-term care system development for dependent elderly

Thailand is entering to aging society with an increasing proportion of population aged over 60. Frail elderly with non-communicable diseases (NCDs) and/or disability have required more dependent. Thailand currently has 10 million of elderly; 70,000 of elderly are bed ridden; 170,000 of elders are homebound. This situation has induced health financial burden not only to the households but also to the society as a whole.

The national health security board has acknowledged these impacts; therefore, sub-committee on Long term care (LTC) system development for dependent elderly was assigned by the board to have the following functions:

1) To develop strategic plan for FY2015-2018 to promote long term care for dependent elderly.
   The strategic plan has been drafted and certified by the National Health Security Board and the National Committee for the Elderly of Thailand. The plan concept is to promote home and community based care, and to promote local administration organization to be a key partner to mobilize the activities with closed collaboration and support from all stakeholders in community. The key objective of the plan is to capacity building, to promote and support families and communities to be able to provide appropriated health care for dependent elderly in the communities.
2) To develop screening tool to assess needs for elderly care so appropriated health and social care can be arranged and appropriated benefit package for the communities can be developed.
3) To develop benefit package on long term care covers both health and social care for dependent elderly
4) To implement the LTC concept in 11 voluntary pilot areas, i.e., 1) Hangdong, Chiang Mai, 2) Wat-boad, Phitsanulok, 3) Thawatburi, Roi-et, 4) Chakarat, Nakhon-ratchasima, 5) Prateaw, Chomporn, 6) Bang Klam, Songkhla, 7) Don Kaew, Chiang Mai, 8) Bang-si-thong, Nontaburi, 9) Rangsit, Phathumtani, 10) Muang, Mahasarakam, and 11) Prik, Songkhla
5) To support researches and studies related to LTC system development for dependent elderly as follow:

   - Benefit package development on LTC system for dependent elderly concentrated on assessment tools for Health & Social Care need, benefit package, and appropriated unit cost for each type of elderly group.

   - Lesson learnt from related case studies in community regarding to influent factors, mechanisms, and related operation models in order to develop a guideline(s) for project expansion in the future

   - Information system development for recording and evaluating LTC implementation as well as for integrating and sharing with other institutes within the area

   - Standard course/curriculum development for community care manager and care worker in LTC system

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Abbreviation List

AIDS	Acquired Immunodeficiency Virus
ART	Anti-Retroviral Therapy
BORA	Bureau of Registration Administration
CAPD	Continuous Ambulatory Peritoneal Dialysis
CGD	Comptroller General's Department
CKD	Chronic Kidney Disease
CSMBS	Civil Servant Medical Benefit Scheme
CUP	Contracting Unit Provider
DM	Diabetes Mellitus
DM/HT	Diabetes Mellitus / Hypertension
HA	hospital accreditation
HD	Hemodialysis
HISRO	Health Insurance System Research Office
HITAP	Health Intervention and Technology Assessment Program
HIV	Human Immunodeficiency Virus
HSQCB	Health Service Standard and Quality Control Board
HSRI	Health Systems Research Institute
HT	Hypertension
IP	In-patient
KT	Kidney Transplantation
LAO	Local Administration Organization
MOF	Ministry of Finance
MOI	Ministry of Interior
MOL	Ministry of Labor
MOPH	Ministry of Public Health
NCH	National Clearing House
NLEM	National List of Essential Medicines
NHSB	National Health Security Board
NHSO	National Health Security Office
NIEMS	National Institute for Emergency Medicine
NSO	National Statistics Office
OP	Out-patient
OPS, MOPH	office of permanent secretary, Ministry of Public Health
PCI	Percutaneous Coronary Intervention
PCU	Primary Care Unit
PP	Promotion and Prevention
RRT	Renal Replacement Therapy
SSO	Social Security Office
SSS	Social Security Scheme
UCS	Universal Coverage Scheme
UHC	Universal Health Coverage
WHO	World Health Organization

Part 1

Improving Universal Health Coverage Overview

- Concept towards the Universal Health Coverage
- Health Financing and Budgeting for Universal Health Coverage
- Coverage, Healthcare uses, and household expenditure for health care
- Healthcare Service Provision and Accreditation
- Accessibility, Efficiency, Quality and Effectiveness in Healthcare System
- Consumers' Right Protection and Stakeholder Participations

– 1 –

Concept towards the Universal Health Coverage

Concept towards the Universal Health Coverage

A basic concept towards Universal Health Coverage is to extend coverage to all population so they can access to health services as needed without financial barriers. Health financing systems are important mechanisms to promote universal health coverage by removing (or reducing) financial risks and barriers to access to health services.

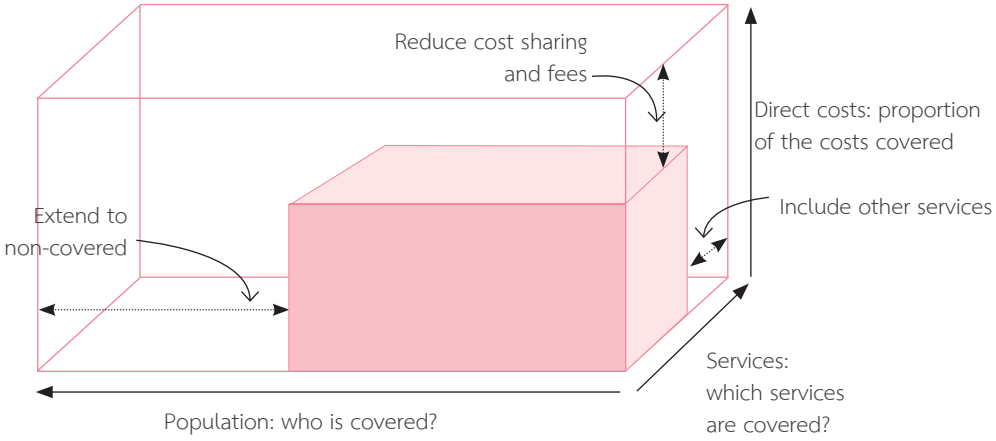
According to the World Health Organization (WHO)[1], the path to universal health coverage involves important policy choices and inevitable trade-offs. The way that pooled funds – which can come from a variety of sources, such as general government budgets, compulsory insurance contributions (payroll taxes), and household and/or employer prepayments for voluntary health insurance - are organized, used and allocated, influences greatly the direction and progress of reforms towards universal coverage.

Figure 1 shows the three dimensions proposed by the WHO in order to be considered when moving towards universal coverage. Pooled funds can be used to extend coverage to those individuals who previously were not covered, to services that previously were not covered or to reduce the direct payments needed for each service. These dimensions of coverage reflect a set of policy choices about benefits and their rationing that are among the critical decisions facing countries in their reform of health financing systems towards universal coverage. Choices need to be made about proceeding along each of the three dimensions, in many combinations, in a way that best fits their objectives as well as the financial, organizational and political contexts.

Extending the coverage from pooled funds along the three dimensions calls for health financing reforms and actions leading to an increase of available funds for health, to an increase in the share of these funds collected through prepayment and the arrangements for pooling them, to efficiency gains and to upholding and increasing the quality of health services.

[1] WHO, Health financing for universal coverage: universal coverage-three dimensions, http://www.who.int/health_financing/strategy/dimensions/en/

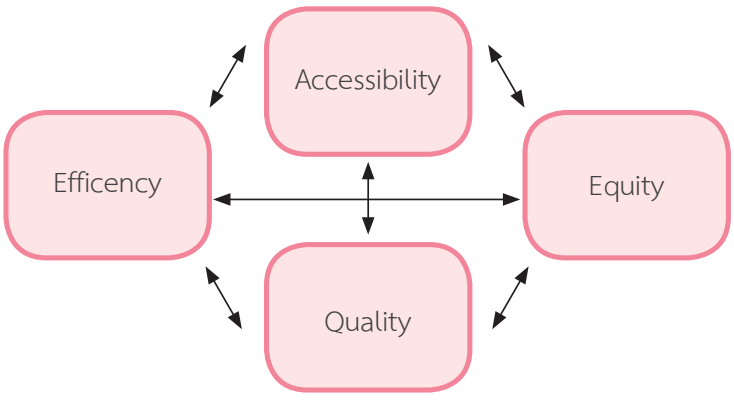
Figure 1 Three dimensions to consider when moving towards universal coverage



Benefit package in desirable universal health coverage should include health services from health promotion, disease prevention, curative care, and rehabilitation. However, extending this health service coverage will affect coverage of the other dimensions. It is difficult to cover 100% of these dimensions. Therefore, some services may not cover or require co-payment. In order to balance the coverage of these dimensions, four related dimension of effectiveness outcomes may be considered. The four dimensions of effective outcomes in healthcare system are shown in figure 2.

Towards universal health coverage implementations are not only using financial mechanisms to extend health coverage but also promoting new relationship of key stakeholders in universal health coverage. The key stakeholders in universal health coverage include purchasers, service providers, and consumers. Roles of purchasers include reimbursing health care cost to service providers according to service agreements, preparing optimal benefit packages to be able to promote effective outcomes and remove financial risks from the beneficiaries, to ensure appropriate distribution of services between regions. Furthermore, consumer right protections and stakeholder participations are also important to promote good relationship with stakeholders. These relationships are summarized in figure 3.

Figure 2 Four dimensions of effective outcomes in healthcare system



The above concepts are applied for creating framework to present improving towards UHC in this annual report into the following 5 aspects as shown in figure 4:

1. Health Financing and Budgeting for Universal Health Coverage
2. Coverage, Healthcare uses, and household expenditure for health care
3. Healthcare Service Provision and Accreditation
4. Accessibility, Efficiency, Quality and Effectiveness in Healthcare System
5. Consumers' Right Protection and Stakeholder Participations

Figure 3 Relationships of key stakeholders in universal health coverage

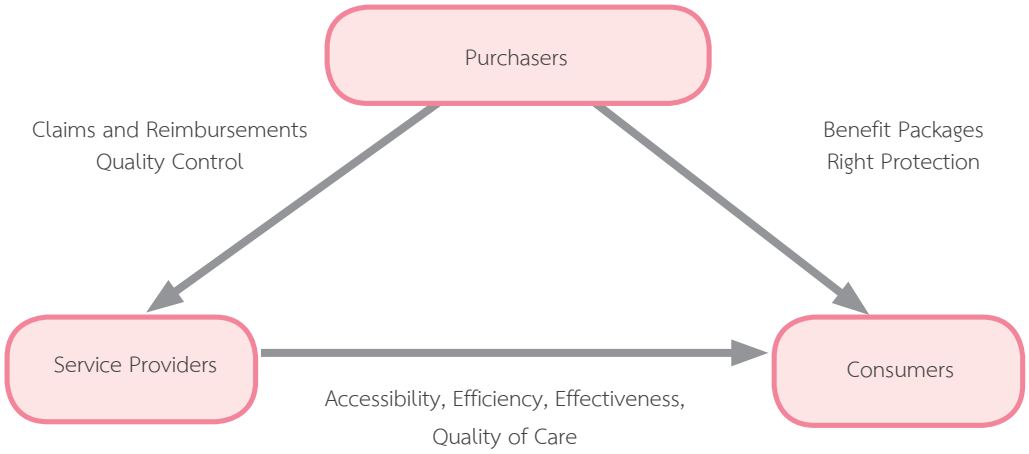
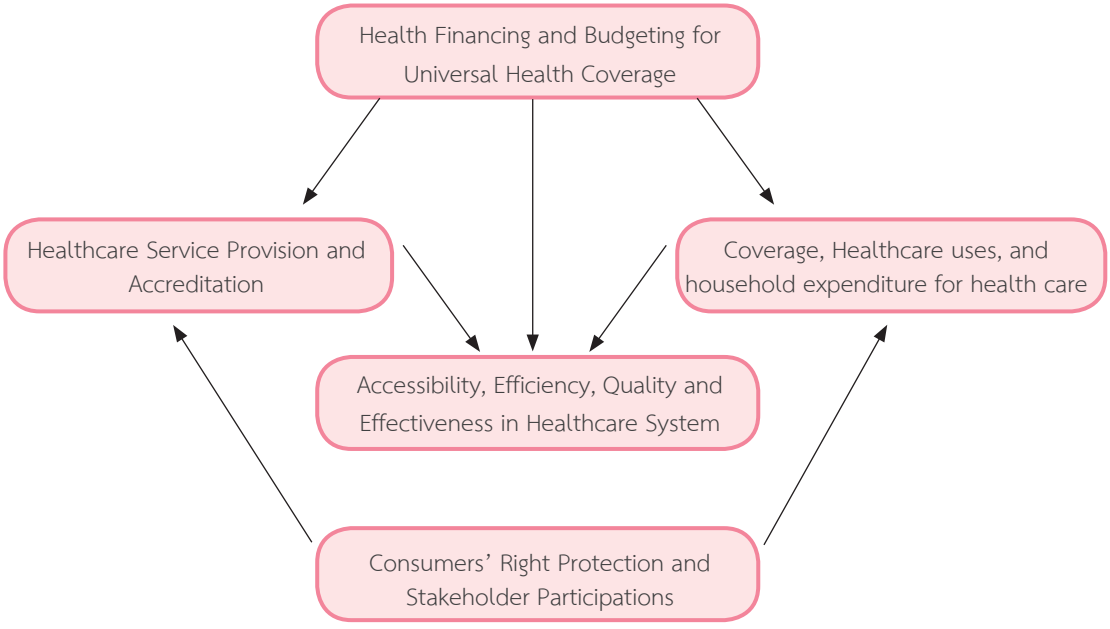


Figure 4 Framework to present the Annual Report for the UHC



– 2 –

Health Financing and Budgeting for Universal Health Coverage

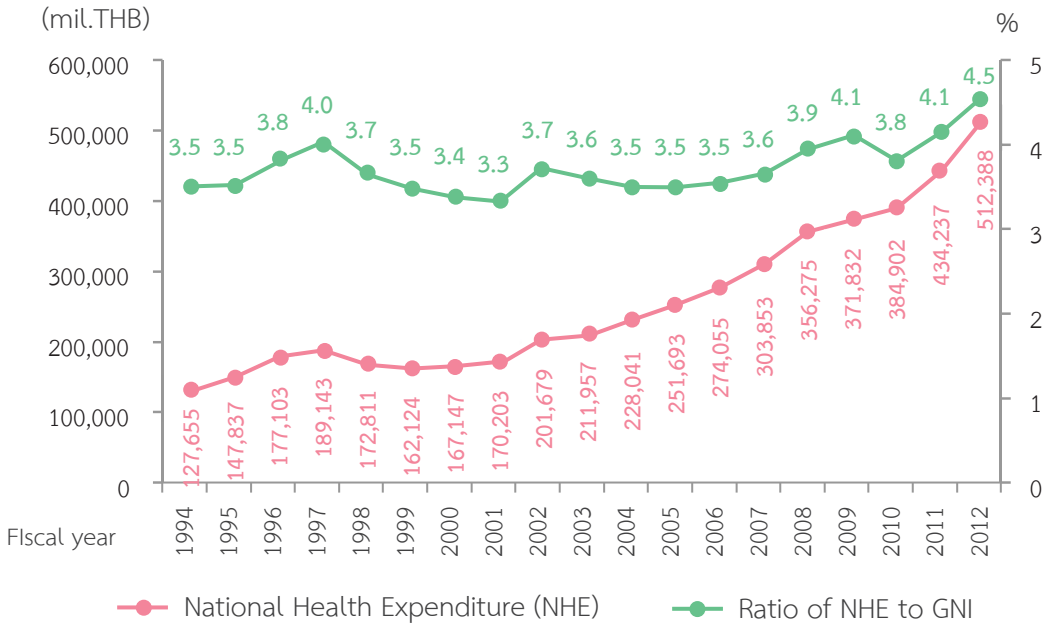
Health Financing and Budgeting for Universal Health Coverage

2.1 Overview of National Health Expenditures

Health financing policies are important mechanisms for universal health coverage (UHC) implementation to protect households from financial risks. Government is an important party towards the UHC. However, it is important for the government to carefully manage the system for sustainable implementation. National health expenditure during FY1994 – 2011 shown in figure 5 has been increased from THB127 billion in FY1994 to THB512 billion in FY2012. However, when compared as a ratio to gross national income (GNI), the ratio has steadily increased between 3.3% – 4.5% of the GNI that is comparatively lower than other developed countries.

According to the National Health Account reported by the International Health Policy Program (IHPP), Ministry of Public Health, the government health expenditure has continued to increase from 44.56% of the national health expenditure in FY1994 to 75.67% in FY2012, as shown in figure 6. Annual health expenditure per capita at current price has also been increased from THB2,160 (or USD86) in FY1994 to THB7,949 (or USD256) in FY2012, as shown in figure 7.

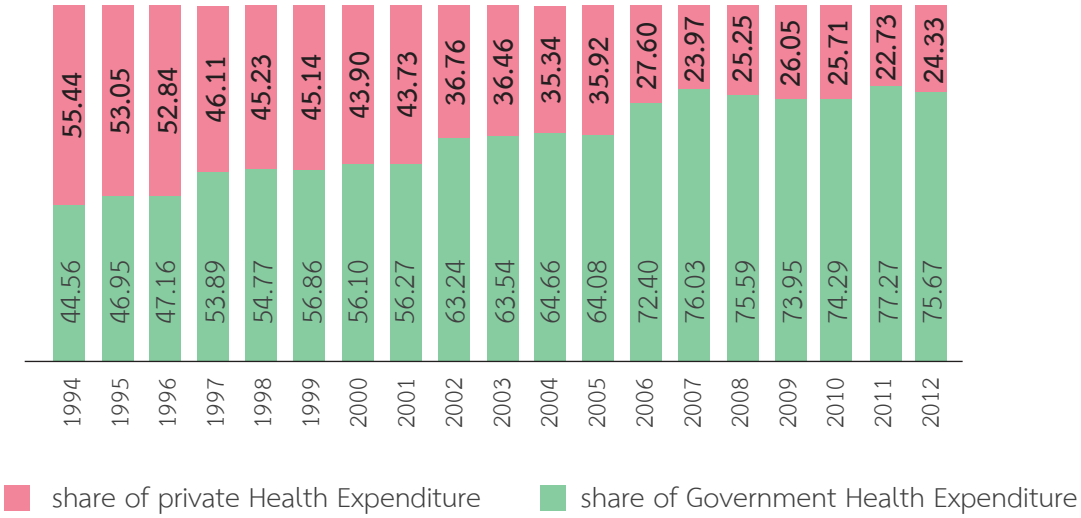
Figure 5 Thai National Health Expenditure, FY1994 – 2012



Source: *Thai National Health Account FY2002-2012, International Health Policy Program (IHPP), Ministry of Public Health, Thailand*

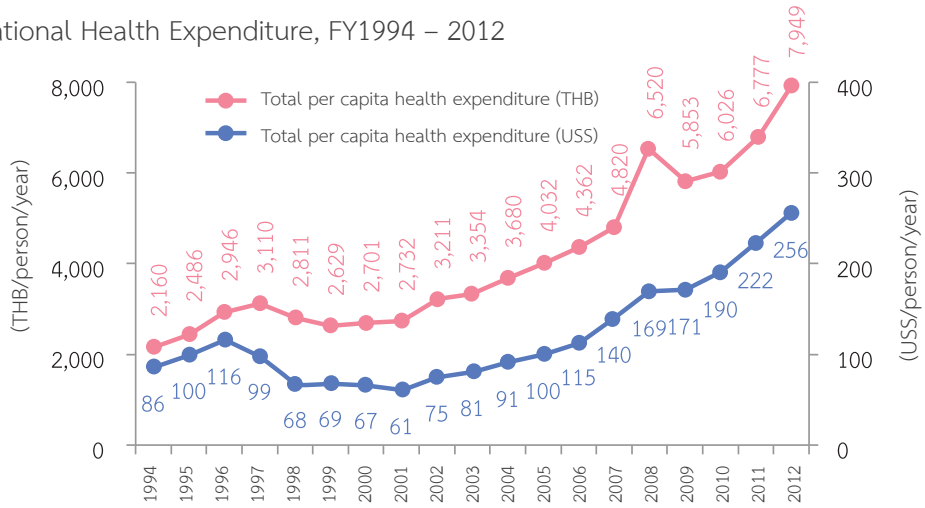
Note: *The FY2008-2010 data were adjusted with new data from some organizations, e.g., local administration offices, non-government organizations, international grants.*

Figure 6 National Health Expenditure ratio between government sector and private and household sector, FY1994 – 2012



Source: *National Health Account FY1994-2012, International Health Policy Program (IHPP), Ministry of Public Health, Thailand*

Figure 7 National Health Expenditure, FY1994 – 2012



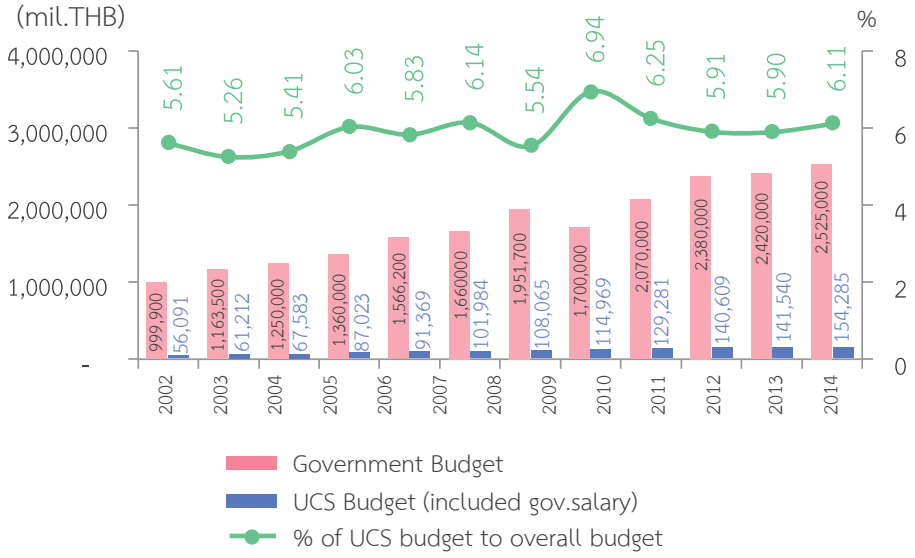
Source: *National Health Account FY2002-2012, International Health Policy Program (IHPP), Ministry of Public Health, Thailand*

Note: *According to the National Health Account Report, average annual exchange rates were used, i.e., 25, 25, 25, 31, 42, 38, 40, 44, 43, 41, 40, 40, 38, 35, 33, 34, 32, 30 and 31 for FY1994 to FY2012, respectively.*

2.2 The Universal Coverage Scheme's budgeting

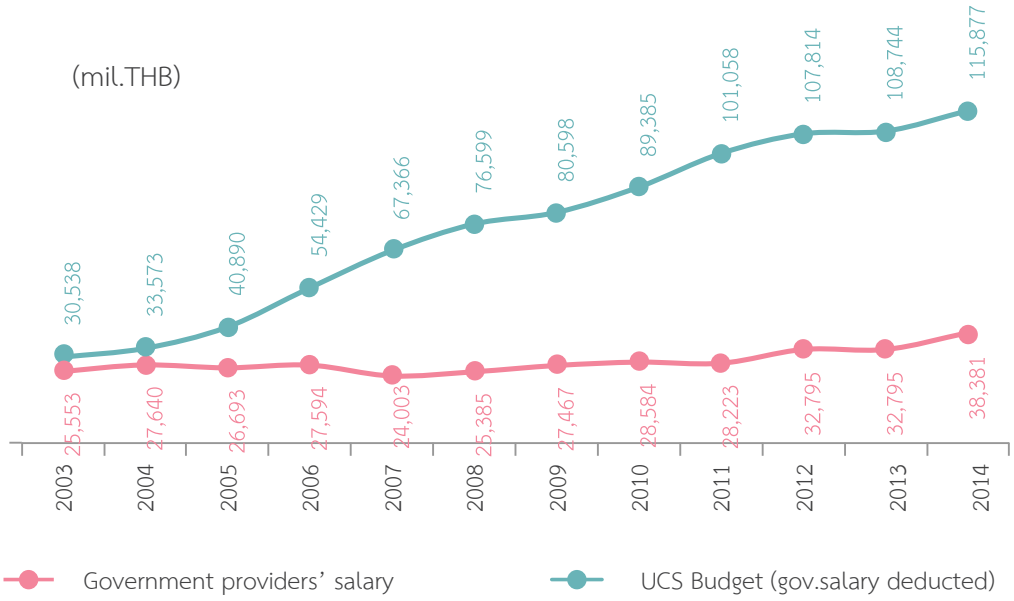
All budgets for implementing the UHC in Thailand through the universal coverage scheme (UCS) have been supplied by the government. Ratio of the UCS budget to the overall government budget during FY2003 – FY2014 is quite steady at the rate from 5.26% to 6.94%. The government budget for the UCS has been increased from THB56,091 million or at 5.61% of the overall government budget in FY2003 to THB154,258 million or at 6.11% of the overall government budget in FY2014 as shown in figure 8.

Figure 8 Government budget for the UCS and ratio to the overall government budget, FY2003 – 2014



Source: Bureau of Plan and Evaluation, NHSO

Figure 9 Approved UCS Budget, FY2003 – 2014



Source: *Bureau of Plan and Evaluation, NHSO*

Note: *The rate for salary deduction from the national health security budget has been reviewed a few times since UHC implementation as follow:*

1. Revisions for health staffs under the office of permanent secretary, MOPH were done in FY2004 and FY2010.

2. Revisions for health staffs under other affiliated departments or ministries were done in FY2004 and FY2011.

3. During FY2003 - 2006, central budgets of the government were added in the amount of THB 5,000 mil., THB3,845.33 mil., THB4,993.33 mil., and THB14,761.83 mil., respectively. The reason for the additional budgets included increasing in capitation rate or the number of beneficiaries.

The UCS budget has been included salaries of health staffs under the Office of permanent secretary, the ministry of public health (MOPH) since FY2002. A total amount of these salaries were ranged from THB23.8 – 38.4 billion per year. However, the percentage of the salaries has decreased from 45.6% in FY2003 to 24.88% in FY2014. The net budget for the UCS scheme after the government salary deduction has been increased from THB30.538 billion in FY2003 to THB115.877 billion in FY2014, as shown in figure 9.

In the past decade, the net UCS budget on capitation for general health services has been increased from THB1,202.40 per capita of the UCS beneficiary in FY2003 to THB2,895.09 per capita of the UCS beneficiary in FY2014 plus other vertical programs. Budgets for vertical programs were started in FY2006 for HIV/AIDS management. Other vertical programs were included later, i.e., kidney replacement services started in FY2009, chronic disease management (DM/HT prevention) started in FY2010, psychosis medicines started in FY2011, and additional budget to improve efficiency in remote areas and incentive for health personnel under the MOPH started in FY2014. However, budgets for vertical programs can be adjusted to health problems and policies, e.g., seasonal influenza vaccines, drug management to increase accessibility to critical or high cost drugs, system development to support primary care or to promote referral system. Details of the UCS budget and subcategories are shown in table 1.

Table 1 Details of the UCS Budget and subcategories, FY2002 - 2014

(Unit: mil. THB)

Budget subcategories	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
1. Capitation	45,934.25	51,091.23	57,367.06	62,589.27	64,464.97	87,513.45	97,601.70	103,551.25	113,438.11	122,222.38	133,186.41	133,495.04	141,430.92
1.1 Medical service	22,138.45	25,538.40	29,727.54	35,896.62	36,870.60	63,510.79	72,216.40	76,083.85	84,853.88	93,999.41	100,391.13	100,699.76	103,049.63*
1.2 Gov. salaries	23,795.80	25,552.83	27,639.52	26,692.65	27,594.37	24,002.66	25,385.30	27,467.40	28,584.23	28,222.98	32,795.28	32,795.28	38,381.29
2. HIV/AIDS health service package		-	-	-	2,796.20	3,855.60	4,382.40	2,983.77	2,770.85	2,997.74	2,940.06	3,276.83	2,947.00
3. CKD health services package		-	-	-	-	-	-	1,530.07	1,455.44	3,226.55	3,857.89	4,357.79	5,178.80
4. Chronic diseases (DM, HT) health service package		-	-	-	-	-	-	-	304.59	630.6	437.9	410.09	801.24
5. Psychosis service package		-	-	-	-	-	-	-	-	203.62	187.14	-	-
6. Budget to improve efficiency in remote areas		-	-	-	-	-	-	-	-	-	-	-	900
7. Incentive for health personnel under the MOPH		-	-	-	-	-	-	-	-	-	-	-	3,000.00
Total UCS budget	**45,934.25**	**51,091.23**	**57,367.06**	**62,589.27**	**67,261.17**	**91,369.05**	**101,984.10**	**108,065.09**	**117,969.00**	**129,280.89**	**140,609.40**	**141,539.75**	**154,257.97**
UCS budget (exclude 1.2)	**22,138.45**	**25,538.40**	**29,727.54**	**35,896.62**	**39,666.80**	**67,366.39**	**76,598.80**	**80,597.69**	**89,384.77**	**101,057.91**	**107,814.12**	**108,744.46**	**115,876.67**
Capitation rate (THB per UCS beneficiary)	**1,202.40**	**1,202.40**	**1,308.50**	**1,396.30**	**1,659.20**	**1,899.69**	**2,100.00**	**2,202.00**	**2,401.33**	**2,546.48**	**2,755.60**	**2,755.60**	**2,895.09**
% of increase in capitation	**-**	**0.00%**	**8.82%**	**6.71%**	**18.83%**	**14.49%**	**10.54%**	**4.86%**	**9.05%**	**6.04%**	**8.21%**	**0.00%**	**5.06%**

Source: *Bureau of Plan and Evaluation, NHSO*

Note: **included THB700 million transferred from FY2013*

The capitation budget in FY2014 is THB2,895.09 per capita for 48.852 million populations. The capitation budget classified into sub-category groups approved by the NHSB is shown in table 2.

Table 2 Capitation budget classification, FY2014

Type of services	Capitation rate (Baht/head)
1. General out-patient services	1,056.96
2. In-patient services	1,027.94
3. Specific vertical programs, e.g., high cost care, disease management programs, OP refer out of province.	271.33
4. Health promotion and disease prevention for all Thai citizens (not only UCS but also other government schemes)	383.61
5. Rehabilitation medical services	14.95
6. Thai traditional medicines	8.19
7. depreciation cost for building and medical investment in registered hospitals	128.69
8. compensation budget to consumer for losses from health services according to Section 41 of the Act	3.32
9. compensation budget to health provider for losses from health services according to Section 41 of the Act	0.10
Total	**2,895.09**

Source: *The NHSB announcement on Operation guideline for UCS budget management, FY2014*

- 3 -

Coverage, Healthcare uses, and household expenditure for health care

Coverage, Healthcare uses, and household expenditure for health care

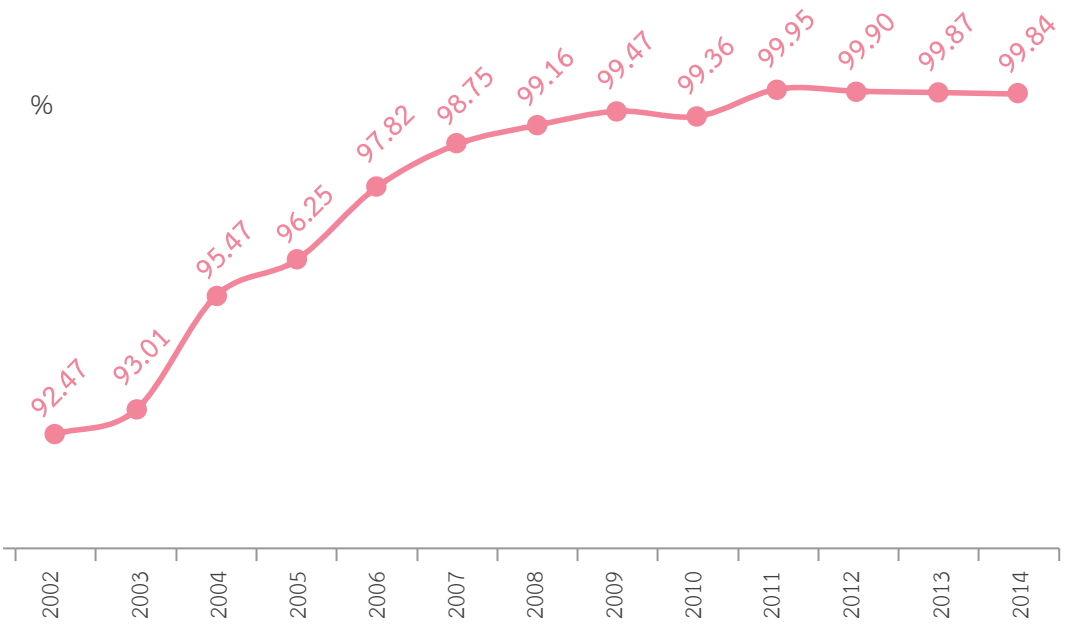
Key goal of implementing universal health coverage in a country is to extend coverage to all population so they can access to health services as needed without financial barriers. The key indicators of achieving the goal are to improve equity in accessing to quality of health care, to reduce household burden on health expenditure, and to protect household from financial disaster and become poverty from health expenditure.

3.1 National Universal Health Coverage

The ultimate goal of the Universal Health Coverage (UHC) implementation is to cover all population. In the past decade, the national UHC coverage of Thai citizens in Thailand has been increased dramatically from 71.00% in FY2001 to 92.47% in FY2002 when implementing the UHC policy, and to 99.84% in FY2014 as shown in figure 10. This coverage was not included stateless group living in Thailand, Thai citizens living aboard, and other foreigners. The number of Thai citizens who are eligible to enroll to the universal coverage scheme (UCS) but have not enrolled in FY2014 is 105,184 people (0.16% of all population). However, the eligible non-registered group will be able to access to health services at any health facility registered to the UCS when they need; and, they can register to the UCS and select their contracting unit near their home.

When classified into the main government health insurance schemes, i.e., the Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS), and the Universal Coverage Scheme (UCS), coverage of every scheme in the past decade has been increased as shown in table 3. A proportion of each government schemes in FY2014 is 73.80% of the UCS, 16.73% of the SSS, 7.11% of the CSMBS, and the rest are other small government schemes such as local administration offices and non-enrolled group.

Figure 10 The national UHC coverage of Thai citizens, FY2002 – 2014



Source: *Bureau of Registration Administration, NHSO*

Table 3 The number of Population in Thailand classified by health insurance status, FY2002 - 2014

(Unit: mil. people)

Status	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
UCS	45.35	45.97	47.10	47.34	47.54	46.67	46.95	47.56	47.73	48.12	48.62	48.61	48.31
SSS	7.12	8.09	8.34	8.74	9.20	9.58	9.84	9.62	9.90	10.17	10.33	10.77	11.07
CSMBS	4.05	4.02	4.27	4.15	4.06	5.13	5.00	4.96	4.92	4.96	4.97	4.98	4.84
Local Administration Office	-	-	-	-	-	-	-	-	-	-	-	0.10	0.58
Others[1]	-	-	-	0.22	0.23	0.24	0.24	0.23	0.52	0.64	0.61	0.49	0.56
Qualified non-registered UCS	4.60	4.37	2.83	2.36	1.36	0.78	0.52	0.33	0.41	0.03	0.06	0.08	0.11
Total coverage	61.12	62.45	62.54	62.81	62.39	62.41	62.55	62.70	63.47	63.92	64.59	65.04	65.46
Unknown citizen status[2]	-	-	-	0.00	0.45	0.90	1.16	1.44	1.35	1.20	0.79	0.62	0.21
Thais living abroad [3]	0.03	0.03	0.06	0.06	0.06	0.06	0.06	0.01	0.02	0.02	0.01	0.02	0.02
Foreigners	-	-	0.26	0.27	0.28	0.30	0.31	0.32	0.18	0.11	0.11	0.12	0.19
Total of others	0.03	0.03	0.32	0.34	0.80	1.25	1.52	1.78	1.54	1.32	0.91	0.77	0.42
Total population	61.15	62.48	62.86	63.15	63.19	63.66	64.07	64.47	65.01	65.24	65.50	65.80	65.88

Source: *Bureau of Registration Administration, NHSO*

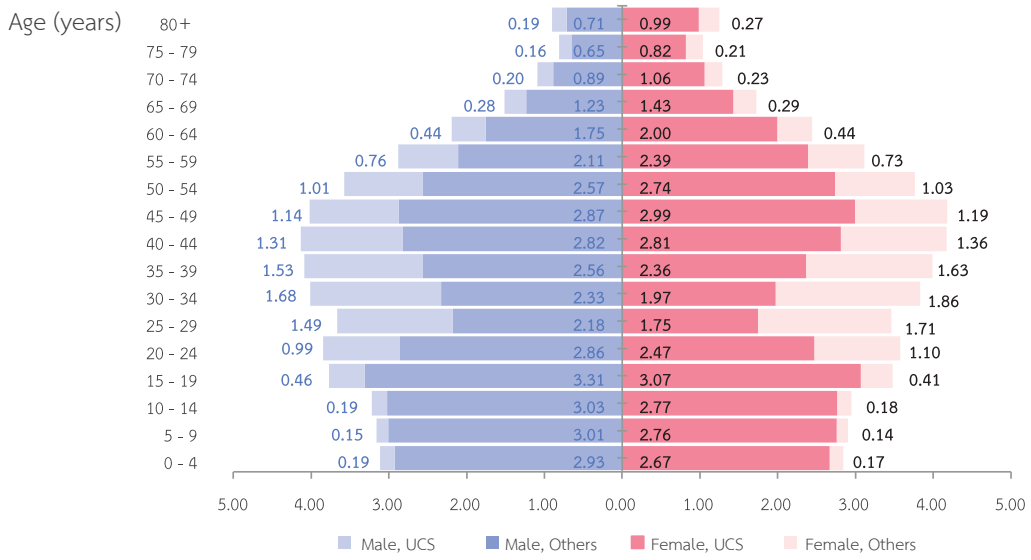
Note: *1. Other government schemes for small group of beneficiaries, e.g., politicians, veterans, private school teachers,*

2. People who have problem on status such as duplicated ID number, wrong ID number, foreigners

3. The number from Bureau of Registration Administration (BORA), Ministry of Interior (MOI)

When comparing proportion of population of the UCS and other government health insurance schemes classified by gender and age group, the result found that most of the UCS are children and elderly (10-19 year-old groups, and older than 59 year-old groups) while most of other schemes are in active working age of 20-54 year-old group as shown in figure 11.

Figure 11 Proportion of population of the UCS and other government schemes classified by gender and age group, FY2014



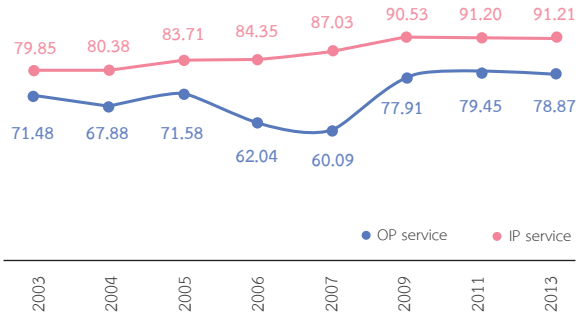
Source: Bureau of Insurance Information Technology, NHSO

3.2 Healthcare uses of patients under the Universal Coverage Scheme

According to health and welfare survey by the National Statistics Office in 2013 analyzed by Prof. Supon Limwattananonta of Khon Kaen University, acceptance rate of the UCS beneficiaries when they access to out-patient and in-patient services has been increased both in out-patient and in-patient services. The results shown in figure 12 found that acceptance rate of out-patient and in-patient services in FY2013 are 78.87% and 91.21%, respectively.

In order to achieve UHC implementation, it is important that the beneficiaries are not only covered by related government health insurance schemes but also be disbursed for their health services according to the benefit

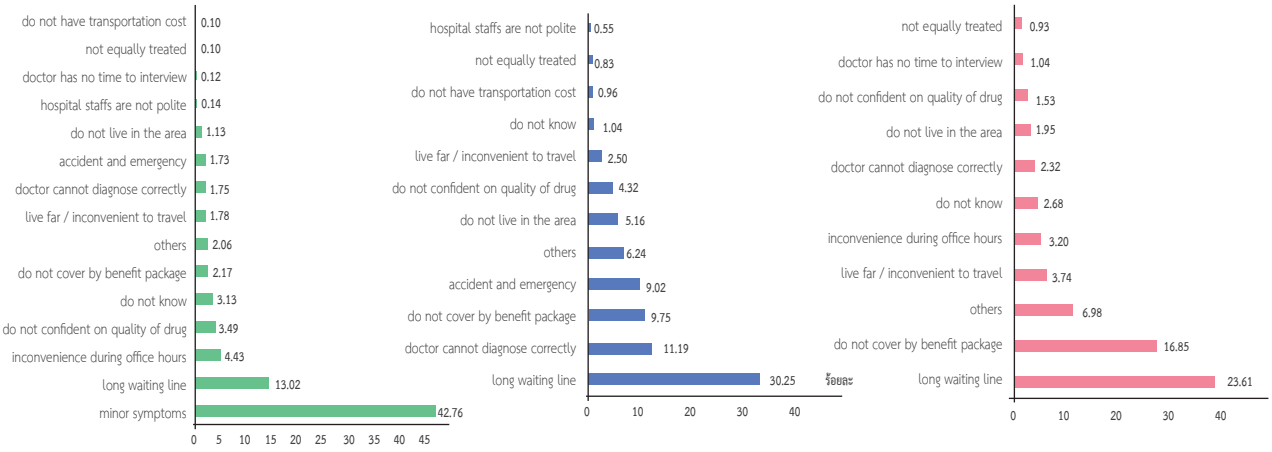
Figure 12 Acceptance rate of out-patient services and in-patient services, FY2003–FY2013



Source: Health and welfare survey, National Statistics Office, analyzed by Associate Prof. Supon Limwattananonta of Khon Kaen University
Note: There was no survey in 2008, 2010, and 2012

packages. However, Health and welfare survey by National Statistics Office in 2013 found that some beneficiaries did not acquired their benefit packages and are willing to pay out of pocket for their health services. The top three reasons in out-patient services are "symptoms are minor", "long waiting line", and "inconvenience during office hours", respectively. The top three reasons in in-patient services are "long waiting line", "doctor cannot diagnose correctly", and "service is not covered by benefit package." The top reasons in health promotion services are "long waiting line", and "service is not covered by benefit package." Other reasons are shown in figure 13.

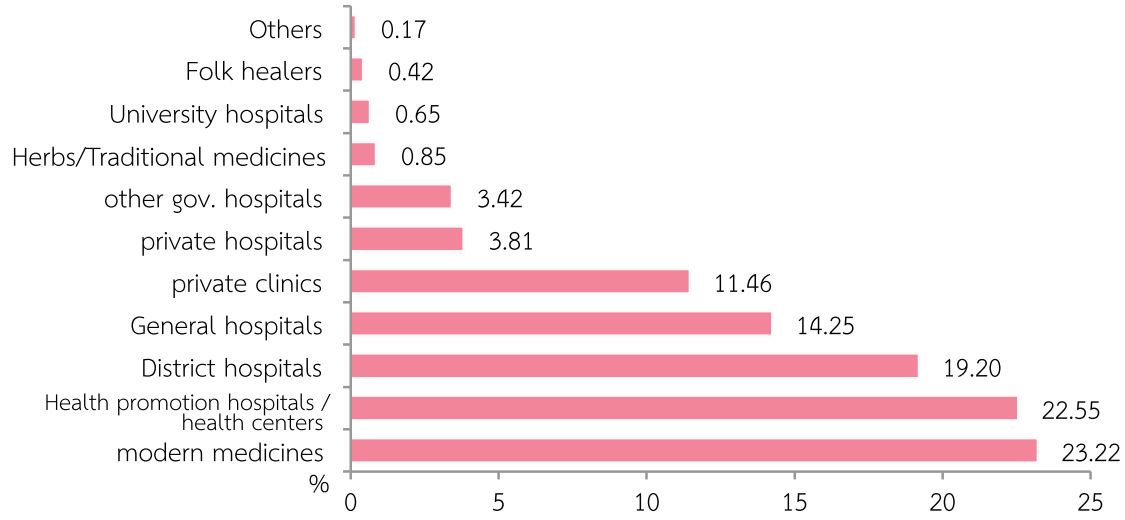
Figure 13 **Reasons for not acquiring the benefit package of the UCS beneficiaries when they accessed to health services, 2013**



Source: *Health and welfare survey 2013, National Statistics Office*
Analyzed by Bureau of Executive Information Administration, NHSO

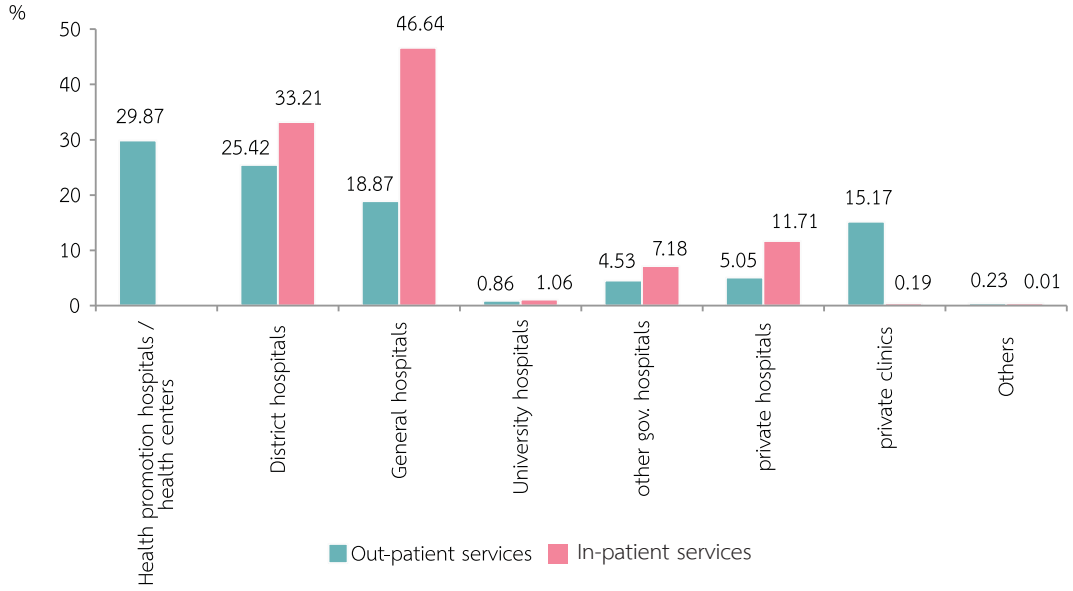
According to the same survey, choices of care the respondents chose when they were sick and did not admit to hospitals were "modern medicines from drug stores" (23.22%), "access to care at health promotion hospital or health centers" (22.55%), and "access to care at district hospitals" (19.20%), respectively as shown in figure 14. For the respondents who chose to access to care for their last illness in health facilities, types of the health facilities were classified as shown in figure 15. Most of out-patient services were accessed at health promotion hospitals or health center (29.87%), district hospitals (25.42%), general hospitals (18.87%), and private clinics (15.17%), respectively. Most of in-patient services were accessed at general hospitals (46.64%), district hospitals (33.21%), private hospitals (11.71%), and other government hospitals (7.18%), respectively.

Figure 14 Choices of care the consumers chose when they were sick and did not admit to hospitals, FY2013



Source: *Health and welfare survey, National Statistics Office, 2013*
Analyzed by Bureau of Plan and Policy, NHSO

Figure 15 Percentage of out-patient services and in-patient services classified by health facility types, FY2013



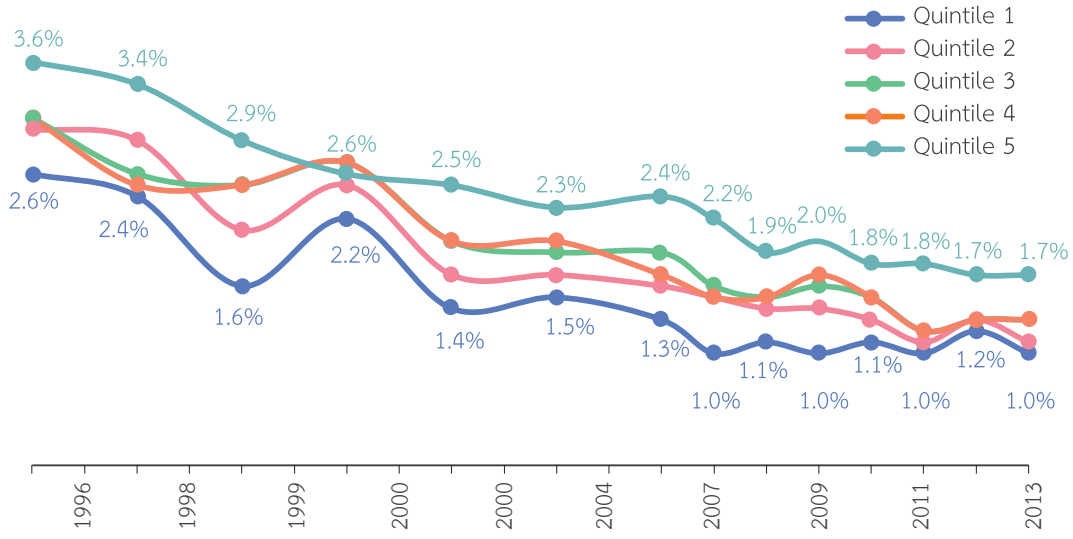
Source: *Health and welfare survey, National Statistics Office, 2013*
Analyzed by Bureau of Plan and Policy, NHSO

3.3 Household's Burden on Health expenditures

Reducing household burden and protecting household from financial disaster from health expenditure is one of indicators to measure achievement in UHC. According to Time Series Analysis by Associate Prof. Supon Limwattananonta of Khon Kaen University using data from the national household socio-economic survey of the National Statistics Office to compare household health expenditure to overall household expenditure classified by income groups, the result found that the percentage of household health expenditure more to the overall household expenditure has continued to reduce in every income group. In the poorest group (quintile 1), the percentage has been reduced from 2.6% in FY1994 to 1% in FY2013, while the one of the richest group (quintile 5) has been reduced from 3.7% in FY1994 to 1.7% in FY2013, as details in figure 16.

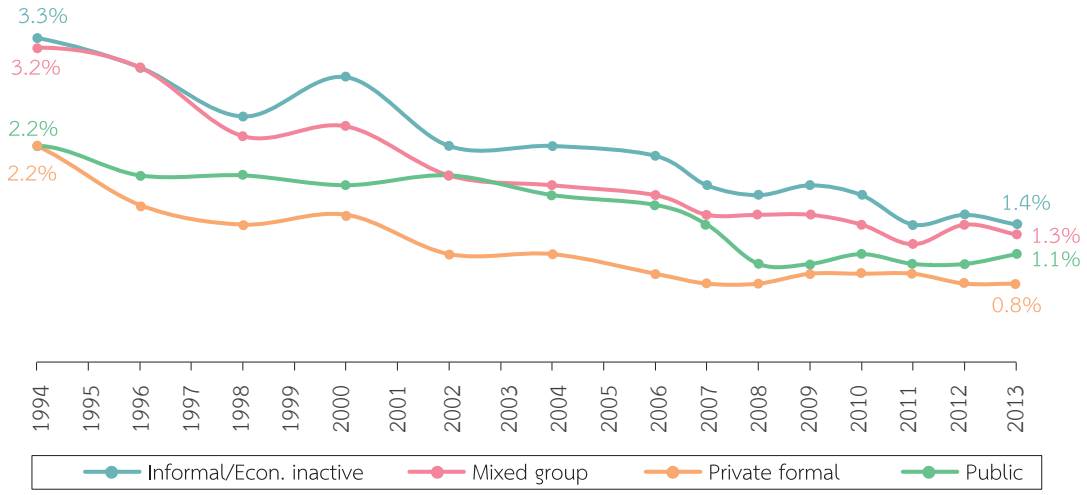
When classifying household according to their employment status, i.e., informal / economically inactive group, public formal group of government employees, private formal group of private company employees, and mixed group, the result found that the percentage of household health expenditure to the overall household expenditure in the informal / economically inactive group has been reduced from 3.3% in FY1994 to 1.4% in FY2013, as shown in figure 17.

Figure 16 Percentage of household health expenditure to the overall household expenditure classified by income groups, FY1994 – 2013



Source: *Supon Limwattananonta analyzed from Household socio-economic survey of the National Statistics Office, FY1994 – 2013*

Figure 17 Percentage of household health expenditure to the overall household expenditure classified by employment status, FY1994 – 2013



Source: *Supon Limwattananonta analyzed from Household socio-economic survey of the National Statistics Office, FY1994 – 2013*

- 4 -

Healthcare Service Provision and Accreditation

Healthcare Service Provision and Accreditation

4.1 Healthcare Service Provision

In order to promote accessibility to health care, supporting health facilities and providers so that the beneficiaries can really access to the care is also important. Registered hospitals under the UCS scheme are classified into three categories, i.e., primary care facilities, main contactors, and referral hospitals. Most of the providers and hospitals are affiliated to the ministry of public health; 94.69% of primary care facilities, 72.44% of the main contractors, and 84.19% of referral hospitals. Details of the registered hospitals are described in Table 4

Table 4 The number of registered hospitals under the UCS scheme, FY2014

Affiliation	Type of hospitals					
	Primary care		Main contractors		Referral Hospitals	
	Units	%	Units	%	Units	%
Ministry of public health	10,900	94.69	878	72.44	900	84.19
Other government affiliations	170	1.48	85	7.01	96	8.98
Private	255	2.22	236	19.47	69	6.45
Local Administration Organization	186	1.62	13	1.07	4	0.41
Total	**11,511**	**100**	**1,212**	**100**	**1,069**	**100**

Source: Bureau of Registration Administration, NHSO, September 2014

The number of main contractors that are not primary care units (PCUs) affiliated to the ministry of public health and other government affiliations is quite constant, while the number of private main contractors has been reduced from 61 hospitals in FY2006 to 36 hospitals in FY2014. However, the number of private primary care units has been increased from 116 units in FY2006 to 200 units in FY2014, while the number of government primary care units not affiliated to the ministry of public health has been reduced from 76 units in FY2006 to only 8 units in FY2014. Details of the number of main contractors classified by their affiliation are shown in table 5.

Table 5 The number of main contractors classified by their affiliation, FY2006 – 2014

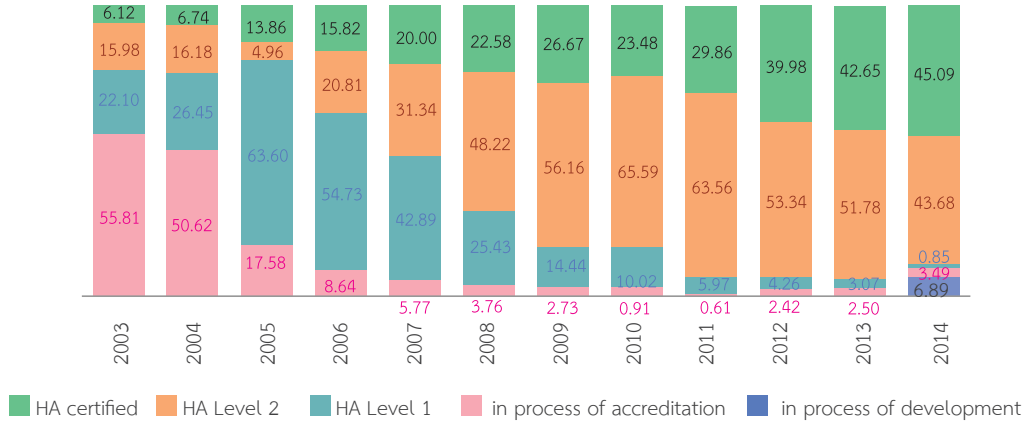
Main contractors by affiliation	2006	2007	2008	2009	2010	2011	2012	2013	2014
Ministry of public health	830	834	849	839	844	850	855	858	878
- hospitals	826	830	836	830	831	831	832	834	845
- health center/PCUs	4	4	13	9	13	19	23	24	33
Other government affiliations	148	153	155	83	81	83	83	84	85
- Hospitals and networks	72	73	75	72	75	76	75	77	77
- health center/PCUs	76	80	80	11	6	7	8	7	8
Private	177	212	205	217	218	211	227	229	236
- Hospitals and networks	61	60	55	50	49	44	40	38	36
- health center/PCUs	116	152	150	167	169	167	187	191	200
Local Administration Organization	-	-	-	10	12	14	15	15	13
- Hospitals and networks				10	2	2	3	3	4
- health center/PCUs				-	10	12	12	12	9
Over all	**1,155**	**1,199**	**1,209**	**1,149**	**1,155**	**1,158**	**1,180**	**1,186**	1,212
- Hospitals and networks	959	963	966	962	957	953	950	952	962
- health center/PCUs	196	236	243	187	198	205	230	234	250

Source: Bureau of Registration Administration, NHSO, September 2014

4.2 Quality Audit and Hospital Accreditation

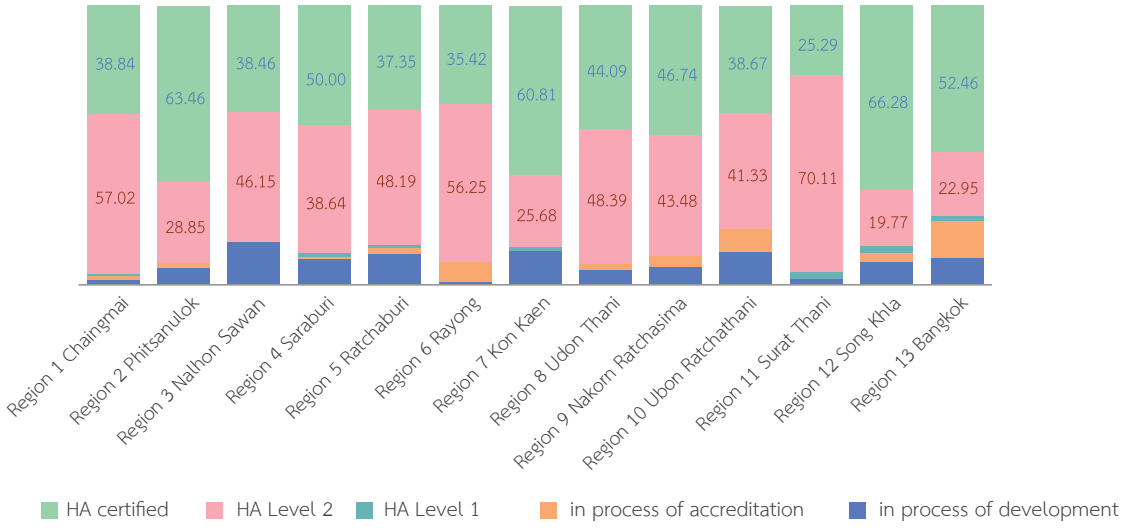
The NHSO has continued to promote quality improvement for its' main contractors and referral hospitals by supporting hospital accreditation (HA) processes. A percentage of accredited main contractors and referral hospitals have continued to increase from only 6.12% in FY2003 to 45.09% in FY2014. When including hospitals that are currently in level 2 of the accreditation, the proportion of the accredited hospitals has been increased from 22.10% (6.12% + 15.98%) in FY2003 to 88.77% (45.09% + 43.68%) in FY2014, as shown in figure 18. When classified the UCS registered hospitals in FY2014 by the NHSO region, the NHSO Region having high proportion of accredited hospital are Region 12 Songkhla (66.28%), Region 2 Phissanulok (63.46%), and Region 7 Khon Kaen (60.81), respectively as shown in figure 19.

Figure 18 Percentage of UCS registered hospitals classified by level of accreditation, FY2003-2014



Source: *The Healthcare Accreditation Institute, FY2014, analyzed by Bureau of Quality and Health Outcome Monitoring, NHSO*

Figure 19 Percentage of UCS registered hospitals classified by level of accreditation in FY2014 classified by the NHSO Region



Source: *The Healthcare Accreditation Institute, FY2014, analyzed by Bureau of Quality and Health Outcome Monitoring, NHSO*

In order to guarantee standard quality of health care to be accessed by the beneficiaries, hospital assessment classified by registered types is performed. The result of the assessment in FY2014 shows that 16.38% of the primary care units are passed while 80.10% of them are conditionally passed; 55.61% of the main contractors are passed while 44.14% of them are conditionally passed; and 6.64% of referral hospitals are passed while 92.42% of them are conditionally passed, as shown in Table 6.

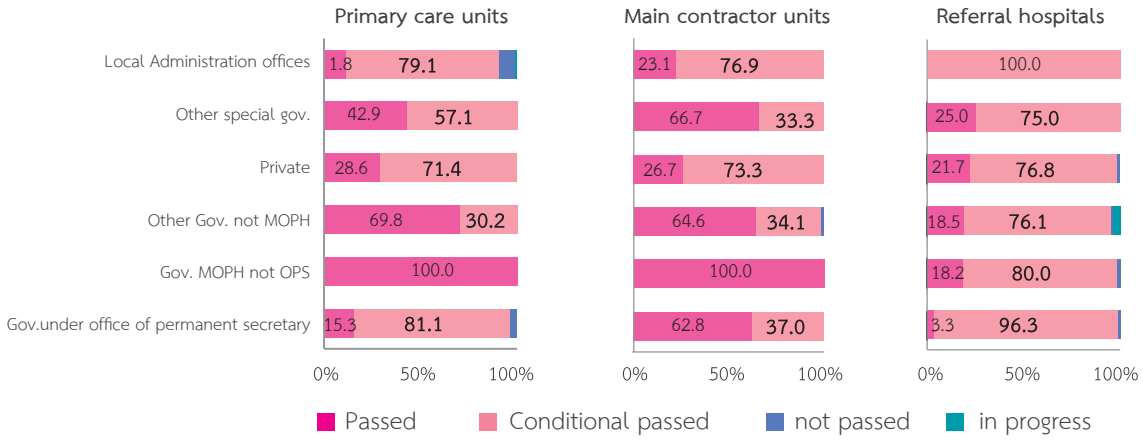
Table 6 Results of hospital assessment classified by type of registration, FY2014

HA assessment	Primary care units		Main contractors		Referral hospitals	
	units	%	units	%	units	%
Passed	1,885	16.38	674	55.61	71	6.64
Conditional passed	9,220	80.10	535	44.14	988	92.42
Not passed	405	3.52	3	0.25	6	0.56
On process	1	0.01	0	0.00	4	0.37
total	11,511	100	1,212	100	1,069	100

Source: Bureau of Registration Administration, NHSO, September 2014

When affiliation of the hospitals is considered, the primary care units and main contractor hospitals both under the ministry of public health and other government affiliation are passed the assessment more than other type of affiliations. However, the referral hospitals under other government affiliations are passed more than the ones under the ministry of public health. Details of the assessment classified by hospital's affiliation are shown in figure 20.

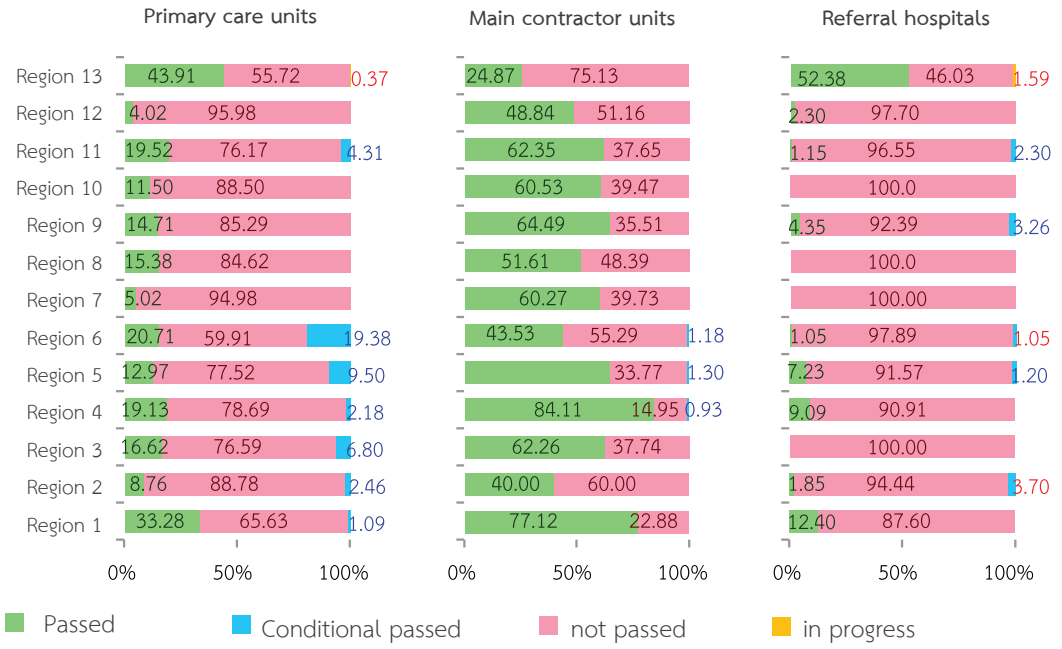
Figure 20 Percentage of hospital assessment results classified by hospital's affiliation, FY2014



Source: Bureau of Registration Administration, NHSO, September 2014

When hospitals' location classified by the NHSO regions is considered, the proportion of primary care units and referral hospitals located in the NHSO Region 13 Bangkok are passed the assessment more than other regions. Main contractor hospitals located in the NHSO region 4 Saraburi are passed the assessment more than other regions. In overall, it is found that main contractor hospitals in every region, except the NHSO region 13 Bangkok, has higher proportion of passed the registration assessment than primary care units and referral hospitals. Details of these results are shown in figure 21.

Figure 21 Percentage of hospital assessment results classified by hospital's location, FY2014



Source: Bureau of Registration Administration, NHSO, September 2014

- 5 -

Accessibility, Efficiency, Quality and Effectiveness in Healthcare System

Accessibility, Efficiency, Quality and Effectiveness in Healthcare System

In order to promote health security of all population in the UHC implementation, accessibility to quality of care without financial risk to their household while also promoting equity and efficiency of the system are important aspects. The benefit packages for the UHC implementation are covered comprehensive care from promotion, prevention, curative and rehabilitation services. Therefore, this report is described performance of the UHC implementation in the following main categories.

1. The NHSO key performance indices in FY2014
2. Out-patient and In-patient Services
3. Disease management and Vertical program
    - 3.1. Heart diseases and cerebro-vascular diseases
    - 3.2. Diabetes Mellitus and Hypertension
    - 3.3. HIV/AIDS
    - 3.4. Chronic Kidney Diseases
    - 3.5. Cataract
4. Health Promotion and Disease Prevention
5. Medical Rehabilitation Services
6. Thai Traditional Medicines
7. Drug and Medical Instruments
8. Health service efficiency
9. Quality and service outcome

To ease report understanding, details in sections of out-patient services, in-patient services, disease management/vertical programs, and health promotion and disease prevention are described as linked topics from all aspects including accessibility, effectiveness, quality of care, and outcome. For example, health services in some diseases may include from disease screening, diagnosis, and treatment in order to reflect service rate, quality of care, and health outcome, e.g., fatality rate, complication rate.

5.1 The NHSO key performance indices in FY2014

Key performance indices (KPIs) of the UCS management are set according to the national health security fund (UCS fund) that are classified into medical service capitation, HIV/AIDS health service package, Chronic Kidney Diseases (CKD) health service package, and vertical program payments related to health promotion, disease prevention, or disease cures. Details of targets and performance of the related KPIs are described in table 7.

Table 7 The NHSO key performance indices in FY2014

KPIs	Units	Goal (according to budget allocation)	Performance	% of performance
Targeted population				
- Thai citizens	Cases	64,871,000	65,841,300	101.50
- UCS beneficiaries	Cases	48,852,000	48,411,833	99.10
1. medical service capitation				
1.1 out-patient services (OP)				
- utilization rate	visits/person/yr	3.35	3.17	94.63
- total OP visits	Visits	163,584,973	153,605,794	93.90
1.2 in-patient services (IP)				
- utilization rate	Admissions /person/yr.	0.115	0.117	101.74
- total admissions	admissions	5,617,980	5,682,749	101.15
- sum Adj. RW		5,617,980	6,565,058	116.86
- Transportation cost for referral cases	visits	222,005	228,800	103.06
1.3 Disease management or vertical programs				
1.3.1 Accident and Emergency (AE)				
- AE in hospitals located outside their registered province, and service outside registered hospital in disabled people	Visits	963,369	1,214,928	126.11
- Birth delivery in new SSS less than 3 months of contribution (IP)	Visits	677,808	614,651	90.68
- number of non-registered UCS accessing to service in the first time	cases	36,024	15,825	43.93

KPIs	Units	Goal (according to budget allocation)	Performance	% of performance
- OP refer out of province or OP refer within province where having university hospital in province	Visits	836,927	925,057	110.53
- referred cases with transportation cost	Visits	222,005	228,800	103.06
1.3.2 to improve confidence in quality of care				
- Peritoneal dialysis and Hemodialysis in acute renal failure	Visits	27,174	16,526	60.82
- Drug treatment in Cryptococcal meningitis	cases	5,611	5,590	99.63
- Stroke (Stroke Fast Track)	cases	1,445	2,100	145.33
- Thrombolytic treatment in acute myocardial infarction type ST-elevation (STEMI)	cases	4,121	3,921	95.15
- OP visits for Chemotherapy/Radiotherapy in cancers	Visits	355,230	404,955	114.00
- Cataract operation	Visits	119,425	159,357	133.44
- Laser treatment in diabetic retinopathy	Visits	12,062	4,391	36.40
- Asthma	cases	106,950	102,984	96.29
- Orthodontics services for cleft lip and cleft palate	cases	384	276	71.88
1.3.3 to reduce financial risk of healthcare providers				
1) Instruments and artificial organ	items	1,067,251	1,518,786	142.31
2) Hemophilia	cases	1,353	1,366	100.961
3) Hyperbaric oxygen therapy in Decompression Sickness as OP cases	cases	105	47	44.76
4) Organ transplantation				
- Corneal transplant	cases	400	400	100.00
- Heart transplant	cases	40	7	17.5
- Liver transplantation in children	cases	80	15	18.75
- Hematopoietic stem cell transplantation	cases	30	41	136.67

KPIs	Units	Goal (according to budget allocation)	Performance	% of performance
1.3.4 services required closed monitoring				
1) Methadone maintenance treatment (MMT) in drug addicts	Cases	4,138	4,082	98.65
2) E(2) category drug list of the NLEM	Cases	14,153	12,963	91.51
3) Orphan drugs	Cases items	4,790 20	5,432 18	113.40 90
4) Compulsory licensing drugs (Clopidogrel)	cases	128,938	182,432	141.49
1.3.5 disease management or vertical programs				
1) Thalassemia	Cases	1,500		
2) Tuberculosis	Cases	51,180	54,886	107.24
3) Morphine treatment in palliative cases	Cases	5,961	9,477	158.98
4) new cases of Leukemia & Lymphoma	Cases	1,231		
1.4 Health promotion and prevention				
- Seasoning influenza vaccines	cases	3,400,000	3,179,991	93.53
1.5 Community health security fund				
- number of collaborated local administration offices/municipality	offices	7,776	7,759	99.78
- amount of co-funded by local administration offices/municipality	million THB	990	990	100
- amount of co-funded by the NHSO	million THB	2560	2,560	100
1.6 Rehabilitation				
1) disables	cases	1,185,240	1,127,097	95.09
2) instruments for disables	cases	46,880	41,553	88.64
3) Orientation and Mobility (O&M) for disables	cases	5,358	3,727	69.56
4) The number of provincial funds promoting rehabilitation	provinces	34	34	100
1.7 Thai traditional medicines				
- Massage, hot compress, herbal stream	visits	3,341,000	4,648,944	139.15

KPIs	Units	Goal (according to budget allocation)	Performance	% of performance
- post-partum care	visits	24,169	35,612	147.35
- registered hospitals having Thai traditional medicine center	units	590	606	102.71
1.8 preliminary compensations according to section 41 of the Act.				
- approved cases: for consumers	cases	903	931	103.10
- approved cases: for providers	cases	514	420	81.71
2. HIV/AIDS health service package				
- HIV/AIDS patients received ART	cases	188,000	190,342	101.25
3. CKD health service package				
- CKD patients received Renal Replacement Therapy (RRT)	cases	35,429	36,519	103.08
4. Health promotion and prevention in chronic diseases (DM and hypertension)				
- secondary prevention in DM and HT patients	cases	2,726,800	3,149,023	115.48

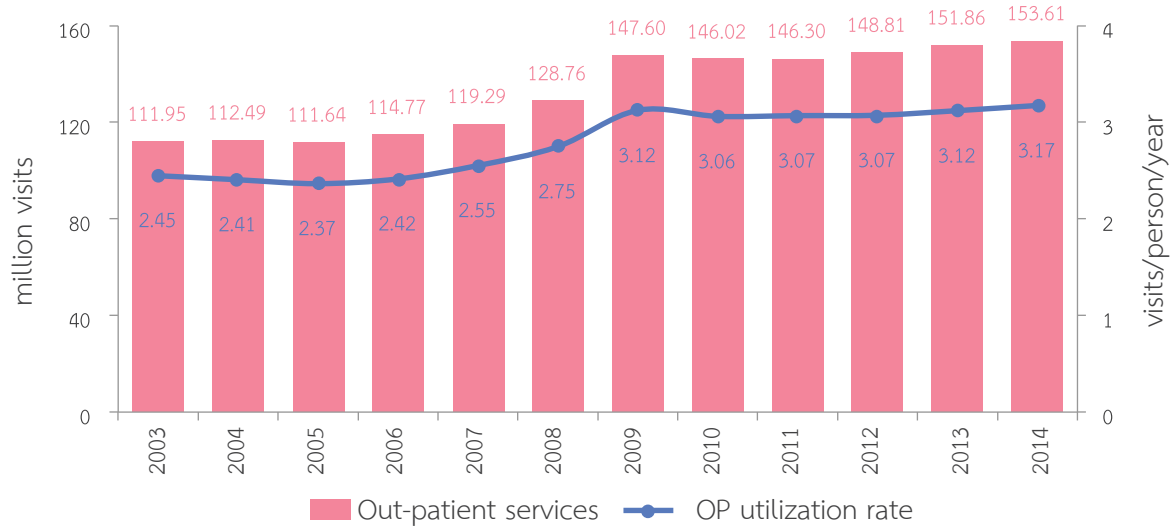
Source: OP and IP services data, NHSO, September 2014

5.2 Out-patient and In-patient Services

Accessibility to out-patient (OP) services can be used to measure the overall access to health services since it is accessed by most people when comparing to other types of health services. It is expected that accessing to OP services would be increased causing from implementing the UHC and increasing of chronic disease patients. OP services data between FY2003 and FY2014 found that the number OP services under the UCS scheme have been increased from 111.95 million visits or 2.45 visit/person/year in FY2003 to 153.61 million visits or 3.17 visit/person/year in FY2014, as shown in figure 22.

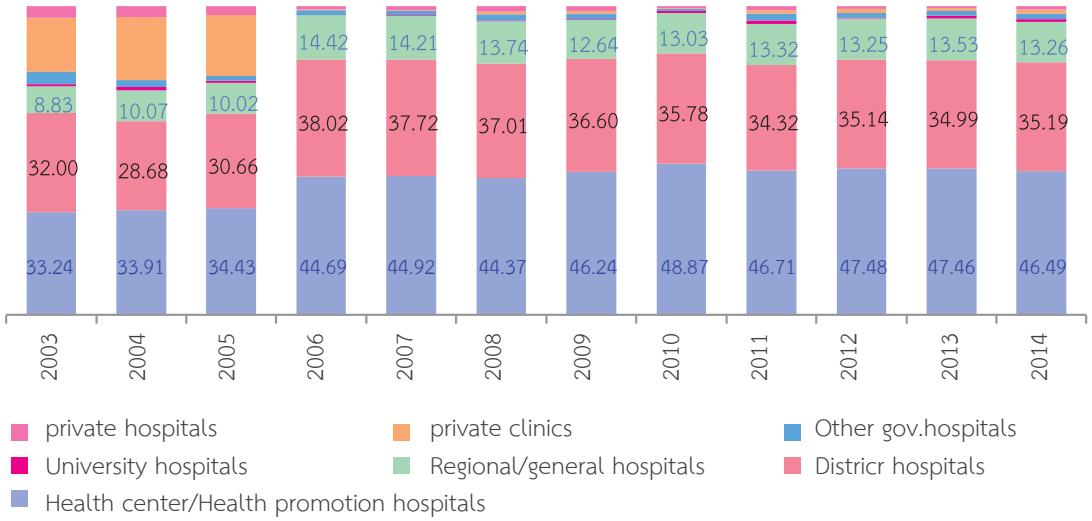
When classifying OP services at health centers or PCUs, and at district or general hospitals, the result found that most of OP services are accessed at health centers or PCUs (increasing from 33.24% in FY2003 to 46.49% in FY2014), at district hospitals (increasing from 32.00% in FY2003 to 35.19% in FY2014), and at regional/general hospitals (increasing from 8.83% in FY2003 to 13.26% in FY2014), respectively as shown in figure 23. It should also be noted that accessing to OP services at private clinics has dramatically reduced from 17.56% in FY2003 to only 1.34% in FY2014.

Figure 22 The number of out-patient visits and utilization rate per person per year of the UCS scheme, FY2003 – 2014



Source: *1) Out-patient data of FY2003-2009 are from 0110RP5 Report, ministry of public health*
2) FY2010 – 2014 data are from NHSO, FY2014 is estimated from 10 month of services

Figure 23 Percentage of out-patient services classified by type of health facilities, FY2003 – 2014

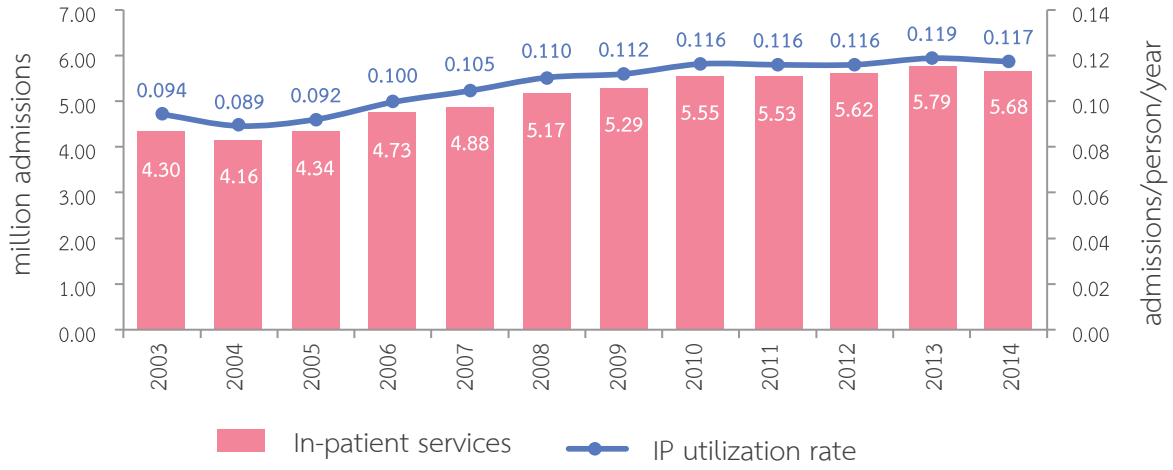


Source: *1) FY2003-2005 data are from health and welfare survey, the National Statistic Office*
2) FY2006-2009 data are from 0110RP5 Report, ministry of public health
3) FY2010 – 2014 data are from NHSO, FY2014 is estimated from 10 month of services

Utilization rate of in-patient (IP) services under the UCS scheme has also continued to increase from 4.30 million admissions or 0.094 admissions/person/year in FY2003 to 5.68 million admissions or 0.117 admissions/person/year in FY2014, as shown in figure 24. However, the rate is slightly increased during this period. This is a good sign of efficiency of the UHC system since cost of IP service is high, therefore, its' high rate of increase may cause inefficiency of the system in long term.

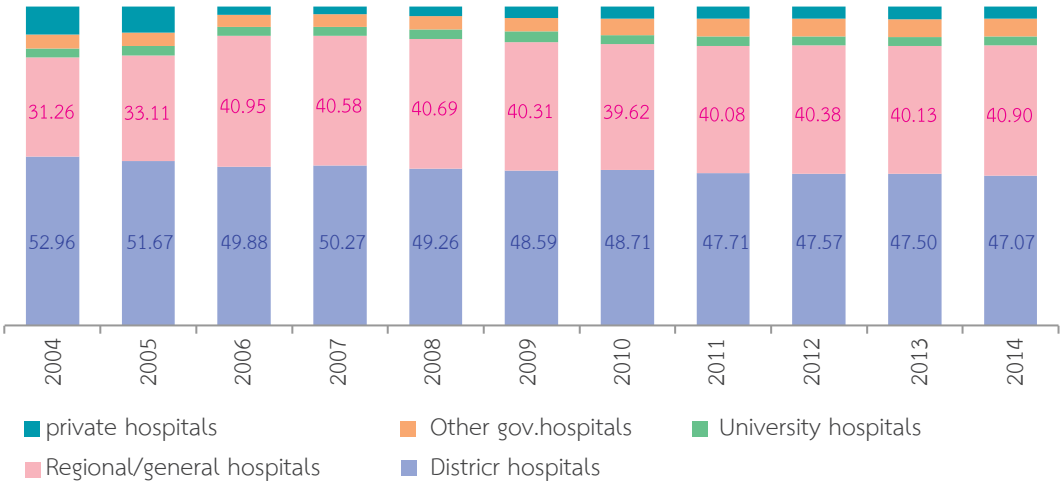
When classifying IP services by type of hospitals, the result found that most of IP services FY2014 are accessed at district hospitals (47.07%), regional/general hospitals (40.90%), other government hospitals (5.60%), private hospitals (3.73%), and university hospitals (2.69%), respectively as shown in figure 25.

Figure 24 In-patient services under the UCS scheme, FY2003 – 2014



Source: *In-patient data, NHSO, December 2014*

Figure 25 In-patient services under the UCS scheme classified by hospital types, FY2003 – 2014



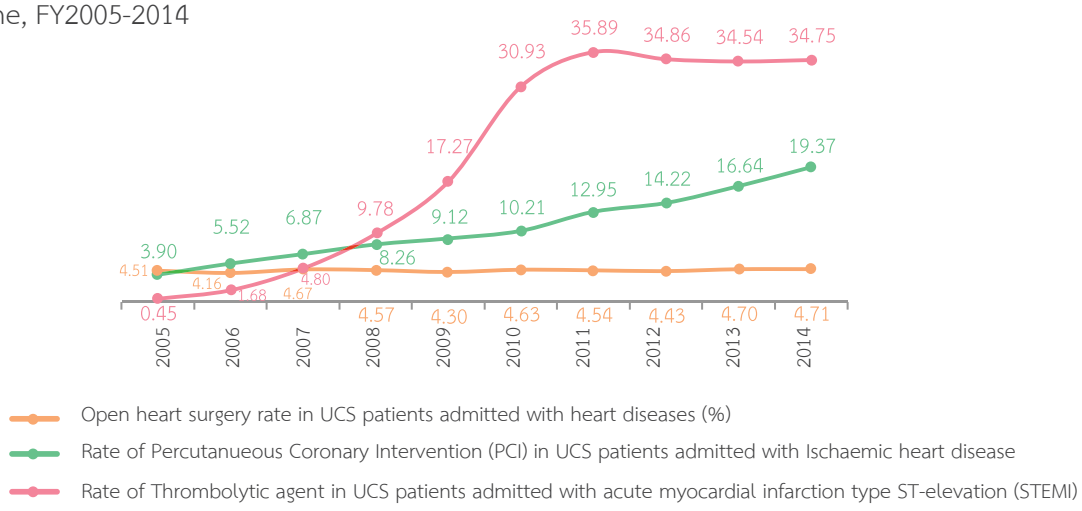
Source: *In-patient data, NHSO, December 2014*

5.3 Disease management and Vertical program

5.3.1 Heart diseases and cerebro-vascular diseases

One of limitations in accessing to health services in heart diseases and cerebro-vascular diseases is specialists both in term of quantity and distribution. Figure 26 describes accessibility rate of heart procedures, i.e., open heart surgery, percutaneous coronary intervention (PCI), and infusion of thrombolytic agent, performed in the UCS scheme patients admitted with heart disease from FY2005-2014. The rate of the procedures done in UCS scheme patients admitted with heart disease has continued to increase since FY2005; i.e., open heart surgeries are increasing from 4.51% in FY2005 to 4.71% in FY2014, PCI procedures are increasing from 3.90% in FY2005 to 19.38% in FY2014, and infusion of thrombolytic agent is increasing from 0.45% in FY2005 to 34.74% in FY2014.

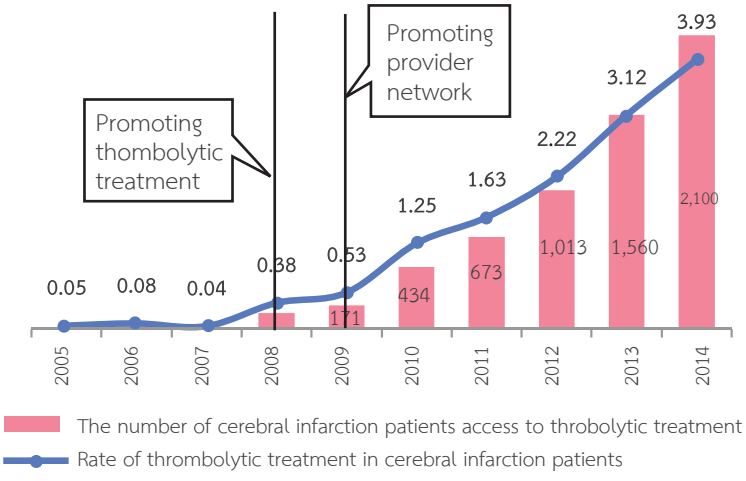
Figure 26 The rate of heart procedures performed in heart disease patients under the UCS scheme, FY2005-2014



Source: In-patient data, NHSO, January 2015

In cerebral infarction patients aged 15 years and older under the UCS scheme, the number of the patient getting thrombolytic treatment has been increased from only 10 cases (or 0.05% of the patients admitted with cerebral infraction) in FY2005 to 2,139 cases (3.91%) in FY2014, as shown in figure 27.

Figure 27 Accessibility to thrombolytic treatment in cerebral infarction patients aged 15 years and older under the UCS scheme

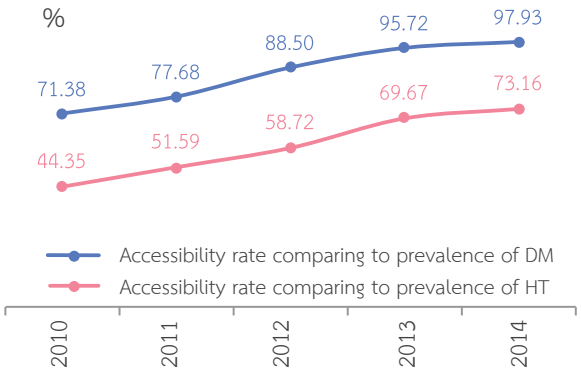


Source: In-patient data, NHSO, January 2015

5.3.2 Diabetes Mellitus and Hypertension

Since it is difficult to identify the total number of patients with metabolic chronic diseases, accessibility to care by comparing to disease prevalence rate is used to measure accessibility. Accessibility rate, when comparing to prevalence of the disease, of both DM and HT has continued to increase, i.e., from 55.0% and 29.0% in FY2009 to 97.93% and 73.16% in FY2014 for DM and HT, respectively as shown in figure 28.

Figure 28 Accessibility rate comparing to prevalence of DM and HT, FY2009-2014

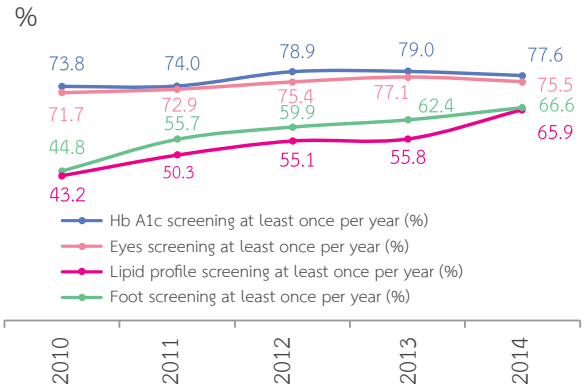


Source: *Out-patient and In-patient data, NHSO, date of data on September 2014*

Note: *prevalence rate used in this analysis is 6.9% and 21.4% for DM and HT, respectively.*

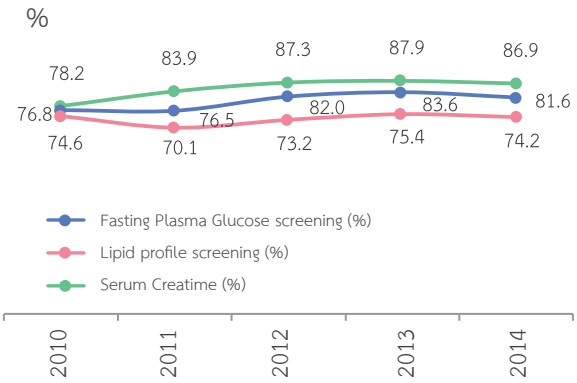
According to an evaluation report on health service outcome of type II-DM and HT in hospitals under the ministry of public health and the Bangkok metropolitan administration office during FY2010-2014 by Medical Research Network (MedResNet) of the Consortium of Thai Medical Schools, screening rate for early complication detection in type II-DM and HT tends to increase during this period, as shown in figure 29 and 30, respectively.

Figure 29 Screening rate -HbA1c, Lipid profile, Albumin or protein, eyes and feet screening-in type II-DM, FY2010-2014



Source: *Evaluation Report on health service outcome of type II DM and HT in hospitals under the ministry of public health and the Bangkok metropolitan administration office during FY2010-2014, by Medical Research Network (MedResNet) of the Consortium of Thai Medical Schools.*

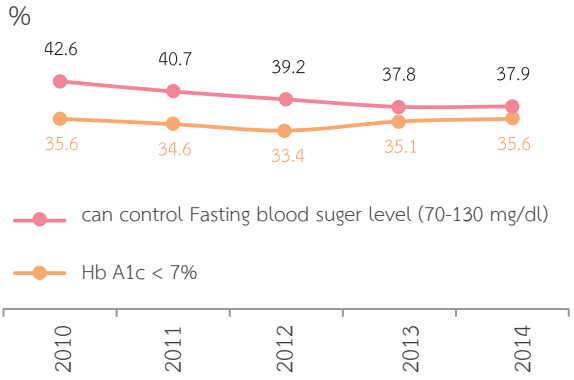
Figure 30 Screening rate for routine laboratory tests in Hypertension, FY2010-2014



Source: *Evaluation Report on health service outcome of type II DM and HT in hospitals under the ministry of public health and the Bangkok metropolitan administration office during FY2010-2014, by Medical Research Network (MedResNet) of the Consortium of Thai Medical Schools.*

It is important to control symptoms in metabolic chronic diseases such as DM and HT in order to prevent complications and reduce losses from preventable admissions and disabilities. According to an evaluation report on health service outcome of type II-DM and HT in hospitals under the ministry of public health and the Bangkok metropolitan administration office during FY2010-2014 by Medical Research Network (MedResNet) of the Consortium of Thai Medical Schools, control rate of risk symptoms in DM and HT is quite steady or a little worst during the period of study, respectively as shown in figure 31 and figure 32.

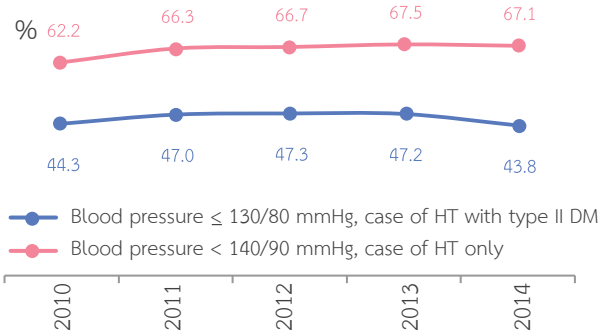
Figure 31 Control rate of risk symptoms in DM, FY2010-2014



Source: Evaluation Report on health service outcome of type II DM and HT in hospitals under the ministry of public health and the Bangkok metropolitan administration office during FY2010-2014, by Medical Research Network (MedResNet) of the Consortium of Thai Medical Schools.

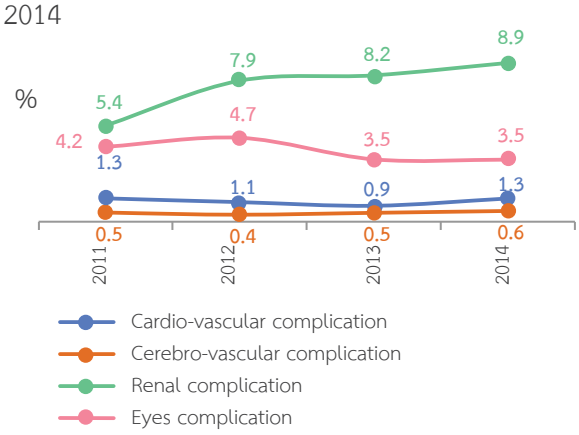
The study also reports complication rate found in DM and HT patients, as shown in figure 33 and figure 34, respectively. In DM patients, complication rate of most organs has been decreased during the period of study except renal complication that has been increased from 5.4% in FY2011 to 8.9% in FY2014. In HT

Figure 32 Control rate of risk symptoms in Hypertension, FY2010-2014



Source: Evaluation Report on health service outcome of type II DM and HT in hospitals under the ministry of public health and the Bangkok metropolitan administration office during FY2010-2014, by Medical Research Network (MedResNet) of the Consortium of Thai Medical Schools.

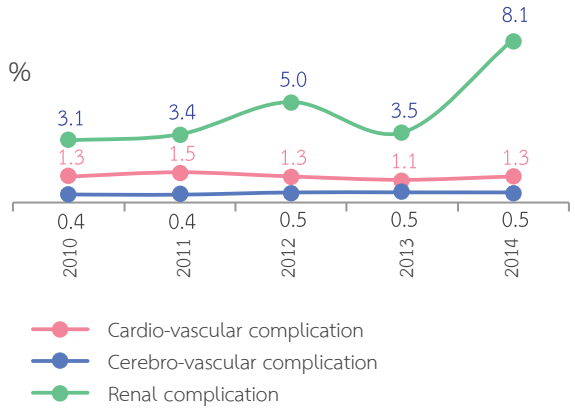
Figure 33 Complication rate in DM, FY2011-2014



Source: Evaluation Report on health service outcome of type II DM and HT in hospitals under the ministry of public health and the Bangkok metropolitan administration office during FY2010-2014, by Medical Research Network (MedResNet) of the Consortium of Thai Medical Schools.

patients, while complication rate in cerebro-vascular diseases and cardio-vascular diseases is quite steady, its renal complication rate has been increased from 3.1% in FY2011 to 8.1% in FY2014.

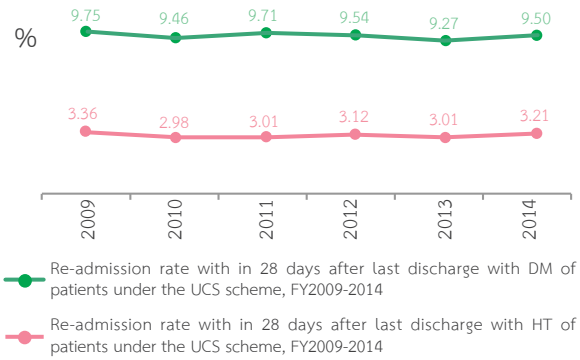
Figure 34 Complication rate in Hypertension, FY2011-2014



Source: Evaluation Report on health service outcome of type II DM and HT in hospitals under the ministry of public health and the Bangkok metropolitan administration office during FY2010-2014, by Medical Research Network (MedResNet) of the Consortium of Thai Medical Schools.

Re-admission rate within 28 days after last discharge could be another indicator to reflect quality of IP care or effectiveness of the last treatment. Re-admission rate within 28 days after last discharge of patients aged 15 years and older under the UCS scheme has been slightly reduced from 9.75% in FY2009 to 9.5% in DM patients and from 3.36% in FY2009 to 3.21% in HT patients, respectively as shown in figure 35.

Figure 35 Re-admission rate within 28 days after last discharge with DM or HT of patients under the UCS scheme, FY2009-2014



Source: In-patient data, NHSO, January 2015

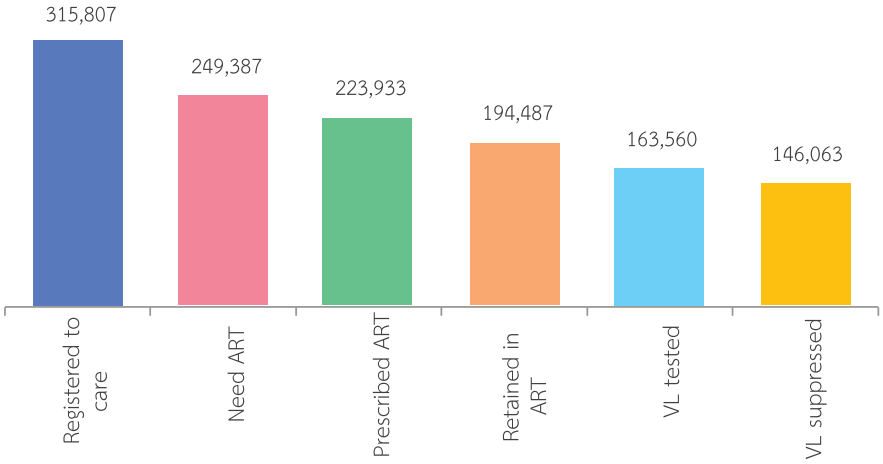
5.3.3 HIV/AIDS

AIDS has been one of the top causes of death of Thailand. Therefore, the NHSO has continued to promote interventions to prolong the patients' life and to reduce economic losses of the country. Examples of these interventions are voluntary counseling and testing (VCT) for counseling and blood testing services in risk groups, registration for necessary health treatments and antiviral drugs in HIV/AIDS.

The NHSO has also supported service system development for HIV/AIDS: 1) counseling service development; 2) service strengthening in order to stop growth of the virus by promoting patients' health in order to reduce opportunistic infections, to reduce disease transmission, and to promote overall quality of life; 3) capacity building to health personnel; and 4) monitoring and evaluation as well as promoting Laboratory Accreditation (LA).

Figure 36 is described situation of HIV/AIDS patients analyzed from the revised version of the National AIDS Program (NAP Plus), the registration application of the NHSO. The total number of patients registered to the program is 315,656 cases; 249,387 patients (79.01% of all registered) are qualified to get ARV treatment; 223,933 patients (89.79% of all qualified) are on ARV treatment. Within the group of patients that are qualified on ARV treatment, a number of 194,487 patients (86.85% of qualified on ARV treatment patients) are still on treatment at the end of FY2014 (September 30, 2013); 84.10% (163,560 patients) of this group are accessed to the viral load (VL) test. The results from the viral load test found that 146,063 patients (89.30% of all patients accessed to the test) had a number of viral load < 50 copies/ml. The overall results found that target groups have accessed to services, i.e., VCT, ARV treatment, and viral load laboratory test, higher than the FY2014 goal.

Figure 36 The number HIV/AIDS accessed to health services under the UCS scheme, FY2014



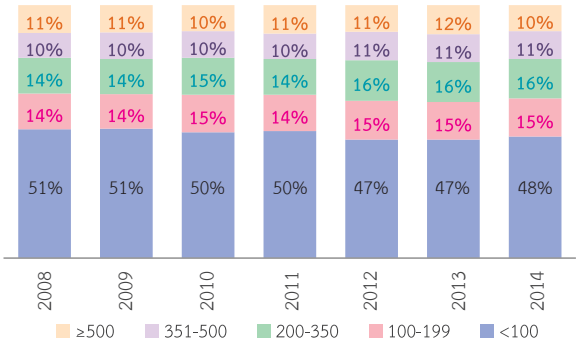
Source: *The National AIDS Program (NAP Plus), NHSO, date of data on November 2014*

Note: *"Registered to care" represents HIV/AIDS patients registered in the NAP program*
"Need ART" represents HIV/AIDS patients qualified to get ARV treatment
"Prescribed ART" represents HIV/AIDS patients are on ARV treatment
"Retained in ART" represents HIV/AIDS patients that are still on treatment on September 30, 2014
"VL tested" represents HIV/AIDS patients that are accessed to viral load test.
"VL suppressed" represents HIV/AIDS patients that have a number of viral load < 50 copies/ml.

According to follow-up services from providers, evidence shown that delays in accessing to health service is a main cause of death in the patients. The number of new cases enrolled to the NAP program under the UCS and received CD4 test has been increased from 5,732 cases in FY2008 to 9,226 cases in FY2014. The percentage of the enrolled patients having CD4 result before starting ART has been classified by level of CD4 in order to identify severity of their immune system when entering to the UCS system. The new cases having severe immune deficiency (CD4 < 100 cell/mm3) when enrolled to the program has continued to reduce slightly from 51% in FY2008 to 47% in FY2014, as details shown in figure 37.

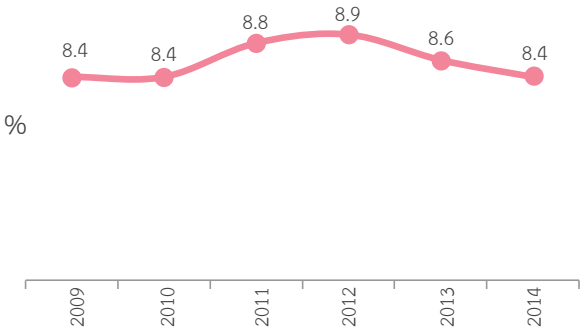
Another indicator that can be used to measure overall effectiveness of the system is a mortality rate of the patients. Figure 38 shows the mortality rate of HIV/AIDS patients within 12 months after starting ARV treatment between FY2008-2014. The result found that the mortality rate of the patients within 12 months after starting ARV treatment in this period is steady between 8.4% – 8.9%.

Figure 37 CD4 level classification in new HIV/AIDS cases age 15+ years, FY2008-2014



Source: *The National AIDS Program (NAP Plus), NHSO, date of data on December 2014*

Figure 38 Mortality rate of HIV/AIDS patients under the UCS scheme within 12 months after starting ART, FY2009-2014



Source: The National AIDS Program (NAP Plus), NHSO, date of data on December 2014

5.3.4 Chronic Kidney Diseases

Chronic kidney diseases (CKD) have continued to be one of important health problems in Thailand. The reasons of its important are its increasing trend in fatality rate and mortality rate, and its high losses from cost of care and disabilities. Furthermore, financial barriers from high cost of care and limitation of service facilities have affected accessing to necessary cares of the patients. The NHSO, therefore, has continued to promote the services not only including them in the benefit package but also supporting related health system development.

In order to promote quality of care, quality of life, and health outcome, kidney replacement therapy, i.e., peritoneal dialysis for end-stage chronic kidney diseases has been included in the UCS benefit package under the "PD first" policy since FY2008. Other methods, i.e., hemodialysis (HD) and kidney transplantation (KT), have been included later for the cases that Continuous Ambulatory Peritoneal Dialysis (CAPD) could not functioned.

The number of registration to chronic kidney disease management program under the UCS scheme has continued to increase since FY2008. In FY2014, accessibility to renal replacement therapy (RRT) in end-stage chronic kidney diseases has been increased in every type of treatment as shown in table 8.

Table 8 The number of CKD patients accessed to Renal Replacement Therapy classified by method of RRT, FY2013-2014

	FY2013	FY2014	
	cases	cases	% increased
1) Continuous Ambulatory Peritoneal dialysis (CAPD)	14,225	20,370	43.20
Old cases	7,407	10,748	45.11
New cases	5,554	7,816	40.73
Changed from other RRT methods	1,264	1,806	42.88
Deaths	3,233	3,817	
2) Hemodialysis (HD)	10,368	14,796	42.71
Old cases	6,606	8,668	31.21
New cases	2,868	5,363	86.99

	FY2013	FY2014	
	cases	cases	% increased
Changed from other RRT methods	894	765	-14.43
Deaths	1,426	1,742	
3) Kidney Transplantation (KT)	86	88	2.33
New cases	86	88	2.33
Deaths	3	8	
4) Immunosuppressive drug after KT	1,197	1,265	5.68
Old cases	998	1,068	7.01
New cases	199	197	-1.01
Deaths	24	19	

Source: *Chronic kidney disease management data, NHSO*

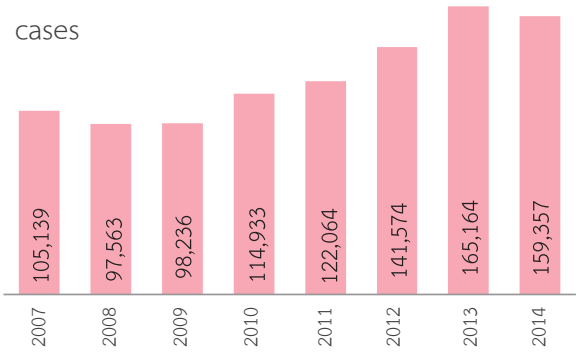
Note: *1. Patients can be change RRT method according to their medical indications.*

2. The number of patients accessed to RRT services is not included the number of dead patients.

5.3.5 Health services for Cataract surgery

Cataract is a common disease found in elderly which leads to a decrease in vision impacted to quality of life. Therefore, the UCS scheme has included cataract surgery in a vertical program to promote cataract surgery in elderly since FY2007. The number of cataract surgeries has been increased from 105,139 cases in FY2007 to 159,357 cases in FY2014, as shown in figure 39.

Figure 39 The number of cataract surgeries of UCS patients, FY2007-2014



Source: *In-patient data, NHSO, date of data on October 2014*

5.4 Health Promotion and Disease Prevention

Health promotion and disease prevention policy is an important strategy for promoting UHC in order to reduce sickness from preventable diseases and to prolong quality of life by avoiding risk behaviors. Because of this important and it covers both healthy and sick population, the National Health Security board has increased a share of the UCS budget for health promotion and disease prevention from THB175.00 per capitation in FY2003 to THB383.61 per capitation in FY2014, or 2.19 times increased.

Target and outcome of key indicators in health promotion and disease prevention of the UHC are shown in table 9.

Table 9 Performance on health promotion and disease prevention, FY2014

ID	Indicator list	Target	Outcome
1. Maternal care			
1.1	Rate of pregnancies attended the first visit of ANC within the first 12 GA. [1]	60% or more	58.08
1.2	Rate of pregnancies attended at least 5 times for antenatal care during pregnancy[2]	60% or more	55.84
1.3	Maternal mortality rate (cases per 100,000 live births) [1]	15 or less	20.9
1.4	Birth asphyxia rate in UCS (cases per 1,000 live births) [2]	25 or less	26.16
1.5	Percentage of low birth weight (<2,500 grams) in UCS	Less than 7%	10.28
1.6	Fatality rate of low birth weight (<2,500 grams) within 28 days in UCS[2]		
	- BW < 1,000 grams	< 50%	26.62
	- BW 1,000 - 1,499 grams	< 10%	10.7
	- BW 1,500 - 2,499 grams	< 2%	0.99
1.7	Incident rate of teenage pregnancy, age 15-19 years, UCS (per 1000 girls aged 15-19 years) [2]		75.17
1.8	Birth delivery rate of teenage pregnancy, age 15-19 years, UCS (per 1000 girls aged 15-19 years) [2]	Not more than 50	46.09
2. Child health			
2.1	Infant mortality rate (per 1000 live births)[1]	Not more than 15	6.6
2.2	Rate of children aged 9 months received routine growth monitoring according to guideline [2]	80% or more	91.8
2.3	Rate of children aged 18 months received routine growth monitoring according to guideline [2]	80% or more	91.8
2.4	Rate of student grade 1 received oral health examination[5]	85% or more	70.42
2.5	Rate of children aged 6-12 years received body weight and height check-up (not included Bangkok area) [3]	5,618,022	49.24
3. Workforces and elderly care			
3.1	Mortality rate of cardio-vascular diseases (per 100,000) [1]	Not more than 23	27
3.2	Mortality rate of cerebro-vascular diseases (per 100,000) [1]	Not more than 12	37.1
3.3	Fatality rate from head injuries (cases per 100 admission cases with head injury, S06.0-S06.9) [2]	reduce	9.31(0.58% increased)
3.4	Admission rate with Carcinoma insitu of cervix (Cases per 100 admission cases of all cervix cancer) [2]	25% or more	20.02
3.5	CA cervix screening rate at least once within 5 years, women aged 30-60 years old [4]	9,495,420	82.25

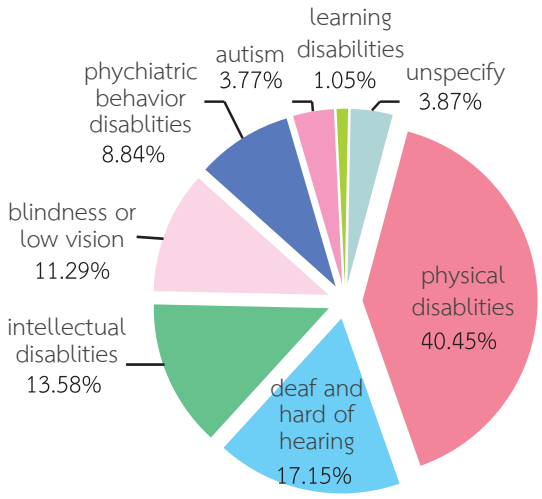
ID	Indicator list	Target	Outcome
3.6	Depression screening rate [3]		
	· Aged 30-59 years old	30,069,108	31.83
	· Aged 60 years or older	9,421,444	49.71
3.7	DM and Hypertension screening rate [3]		
	· Aged 30-59 years old	30,069,108	53.77
	· Aged 60 years or older	9,421,444	48.65
3.8	Denture service in elderly group aged 60 years and older [6]	45,462	76.9
3.9	Seasonal influenza vaccines in risk groups[2]	3,000,000	88.37

Source: *1. Health statistics, Bureau of policy and strategy, Ministry of Public Health, September 2014*
2. National Health Security Office
3. Health promotion and disease prevention from hospitals, FY2014 http://ppitem.nhso.go.th/PPI/ December 2014
4. Cervix Cancer screening report, National Cancer Institute, http://122.155.167.188/ , January 2015
5. Summarized from report of Bureau of Dental Health, Department of Health, FY2014
6. Denture service report http://nakhonsawan.nhso.go.th/denture/denture1.php January 2015

5.5 Medical Rehabilitation Services

The accumulative number of disabled people registered to the UCS scheme has been increased from 361,472 cases in FY2005 to 1,127,097 cases in FY2014. Figure 40 shows the number of disabled people classified by types of disability; most of the disabled are physical disabilities (40.45%), deaf and hard of hearing (17.15%), intellectual disabilities (13.58%), blindness or low vision (11.27%), psychiatric/ behavior disabilities (8.84%), autism (3.77%) and learning disabilities (1.05%), respectively.

Figure 40 Disabled people registered to the UCS scheme classified by types of disability, FY2014

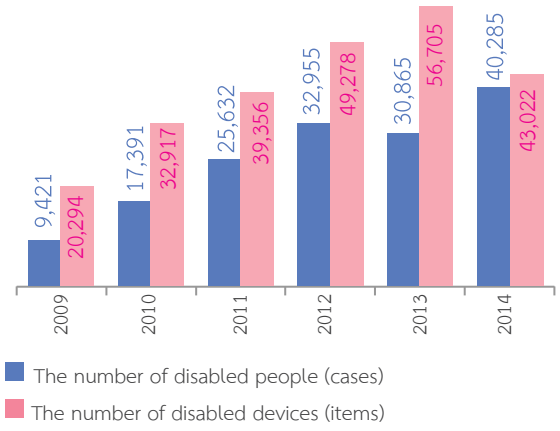


Source: *Claim data for rehabilitation services and instruments, NHSO, September 2014*
Note: *A disabled person can have more than one type of disability.*

The number of aiding devices claimed for disabled has been increased from 13,397 items for 6,185 cases in FY2008 to 41,553 items for 28,818 cases in FY2014; however, average items per person has been decreased from 2.17 items per person in 2008 to 1.44 items per person in FY2014, as shown in figure 41.

Accessibility to rehabilitation services for elderly, disabled people, and other needed patients under the UCS scheme has continued to increase since FY2008 as shown in figure 42. In FY2014, the number of rehabilitation services for beneficiaries under the UCS scheme is 1,836,315 visits for 534,233 cases or average 3.44 visits per person per year. Most of rehabilitation services are accessed by other needed patients (39.6% or 727,759 visits for 212,250 cases), the elderly (30.5% or 560,882 visits for 170,201 cases), and disabled people (29.8% or 547,674 visits for 151,782 cases), respectively.

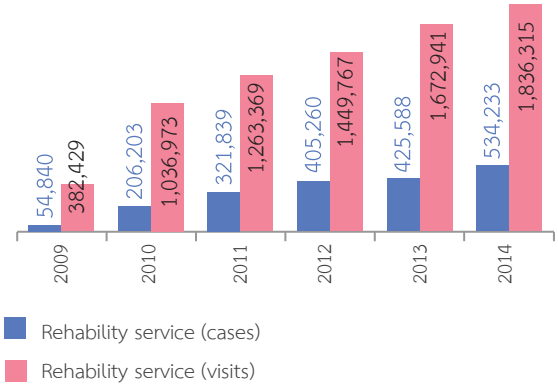
Figure 41 The number of aiding devices claimed for disabled people, FY2008-2014



Source: *Claim data for rehabilitation services and instruments, NHSO, September 2014*

Note: *A disabled person can have more than one type of disability.*

Figure 42 The number of rehabilitation services accessed by the beneficiaries under UCS, FY2008-2014



Source: *Claim data for rehabilitation services and instruments, NHSO, September 2014*

5.6 Drugs and Medical Instruments

The NHSO in collaborated with the Food and Drug Administration (FDA) of the ministry of public health has continued to promote system development for claims and administration, as well as drug usages in order to improve accessibility to the necessary high cost drugs. In FY2014, there are two groups of drugs separately managed to promote accessibility, i.e., E(2) category list of the national list of essential medicines (NLEM)[2], and orphan and antidote drugs.

[2] The National List of Essential Medicines (NLEM) is classified into six categories as follow:

- A category: the first line drugs used in most hospitals
- B category: the second line drugs
- C category: used only by specialists
- D category: variety of indications but only suitable in some indications, or limited of usage, or expensive than other medicines with the same indication
- E(1) category: under special programs of government agencies requires closed evaluation according to the programs
- E(2) category: very specific indications and required special central mechanism to monitor drug access

1) E(2) category list of the national list of essential medicines

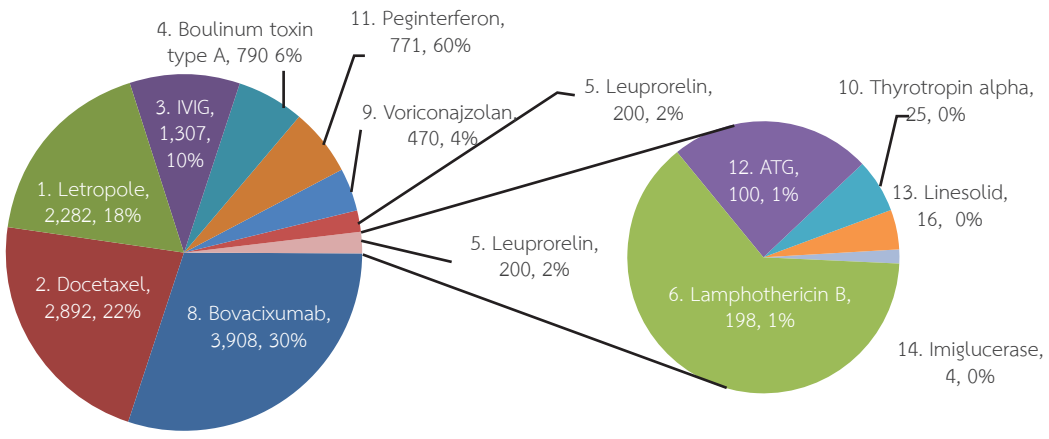
There are 14 drugs under the E(2) category list. Guidelines for indications, qualified doctors and hospitals that can prescribe the drugs are developed. The number of qualified new patients accessed to drugs listed in the E(2) category has been increased since FY2009, as shown in table 10. Most of E(2) drugs in the list accessed in FY2014 are Bevacixumab (30%), Docetaxel (22%), Letrozole (18%), and IVIG (10%), respectively as shown in figure 43.

Table 10 The number of new patients accessed to drugs listed in the E(2) category list of the national list of essential medicines, FY2010–2014

Drug name	2009	2010	2011	2012	2013	2014
1. Letrozole	-	1,558	2,629	1,330	1,382	2,282
2. Docetaxel	321	527	879	1,439	1,447	2,892
3. IVIG	271	679	901	1,059	1,318	1,307
4. Boulinum toxin type A	102	313	704	690	677	790
5. Leuprorelin	146	145	281	200	204	200
6. Lamphothericin B	5	68	139	134	133	198
7. Verteporfin	-	9	30	22	61	-
8. Bevacixumab	-	-	-	-	2,694	3,908
9. Voriconajzole	-	-	-	-	216	470
10. Thyrotropin alpha	-	-	-	-	21	25
11. Peginterferon	-	-	-	-	559	771
12. ATG	-	-	-	-	56	100
13. Linesolid	-	-	-	-	4	16
14. Imiglucerase	-	-	-	-	5	4
Total	845	3,299	5,563	4,874	8,777	12,963

Source: *Bureau of Medicines Medical Supplies and Vaccines Management, NHSO*
Note: *Item 8 – 14 were included in the benefit package since FY2013*

Figure 43 The number of new patients accessed to drugs listed in the E(2) category list of the national list of essential medicines in FY2014



Source: *Bureau of Medicines Medical Supplies and Vaccines Management, NHSO*

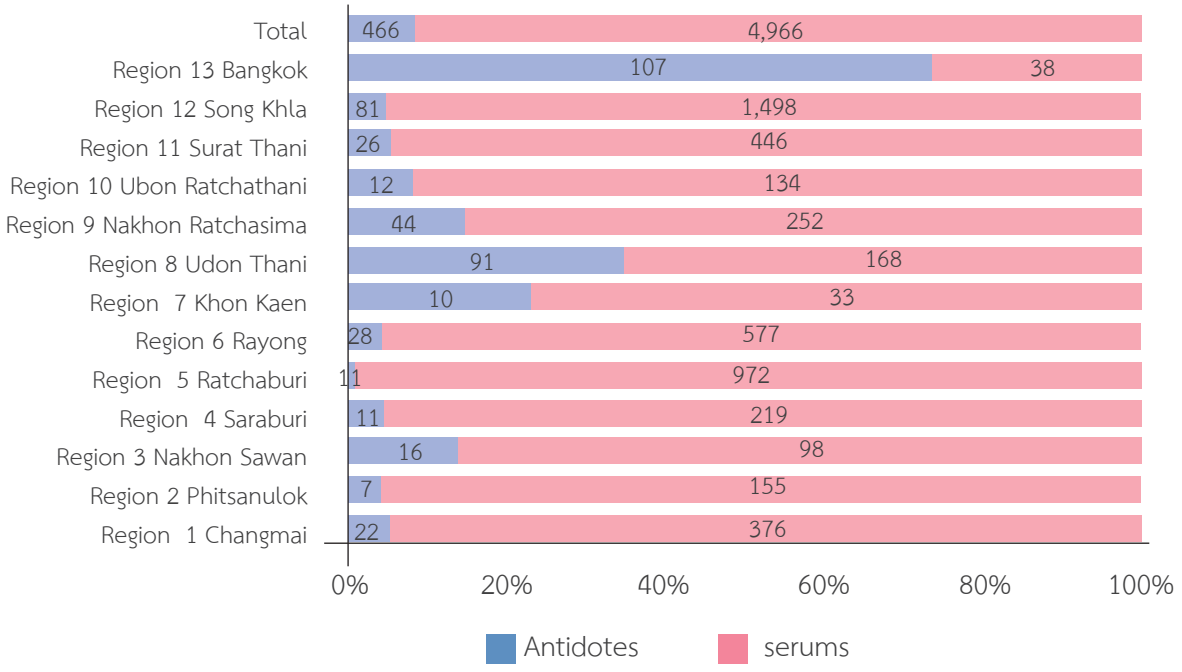
2) Orphan and antidote drugs

A small scale of orphan drug market has caused limitation in stocking and distributing them. In FY2014, UCS benefit package has expanded to include 17 orphan and antidote drugs managed through the VMI system of the Government Pharmaceutical Office (GPO). The orphan and antidote drugs introduced in the benefit package are listed below:

1. Dimercaprol injection
2. Sodium nitrite injection
3. Sodium thiosulfate injection
4. Methelene blue injection
5. Succimer capsule (DMSA)
6. Calcium disodium edentate
7. Esmolol injection
8. Digoxn specific antibody fragment
9. Diptheria antitoxin
10. Botulinium antitoxin
11. Anti-venom serum
12. Green Pit Viper antivenin
13. Russell's Viper antivenin
14. Malayan Pit Viper antivenin
15. Malayan Krait antivenin
16. Polyvalent antivenum for hematotoxin
17. Polyvalent antivenum for neurotoxin

The number of new patients accessed to the orphan and antidote drugs in FY2014 is 5,432 cases. Ninety one percent (4,966 cases) of the new patients are accessed to serums. Proportion of patients in most regions, except the NHSO region 13 Bangkok, are also accessed to serums. Details of the new patients accessed to orphan and antidote drugs classified by the NHSO Regions are shown in figure 44. Most of the new patients accessed to antidotes and serums are located in Region 12 Song Khla (30%), Region 5 Ratchaburi (18%), Region 6 Rayong (11%), and Region 11 Surat Thani (9%), respectively as shown in figure 45.

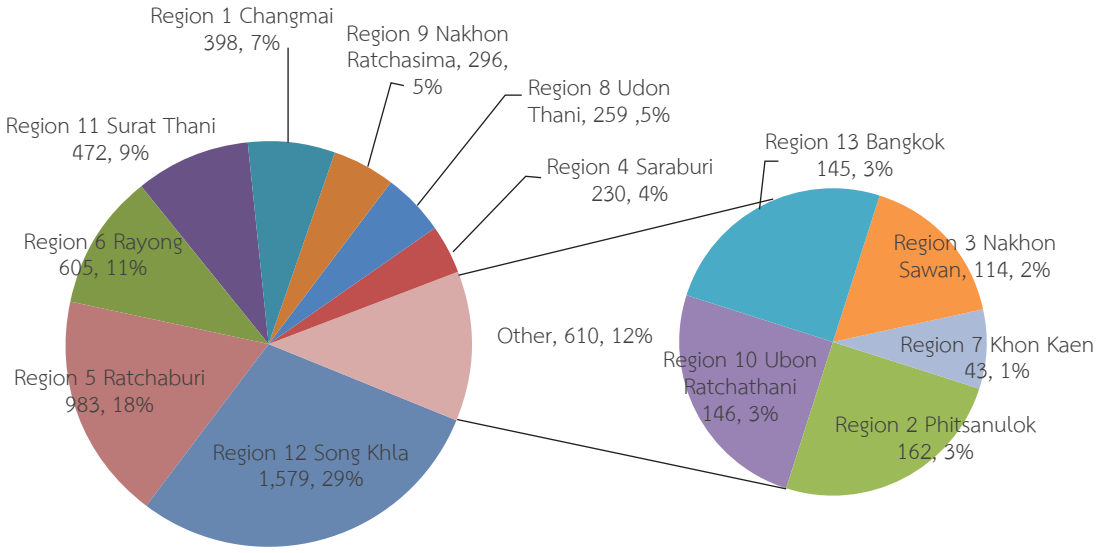
Figure 44 The number of patients accessed to Antidote and serum drug list, FY2014



Source: Bureau of Medicines Medical Supplies and Vaccines Management, NHSO

0%

Figure 45 The number of new patients accessed to antidotes and serums classified by the NHSO regions in FY2014

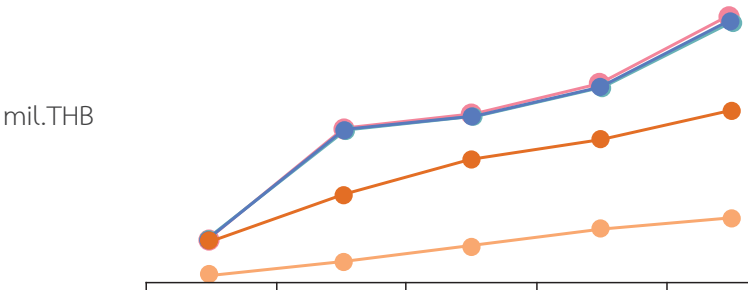


Source: Bureau of Medicines Medical Supplies and Vaccines Management, NHSO

Management of drugs and medical instruments under the UCS scheme is not only to promote accessibility to necessary drugs of the patients under the scheme but also to improve efficiency and quality of the system in order to promote sustainability of UHC in the country. Central management on specific drugs and medical instruments that have high cost or required intervention such as the orphan drugs is an important mechanism to improve accessibility and efficiency of the overall system under limitation of the budget. Central procurement and management has continued to save budget from THB1.28 billion in FY2010 to THB7.21 billion in FY2014, as shown in figure 46.

In term of clinical outcome, the study by Thai society of Toxicology (T.S.T) has monitored effectiveness of treatment in patients prescribed antidotes and serums, the results found that initial severity of most of patients was "moderate" (74.29% and 62.50%) and final severity of patients after the treatment was none (cured) (94.29% and 87.50%) in patients prescribed serums and antidotes, respectively as details shown in figure 47.

Figure 46 Value of government budget saved from central management on specific drugs, FY2010 – 2014



	2010	2011	2012	2013	2014
Serums*****				55.37	23.52
Influenza vaccines****			65.67	95.05	105.75
J2 sub-list and Clopidogrel***	108.01	1,738.48	1,172.56	1,429.00	2,382.32
ARV CL**	866.28	1,732.83	2,319.00	2,377.05	2,870.03
ARV Non CL*	311.77	625.51	1,032.53	1,531.09	1,827.69
total	1,286.07	4,096.82	4,589.75	5,487.56	7,209.31

Source: *Bureau of Medicines and Medical Supplies Management, NHSO*

Note: *1) * calculated based on budget spent in FY2009*

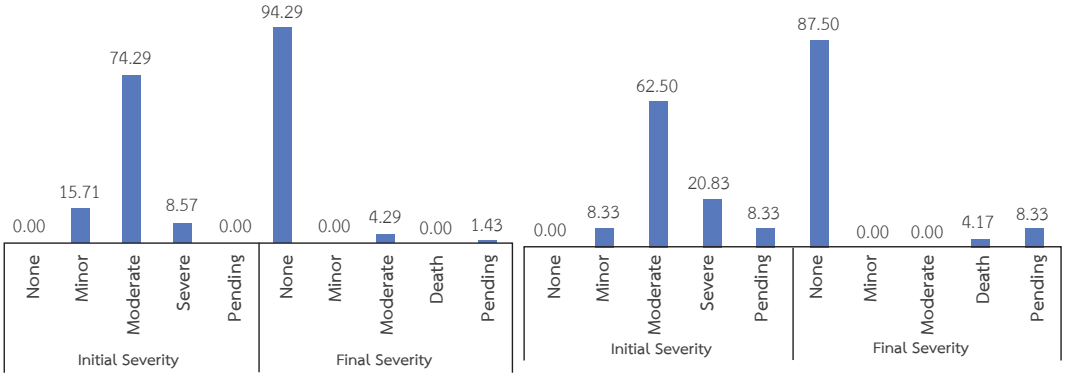
*2) ** calculated based on drug price before compulsory licensing (CL) announced by the government*

*3) *** calculated based on drug price before having vertical program on E(2) category list and before CL on Clopidogrel*

*4) **** calculated based on budget spent in FY2012*

*5) ***** calculated based on value of serums that hospitals paid to the Queen Saovabha Memorial Institute (producer of serums under the Thai Red Cross Society) and the Government Pharmaceutical Office (GPO) before having vertical program on serums under the UCS*

Figure 47 Clinical outcome in patients prescribed serums and antidotes, FY2014

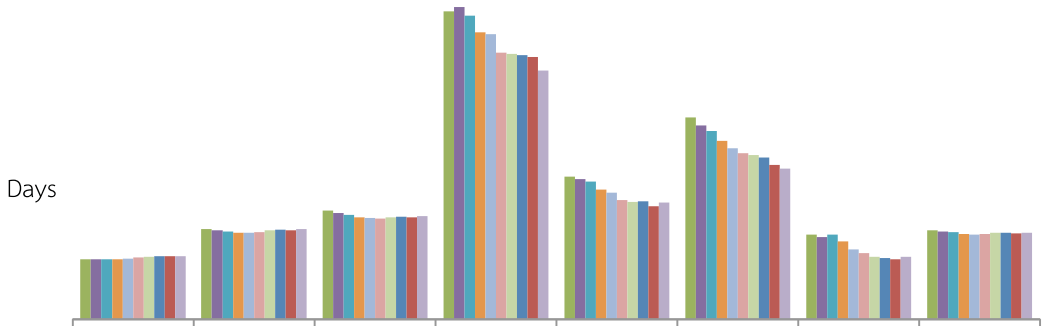


Source: *Bureau of Medicines Medical Supplies and Vaccines Management, NHSO*

5.7 Health service efficiency

Average length of stay (LOS) is one of indicators to measure effectiveness of IP services since longer LOS will consume more resources. Average LOS of patients under the UCS scheme during FY2005-2014 has been slightly reduced from 4.27 days per admission in FY2005 to 4.17 days per admission in FY2014. When classifying by types and affiliation of hospitals in FY2014, hospital types or affiliations having high average LOS are other government hospitals not under the office of permanent secretary (OPS), ministry of public health (MOPH) (11.94 days per admission), hospital under medical universities (7.25 days per admission), other government hospitals not under the OPS, MOPH (5.62 days per admission), and regional hospitals (4.96 days per admission), respectively as shown in figure 48.

Figure 48 Average length of stay (LOS) classified by types and affiliations of hospitals, FY2005-2014



	District hospitals	General hospitals	Regional hospitals	Other gov. under MOPH	Othe gov. not under MOPH	University hospitals	private hospitals	Overall
2005	2.88	4.33	5.22	14.78	6.86	9.69	4.07	4.27
2006	2.89	4.28	5.1	15	6.72	9.32	3.96	4.23
2007	2.89	4.23	5.02	14.59	6.62	9.04	4.07	4.19
2008	2.89	4.15	4.9	13.79	6.23	8.58	3.74	4.11
2009	2.91	4.15	4.86	13.7	6.07	8.21	3.35	4.07
2010	2.96	4.2	4.84	12.82	5.74	7.99	3.19	4.09
2011	3.01	4.27	4.9	12.74	5.64	7.88	3	4.15
2012	3.04	4.31	4.93	12.7	5.68	7.76	2.94	4.17
2013	3.03	4.28	4.91	12.6	5.42	7.43	2.89	4.14
2014	3.04	4.33	4.96	11.94	5.62	7.25	2.99	4.17

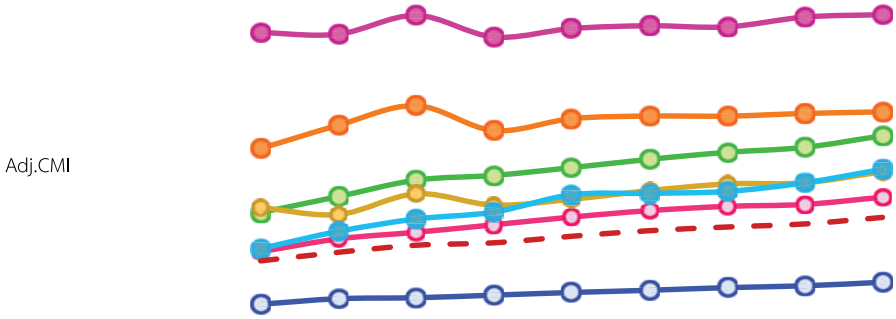
Source: *In-patient data, NHSO, January 2015*

Note: *Types and affiliation of hospitals is classified from main contracting hospitals of the patients.*

Case Mix Index (CMI) is an indicator to measure severity of diseases calculated from Relative Weight (RW) or Adjusted Relative Weight (AdjRW) of all IP cases within a specific period of time to reflect effectiveness of service system. Admission may be more necessary in patients with higher RW or AdjRW.

Calculated with DRG application version 5, Adj.CMI of IP service under the UCS scheme has been increased from 0.81 in FY2006 to 1.16 in FY2014; this increasing pattern is also true if classifying by types and affiliation of hospitals, as shown in figure 49.

Figure 49 Adjusted CMI of in-patient service under the UCS scheme, FY2006-2014

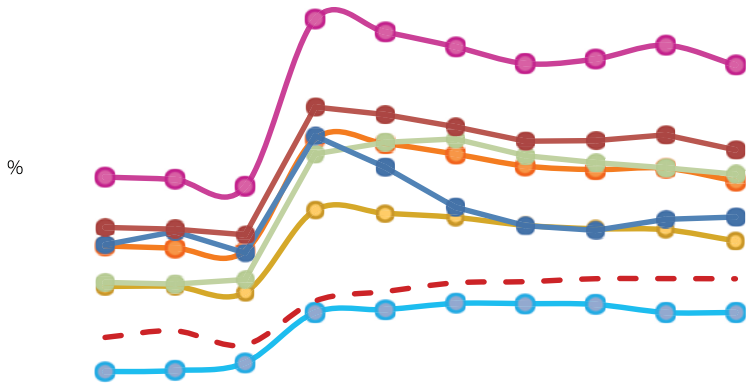


	2006	2007	2008	2009	2010	2011	2012	2013	2014
District hospitals	0.47	0.52	0.52	0.54	0.56	0.58	0.60	0.62	0.64
general hospitals	0.88	0.99	1.04	1.10	1.16	1.21	1.24	1.26	1.31
Regional hospitals	1.19	1.32	1.45	1.49	1.55	1.61	1.67	1.71	1.80
University hospitals	2.61	2.60	2.75	2.58	2.64	2.66	2.66	2.73	2.75
Other gov. hospitals under MOPH	1.70	1.88	2.03	1.84	1.93	1.95	1.95	1.97	1.99
Other gov. hospitals, not under MOPH	1.23	1.18	1.34	1.25	1.30	1.37	1.42	1.43	1.52
private hospitals	0.91	1.05	1.14	1.20	1.33	1.34	1.36	1.43	1.53
Overall	0.81	0.88	0.94	0.96	1.01	1.05	1.08	1.10	1.16

Source: In-patient data, NHSO, January 2015

In cases of admission having less severity with a Relative Weight (RW) less than 0.5 in FY2014, most of these patients are admitted at district hospitals (53.7%), other government hospitals not under the MOPH (36.72%), and general hospitals (35.63%), respectively as shown in figure 50.

Figure 50 Percentage of admission in the UCS scheme having RW<0.5 classified by classify by types and affiliation of hospitals, FY2005-2014

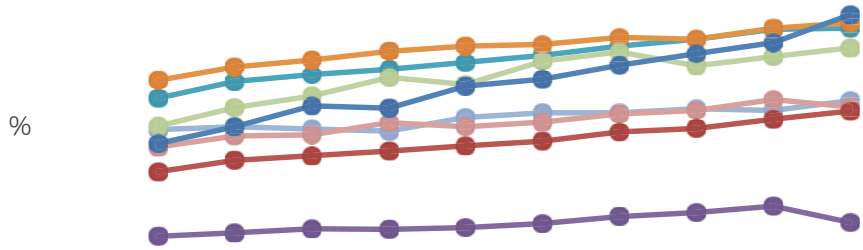


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
District hospitals	36.24	35.86	34.77	60.82	58.83	56.53	53.92	54.63	56.78	53.7
general hospitals	25.52	25.19	24.79	42.2	41.45	39.83	37.98	37.42	37.63	35.63
Regional hospitals	19.24	19.22	18.32	31.11	30.61	29.98	28.74	28.21	28.06	26.32
University hospitals	5.94	6.14	7.35	15.18	15.63	16.58	16.55	16.43	15.18	15.18
Other gov. hospitals under MOPH	11.29	12.32	10.14	16.97	18.43	19.79	19.97	20.43	20.45	20.42
Other gov. hospitals, not under MOPH	19.85	19.6	20.3	39.83	41.63	42.2	39.6	38.54	37.67	36.72
private hospitals	25.74	27.78	24.44	42.66	37.82	31.56	28.64	27.96	29.69	30.05
Overall	28.39	28.11	27.27	47.18	45.98	44.1	41.88	41.89	42.83	40.46

Source: In-patient data, NHSO, January 2015

Unnecessary surgeries, e.g., cesarean section, are usually consuming higher resources than normal cases. Unit cost for cesarean section is higher than normal labor. Cesarean section under the UCS scheme has continued to increase from 18.20% in FY2005 to 29.14% in FY2014; this increasing pattern is also true if classifying by types and affiliation of hospitals, as shown in figure 51. This shows that elective cesarean delivery is existed.

Figure 51 Cesarean section rate under the UCS scheme classified by hospital types, FY2005- 2014



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
District hospitals	6.61	7.29	7.94	7.92	8.20	8.97	10.16	10.88	11.99	9.09
General hospitals	31.36	34.30	35.56	36.55	37.72	38.97	40.64	41.96	43.72	43.93
Regional hospitals	34.50	36.89	38.20	39.76	40.62	40.98	42.20	41.91	43.88	44.80
Other gov. under MOPH	25.70	26.28	25.81	25.46	27.92	28.73	28.75	29.41	29.13	30.93
Othe gov. not under MOPH	22.61	24.56	24.77	26.94	26.27	27.07	28.57	29.19	31.14	29.77
University hospitals	26.35	29.65	31.77	35.09	33.77	37.95	39.63	37.17	38.82	40.37
private hospitals	23.21	26.22	29.95	29.52	33.52	34.80	37.25	39.36	41.24	46.28
Overall	18.20	20.20	21.06	21.90	22.80	23.70	25.32	25.95	27.58	29.04

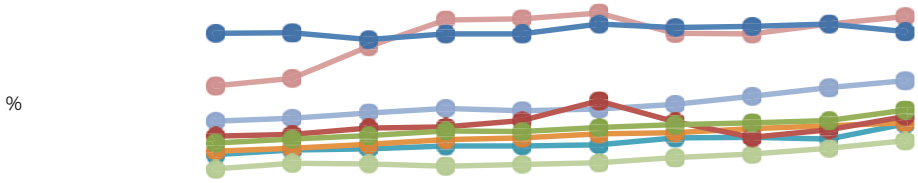
Source: In-patient data, NHSO, January 2015

5.8 Quality and service outcome

Re-admission rate within 28 days after last discharge could be another indicator to reflect quality of IP care or effectiveness of the last treatment. In FY2014, the average re-admission rate is 14.98%; hospital types or affiliations having high re-admission rates are hospitals not under the ministry of public health (23.38%), university hospitals (22.06%), regional hospitals (17.65%), general hospitals (13.86%), and private hospitals (14.44%), respectively as shown in figure 52.

Adverse events that may happen from errors of treatments, and/or delays in diagnosis or treatments can be used to evaluate quality of care. Fatality rate within 30 days after treatments is one of indicators that are used to reflect quality of care in health system. Figure 53 represents comparison between fatality rate within 30 days after last admission in heart disease patients with open heart surgery and PCI procedure during FY2005-2014. Trend of fatality rate within 30 days after last admission in both treatments shows a slight increase during this period.

Figure 52 Re-admission rate within 28 days after last discharge of patients under the UCS scheme classified by type and affiliation of hospitals, FY2005-2014



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
District hospitals	10.99	11.41	11.52	11.79	11.75	11.90	12.50	12.55	12.42	13.75
General hospitals	11.29	11.57	11.94	12.37	12.50	12.85	12.99	13.32	13.58	13.86
Regional hospitals	13.98	14.28	14.73	15.14	14.95	15.11	15.52	16.22	16.99	17.65
Other gov. under MOPH	17.17	17.85	20.68	23.09	23.17	23.71	21.87	21.86	22.70	23.38
Othe gov. not under MOPH	9.72	10.22	10.16	9.95	10.12	10.29	10.76	11.03	11.58	12.22
University hospitals	21.89	21.96	21.33	21.85	21.85	22.70	22.39	22.50	22.70	22.06
private hospitals	12.68	12.83	13.36	13.49	14.03	15.80	13.94	12.54	13.22	14.44
Overall	12.04	12.42	12.70	13.10	13.07	13.42	13.70	13.85	14.08	14.98

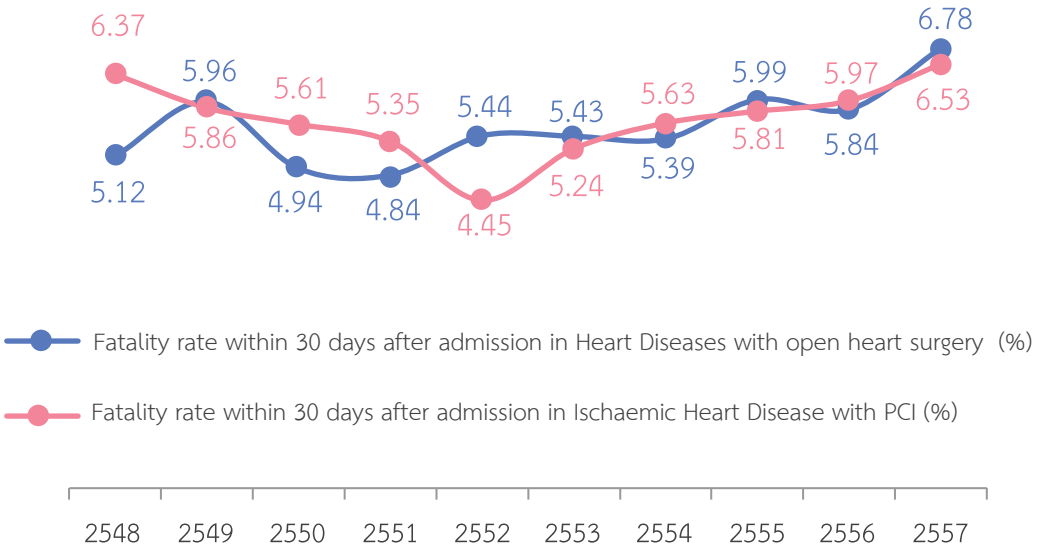
Source: *In-patient data, NHSO, January 2015*

Note: *1) In-patient data that discharge type of last admission = "improve" are selected.*

2) Planned or unplanned admissions cannot be classified. Therefore, the second admission may be planned for follow-up treatment.

3) Types and affiliation of hospitals is classified from main contracting hospitals of the patients.

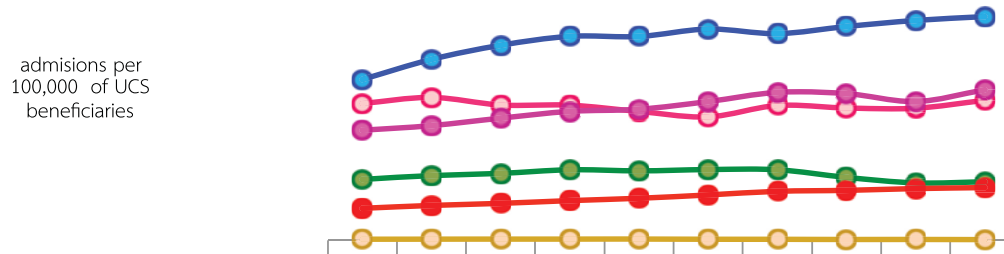
Figure 53 Fatality rate within 30 days after last admission in heart disease patients with open heart surgery and PCI procedure during FY2005-2014



Source: *In-patient data, NHSO, date of data on March 2015*

Admission rate of preventable admission diseases with ambulatory care sensitivity condition (ACSC) is one of indicators to measure health service performance from quality of care to efficiency and effectiveness of services at primary care level in order to prevent admissions from complicated symptoms of chronic diseases, e.g., DM, hypertension, asthma, chronic obstructive pulmonary diseases (COPD), and heart failure with pulmonary emphysema condition. By analyzing admission rate with the ACSC conditions in the UCS patients during FY2005-2014, the results found that the admission rate of most conditions has increasing trend during this period. However, the trend of admission rate of the ACSC conditions in DM is higher than other conditions which can be represented that it is required more intervention in order to reduce the preventable admission diseases. Details of these admission rates of the ACSC conditions are shown in figure 54.

Figure 54 Admission rate of the UCS scheme with ACSC conditions of chronic diseases, FY2005-2014

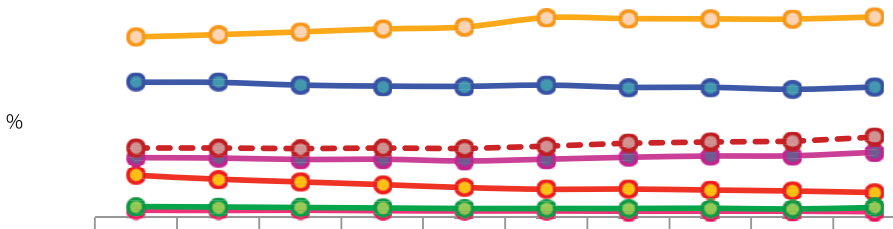


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Admission rate with DM or complication from DM, age 15 or up	158.70	178.56	192.47	201.27	201.17	208.49	203.97	211.00	217.00	220.77
Admission rate with Hypertension (HT) or complication from HT, age 15 or up	135.05	141.02	133.54	133.39	127.18	121.84	133.03	130.60	130.38	138.17
Admission rate with Asthma, age 15 or up	60.27	63.88	66.07	69.63	68.56	69.84	69.64	62.12	56.71	57.75
Admission rate with COPD, age 15 or up	108.50	113.20	120.55	127.26	129.37	136.94	145.98	144.80	136.98	148.56
Admission rate with Epilepsy	31.60	34.44	36.48	39.21	41.52	44.79	48.37	49.32	51.08	52.05
Admission rate with heart failure having pulmonary emphysema condition	1.08	1.17	1.23	1.24	1.28	1.08	1.03	0.85	0.88	0.73

Source: In-patient data, NHSO, January 2015

For overall outcome of IP services, hospital fatality rate or ratio can be used as a result from both disease severity and service quality so it can be used as an indicator to measure disease severity reflected from efficiency, quality of care, service system, and local epidemiology of diseases. Figure 55 shows fatality rate within 30 days after last admission of patients under the UCS scheme classified by age groups during FY2005-2014. The fatality rate of the overall IP services has been increased from 2.81% in FY2005 to 3.26% in FY2014. While the fatality rate of patients aged 70 years and older has been increased, the one of patient age less than 1 year old has been decreased. The rate of most age groups is quite steady or is slightly increase during the same period of time.

Figure 55 Fatality rate of patients under the UCS scheme classified by age groups, FY2005-2014



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Less than 1 yr	1.70	1.55	1.44	1.33	1.21	1.14	1.15	1.11	1.07	1.01
1-4 yr.	0.29	0.28	0.29	0.27	0.26	0.26	0.25	0.25	0.25	0.23
5-14 yr.	0.44	0.42	0.40	0.38	0.36	0.36	0.36	0.37	0.34	0.40
15-59 yr.	2.42	2.41	2.35	2.36	2.29	2.36	2.44	2.49	2.50	2.64
60-69 yr.	5.48	5.48	5.37	5.33	5.32	5.37	5.28	5.28	5.20	5.29
70 yr or up	7.32	7.42	7.53	7.65	7.73	8.11	8.07	8.06	8.05	8.14
Overall IP	2.81	2.82	2.79	2.81	2.79	2.88	3.01	3.07	3.08	3.26

Source: *In-patient data, NHSO, January 2015*
Note: *Fatality rate of patients age < 1 year was not include Diagnosis code (ICD-10) = Z380*

- 6 -

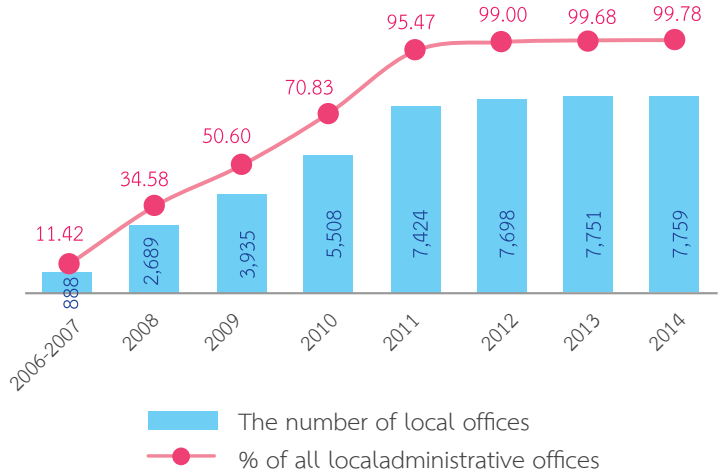
Consumers' Right Protection and Stakeholder Participation

Consumers' Right Protection and Stakeholder Participation

6.1 Promoting local community participation

Promoting local community participation is one of key mechanisms according to Article 47 of the National Health Security Act to respond to health needs of local community by engaging community society in decision making and co-funding in health related programs. The number of local administration offices co-funding in community health security funds has been increased from only 888 sub-districts (11.42%) in FY2006 to 7,759 sub-districts or 99.78% of all local administration offices in FY2014, as shown in figure 56. The community health security funds have been set up in order to promote health related activities that are suitable and responded to health needs of each community. Consumers and related organizations in each of the community are not only paying contribution to the community health security funds but also engaging in related decision making processes.

Figure 56 The number of local administration offices co-funding in community health funds, FY2006-2014

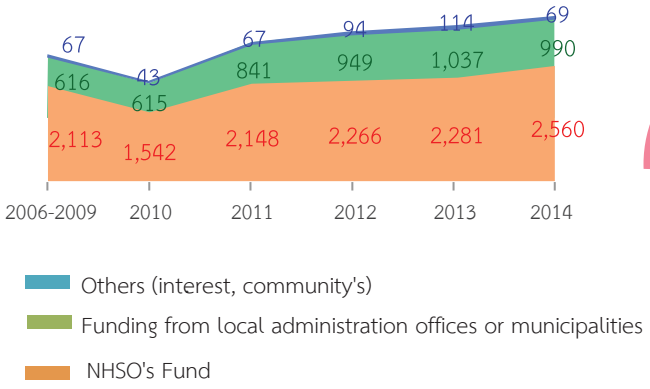


Source: Local administration management data, NHSO

The total amount of community health security funds in FY2014 is THB3,619 million sharing from three sources: the NHSO, local administration offices, and others (such as interests, consumers and community). Funding from local administration offices has been increased from THB616 million (22.03% of the annual fund) in FY2006 to THB990 million (27.36% of the annual fund) in FY2014. Funding from the NHSO has been increased from THB2,113 million (75.57% of the annual fund) to THB2,560 million (70.74% of the annual fund) in FY2014. Details of community health security fund classified by sources of fund are shown in figure 57.

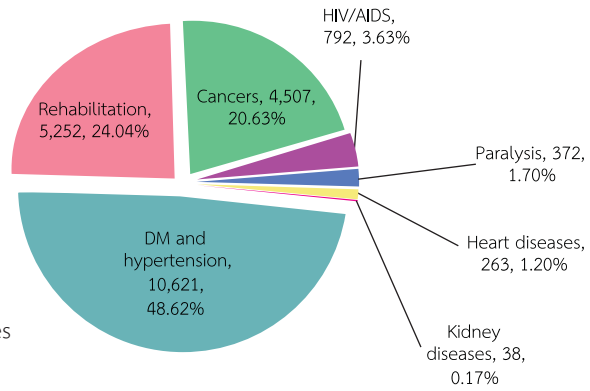
Most of health related activities supported by community health security funds classified by types of related diseases of the projects in FY2014 are chronic diseases (DM and Hypertension) (10,621 projects, 48.62%), rehabilitation (5,252 projects, 24.04%), cancers (4,507 projects, 20.63%), and HIV/AIDS (792 projects, 3.63%), respectively as shown in figure 58.

Figure 57 Community health security funds classified by sources of fund, FY2006-2014



Source: Local administration management data, NHSO

Figure 58 Health related activities supported by community health security funds classified by types of related disease, FY2014



Source: Local administration management data, NHSO

6.2 Consumer Right's Protection

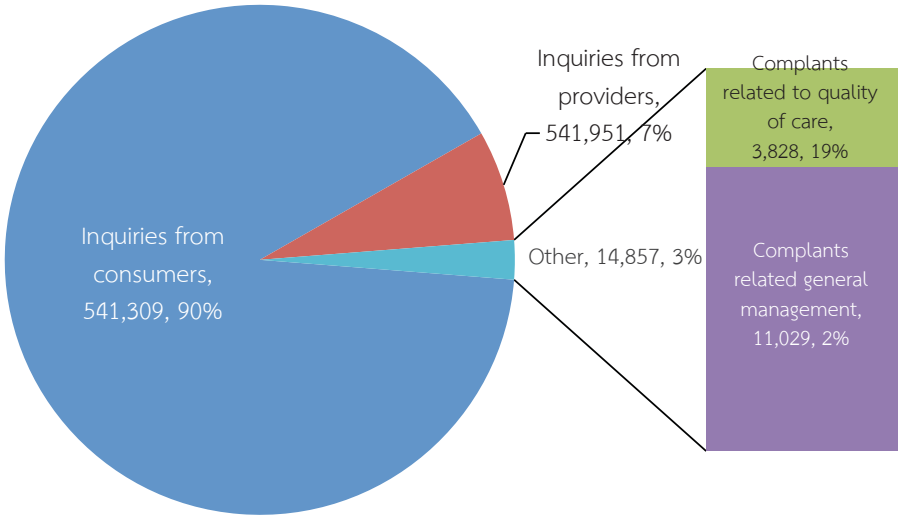
Complaint service center is one of consumer rights protection mechanism to be a channel that consumers can report complaints about health service. Although some complaints may occur from misunderstanding between patients and providers instead of providers' mistake, complaint service center could be a good channel to ease the conflict between consumers and providers. The number of inquiries and complaints has been reduced from 875,661 cases in FY2008 to 598,117 cases in FY2014. Most of these cases are inquiries from consumers, as shown in figure 59. In FY2014, most of these cases are inquiries from consumers (90%), inquiries from providers (7%), complaints related to general management (2%), and complaints related quality of care (1%), respectively as shown in figure 60.

Figure 59 The number of inquiries and complaints, FY2008 - 2014

	2008	2009	2010	2011	2012	2013	2014
3. Complaints related to quality of care (cases)	4,239	4,298	4,186	4,386	4,370	4,420	3,828
2. Complaints related general management (cases)	19,419	10,107	6,184	5,756	6,324	6,616	11,029
1.2 - providers (cases)	96,742	40,155	30,995	31,995	36,830	37,733	41,951
1.1 - consumers (cases)	755,261	728,927	777,798	697,325	570,220	574,777	541,309
1. Inquiries (cases)	852,003	769,082	808,793	729,320	607,050	612,510	583,260
Total (cases)	875,661	783,487	819,163	739,462	617,744	623,546	598,117

Source: Consumer rights protection data, NHSO

Figure 60 Percentage of inquiries and complaints, FY2014

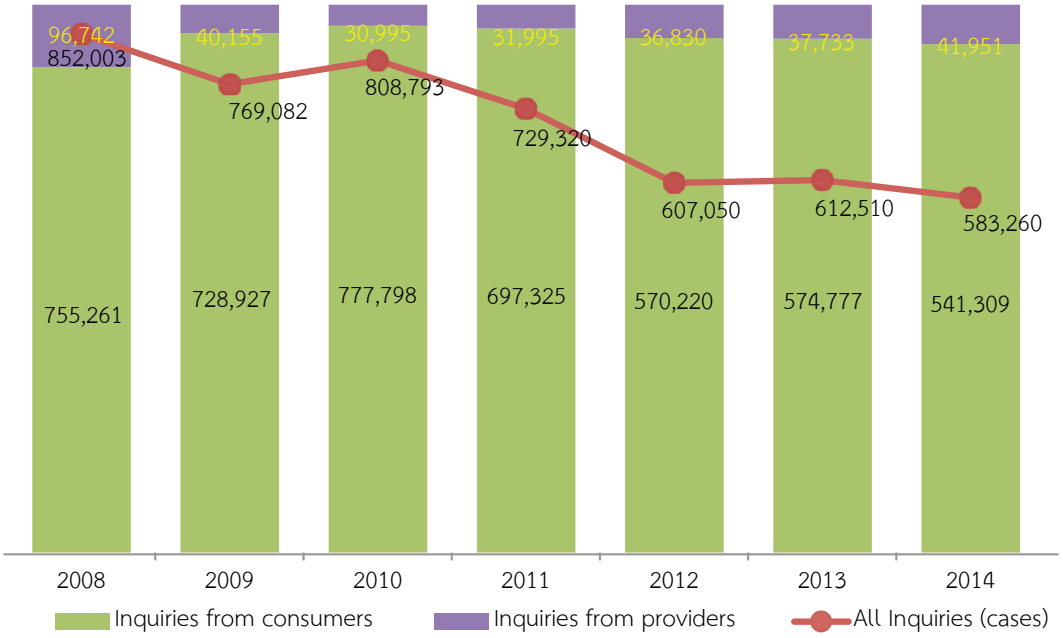


Source: Consumer rights protection data, NHSO

6.2.1 Inquiries

The NHSO 1330 hotline was setup to serve the UCS beneficiaries, however, anyone can call if there is any question regarding to one's government health insurance status which could be status of his/her own or his/her patients. The number of inquiries has been reduced from 852,003 cases in FY2008 to 583,260 cases in FY2014. Most of inquiries are from consumers; reducing from 755,261 cases (88.6% of all inquires) in FY2008 to 541,309 cases (92.8% of all inquires) in FY2014, as shown in figure 61.

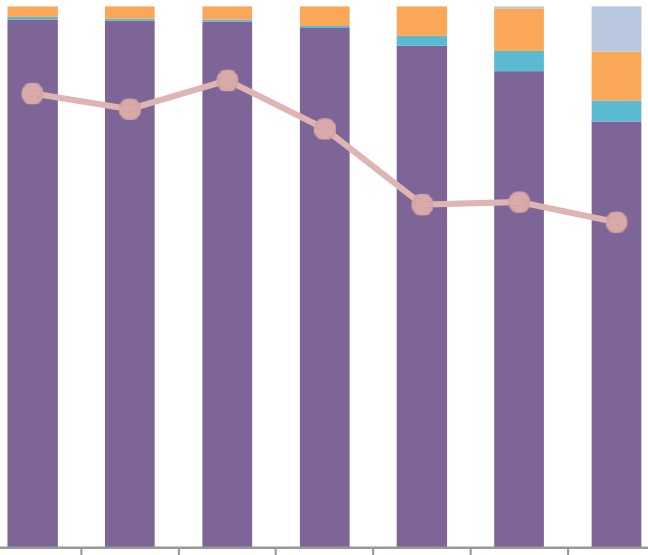
Figure 61 The number of inquiries classified by callers, FY2008-2014



Source: Consumer rights protection data, NHSO

Although most of the inquiries from consumers are related to the UCS scheme, the number and share of inquiries related to the UCS scheme has been reduce from 750,755 cases (99.4% of all inquiries from consumers) in FY2008 to 512,490 cases (94.7% of all inquiries from consumers) in FY2014, as shown in figure 62. In FY2014, most of the inquiries related to the UCS scheme are "health insurance status confirmation" (244,111 cases or 47.6% of inquiries from consumers related to UCS scheme), "issues related to benefit package and accessing to the benefit package" (114,362 cases or 22.3% of inquiries from consumers related to UCS scheme), and "registration and choosing service provider" (94,798 cases or 18.5% of inquiries from consumers related to UCS scheme), respectively as shown in figure 63.

Figure 62 The number of inquiries from consumers classified by related government schemes, FY2008 - 2014

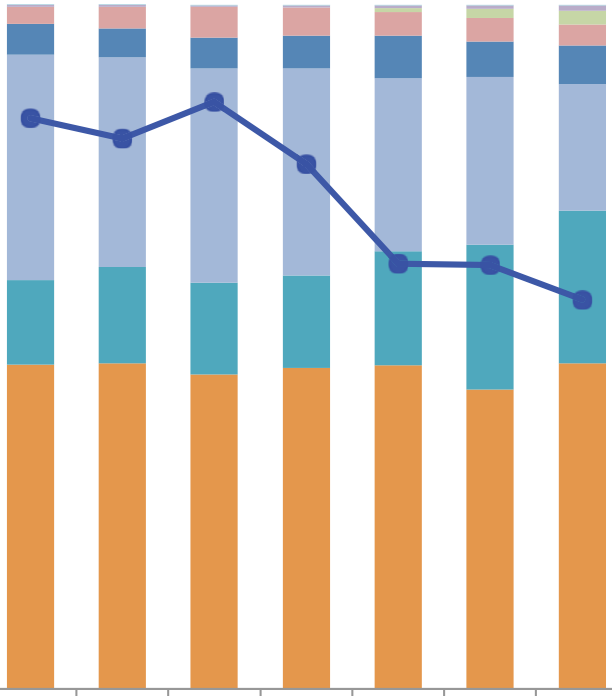


	2008	2009	2010	2011	2012	2013	2014
4. Local administrative office scheme	0	0	0	0		512	11,294
3. SSS scheme	3,632	4,248	4,636	6,294	7,777	11,285	12,175
2. CSMBS scheme	874	653	635	681	2,497	5,290	5,350
1. UCS scheme	750,755	724,026	772,527	690,350	559,946	557,690	512,490
Total (cases)	755,261	728,927	777,798	697,325	570,220	574,777	541,309

Source: *Consumer rights protection data, NHSO*

Note: *The NHSO has developed registration system for local administration offices since FY2014 according to the government policy.*

Figure 63 The number of inquiries from consumers related to UCS scheme classified by topics, FY2008-2014



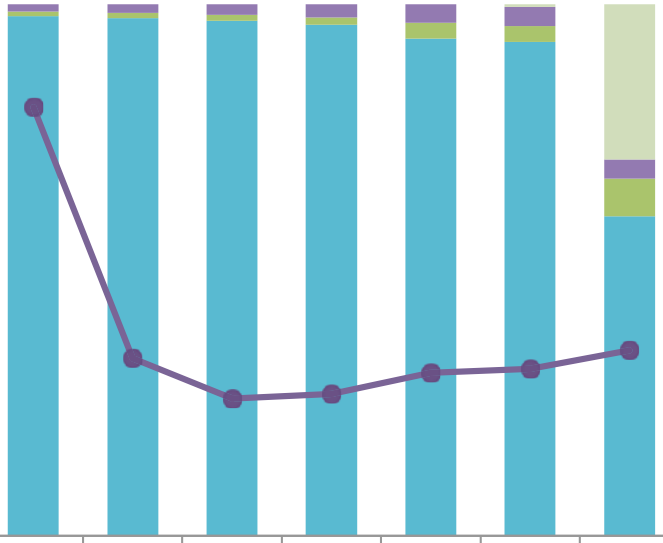
	2008	2009	2010	2011	2012	2013	2014
1.8 basic payment for lost or injuries from health service according to section 41 of the Act.	182	185	264	262	196	259	301
1.7 Organization information	1,889	1,811	1,913	2,027	2,180	3,076	3,869
1.6 Emergency Medical Claim for all*	0	0	0	0	3,579	7,359	10,321
1.5 Hospital information	18,579	22,829	34,578	29,008	19,156	19,106	15,793
1.4 Others (news, other organization, follow-up cases, etc.)	33,732	30,537	35,233	32,773	35,017	29,060	28,935
1.3 registration and choosing service provider	247,367	221,877	241,394	208,775	141,399	136,596	94,798
1.2 issues related to benefit package and accessing to the benefit package	93,354	101,749	103,606	93,629	93,426	117,989	114,362
1.1 Health insurance status confirmation	355,652	345,038	355,539	323,876	264,993	244,245	244,111
1. UCS scheme	750,755	724,026	772,527	690,350	559,946	557,690	512,490

Source: *onsumer rights protection data, NHSO*

Note: ** The NHSO has developed the emergency medical claim for all since April 1, 2012 when the government announced the emergency policy for every government schemes*

The number and share of inquiries from providers related to the UCS scheme has been reduced from 95,663 cases (98.9% of all inquiries from providers) in FY2008 to 33,586 cases (80.1% of all inquiries from providers) in FY2014, as shown in figure 64. In FY2014, most of the inquiries from providers related the UCS scheme are "health insurance status confirming" (15,605 cases or 46.5% of inquiries from providers related to UCS scheme), "Others (capitation allocation, news, follow-up case, etc.)" (8,118 cases or 24.2% of inquiries from providers related to UCS scheme), "registration and choosing service provider" (4,239 cases or 12.6% of inquiries from providers related to UCS scheme), and "health service and benefit package" (3,407 cases or 10.1% of inquiries from providers related to UCS scheme), respectively as shown in figure 65.

Figure 64 The number of inquiries from providers classified by related government schemes, FY2008 - 2014

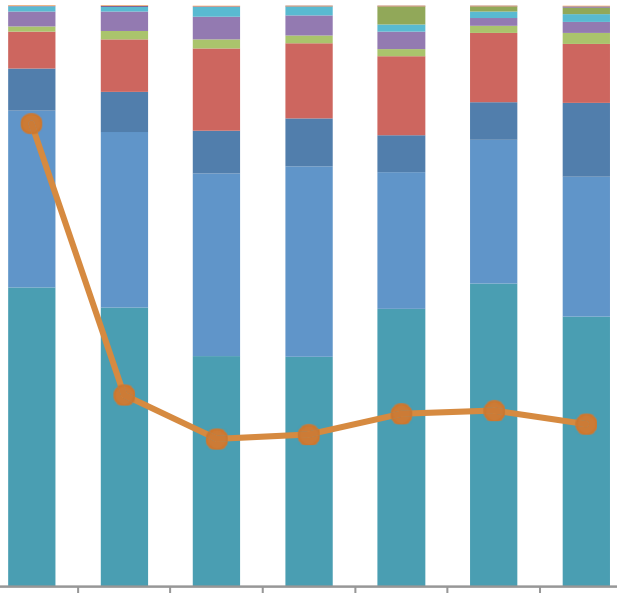


	2008	2009	2010	2011	2012	2013	2014
4. Local administrative office scheme**	0	0	0	0	0	93	6,114
3. SSS scheme	643	327	311	396	647	678	775
2. CSMBS scheme	436	203	161	223	534	555	1,476
1. UCS scheme	95,663	39,625	30,523	31,376	35,649	36,407	33,586
Total (cases)	96,742	40,155	30,995	31,995	36,830	37,733	41,951

Source: *Consumer rights protection data, NHSO*

Note: *The NHSO has developed registration system for local administration offices since FY2014 according to the government policy.*

Figure 65 The number of inquiries from providers related to UCS scheme classified by topics, FY2008-2014



	2008	2009	2010	2011	2012	2013	2014
1.10 basic payment for losses or injuries from health service according to section 41 of the Act.	24	12	20	18	28	27	27
1.9 basic payment for losses or injuries from health service according to section 18(4) of the Act.	98	48	28	22	21	22	79
1.8 Emergency Medical Claim for all*	0	0	0	0	1,096	308	390
1.7 Hospital information	771	338	522	489	447	415	433
1.6 method for claims and reimbursement	2,503	1,328	1,211	1,092	1,074	491	637
1.5 Organization information	867	583	455	400	436	444	651
1.4 health service and benefit package	6,104	3,541	4,326	4,065	4,846	4,354	3,407
1.3 registration and choosing service provider	6,862	2,781	2,264	2,584	2,276	2,333	4,239
1.2 Others (capitation allocation, news, follow-up case, etc)	29,169	11,943	9,576	10,291	8,361	9,025	8,118
1.1 Health insurance status confirmation	49,265	19,051	12,121	12,415	17,064	18,988	15,605
1. UCS scheme	95,663	39,625	30,523	31,376	35,649	36,407	33,586

Source: *Consumer rights protection data, NHSO*

Note: ** The NHSO has developed the emergency medical claim for all since April 1, 2012 when the government announced the emergency policy for every government schemes*

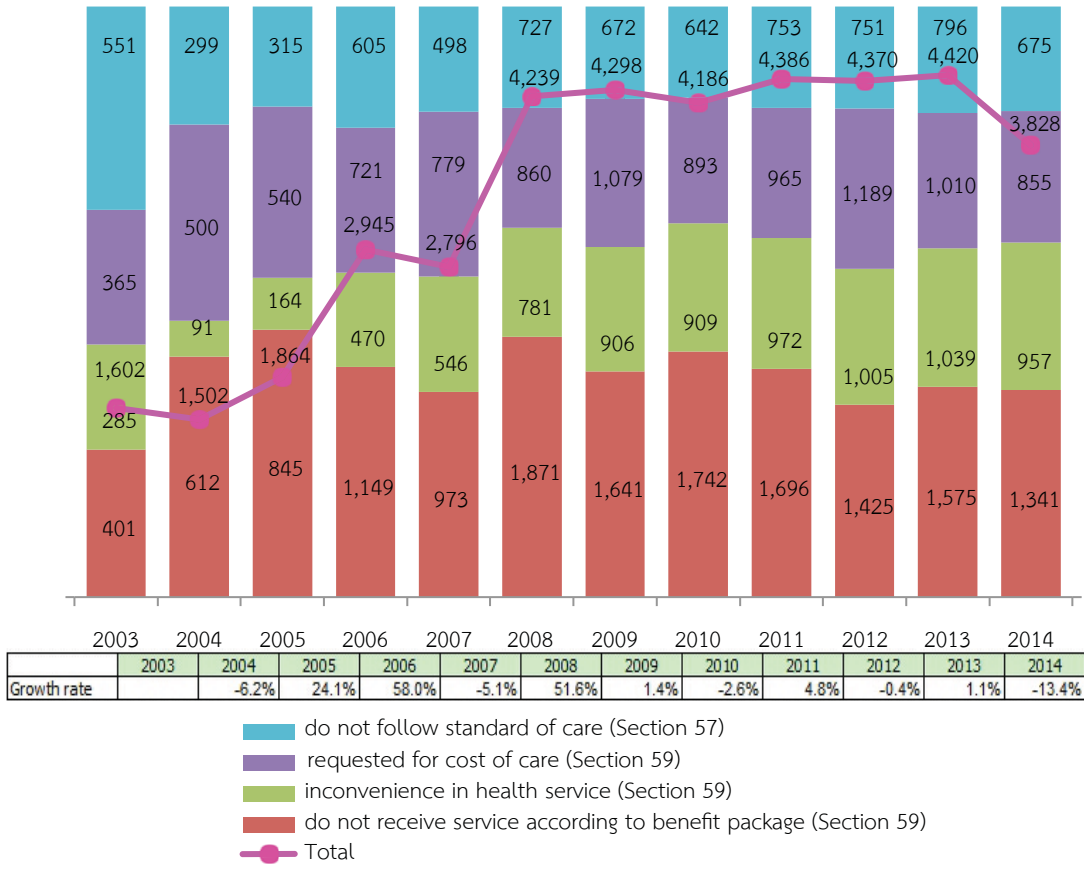
*** The NHSO has developed registration system for local administration offices since FY2014 according to the government policy.*

6.2.2 Complaints

In order to find suitable solutions for complaints, complaints are classified into two categories, i.e., complaints concern general management of the UCS scheme, and complaints concern quality of care defined in the National Health Security Act, Section 57 and 59.

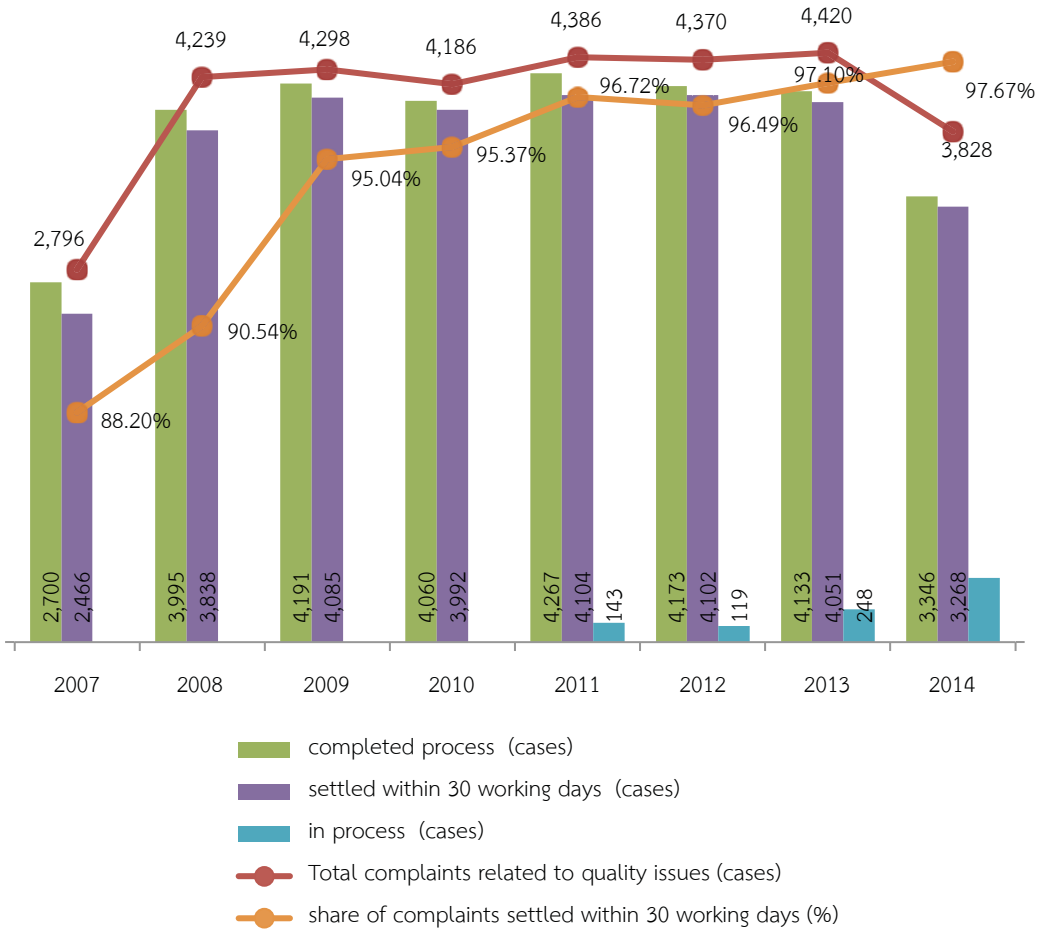
Complaints concern quality of care has been increased from 1,602 cases in FY2003 to 3,828 cases in FY2014. The number of the complaints has been steadied between 4,200-4,400 cases since FY2008. However, change in the number of complaints concern quality of care in FY2014 was in negative trend. Most of the complaints concern quality of care in FY2014 are "do not receive service according to their benefit package" (1,341 cases or 35% of all complaints), "inconvenience in health service" (957 cases or 25% of all complaints), "requested for cost of care" (855 cases or 22% of all complaints), and "do not follow standard of care" (675 cases or 18% of all complaints), respectively as shown in figure 66. The number of complaints that are settled within 30 working days has been increased from 88.20% in FY2007 to 97.67% in FY2014, as shown in figure 67.

Figure 66 The number of complaints concerning quality of care classified by issues, FY2003-2014



Source: Consumer rights protection data, NHSO

Figure 67 Performance on complaints concern quality issues, FY2007-2014

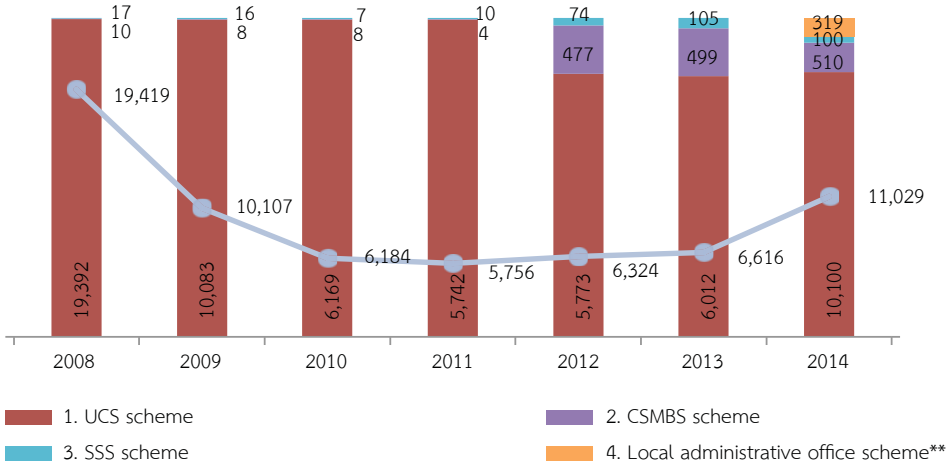


Source: Consumer rights protection data, NHSO

The number of complaints concern general management of the UCS scheme has been continued to reduce from 19,392 cases (99.9%) in FY2008 to 10,100 cases(91.6%) in FY2014, as shown in figure 68; this can show that the overall general management of the scheme has been improve. However, the increasing trend started since FY2013 may have been affected from the new government policies. The number of share of complaints concern general management related to other government schemes has been increased since FY2012 when government policies of harmonization on claim and registration were promoted.

In FY2014, most of the complaints about the UCS scheme are "wrong health insurance status" (7,343 cases or 72.7% of all UCS scheme complaints), "request for helps" (1,040 cases or 10.3% of all UCS scheme complaints), "registration and health card" (767 cases or 7.6% of all UCS scheme complaints), and "consultation/suggestion" (464 cases or 4.6% of all UCS scheme complaints), respectively as shown in figure 69.

Figure 68 The number of complaints concern general management classified by related government schemes, FY2008 - 2014

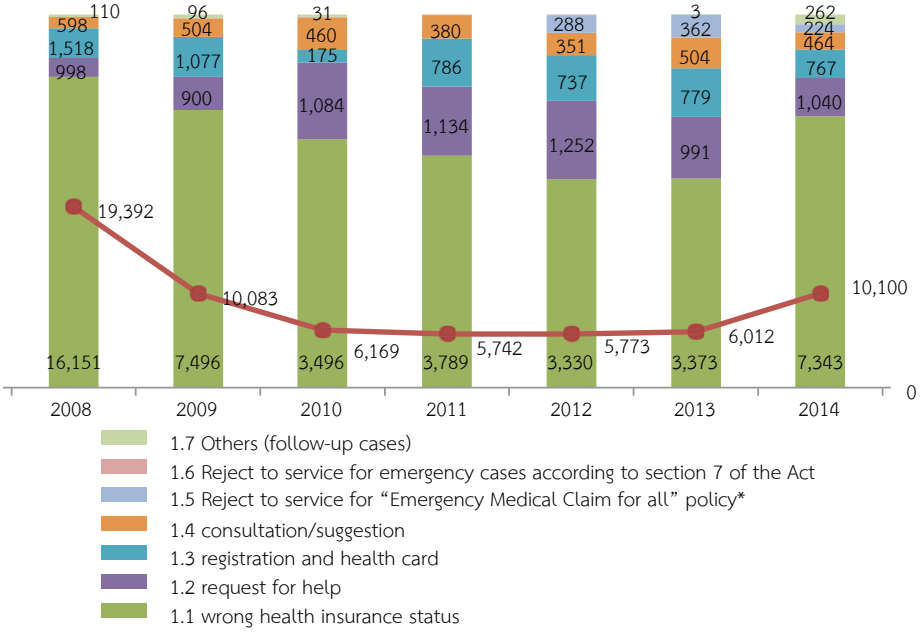


Source: *Consumer rights protection data, NHSO*

Note: ** The NHSO has developed the emergency medical claim for all since April 1, 2012 when the government announced the emergency policy for every government schemes*

*** The NHSO has developed registration system for local administration offices since FY2014 according to the government policy.*

Figure 69 The number of complaints concern general management of UCS scheme classified by topics, FY2008 - 2014



Source: *Consumer rights protection data, NHSO*

Note: ** The NHSO has developed the emergency medical claim for all since April 1, 2012 when the government announced the emergency policy for every government schemes*

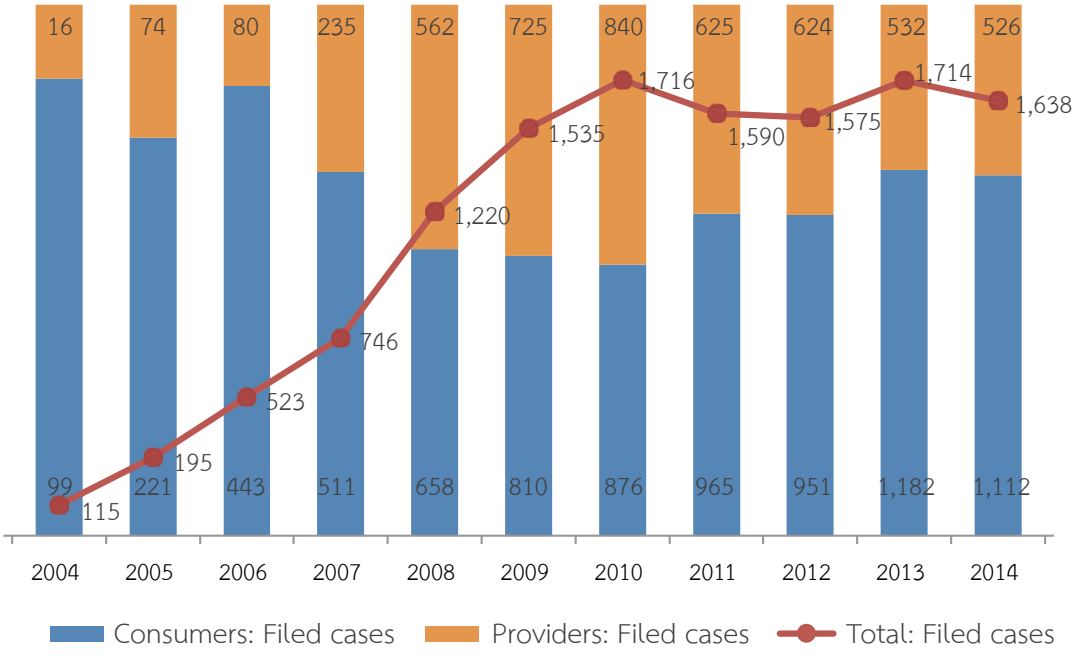
*** The NHSO has developed registration system for local administration offices since FY2014 according to the government policy.*

6.2.3 Preliminary support for losses from health services

The number of application filed for preliminary compensations for losses from health service according to section 41 of the National Health Security Act has been increased from 115 cases in FY2004 to 1,638 cases in FY2014. Most of the applications were applied from consumers, as details shown in figure 70. Approved applications filed for the compensation has also increased. Preliminary compensations to consumers filed for the losses has been increased from only THB4.86 million in FY2004 to THB218.44 millions in FY2014, as shown in figure 71.

Figure 72 shows detail of consumer applications filed for compensations from their losses according to section 41 of the National Health Security Act. The number of consumers filed for compensations from their losses has been increased from 99 cases in FY2004 to 1,112 cases in FY2014. The number of approved cases for the losses has been increased from 73 cases in FY2004 to 931 cases in FY2014. The amount of approved compensation has been increased from THB4.86 million in FY2004 to THB218.44 million in FY2014. The rate of approved applicants is between 73.7% and 87.7%. The average rate of approved application from consumers during this period is 82.27%.

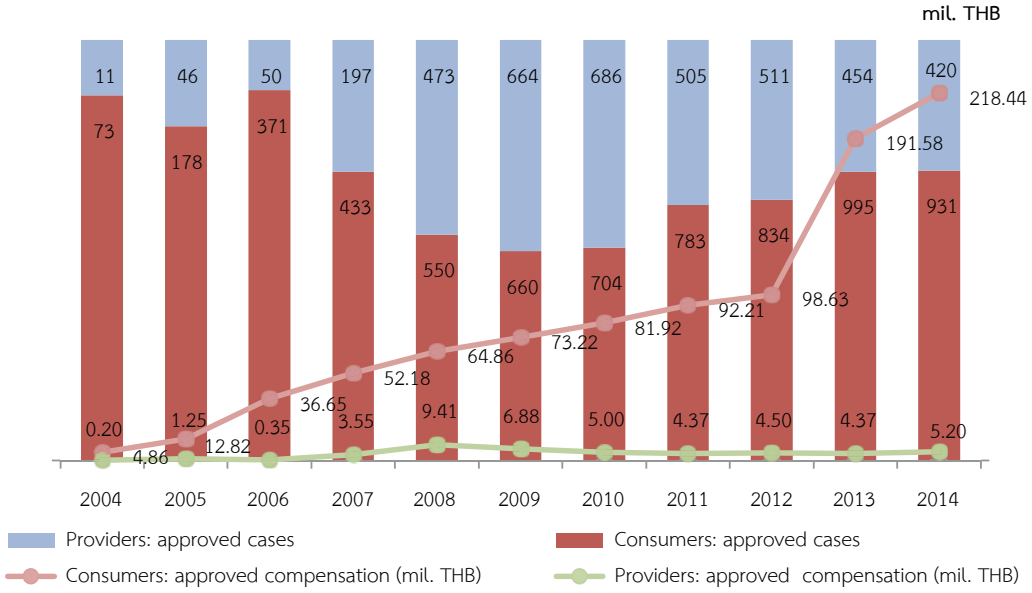
Figure 70 The number of cases filed for compensations from their losses according to section 41 of the Act classified by target group, FY2004-2014



Source: *Bureau of Legal Affair, NHSO*

Note: *The national health security board has approved the national guideline for preliminary compensations for losses or injuries according to section 41 of the Act on October 1, 2012.*

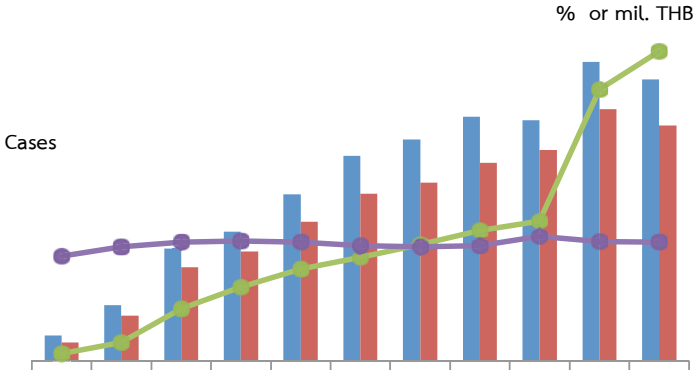
Figure 71 Approved application filed for compensations from their losses according to Section 41 of the Act, FY2004-2014



Source: *Bureau of Legal Affair, NHSO*

Note: *The national health security board has approved the national guideline for preliminary compensations for losses or injuries according to section 41 of the Act on October 1, 2012.*

Figure 72 Consumers' application filed for compensations from their losses according to section 41 of the Act and the amount of approved compensations for the losses, FY2004-2014



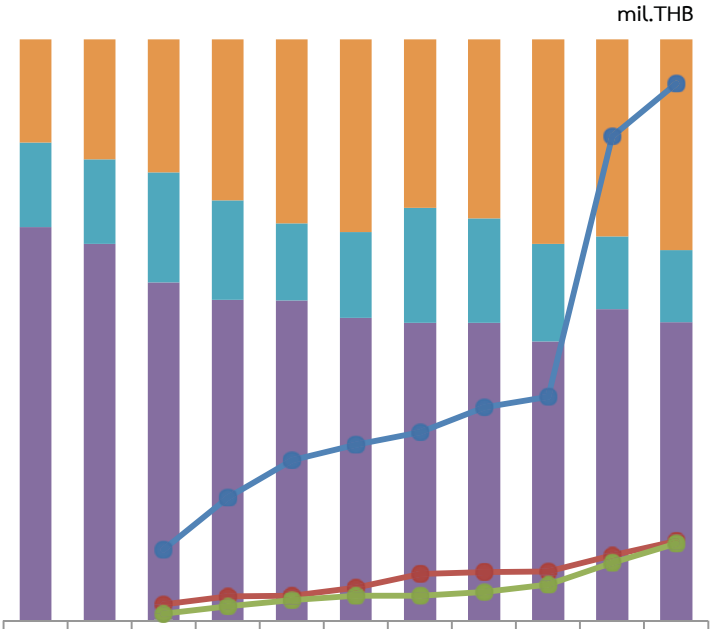
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Consumers: Filed cases	99	221	443	511	658	810	876	965	951	1,182	1,112
Consumers: approved cases	73	178	371	433	550	660	704	783	834	995	931
Consumers: approved compensation (mil. THB)	4.86	12.82	36.65	52.18	64.86	73.22	81.92	92.21	98.63	191.58	218.44
Consumers: Approved rate (%)	73.74	80.54	83.75	84.74	83.59	81.48	80.37	81.14	87.70	84.18	83.72

Source: *Bureau of Legal Affair, NHSO*

Note: *The national health security board has approved the national guideline for preliminary compensations for losses or injuries according to section 41 of the Act on October 1, 2012.*

When classifying the number of approved cases for their losses into three main types of lost: 1) death or permanent disability, 2) partial disability, and 3) injuries as shown in figure 73, most of losses in FY2014 are deaths or completed disability (478 cases or 51.3% of all approved cases), injuries (337 cases or 36.2% of all approved cases), and partial disability (116 cases or 12.5% of all approved cases), respectively. The amount of approved compensations to each type of losses in FY2014 is THB166.37 million, THB24.63 million, and THB23.88 million, respectively. Please be noted that additional compensation after appeal was not included in the figure.

Figure 73 Approved applications of consumer filed for compensations from their losses according to section 41 of the Act classified by type of losses, FY2004-2014



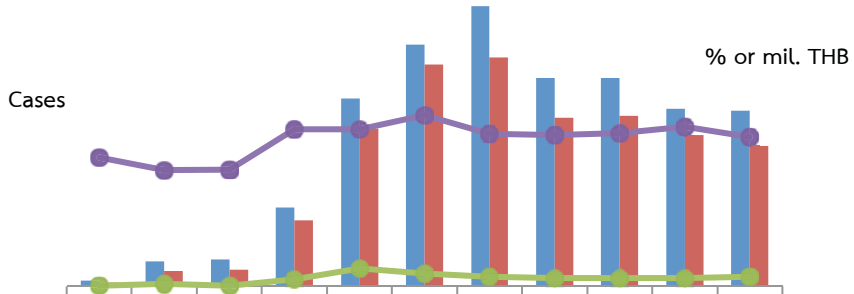
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Injury (cases)	11	37	85	120	174	219	204	241	293	337	337
Partial disability (cases)	9	26	70	74	73	97	139	141	140	125	116
dead or permanent disability (cases)	42	116	216	239	303	344	361	401	401	533	478
dead or permanent disability (mil.THB)			22.02	38.09	49.72	54.52	58.45	66.16	69.36	149.93	166.37
Partial disability (mil.THB)			5.06	7.57	7.72	10.20	14.48	15.10	15.25	20.31	24.63
Injury (mil.THB)			2.18	4.53	6.41	7.81	7.79	9.01	11.25	17.94	23.88

Source: *Bureau of Legal Affair, NHSO*

Note: *The national health security board has approved the national guideline for preliminary compensations for losses or injuries according to section 41 of the Act on October 1, 2012.*

Figure 74 shows details of provider applications filed for compensations from their losses according to section 41 of the National Health Security Act. The number of providers filed for compensations from their losses has been increased from 16 cases in FY2004 to 526 cases in FY2014. The number of approved cases for the losses has been increased from 11 cases in FY2004 to 420 cases in FY2014. The amount of approved compensation has been increased from THB0.20 million in FY2004 to THB5.20 million in FY2014. The rate of approved applicants has been increased from 68.75% in FY2004 to 79.85% in FY2014

Figure 74 Providers' application filed for compensations from their losses according to section 41 of the Act and the amount of approved compensations for the losses, FY2004-2014



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Filed cases	16	74	80	235	562	725	840	625	624	532	526
approved cases	11	46	50	197	473	664	686	505	511	454	420
approved compensation (mil. THB)	0.20	1.25	0.35	3.55	9.41	6.88	5.00	4.37	4.50	4.37	5.20
Approved rate (%)	68.75	62.16	62.50	83.83	84.16	91.59	81.67	80.80	81.89	85.34	79.85

Source: *Bureau of Legal Affair, NHSO*

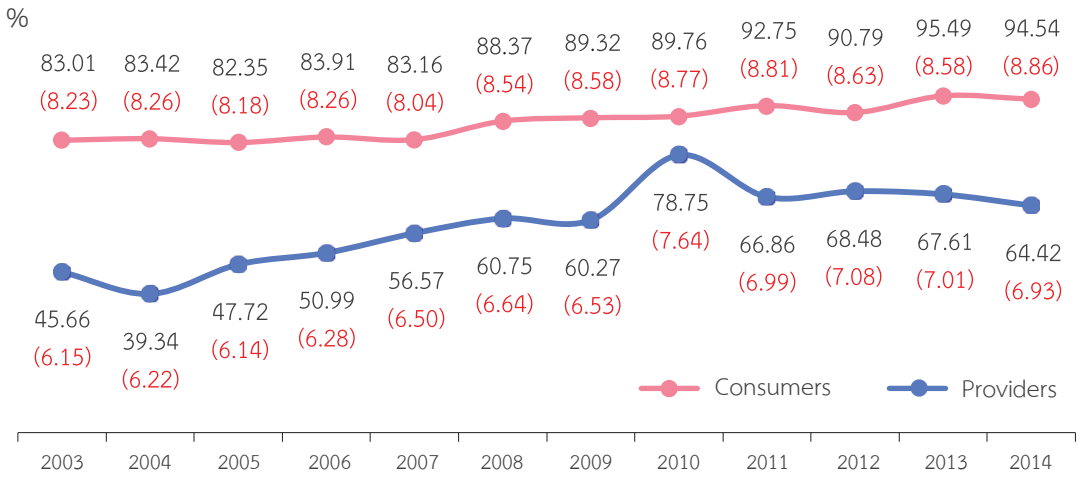
Note: *The national health security board has approved the national guideline for preliminary compensations for losses or injuries according to section 41 of the Act on October 1, 2012.*

6.3 Satisfaction of Consumers and Health care providers

According to the Satisfaction survey report of the universal coverage scheme, average satisfactory score and percentage of satisfied respondents (with satisfaction level at 6 or more) of both consumers and providers have continued to improve from FY2003 to FY2014. This shows that situation of the UHC implementation has been improved. However, both of the average satisfactory score and percentage of satisfied respondents in consumers are higher than the ones in providers, as shown in figure 75.

The percentage of satisfied consumers at level 6 or more has been increased from 83.01% in FY2003 to 94.54% in FY2014, while the one of the providers has been increased from 44.66% to 64.42% in same period. The average satisfactory score of consumers has also been increased from 8.23 in FY2003 to 8.86 in FY2014, while the one of the providers has been increased from 6.15 to 6.93 in the same period.

Figure 75 The percentage of respondents satisfy at level 6 or more and average satisfactory score, FY2003-2014



Source: *1. FY2003 – 2013: Satisfaction survey report, Academic Network for Community Happiness Observation and Research (ANCHOR), Assumption University of Thailand*

2. FY2014: Satisfaction survey report, NIDA poll, National Institute of Development Administration, Thailand

Note: *Percentage of satisfaction is a summation of all respondents satisfied at level 6 or more.*

Part 2

The National Health Security Office

1. Vision, Mission, Goals and strategic operation
2. Financial Report
   2.1. National Health Security Fund
   2.2. Administrative Fund
3. Operational Report for FY2014
4. Challenges in Universal Health Coverage system implementation

– 1 –

Vision, Mission, Goals, Strategies and Operations of the NHSO

Vision, Mission, Goals, Strategies and Operations of the NHSO

The National Health Security Office (NHSO) was established by the National Health Security Act B.E. 2545, in 2002. All Thai citizens have been insured by the health universal coverage since the Act was passed by the parliament in November 2002. The National Health Security Office (NHSO) was established by the Act to manage universal health coverage for Thai citizens. By Section 24 of the Act, the NHSO is a government legal entity to operate autonomously under policies set by the National Health Security Board chaired by the public health minister.

The universal coverage scheme (UCS) announced by the National Health Security Act has covered all Thai citizens who are not insured by other government health insurance schemes, i.e., 1) the civil servants medical benefit scheme (CSMBS) for civil servants and their dependents; 2) the Social Security Scheme (SSS) providing health care for employees of all private firms; 3) other state enterprise schemes or by the local government schemes in comparative to the CSMBS. At anytime, Thai citizens are eligible to at least one of one of the schemes based on their employment, or they may eligible to register to the UCS scheme. They, therefore, can access to quality of health care as need.

Head office of the NHSO is located at the following address:

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2-4 Floor 120 Moo 3 Chaengwattana Road,
Lak Si District, Bangkok 10210 Thailand
Tel 66 2 141 4000 (Office hours)
Fax 66 2 143 9730-1
Office Hours: Mon.-Fri. 08:30 – 16:30
Call Center (24 hrs.): 1330 (Local calls only)

There are total of 13 branches of the NHSO regional offices nationwide as follow.

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Chiangmai 50200 Thailand
Tel 66 53 285 355 (Office hours)
Fax 66 53 285 364
Provinces in Region 1:
Chiang-Mai, Chiang-Rai, Phayao, Mae-hong-son, Lampang, Lampoon, Phrae, Nan

National Health Security Office Region 2 Phitsanulok

Post Office Building, 4th Floor
118 Bhutabucha Road, Nai-Muang District,
Muang, Phitsanulok 65000 Thailand
Tel 66 55 245 111 (Office hours)
Fax 66 55 247 111
Provinces in Region 2:
Phitsanulok, Tak, Phetchabul, Sukothai, Uttaradit

National Health Security Office Region 3 Nakhon Sawan

1045/2 Moo 10 Nakhon-Sawan-Tok, Muang,
Nakhon Sawan 60000 Thailand
Tel 66 56 371 831-7 (Office hours)
Fax 66 56 371 838
Provinces in Region 3:
Nakhon Sawan, Kampangphet, Chainard, Phichit, Uthaitani

National Health Security Office Region 4 Saraburi

65/3 Soi 1 Pichai-Narong-Songkram Road,
Pak-Preal District,
Muang, Saraburi 18000 Thailand
Tel 66 36 213 205 (Office hours)
Fax 66 36 213 263
Provinces in Region 4:
Saraburi, Ayuthaya, Lopburi, Singburi, Angthong, Phathumtani, Nontaburi, Nakhon Nayok

National Health Security Office Region 5 Ratchaburi

Post Office Building, 3rd Floor
2 Samut-sakdaruk Road, Nar-Muang District,
Muang, Ratchaburi 70000 Thailand
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Fax 66 32 332 593
Provinces in Region 5:
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National Health Security Office Region 6 Rayong

115 Star Plaza Building, 2nd Floor, Shopping Center 4 Road,
Chuang-Noen District, Muang, Rayong 21000 Thailand
Tel 66 38 864 313 (Office hours)
Fax 66 38 864 320
Provinces in Region 6:
Rayong, Chantaburi, Chachoengsao, Chonburi, Trad, Sakaew, Prachinburi, Samut-Prakarn

National Health Security Office Region 7 Khon Kaen

356/1 CP Building, 3rd Floor, Mittapap Road,
Muang-Kual Road,
Muang, Khon Kaen 40350 Thailand
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National Health Security Office Region 8 Udon Thani

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Fax 66 42 325 674
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National Health Security Office Region 9 Nakhon Ratchasima

154/1 Ratchasima Center Building, 3rd Floor
Manus Road, Nai-Muang District, Muang,
Nakhon Ratchasima 30000 Thailand
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Fax 66 44 248 875
Provinces in Region 9:
Nakhon Ratchasima, Chaiyaphum, Buriram, Surin

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Muang, Ubon Ratchathani 34000 Thailand
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National Health Security Office Region 11 Surat Thani

91/1 Moo 1 C.P. Tower, 10th Floor
Kanchana-vithi Road, Bang-Kung District
Muang, Surat Thani 84000 Thailand
Tel 66 77 274 811 – 3 (Office hours)
Fax 66 77 274 818
Provinces in Region 11:
Surat Thani, Kabi, Chumporn, Nakhon Sithamarat, Phang-Nga, Phuket, Ranong

National Health Security Office Region 12 Song Khla

456/2 Petkrasem Rd., Hadyai, Songkhla
90110 Thailand
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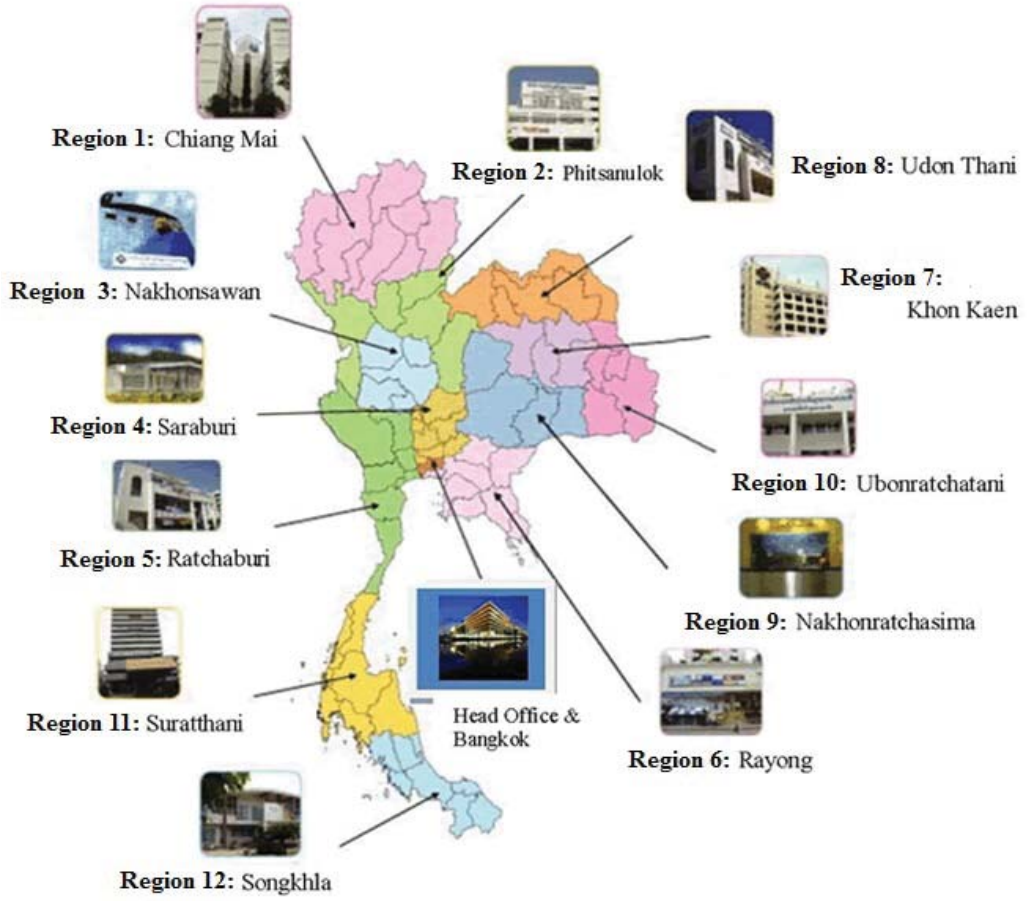
Fax 66 74 235 494
Provinces in Region 12:
Song Khla, Trang, Narathiwad, Pattani, Patalung, Yala, Satun

National Health Security Office Region 13 Bangkok

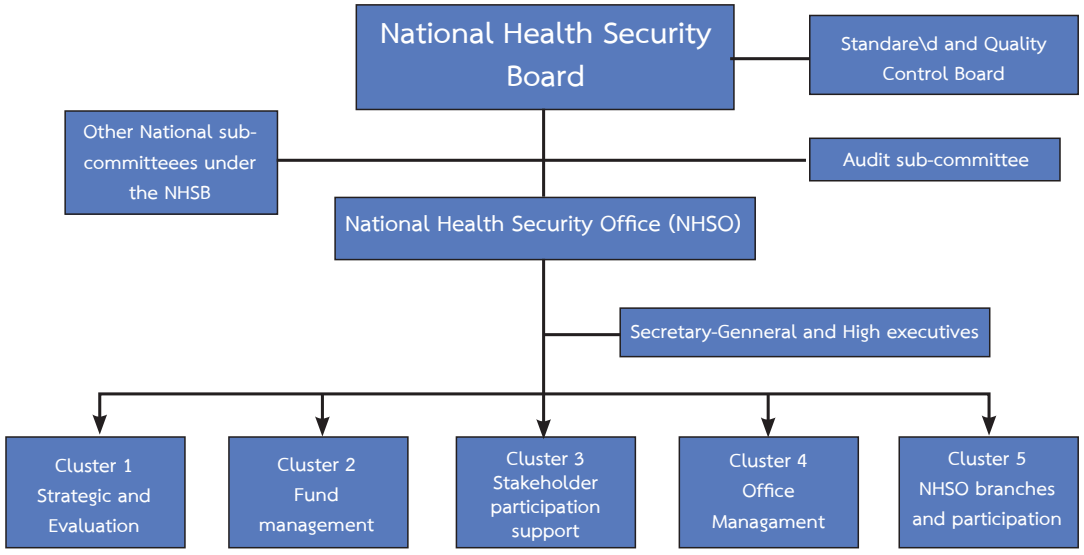
"The Government Complex",
5th Floor (Parking Building)
120 Moo 3 Chaengwattana Road,
Lak Si District, Bangkok 10210 Thailand
Tel 66 2 142 1000 (Office hours)
Fax 66 2 143 8772-3
Provinces in Region 13:
Bangkok



Board of Directors

The NHSO operates autonomously under policies set by the National Health Security Board chaired by the public health minister. Other committee and sub-committees are also established by the National Health Security Act, i.e., the Standard and Quality Control Board, and the Audit sub-committee, and other 13 related sub-committees in order to support the Board policies. A Standard and Quality Control Board was assigned by the law to have powers and duties related to standard and quality in health care. An Audit sub-committee acts as independent auditors to audit the NHSO operations. Structure of the NHSO's Board of Directors is shown in the following diagram Strategic framework of Universal Health Coverage

The NHSO's Board of Director



1.1 Vision

"All residents in Thailand are assured under the universal health coverage"

1.2 Goals

All residents in Thailand are assured under the universal health coverage that can access to necessary health care without financial risk, especially in catastrophic illness. It is equity for everyone to access to quality of care regarding to their gender or social status. The health care should be efficiency, effective, and social accountability.

1.3 Mission

1. Promoting universal health coverage (UHC) to cover all residents living in Thailand.

2. Promoting stakeholder participation to have a shared sense of ownership on the universal coverage scheme (UCS)

3. Promoting health system development under the universal coverage scheme to meet quality standard in order to improve accessibility while keeping satisfaction of both consumers and health providers

4. Promoting consumer and provider relationship with human rights and dignity consideration

Continuing to improve efficiency on financial management of the National Health Security Fund

5. Promoting equity between government health insurance schemes on both the benefit packages and service provision.

1.4 Strategies

1. Promoting robust mechanisms and measurements on universal health coverage (UHC) to assure all residents living in Thailand

1.1 Promoting the development of mechanism to the assure residents that are not cover under any of the government health insurance schemes

1.2 Collaborating and Promoting the development of mechanism to assure the protection of individuals that are cover under other small government health insurance schemes, e.g., Local Administration Health Insurance Scheme, State Enterprise Health Insurance Scheme, other small autonomous government offices.

1.3 Promoting the development of mechanisms to promote public relations and right protection of consumers and providers so that they can understand and know their rights and responsibilities under the universal health coverage (UHC) concept.

2. Developing positive seamless work processes between stakeholders to have a shared sense of ownership.

2.1 Developing positive seamless work processes between stakeholders.

2.2 Promoting knowledge and understanding in all stakeholders at both individual level and organizational level.

2.3 Promoting regional and local participation on health service management system for other small government health insurance schemes, e.g., Local Administration Health Insurance Scheme, State Enterprise Health Insurance Scheme, other small autonomous government offices

2.4 Promoting consumer and provider relationship with human rights and dignity consideration

3. Strengthening health service system development especially on primary care to meet local contexts and requirements (Primary care strengthening)

3.1 Promoting hospital quality improvement at all levels to meet the national standard so that consumers can access to health services as needed

3.2 Promoting innovative care in health promotion and disease prevention in order to increase accessibility and equity of care.

3.3 Promoting the increasing of dignity and quality of life of the providers at primary care level using local collaboration and capacity.

3.4 Promoting national seamless health system development to increase a convenient access to health services at all level from primary care to tertiary care.

3.5 Promoting primary care unit management by local administration offices and private sector, especially in urban areas.

4. Promoting harmonization between government health insurance schemes

4.1 Developing benefit package based on the overall benefit and value as well as appropriated service delivery development that can increase accessibility, equity, efficiency, and effectiveness.

4.2 Supporting relevant policy research on resource management for future sustainability system management.

4.3 Developing standard financial mechanisms that are harmonized with other government health insurance schemes.

4.4 Developing integrated health information management to have national standard data set that can be shared and used among stakeholders.

5. Promoting and strengthening good governance management in universal coverage scheme

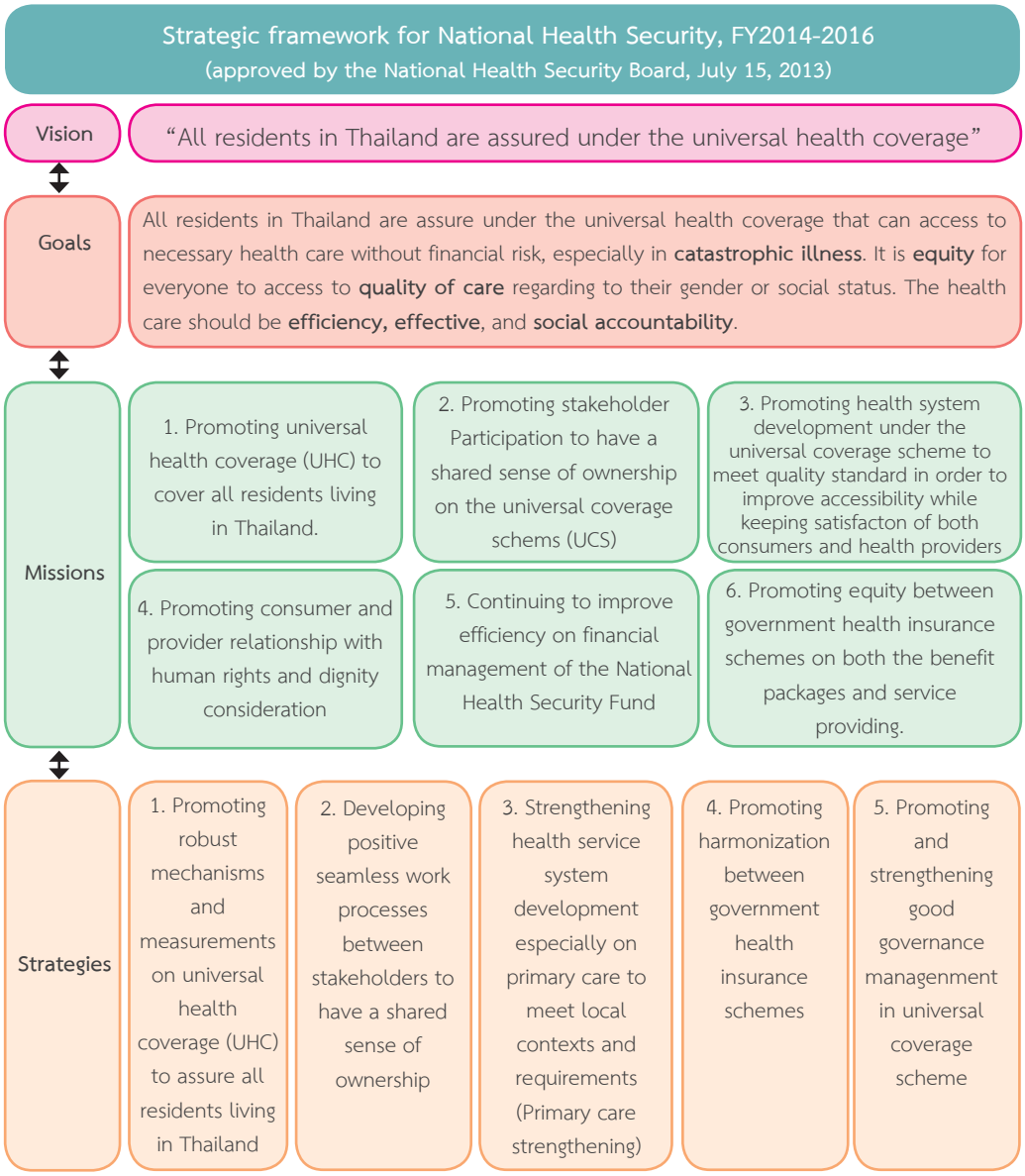
5.1 Developing effective financial management on universal coverage fund management that is acceptable on good governance aspect.

5.2 Promoting decentralized policy as well as the effective continuous audit, monitoring and evaluation especially on health outcome.

5.3 Promoting capacity building for health personnel in the universal health coverage system not only on knowledge but also on moral and ethics in order to be a mechanism to keep good governance at national level.

5.4 Promoting the National Health Security Office to be a learning organization for knowledge sharing and resource center on universal health coverage implementation at national and international level.

Figure 76 Strategic framework of Universal Health Coverage Development, FY2014-2016



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Budget Management

Budget Management

The NHSO's budgets are managed under supervision of the National Health Security Board and classified into two group of funds as follow.

1. National Health Security fund (or UCS fund) is provided for health expenditures to registered hospitals and health providers. It is managed in order to support UHC implementation cover health services from health promotion, disease prevention and curative according to the UCS benefit package.

2. NHSO administrative fund is provided for operation cost of the NHSO classified into two sub-funds, i.e., routine operation budget, and strategic operation budget.

The approved government budgets for the UCS fund and the NHSO administrative fund has been increased from THB82,023 million in FY2006 to THB154,257.98 million in FY2014, and from THB647 million in FY2006 to THB1,442.19 million in FY2014, respectively as shown in table 11.

Table 11 Approved government budgets for the UCS fund and the NHSO administrative fund, FY2006-2014

(unit: million THB)

Approved	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
(1) UCS fund	82,023.00	91,369.05	101,984.10	108,065.09	117,969.00	129,280.89	40,609.40	141,302.75	154,257.98
(2) NHSO administrative fund	647.00	810.96	807.65	936.75	858.46	961.30	1,099.80	1,209.12	1,442.19
% of (2) to (1)	0.79%	0.89%	0.79%	0.87%	0.73%	0.74%	0.78%	0.85%	0.93%

Source: Bureau of Planning and Evaluation, NHSO

Net UCS fund approved from the government for FY2014 after deducted with TH38,381.29 million of government providers' salary was THB115,176.674 million classified into the following sub-categories:

1. Medical services (THB102,349.633 million)
2. HIV/AIDS health service package (THB2,946.997 million)
3. CKD health services package (THB5,178.804 million)
4. Chronic diseases (DM, HT) health service package (THB801.240 million)
5. Budget to improve efficiency in remote areas (THB900 million)
6. Incentive for health personnel under the MOPH (THB3,000 million)

Other income in FY2014 are bank interest (THB183.575 million), medical service cost refund from FY2013 (THB140.582 million), returned medical service cost paid in FY2013 after medical audit (THB157.155 million), and other income (THB8.443 million). Therefore, the total income of the UCS fund in FY2014 is THB428.085 million higher than the total expenses.

The UCS fund has been allocated to healthcare providers during FY2014 is THB115,238.34 million. This allocated budget is classified into the following sub-categories:

1. Medical services (THB102,411.303 million)
2. HIV/AIDS health service package (THB2,946.997 million)
3. CKD health services package (THB5,178.804 million)
4. Chronic diseases (DM, HT) health service package (THB801.240 million)
5. Budget to improve efficiency in remote areas (THB900 million)
6. Incentive for health personnel under the MOPH (THB3,000 million)

For the NHSO administrative fund, total income in FY2014 is THB1,531,724,997.40 from government budget (THB1,442,185,400) and other income (THB89,539,597.40). Total expense during FY2014 is THB1,367,904,350.77 classified into human resource expenditure (THB513,443,886.39), operation cost (THB729,860,950.84), depreciation cost (THB124,219,362.86), and other expenditures (THB380,150.68). Therefore, the income of the NHSO administrative fund in FY2014 is THB163,820,646.63 higher expenditures.

- 3 -

The NHSO Key Performance Indices in FY2014

The NHSO Key Performance Indices in FY2014

Performance of the NHSO's operation has been evaluated by the Comptroller General's Department (CGD) using KPI identified by consultant team of the CGD. The KPI was aimed to measure four dimensions of performance, i.e., financial management, operation management, responding to stakeholders' needs, and development and management of working capital. The top score of each dimension is classified in five levels. The overall score of the NHSO performance is 4.8484 from 5.0. Detail of scores is shown in table 12.

Table 12 Key performance indices of the NHSO's operation in FY2014

Dimension	Weight	# of indicators	Score
1. Financial management	12%		
1.1. Financial report and managed according to financial plan		3	5.0
1.2. Efficiency in budget management		3	5.0
2. Operation management	40%		
2.1. promoting quality of healthcare providers		2	5.0
2.2. promoting participation of local administration offices in community health services		2	5.0
2.3. percentage of population having family doctor		1	5.0
2.4. Percentage of UCS beneficiaries do not using benefit package because of service quality concerns.		1	5.0
2.5. Accessibility rate of specific diseases		4	5.0
2.6. Succession rate of collaborated activities of the three main government health insurance schemes		1	5.0
3. Responding to stakeholders' needs	23%		
3.1. satisfactory of stakeholders		3	
3.1.1. satisfactory of healthcare providers			1.8
3.1.2. satisfactory of consumers			5.0
3.1.3. satisfactory of other stakeholders			5.0
3.2. Others: UCS service center in hospitals and its operation, complaint management		5	5.0
4. Development and management of working capital	25%		
4.1. Risk management		1	4.5714
4.2. Others: working capital committee, internal audit, internal control, information management, human resource management		5	5.0

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Challenges in Universal Health Coverage System Implementation

Challenges in Universal Health Coverage System Implementation

4.1. Efficiency of UCS fund management under limited resources

The ultimate goal of having universal health coverage in Thailand is all Thai people can access to quality of health services they need without financial hardship. Defining standard for health services, establishing the UCS fund, and establishing the National Health Security Office (NHSO) are parted of models to have mechanisms on budget management, acquiring quality of health services for population, and defining scope and types of service required for good health of people. Balancing roles of purchasers and providers is an important strategy to gain the most benefit for population and overall health system.

Limitation on financial resource of the country has been the most important challenge in fund management. While unit cost of health services has continued to increase from increasing in labor cost, and burden on chronic diseases and aging population, government budget for the UCS fund was not increased as needed. Therefore, it is important find appropriate mechanisms in order to maintain efficiency in financial management. Mechanisms that have been used included minimizing unit cost in health services while controlling quality of health services, improving efficiency in fund management of related organizations in every level, proposing government budget request based on clinical guidelines and health service evidences, as well as promoting stakeholder participation.

4.2. Promoting collaboration between stakeholders in universal health coverage system

Implementing sustainable universal health coverage policy for Thai citizens requires extensive collaboration between stakeholders not only in information exchange but also concept sharing and continuous process development.

The NHSO has continued to promote stakeholders participation as an important mechanism not only to achieve the UHC goal in promoting accessibility to quality of health services of the population without facing financial disaster but also to share sense of ownership on the universal health coverage.

4.3. Implementing "National Emergency Policy" of the Government

There are government policies to reduce differences between schemes. The national emergency project called " "*When emergency threatened to life occurs, go to the nearby*

hospital, no question on health insurance" **project** (Translated from Thai: "เจ็บป่วยฉุกเฉินถึงแก่ชีวิต ไม่ถามสิทธิใกล้ที่ไหน ไปที่นั่น") has been the most high impact policy since FY2013. The project is aimed to protect the citizens in emergency, so they can access to necessary health care at the nearby hospital without question on their health insurance scheme and without pre-payment for the care; and, referral system to higher capacity of health care is available as needed. After a year of implementing this policy, limitations in implementation have been identified. These limitations include lacking of efficient mechanism to promote implementation, lacking of laws and regulations to support operations in gaining agreement with non-registered private hospitals to except payment from patients, and in supporting operations that are not roles of the organizations assigned by related laws. In order to solve these limitation, National Institute for Emergency Medicine (NIEMS) was assigned to manage and to collaborate with related government and private organizations as well as local administration offices in emergency services so people can have equity access to standard emergency services.

Furthermore, a national guideline for referral system after critical period should be developed since there are different guidelines among health insurance schemes. The national guideline should not only cover all cases but also equity among government health insurance schemes.

4.4. Preparing strategy and policy for aging society

Thailand is entering to aging society. Aging society will impact to both household and national health expenditure. It is important to have clear policy and strategies for aging society. Burden on health expenditure from aging population will be increased from chronic diseases and long term care for dependent elderly. Experiences from other countries have shown that family and community health care is an appropriated model for financial sustainability.

Activities and processes related to elderly are related to not only many ministries such as ministry of public health, ministry of interior, ministry of social development and human security, ministry of education, ministry of science and technology, but also many organizations such as the NHSO, Thai health promotion foundation, Health system research institute. The most challenge in mission on aging society is how to classified roles and missions as well as to integrate operations among these organizations.

4.5. Expanding right protection to organizations under the CSMBS schemes according to Section 9 of the National Health Security Act

Employees and dependents of government organizations covered under the Civil Servant Medical Benefit Scheme (CSMBS) are not only government offices but also state enterprises and other small government autonomous organizations. Some of small group of government autonomous organizations such as Local Administration Offices (LAO) may have limitation in managing fund to protect their beneficiaries efficiently.

In FY2013, the prime minister has assigned the ministry of public health and the NHSO to discuss with other related organizations to develop CSMBS system for the employees of the LAO in order to promote accessibility, equity, and standard quality of care aiming to reduce problem in having to pre-pay for health care cost of the beneficiaries, especially for comprehensive high cost of care and employees of small size of LAO with limited of health benefit fund.

In FY2014, The NHSO has acted as clearing house for claims and reimbursements for employees of LAO and their dependents. The concept of pooling risk from national clearing house has proved to reduce burden and risk in high cost care for health benefit funds of LAOs. Therefore, it should be expanded to other small government organizations in the future.

Part 3

The National Health Security Board and The Health Service Standard and Quality Control Board

1. The National Health Security Board
2. The Health Service Standard and Quality Control Board

- 1 -

The National Health Security Board

List of the National Health Security Board, FY2014

1.	Mr. Pradit นายประดิษฐ Prof. Rajata ศ.รัชตะ	Sintavanarong สินธวณรงค์ Rajatanavin, รัชตะนาวิน	Minister of ministry of public health (to May 2014) รัฐมนตรีว่าการกระทรวงสาธารณสุข (started in September 2014)	Chair
2.	Mr. Charal นายจรัล	Trinvuthipong ตฤณวุฒิพงษ์	Medicine and public health expert in the board ผู้ทรงคุณวุฒิด้านการแพทย์และสาธารณสุข	Member
3.	Mr. Kanit นายคณิศ	Sangsubhan แสงสุพรรณ	Fiscal financing expert in the board ผู้ทรงคุณวุฒิด้านการเงินการคลัง	Member
4	Prof. Somsri Phaosawat ศ.เกียรติคุณ สมศรี เผ่าสวัสดิ์		Health insurance expert in the board ผู้ทรงคุณวุฒิด้านประกันสุขภาพ	Member
5.	Mr. Pinit นายพินิจ	Hirunyachote หิรัญโชติ	Alternative medicine expert in the board ผู้ทรงคุณวุฒิด้านการแพทย์ทางเลือก	Member
6.	Mr. Narongsak นายณรงค์ศักดิ์	Angkasuwapla อังคะสุวพลา	Thai traditional medicine expert in the board ผู้ทรงคุณวุฒิด้านการแพทย์แผนไทย	Member
7.	Gp. Capt. Ittiporn Khanacharoen นอ.(พิเศษ)อิทธพร คณะเจริญ		Social science expert in the board ผู้ทรงคุณวุฒิด้านสังคมศาสตร์	Member
8.	Mr. Sangiam นายเสงี่ยม	Boonjuntr บุญจันทร์	Law expert in the board ผู้ทรงคุณวุฒิด้านกฎหมาย	Member
9.	Mr. Narong นายณรงค์	Sahametapat สหเมธาพัฒน์	Permanent Secretary, Ministry of public health ปลัดกระทรวงสาธารณสุข	Member
10.	Mr. Charin นายจรินทร์	Chakapak จักกะพาก	Deputy Permanent Secretary, Ministry of Interior รองปลัดกระทรวงมหาดไทย	Member

11.	Mr. Artit นายอาทิตย์ Mr. Prakorn นายปกรณ์ Mr. Jirasak นายจิรศักดิ์ Mrs. Omorn นางอำมร Mrs. Pannee นางพรรณี	Isamo อิสโม Amorncheewin อมรชีวิน Sukonthachat สุคนธชาติ Chaowalit เชาวลิต Sriyuthasak ศรียุทธศักดิ์	Deputy Permanent Secretary, Ministry of Labor (to June 2013) (July - September 2013) Secretary General of Social Security Office (September 2013) Secretary General of Social Security Office (September 2013 – September 2014) Deputy Permanent Secretary, Ministry of Labor (started October 2014)	Member
12.	Maj.Gen Kobpanya พลตรีกอบปัญญา Lt.Gen. Therayuth พลโทธีรยุทธ Lt.Gen. Boonyark พลโทบุณยรักษ์	Wongwisetkij วงศ์วิเศษกิจ Sasiprapa ศศิประภา Poonchai พูลชัย	Representative of Permanent secretary, Ministry of defense (to September 2013) (October 2013 – October 2014) (started in October 2014) แทนปลัดกระทรวงกลาโหม	Member
13.	Mr. Sombat นายสมบัติ Mrs. Suthasri นางสุทธศรี	Suwanpitak สุวรรณพิทักษ์ Wongsaman วงศ์สมาน	Deputy Permanent Secretary, Ministry of education (to September 2013) Permanent Secretary, Ministry of education (started in October 2013)	Member
14.	Mr.Boonnaris นายบุญนริศร์ Mrs. Uraiwan นางอุรวี	Suwanpool สุวรรณพูล Ngourungrueng เงารุ่งเรือง	Inspector of ministry of commerce (to September 2013) Deputy Permanent Secretary, Ministry of Commerce (started October 2013)	Member
15.	Mrs. Supha นางสาวสุภา Mrs. Pongpanu นางพงษ์ภาณุ	Piyajitti ปิยะจิตติ Savetroon เศวตรุนทร์	Deputy Permanent Secretary, Ministry of Finance (To May 2013) (started in June 2013) รองปลัดกระทรวงการคลัง	Member
16.	Mr. Somsak นายสมศักดิ์	Chotrattanasiri โชติรัตนะศิริ	Director of Budget Bureau ผู้อำนวยการสำนักงบประมาณ	Member
17.	Prof. Umnaj ศ.อำนาจ	Kussanant กุสลานันท์	Representative of Medical council ผู้แทนแพทยสภา	Member
18.	Mr. Sirichai นายศิริชัย Mr. Thornint นายธรณินทร์	Chuprawat ชูประวัติ Charusrungkait จรัสจรุงเกียรติ	Representative of Dentist council (to February 2013) (started in March 2013) ผู้แทนทันตแพทยสภา	Member
19.	Ass.Prof. Kitti รศ.กิตติ	Pitaknitinum พิทักษ์นิตินันท์	Representative of Pharmacy Council ผู้แทนสภาเภสัชกรรม	Member

20.	Asso.Prof.Suchittra Luangamornlert รศ.สุจิตรา เหลืองอมรเลิศ Asso.Prof. Tassana Boontong รศ.ดร. ทัศนา บุญทอง		Representative of Nursing Council (to May 2014) (started in June 2014) ผู้แทนสภาการพยาบาล	Member
21.	Mr. Aurchat นายเอื้อชาติ	Kanjanapitak กาญจนพิทักษ์	Representative of Private Hospital Association ผู้แทนสมาคมโรงพยาบาลเอกชน	Member
22.	Mr. Ittipol นายอิทธิพล	Khunplem คุณปลื้ม	Representative of other form of community administration offices ผู้แทนองค์กรปกครองส่วนท้องถิ่นรูปแบบอื่น	Member
23.	Mr. Worawit นายวรวิทย์	Buranasiri บุรณศิริ	Representative of Provincial administration offices ผู้แทนองค์การบริหารส่วนจังหวัด	Member
24.	Mr. Pipat นายพิพัฒน์ Mr. Kittisak นายกิตติศักดิ์	Panma พันมา Kanasawat คณาสวัสดิ์	Representative of Municipality agency ผู้แทนเทศบาล (started in March 2014)	Member
25.	Mr Sanit นายศานิต Mr. Krit นายกฤษณ์ Mr. Surakij นายสุรกิจ	Klatar กล้าแท้ Kaewrat แก้วรัตน์ Suwankam สุวรรณแกม	Representative of Sub-district administration office (February 2011 - September 2013) (November 2013 – August 2014) (started in September 2014) ผู้แทนองค์การบริหารส่วนตำบล	Member
26.	Mr. Vichai นายวิชัย	Chokevivat โชควิวัฒน	Representative of NGO in area of elderly issues ผู้แทนองค์กรเอกชนด้านผู้สูงอายุ	Member
27.	Mr. Chusak นายชูศักดิ์	Janthayanond จันทยานนท์	Representative of NGO in area of disability and psychosis ผู้แทนองค์กรเอกชนด้านคนพิการและจิตเวช	Member
28.	Miss Boonyuen นางสาวบุญยืน Miss Saree นางสาวสารี	Siritham ศิริธรรม Aongsomwan อ่องสมหวัง	Representative of NGO in area of agriculture (started in May 2014) ผู้แทนองค์กรเอกชนด้านเกษตรกร	Member
29.	Mrs. Suntaree นางสุนทรี	Sarng-Ging เซ่งกิ่ง	Representative of NGO in area of labour force ผู้แทนองค์กรเอกชนด้านผู้ใช้แรงงาน	Member
30.	Mr. Nimit นายนิมิตร์	Teinudom เทียนอุดม	ผู้แทน Representative of NGO in area of HIV and chronic diseases ผู้แทนองค์กรเอกชนด้านผู้ติดเชื้อเอชไอวีหรือผู้ป่วยเรื้อรังอื่น	Member
31.	Mr. Winai นายวินัย	Sawasdivorn สวัสดิวร	Secretary General, NHSO เลขาธิการ สปสช.	Secretary

Duties and Authorities of the National Health Security Board

According to section 18 of the National Health Security Act B.E. 2545 (A.D.2002), the national health security board is assigned to perform the following duties and authorities.

1. To set standard of health services of registered health providers and their networks, and to set operational guideline for effective national health security system

2. To provide consultation to the minister in officer appointment, and ministerial regulations and declarations enactment related to this act.

3. To define scope and type of necessary health services as well as rate of service cost according to section 5 of this Act

4. To set rules and regulations for the national health security fund operation and management

5. To set rules, methods, and conditions to impeach the NHSO secretary general according to section 31, and to define qualification or non-qualification of the secretary general according to section 32.

6. To issue rules or regulations about receivable fund, payment, maintenance funds, as well as making benefit from the fund according to section 40.

7. To set rules, methods, and conditions for preliminary compensations to the beneficiaries for their lost or injuries from health service that the wrongdoer is nonappearance or the wrongdoer is appearance but the beneficiaries may not receive the compensation within appropriate period of time according to section 41

8. To support and collaborate with local administration offices in local community health security system management and implementation based on community contexts and health needs of community population according to section 47.

9. To support and define rules for community organizations, private organizations and non-profit organizations in local community health security system management and implementation based on community contexts and promote civil society participation in community health security system according to section 47.

10. To set guideline for public hearing from consumers and providers in order to improve quality and standard of healthcare

11. To set guideline for punishment both in financing fines and registration revocations

12. To prepare annual reports about performance and operation challenges, as well as accounting and financial report of the board to be reported to the cabinet, the House of Representatives, and the senate within six months after the end date of the fiscal year.

13. To convene annual meeting to hear general comments and suggestions from consumers and providers.

14. To perform other duties as assigned by this Act, or other laws, or the cabinet.

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The Health Service Standard and Quality Control Board

The Health Service Standard and Quality Control Board

1. Asso. Prof. Prasobsri Ungthavorn
   รศ.พญ.ประสบศรี อึ้งถาวร
   Representative of Royal Thai College of Pediatricians
   ผู้แทนราชวิทยาลัยกุมารแพทย์แห่งประเทศ
   Chair
2. Suphan Srithamma, M.D.
   นพ.สุพรรณ ศรีธรรมมา
   Director General, Medical department
   อธิบดีกรมการแพทย์
   Member
3. Paisarn Dunkum, M.D.
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Member

Duties and Authorities of the Health Service Standard and Quality Control Board

According to section 50 of the National Health Security Act B.E. 2545 (A.D.2002), the health service standard and quality control board is assigned to perform the following duties and authorities.

1. To control standard and quality of registered health providers and their service networks according to section 45.

2. To monitor standard and quality of care provided by health providers in the cases that the health providers provide service at higher level than health services defined in section 5

3. To define standard measures to control and promote standard and quality of registered health providers and their networks.

4. To guide standard price of all diseases to the board for preparing health service cost guideline for claims and reimbursement to the health providers according to section 46

5. To set rules, methods, and conditions for complaints and complaint reviews, as well as guideline and method for preliminary compensations for the lost or injuries, and to provide complaint centers that are independent from the providers to facilitate complaints.

6. To report the results of inspecting and controlling the standard and quality of registered health providers and their networks to the board, and notify such results to the health providers and their authority in order to correct, improve, and evaluate the standard and quality improvement.

7. To promote civil society participation in inspection and controlling the registered health providers and their networks.

8. To provide preliminary compensations in case of losses or injuries from health services that the wrongdoer is nonappearance or the wrongdoer is appearance but the beneficiaries may not receive the compensation within appropriate period of time

9. To promote information sharing channels development for consumers in order to be considered for decision making related to health service

10. To perform other duties as assigned by this Act, or other laws, or the board.

“Call”

NHSO Hotline 1330

- To inquire information about the “30-Baht” universal covearage scheme
- To verify government health insurance benefit status of individual
- To complaint about inconvenient service or impact from services
- To seek out coordination in referral system

สปสช.
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