Business trip report

On attending the "Health Care Finance study visit"

for Global Health and Universal Health Coverage (GLO+UHC)

Tokyo Japan

Date JUNE 17th–23th 2018

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HEALTH CARE FINANCE, JAPAN

Trip Report **17-23 June, 2018**

The Partnership Project for Global Health and Universal Health Coverage conducts a study visit on "Health Care Finance" in Tokyo Japan for the purpose of learning and sharing experiences in the management of social health insurance, health system and the role of central and local government in the financial management of health insurance. Focus in the Japan UHC and fee schedule to establish alterative lessons for Thailand.

Objective:

To learn about political process of budget formulation, fee schedule payment design and the healthcare reimbursement system in japan.

Contents

Duration:

June 18 (Mon) – 22 (Fri), 2018

Arriving on June 17 (Sun) and leaving on June 23 (Sat)

Schedule

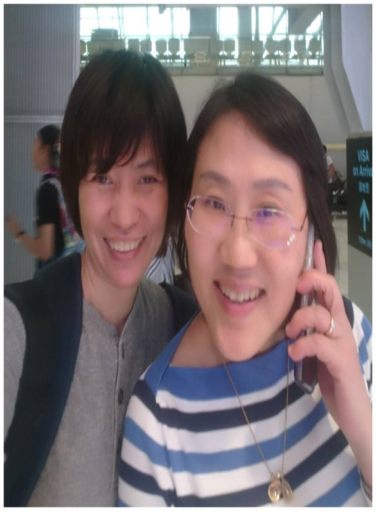
Date	Time		Sessions and contents	Remarks
June 17 (Sun)				
June 18 (Mon)	8:20	9:00	JICA Briefing	JICA Tokyo (TIC)
			Ministry of Health, Labour, and Welfare Japan	
	10:00	10:20	Courtesy call on Minister of Health, Labour and Welfare	TBC
	10:35	11:00	Opening remarks by MHLW official, Thai side, and JICA HQ Representatives	TBC
	11:10	12:00	Japan's health insurance system: General information (policy perspective)	**General Affair Division, Health Insurance Bureau, MHLW** • **[Overview]** The history of establishment of the fee schedule system and universal health coverage in Japan, the transition of Japan's health finance system and the resources • **[Development and political economy]** Japan's budget formulation process (process of fee schedule revision (Cabinet decision, Social Security Council, Central Social Insurance Medical Council, etc.)) and the trend
			(Lunch)	MHLW (Central Gov't Bldg.No.5) 26F Chinese restaurant Ryukou will be the first choice
	13:15	14:45	Statistics on health insurance system	**Actuarial Research Division, Health Insurance Bureau, MHLW** **[Assessment and Information system]** • Trend survey and statistics of medical care expenditures, statistics (a survey of medical care activities in public health insurance, a survey on medical economic, etc.) • Estimation of medical care expenditure for fee schedule revision **DG for General Policy and Evaluation** • Survey of Medical Care Activities in Public Health Insurance **Health Policy Bureau** • Survey of Pharmaceutical Pricing
	15:00	15:50	Japan's Fee schedule system	**Medical Economics Division, Health Insurance Bureau, MHLW** • **[Development]** Overview of Japan's fee schedule system • **[Assessment and negotiation processes]** The role of Central Social Insurance Medical Council
	16:00	16:40	Medical guidance and Inspection	**Office of Medical Guidance and Inspection, Medical Economics Division, Health Insurance Bureau, MHLW** **[Audit]** Audit of claims under the Japanese fee schedule system
	16:50	17:00	(Spare)	**[Options]** **Depending on Thai-side requests.**
	18:00		NHSO iGHP MOU Signing ceremony	At iGHP. Only 5 participants will attend the ceremony.
June 19 (Tue)	10:00	12:00	Visit to Setagaya Ward, Tokyo Metropolitan Government	[Implementation, and Insurer's perspective] • As an insurer of the National Health Insurance • As a health care service provider, including a public hospital
			(Lunch)	
	13:00	13:50	Courtecy call to the Head of Setagaya Ward	
	15:00	17:00	Teikyo University Hospital visit: Advanced medical care	[Implementation of claiming] • Claiming process based on the Japanese fee schedule at tertiary care setting • Difference between the fee schedule and DPC (Diagnosis Procedure Combination (similar to Thai DRG))
June 20 (Wed)	9:00	12:00	Observing a meeting of Central Social Insurance Medical Council	TBC
	14:00	TBC	Fee schedule system from clinical perspective	[Negotiation processes from a clinician's point of view] Japanese Association for Acute Medicine • Roles of a clinical professional association in revision of Japanese fee schedule system
June 21 (Thu)	10:00	12:00	Preparation for wrapping-up	Individually prepare: "What we have learned, how we can move forward" The participant is going to be divided into two groups. Each group is to make a presentation and discuss with Japanese resource persons in the afternoon on June 22.
	13:00	16:00	Visit to a primary health care setting: Visit to Nitta Clinic	• [Implementation of claiming] Claiming process based on the Japanese fee schedule at primary health care setting • Integrated Community-based Care System, focusing on primary health care.
June 22 (Fri)	10:00	12:00	Process of auditing fee schedule: Visit to kanagawa Branch, Health Insurance Claims Review & Reimbursement Services	[Implementation of audit] Audit of claims under the Japanese fee schedule system
	14:00		Short presentation from Thai participants Summary of the current challenges from Japanese experts Wrapping-up from two Thai groups, Evaluation meeting Closing ceremony [JICA HQ]	• Short presentation on the Thai fee schedule systems and challenges from Thai participants • Summary of the current challenges of the Japanese fee schedule systems, focusing on 'What are the 'dos' and don'ts' for the systems", from Japanese experts • Wrapping-up "What we have learned, how we can move forward" from two Thai groups • Comments, reflections and advice from Japanese resource persons [Assessment and Information system (TBD)] • Discussion and collaboration with Health Finance Team • How to estimate a necessary budget
June 23 (Sat)				

PARTICIPANTS

EXECUTIVE, UNIVERSITY PROFESSORS, TEAM LEADER, NHSO STAFF

Participants

Participants



Participants

PARTICIPANTS: TOTAL 21 PERSONS WITH 3 JPN EXPERTS

Overview

The Overview of Japan UHC

Vision for Health Insurance System Reforms
- To provide

all citizens secure access to necessary medical services
- To ensure

the sustainability of the health insurance system

- Health Insurance Revenue
  - Premiums approx. 50%
  - Public fund approx. 40%
  - Copayments approx. 10%
- Average premium rate for employee insurance has remained 9%-10%

⇒ Review of health Benefits and Costs
⇒ Dividing the functions of medical institution
⇒ Facilitating preventive care and health promotion

Patient copayment
- ≥75 years 10% copay.
- 70 to74 years 20% copay.

(30% for income earners equivalent to pre-retirement ones)
- Start to compulsory education to 69 years 30% copay.
- Yet to Start compulsory education 20% copay.

Japan's health insurance system

- 1927 Health Insurance Law enacted
- 1961 Japan's health insurance system has covered 100%.
- Covers all services People can go for treatment anywhere and limits to the public, co-pays up to 30%.
- Clearly divide the role between the medical treatment and rehabilitation leave out health promotion and disease prevention Medical care and rehabilitation services provided by the private sector include clinics and hospitals
- Payment to service providers is the only standard ,centralized in the form of Fee Schedule.

The breakdown by source of funding Y2015

- **Public funding 38.9%**
  - ⇒National treasury 25.7 %
  - ⇒Local governments 13.2%
- **Insurance premium 48.8%**
  - ⇒Business owners 20.6 %
  - ⇒Insured persons 28.2%
- **Other**
  - ⇒ Patient funding 11.6%

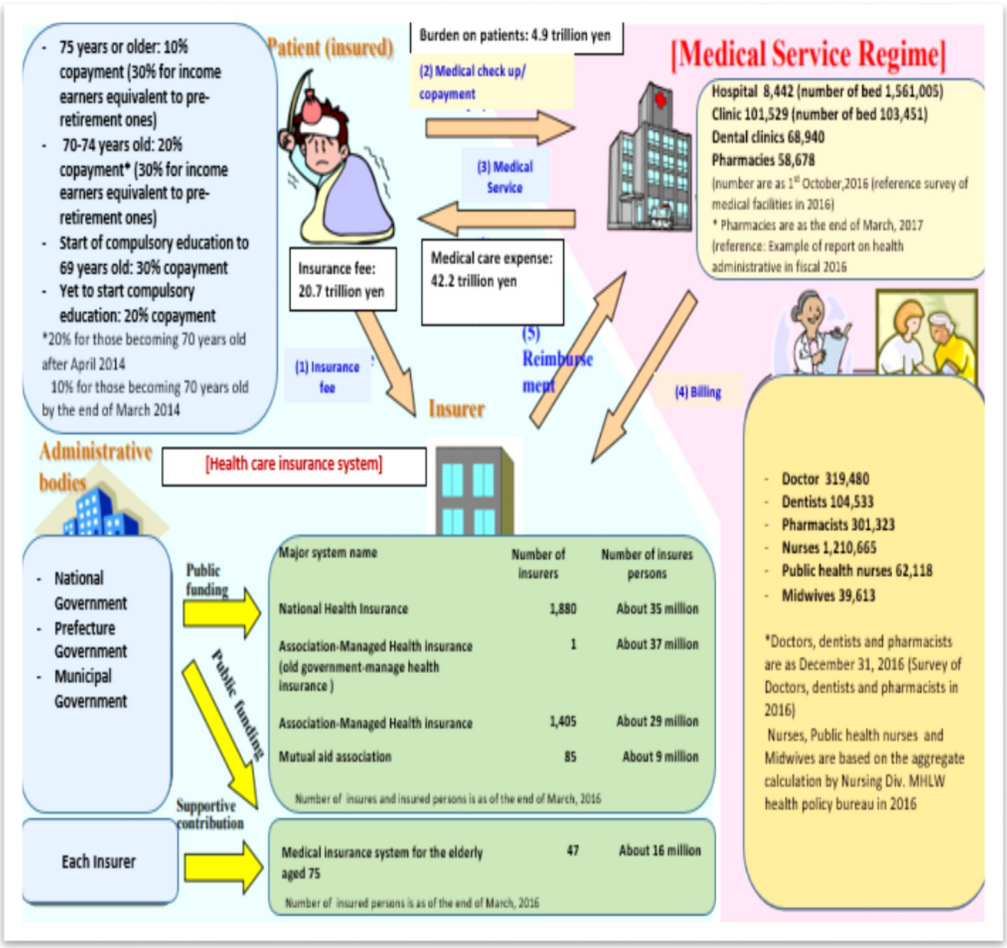
Data overview of Japan

Demographic	Y2015
Population (thousands) (Y2011)	126.94
• 0-14 years (% of total)	12.40%
• 65-79 years	27.30%
• ≥80 years	8.20%
Annual population growth rate (%)	-0.17%
Total fertility rate (per woman)	1.44
Age-dependency ratio (%)	65.8
urban population (%)	93.5

GDP (US$)	4383
GDP per capita (1,000 yen)	4173
Total health expenditure (% of GDP)	10.2
National medical care expenditure (trillion yen)	42.3644 (increase 3.8% on the previous fiscal year)
National medical care expenditure per capita	333.300 yen (increase 3.8% on the previous fiscal year)
Public funded medical care benefits (trillion yen)	3.1498 (7.4% of all system)
Health insurance benefits (trillion yen)	19.8284 (46.8%)
Medical care benefits for the latter stage elderly (trillion yen)	14.0255 (33.1%)
Patient funded (trillion yen)	5.2042 (12.3 %)
Life expectancy (years)	83.9 (OECD, 2016)

source reference : 1.Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA
2. Japan Health System Review ,Asian Public Observatory on Health System and Policies,Vol.8 No.1,2018

Overview



Overview of the health care system in japan

Health System

System

⇒ Universal Health Insurance (covered all residents of japan)

⇒ Provide excellent health outcomes (low cost,equity)

Main Type of health in-surance

⇒ The employees' Health Insurance System (Employed workers and their dependents)

⇒ National Health insurance (self and unemployed people)

◊ 81% of hospitals, 95% of clinics, almost 100% of dental clinics are private.

♦ Run by 47 prefectural governments (Merging 1,880 Municipalities to 47 prefectures in April 2018, the prefectures become local government units.

Payer

⇒ Patients' copayments for medical expenses 10-30% of the cost

⇒ 70-90% of the cost

Provider payment methods

⇒ Outpatient :

- Fee for service

⇒ Inpatient :

- Per Diem

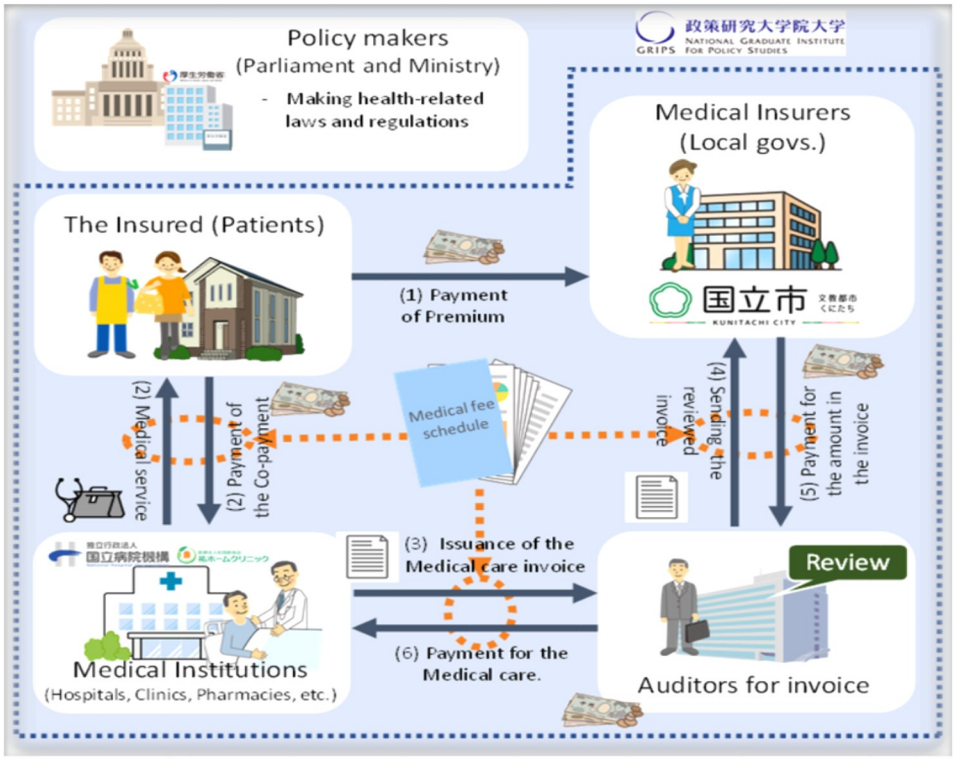
-Bundled payment (DPC/PDPS)

-Fee for service

National Healthdata clearing

⇒ Examination and Payment organization

Flowchart of Insurance-covered medical service



source reference : Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA

DATE JUNE 17TH-23TH, 2018.

On attending the "Health Care Finance Study Visit" for Global Health and Universal Health Coverage (GLO + UHC) Tokyo, Japan.

THE CONTENT SUMMARIES

Health Care Finance Study Visit

Background : Sequence on expanding coverage

1927 : Health Insurance Law enacted

Formulate of the system : start with employee health insurance, to ensure the health and life safety of workers.

1961 : Universal coverage achieved

Development of the system : Enrolled all citizens in the obligatory national health insurance.

1973 : Free medical care for elderly patients

Maturing of the system : Caused the social problem that hospitals were transformed into places of socializing

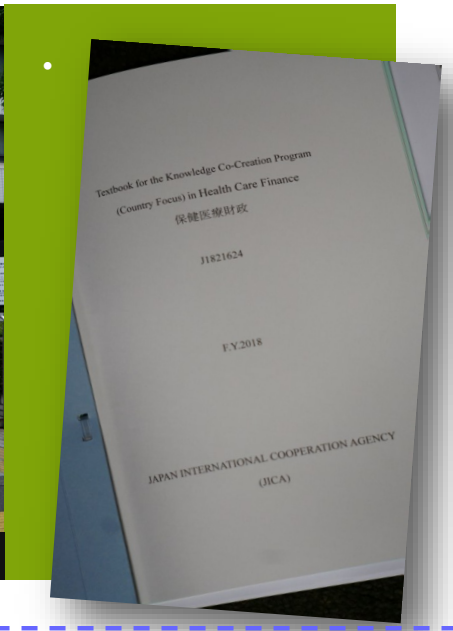
⇒ *Re-introduced copayment in 1983*

2008 : Later-stage Elderly Medical Care System

Structural reform of the system : Established an independent system for people aged 75 and over.

Japan has universal public healthcare: it's a legal requirement for all Japanese citizens to have the health insurance provided by the state. This coverage is quite thorough and entitles people to choose their own clinics and hospitals from any of the vast majority that are part of the system. International private healthcare is the only option for short-term visitors and other private options are available in Japan to supplement the public coverage. the system is structured around public healthcare.

The first day of training — The Ministry of Health, Labour and Welfare



Source reference : 1. Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA

Financial/Accounting Mechanisms to Estimate Health Benefits in the Initial Budget and Adjust Budget to Actual Expenditures.

Government Health Benefit Contributions

= (insured person X health benefits per insured person +financial effects of institutional revisions) X government Contributions rate

- ***Est. No. of insured person = Est. by multiplying the latest number of insured person by the average growth rate insured persons over the last 3 years.***
- ***Est. health benefits per insured person = Est. by multiplying the latest actual health benefits per person by the average growth rate of health benefits per persons over the last 3 years.***
- ***financial effects of institutional revisions***

Such as medical fee revisions, were estimated separately and added to the government contributions estimates.

Remark : 1. when the health benefits are re-calculated in the middle of the fiscal year, the number of insured person and the health benefits per person are also re-estimated base on the latest actual data.

2. If actual expenditures are less than the estimates, the excessive government contributions are returned from insurers to the government next fiscal year.

Source reference : 1.Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA

The challenges facing Japan

⇒ A negative population growth [–17%]

⇒ Low fertility rate [1.44 per woman]

⇒ Ageing population [Population ≥ 65 years, 27.3% in 2016 ,39% in FY 2050 ,Highest among 34 OECD Countries]

⇒ Increase Urban population [In 1980, 76.2% by 2015, this number had increased to 93.5%.

⇒ Shrinking economy and increasing unemployment rate [Increased since 1990, peaking at 5.4% in 2002, and then its decline to 3.4% in 2015 although the proportion of part-time and contingent workers has continued to grow in recent years. The majority of this increase can be attributed to thegrowth in the number of older people and women after childrearing, who had left the workforce and later returned to work. Increasingly, the inequality in working conditions and low wages for part- time and contingent workers have been serious labour issues with social implications.]

⇒ Increasing NCD- related disease burden and degenerative diseases [The top three leading causes of death in 1990 were cerebrovascular disease, ischemic heart disease, and lower respiratory infection (–19.3%, –11.6% and –6.5% in 2015, respectively).]

⇒ High life expectancy [the 12 high-income OECD countries, Japan has the highest life expectancy at 83.7 years in 2015]

⇒ Growing use of expensive technologies have led to an ever-increasing rate of health-care expenditure [THE of % GDP: 6.3% in1995 to 10.9% in 2015, by OECD]

⇒ 2017 Survey Summary : Total profit /loss at medical institutions in 2016 representing a -0.5% decrease from last year

The first day of training

Direction of Reform

[1] Stabilization of health Insurance System [National Health Insurance, Employee Health Insurance]

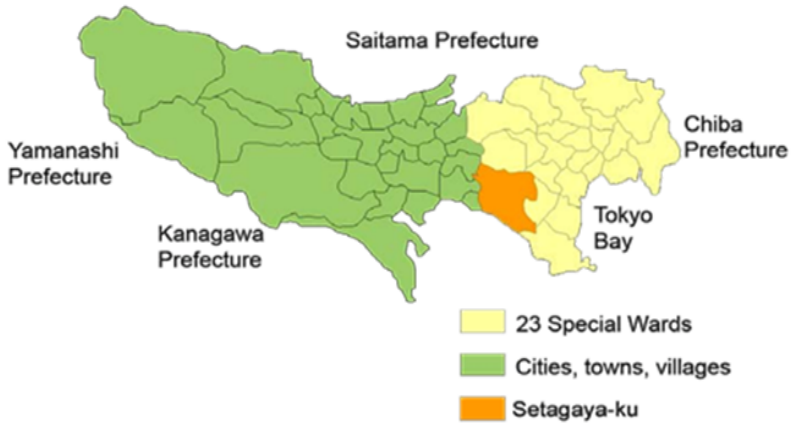
[2] Fairness of the burden between and within generations.

[3] Optimization of Medical Expenses.

- Differentiation and coorperation of hospital facilities, Optimization of Inpatient medical expense. Promotion of comprehensive medical care.
- Promotion of preventive health, ICT utilization.
- Promotion of the use of generic drugs.

Source reference : 1. Presentation of workshop of the Health Finance WT in Thailand : MAY 15th, 2018.
2..Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA
3 Japan Health System Review ,Asian Public Observatory on Health System and Policies,Vol.8 No.1,2018

Health Care System for Critical Care



Health insurance system in critical care

Diagnosis procedure combination

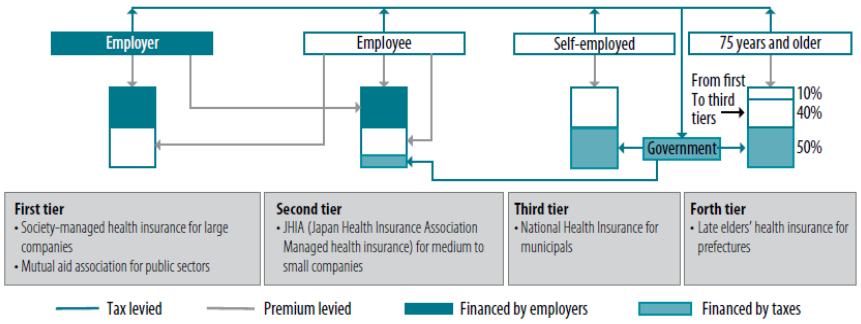
- Fee foe service
- Payment by diagnosis & procedure
- Length of hospital stay

High quality ICUs

1. Designated Dr. allocation
2. Dr. staffs should include certified intensivists
3. Nurse to patient ratio =1:2
4. 24-hrs clinical engineer service
5. Severe patients>90%
6. Spaces >20 m2

Source reference : 1.Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA

Financial flow based on insurance flows



Source: Ikegami N et al., 2011

National Health-Care Expenditure by financial sources (%)

	1985	1995	2000	2005	2011	2014
Total health expenditure	100.0	100.0	100.0	100.0	100.0	100.0
Tax						
Central Government	26.6	24.2	24.7	25.2	25.9	25.8
Local governments	6.8	7.5	8.5	11.4	12.2	13.0
Total	33.4	31.7	33.2	36.6	38.1	38.8
Insurance premiums						
Employees'	23.4	24.5	22.7	20.3	20.1	20.4
NHI (self-employed and others)	30.9	31.9	30.7	28.7	28.3	28.3
Total	54.3	56.4	53.4	49.0	48.5	48.7
OOP payments	12.0	11.8	13.4	14.4	12.7	11.7

Source: Ministry of Health, Labour and Welfare, 2016p

Health-care expenditure in Japan has been increasing.

Expenditure	1995	2000	2005	2010	2014
Total health expenditure (% GDP)	7	8	8	10	10
Public expenditure on health (% of THE)	82	81	82	82	84
Private expenditure on health (% of THE)	18	19	19	18	16
Government expenditure on health (% of GTE)	15	15	18	19	20
OOP payments (% of PHE)	79	81	83	81	85
OOP payments (% of THE)	14	16	16	14	14

Notes: GDP: gross domestic product; THE: total health-care expenditure; GTE: government total expenditure; PHE: private health expenditure; OOP: out-of-pocket

Source: World Health Organization, 2017

Source reference : 1. Japan Health System Review ,Asian Public Observatory on Health System and Policies,Vol.8 No.1,2018

FEE SCHEDULE

Summary of Medical Fees

[1] Provide as compensation (remuneration for insurance - covered service)

[2] Determined by the national government (Ministry of Health ,Labour and Welfare) and applied to all medical institutions across the country. Confer private companies' products/services.

[3] Revise once every 2 years

Function of Medical Fee Point Table

[1]Saving as a price list.

Setting a price for each medical service (1 point = 10 JPY

[1] Serving as an item list.

Determining the scope and content of insurance– covered medical services , Medical services not included in the table are not regarded as insurance covered services.

⇒ Assesment of technique and services (approx. 5,000 items)

⇒ Valuation of materials (approx. 14 Categories about 17,000 items, Drug prices are set based on the NHI Drug Price List)

Source reference : 1. Presentation of workshop of the Health Finance WT in Thailand : MAY 15th, 2018.
2..Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA

National uniform fee schedule controlled by MOH

[1] Uniform fee schedule among all types of insurance programes

[2] Applied to all health service providers under national health insurance system.

[3] Neither balance billing nor extra billing is allowed.

Source reference : 1. Presentation of workshop of the Health Finance WT in Thailand : MAY 15th, 2018.

Activity Pictures

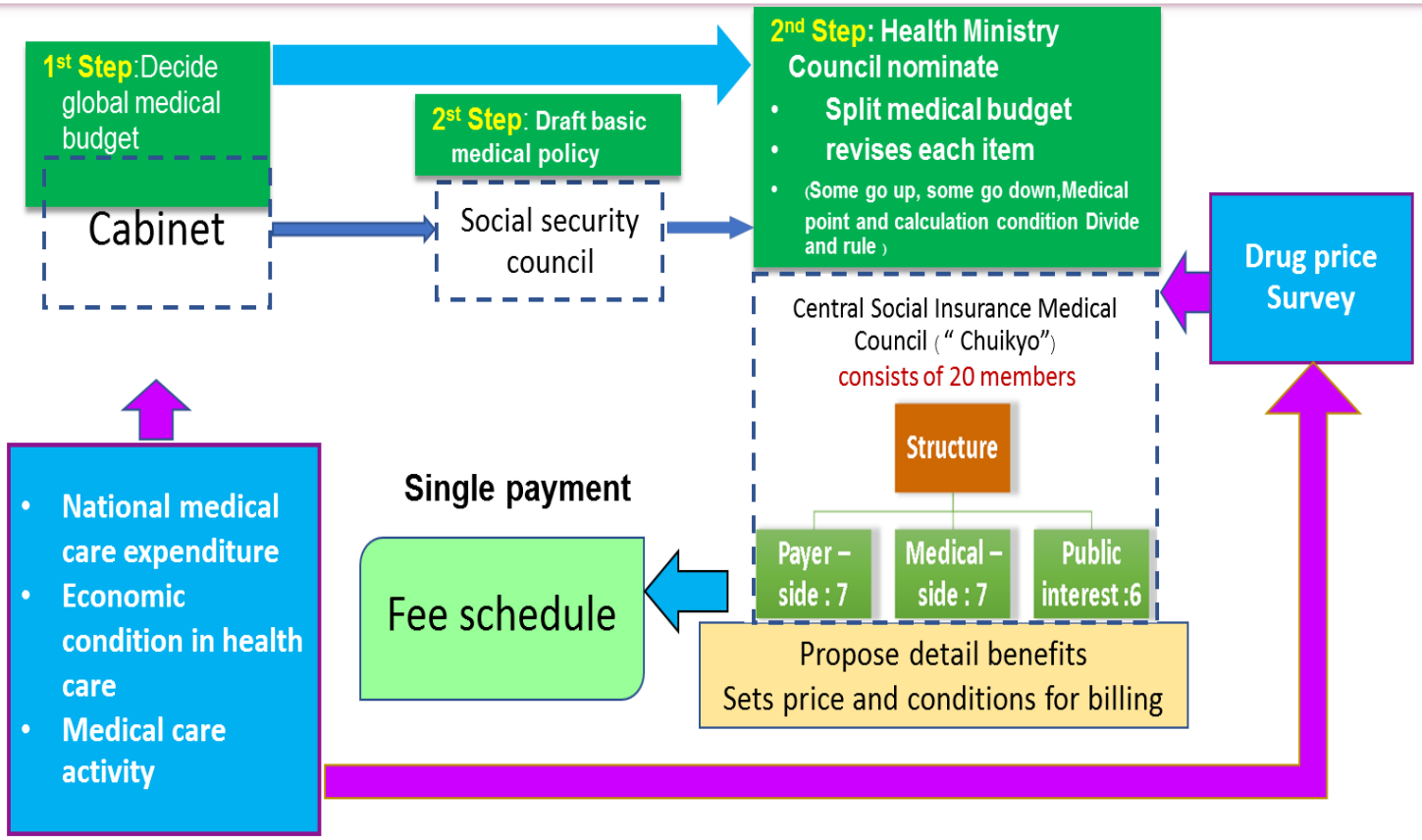
Wrap up Healthcare Finance

" Fee schedule "

Group UME

Dr. Suwit Wibulpolprasert
Dr. Nusaraporn Kessomboon
Ms. Issaree Chuenjitsaowakhon
Mrs. Panjai Tantiphusanon
Mrs. Phanida Klinpipat
Mrs. Pittaya Singtotong
Mrs. Nutchanat Viriyaprasit

Overview "Fee schedule"



Source reference : 1. Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.

We learn about

Compare Japanese fee schedule and Thai UCEP fee schedule

Topic	Issue	Japan (1922)	UCEP, Thailand (2017)
Planning	Evidence	Economic,Demographic, P/L of provider,UR	Drug price, ABC Costing (LC MC CC Overhead cost Development cost)
	Component committee	Payer – side : 7 Medical – side : 7 Public interest :6	Payer Medical Public interest (No NGO) There is no exact proportion specified for each stakeholders
	Ministry of health	Pure regulator	Regulator with service provider

We learn about

Compare Japanese fee schedule and Thai UCEP fee schedule

Topic	Issue	Japan (1922)	UCEP, Thailand (2017)
Implement	Price setting	CHUIKYU	Ministry of Public health
	Patient type	ALL	Emergency
	Fee Schedule lists	- Medical services - Drug and medical device - LAB with condition	medical service such as real items used in service with condition only expensive items
	Service delivery	Co pay 10-30%	Free depend on billing the first 72 hr. after that depend on health insurance scheme
M&E	Revision Fee schedule list	every 2 years	every 3 years Or their needed
	Provider economic situation	Economic and financial impact survey on providers	NO

Source reference : 1. Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.

Apply to Thai UCEP

Apply to the Thai health care finance system

- Revise UCEP fee schedule committee with appropriate stakeholders
- Short term plan: start up at the top 5 of high cost disease groups such as Stroke, STEMI, Craniotomy for trauma, Heart failure, Burn
- Long term plan: expand the UCEP fee schedule to the other related systems in the future

In the future

- Request experts from Japan to be the consultation for UCEP fee schedule
- Sending a NHSO staff who can communicate in Japanese to be trained and practiced with Japanese team

Source reference : 1. Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.

Role and Impacts of Medical Fees

[1] Setting prices for medical services.

⇒ **Affecting to the quality and quantity of medical services.**

[2] Determined the medical revenues of insurance - coveraged medical institutions.

⇒ **Affecting the management of insurance - coverage medical institutions.**

[3] Allocating medical care expenditures (medical resources)

⇒ **Affecting the development of themedical service provision system.**

[4] Determining the national medical care expenditures as well as service supply volume .

Source reference : 1. Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA

The Central Social Insurance Medical Council " Chuikyo"

Story

- BC.1950 Establish (Before UHC)
- BC.2006 Adjust the law, Reduce power

Example : Price Regulation policy

Before 2018
Ratio Pt. with acute condition 15%-25%

Revision 7:1 beds in2018
- Ratio Pt. with acute condition 25%-30%
- 10:1 beds LOS ≤ 19 days

Nurse Benefit
Quality of life

Public &Patient Benefit
Incentive for
Quality of service
Reduce LOS

Objectives

1. To set the average price (Fee for Service) That reflects the cost & Cost containment
2. To achieve the quality standard service or reduce some unnecessary services.

Function

Revision Fee Schedule 2 years 1 time. Set Price per Point

Structure

- Payer – side : 7
- Medical – side : 7
- Public interest :6

Source reference : 1. Presentation of workshop of the Health Finance WT in Thailand : MAY 15th, 2018.
2.Observing and Document a meeting of Chuikyo : JUNE 20th, 2018

Role of Chuikyo

Split medical budget

Based on total medical budget from Cabinet.

Activities

1. Discuss based on Basic Guidelines formulated by Social Security Council (Health Insurance Working Group / Medical Affairs Working Group)
2. Discuss individual medical fee points and calculation conditions.

Note

Cabinet : Decide revision rate through budgeting process.
Social Security Council : Discuss basic medical policies ,
Formulate Basic Guidelines on medical fee revision.

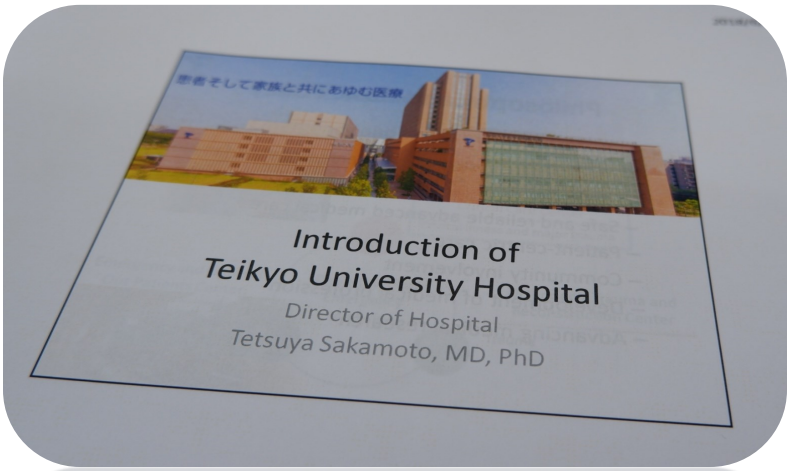
Medical fees are revised based on :

[1] A given revision rate decided by the Cabinet through the budgeting process.

[2] Basic Guidelines formulated by the Health Insurance Working Group and the Medical Affairs Working Group of the Social Security Council .

[3] Discussion on the setting of medical fee points at the Central Social Insurance Medical Council.

source reference : 1.Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA



CLAIM

DPC/PDPS System

As of April 1,2018,the system is estimate to cover 1,730 hospitals and approx. 490,000 beds, accounting for approx. 83% of the hospital beds subject to the general acute hospitalization basic fee.

Hospitalization points are calculated by multiplying one of the three fixed unit points giving according to the number of hospitalization days and the diagnosis procedure combination classification by the coefficient.





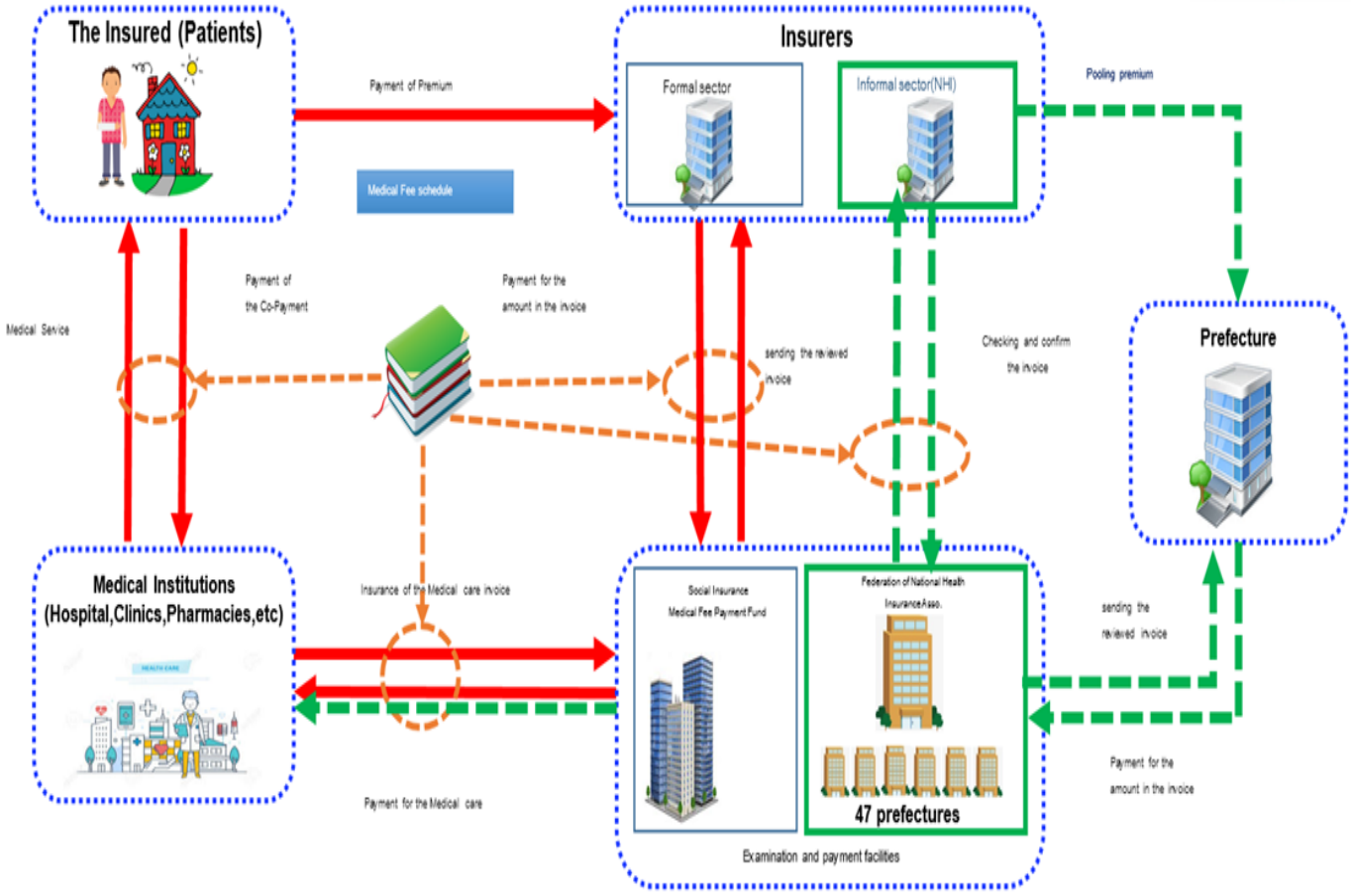
Source reference : 1.Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA

Wrap-up
"Claim"
Group Sakura

Member

1. Dr. Winai Sawasdivorn
2. Dr. Kasame Tungkasmesamran
3. Dr. Khunjira Udomaksorn
4. Mr. Pratueang Paodit
5. Ms. Vipada Wongcharoenwitaya
6. Ms. Kiriya Janchot
7. Mr. Natthaphon Imkaew

Flow of Health Insurance Treatment



What we have learned on claim audit and processing system

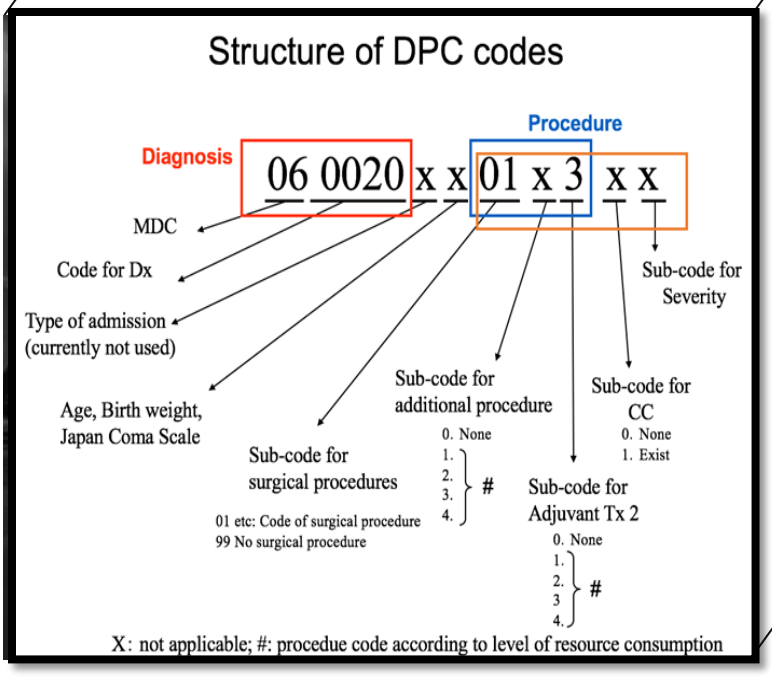
Attributes	Japan Fee Schedule	Thailand (UCEP)
1. Information technology system	- The standardized data with information technology supporting system is in place and efficient.	- Variety of IT systems employed by each health care providers.
2. The Claim examination and processing organization	Independent from insurer by one public with local branches and two private agencies	Done by the biggest insurer, i.e., UC scheme. The other two insurers are not involved
3. Operation	Branching system based on prefecture	Centralized system by three organizations
4. Pre-payment audit	- All claims are pre-payment audited (IT) - There is professional pre-payment audit system	Sampling some claims for pre-payment audit.
6. Reference fees schedule	Clear conditions fee schedules easy to claim audit	Some conditions are ambiguous or not specified
7. Claim cycle	Monthly	Daily
8. Allowance Period to submit claim	3 years (no deduction on reimbursed amounts)	1 years (deduction on reimbursed amounts)
9. Workforces	Formal training system of skillful workforces: medical admin	Learning by Doing

Source reference : 1. Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.

Applications & Want to learn more

Applications	Want to learn more
1. Standard codes of identification for all medical service and drug need to be developed soonest 2. Employment of efficient IT systems to support claim and audit	Information management system to make use of claims data utilization.
3. Consider the necessity of an independence claim examination and processing org. from the insurer	
4. Consider the necessity of the branching operation system of claims audit and processing	
5. Pre-payment claims audit system by health professional should be considered for doubtful claims.	Management and incentive system to set up pre-payment claims audit and processing by health professional

Source reference : 1. Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.



Summary: The impact of DPC in Japan

⇒ **First,** the DPC in Japan could not decrease the absolute value of medical costs.

⇒ **Second,** the internal efficiency of the institutions was improved, for example, by reducing the mean length of hospitalizations.

⇒ **Third,** the DPC-based diagnosis classification is considered to be effective for simplifying the medical fee system

⇒ **fourth,** after introduction of the DPC, structural problems remain in the flat-fee payment system, such as examination and treatment of low quality, selection of patients and up coding. Its

Source reference : 1. Presentation of workshop of the Health Finance WT in Thailand : MAY 15th, 2018.

AUDIT SYSTEM

Audit

Legal basis for audit (Art.78 of Health Insurance Act)

The Minister of Health,Labour and Welfare may order a health insurance covered medical institution or pharmacy to

[1] make a report or submit or present medical records or other books and documents.

[2] Appear,

[3] Have the official question person involved,or

[4] Inspect any equipment or medical records, record books and documentas or other objects.

Purpose of audit (Notification issued by Director of Health Insurance Bureau, Ministry of Health, labour and Welfare)

⇒ *Find the fact and take fair and appropriate measure when an unfair or significantly inappropriate medical treatment or medical fee claim is suspected.*

Source reference : 1.Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA

Wrapping Up

"Fee Schedule for UCEP"

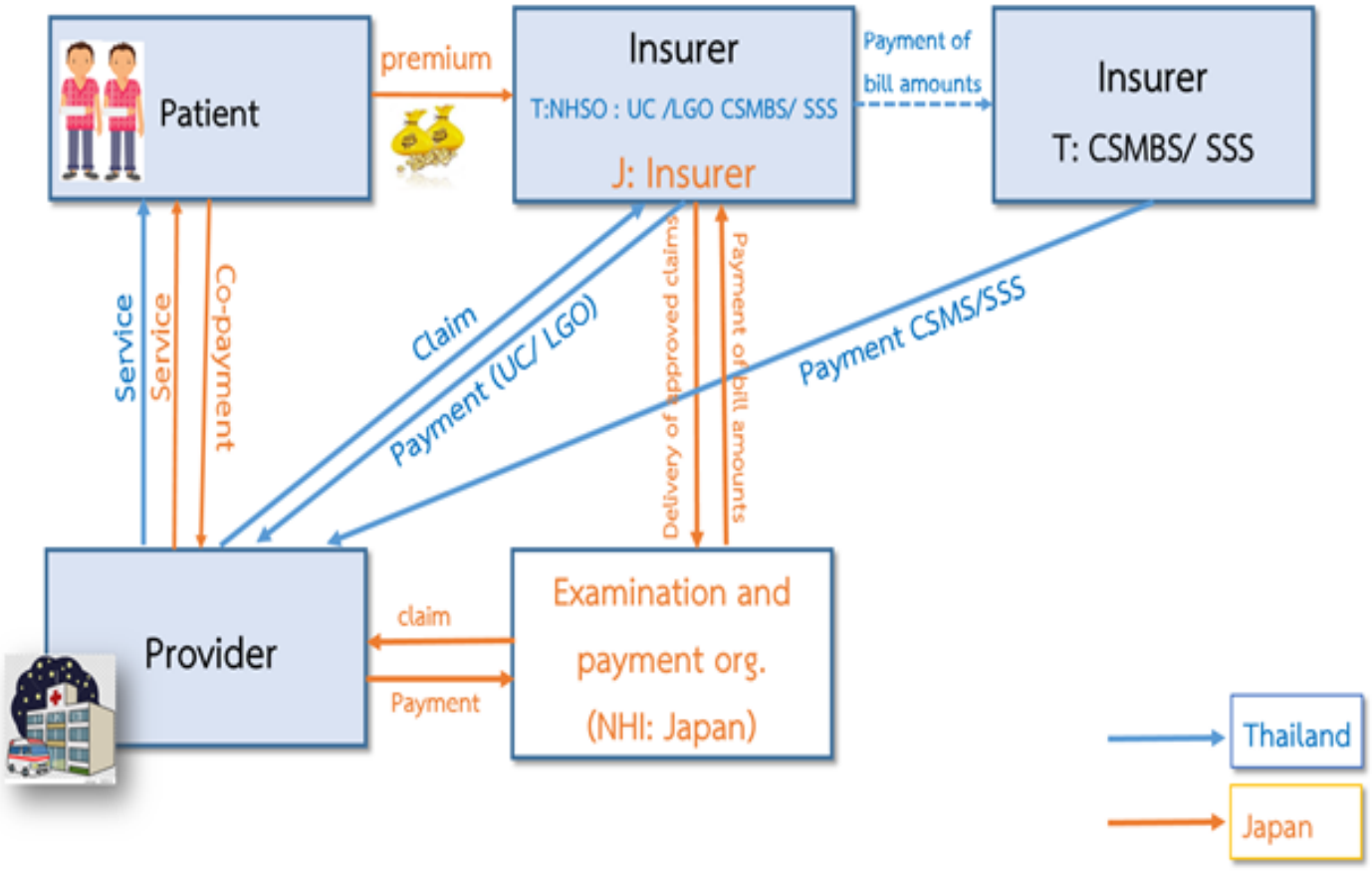
June, 18-22 2018

Audit System

Group 3: Take

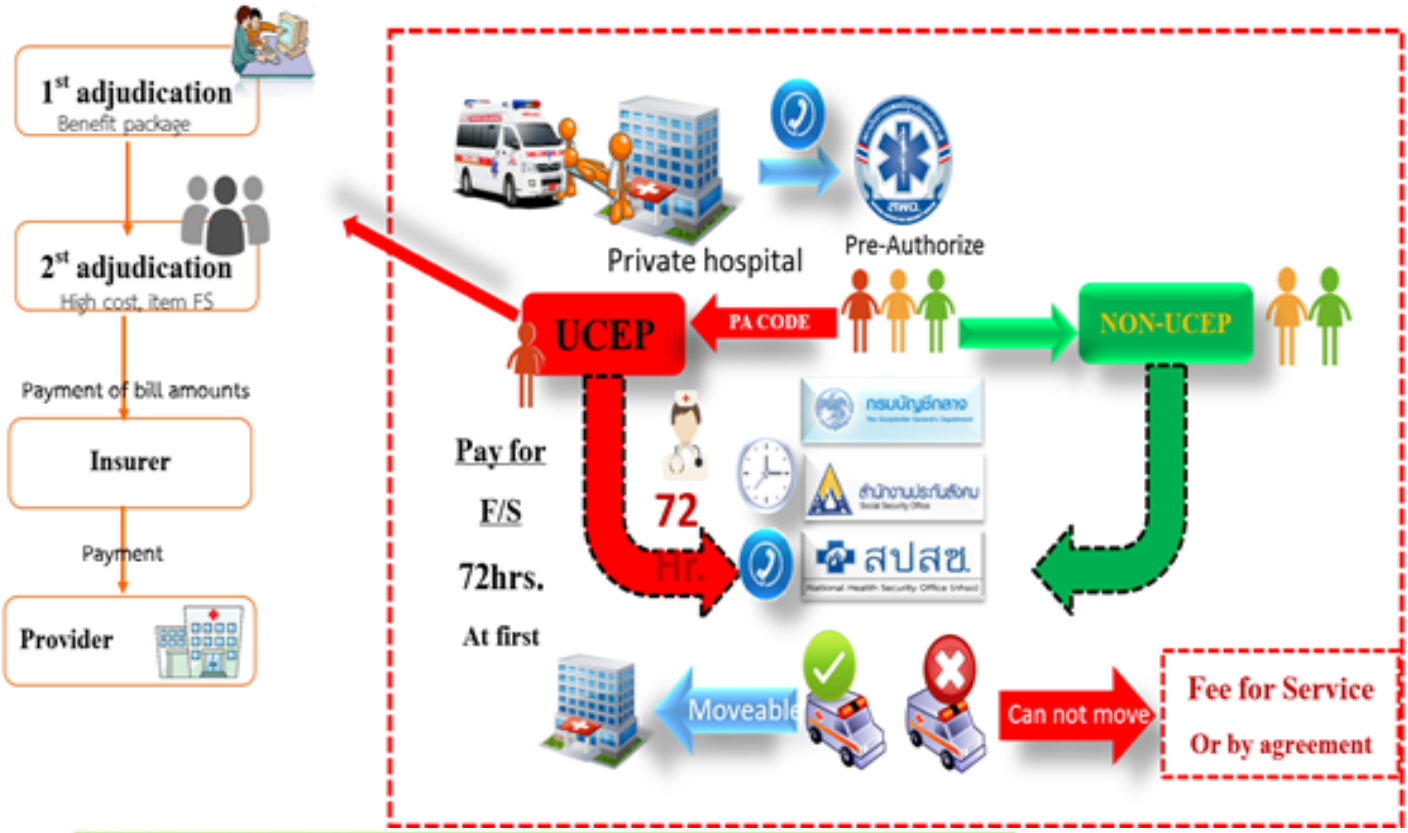
Dr.Jadej Thammatacharee
Dr.Rungpetch Sakulbumrungsil
Ms.Jaruwan Sawadklin
Ms.Naruomon Chairangsinant
Ms.Supanan Inphlang
Ms.Rajit Saelim
Mr.Grid Phonprisan

Flow Chart for Health Insurance: Thailand UCEP vs Japan

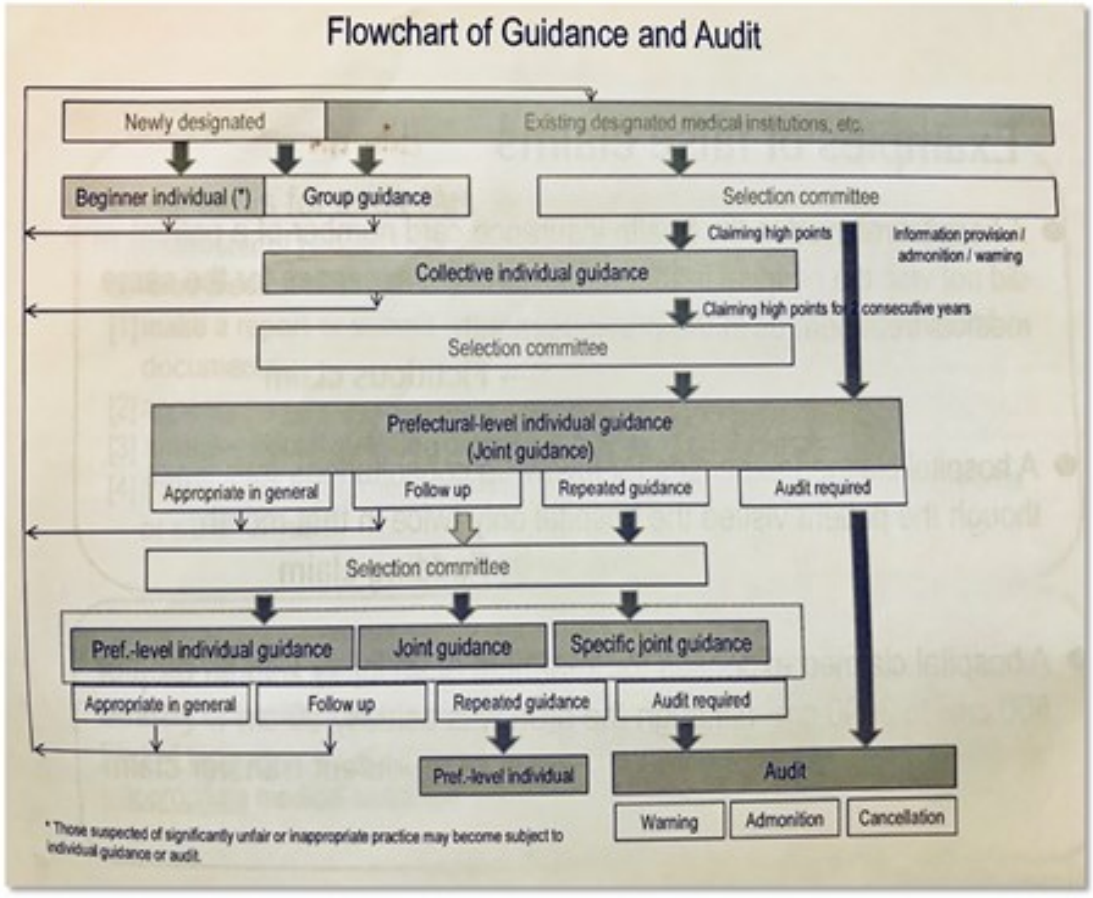


Source reference : 1. Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.

Flow Chart for UCEP in Thailand



Flow Chart of Audit System in Japan



Adopt from presentation of Medical Guidance and Audit Office, MHLW: 18 June 2018

Source reference : 1. Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.

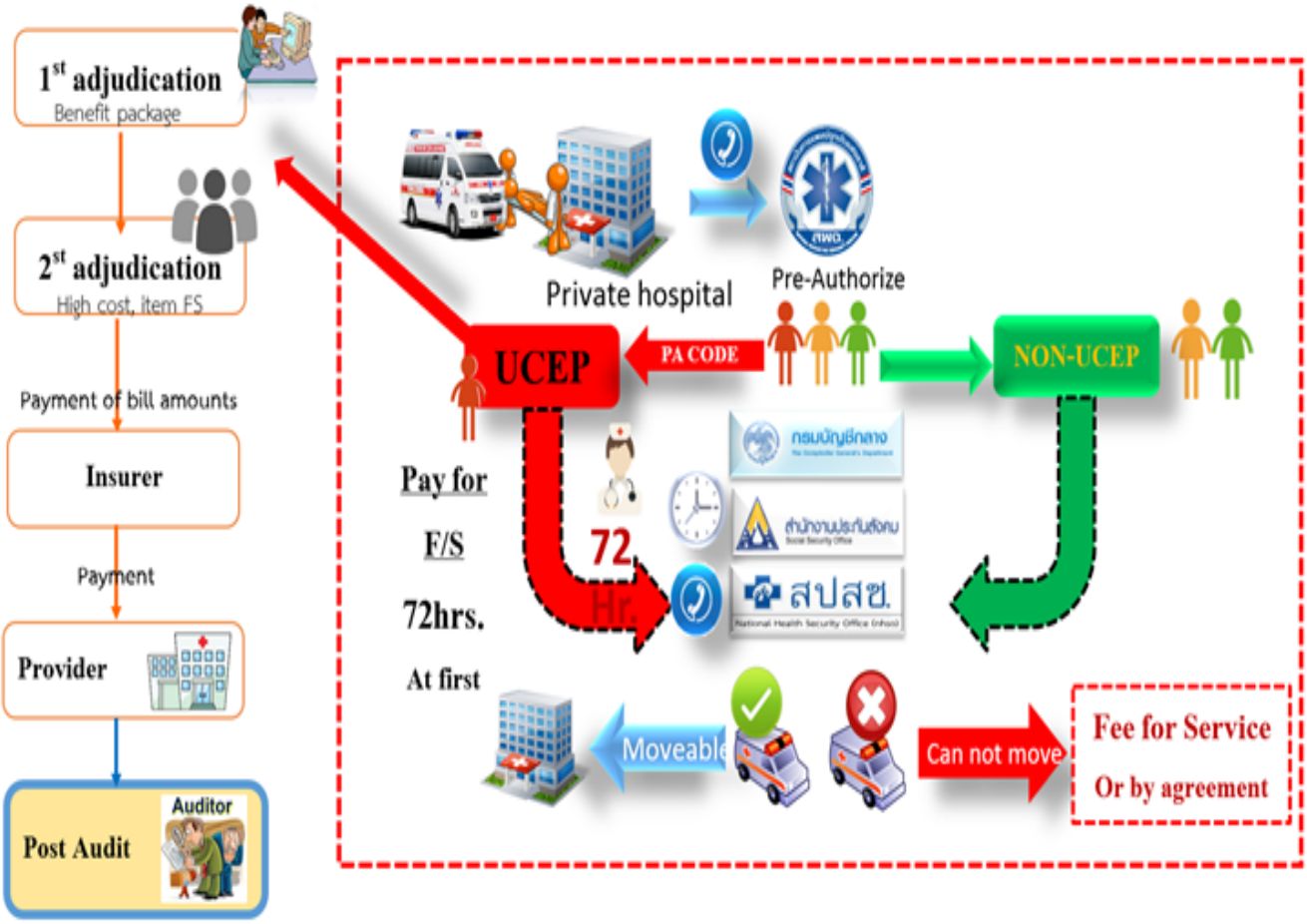
1.What we have learned from this visit

Topic	Japan (FS)	Thailand (UCEP/UC)
Structure	-Insurer -Examination & Payment Org	Insurer & Auditor within the same org for UC -NHSO conducts pre-payment audit for other schemes
Claim Auditing process	-Pre-Submission screening -Pre-Payment audit -Post-Payment audit -High point -Quality	-Pre-Submission screening -Pre-Payment audit -Post-Payment audit -No for UCEP -According to conditions (UC)
Institution Audit	Pre-registration Timely investigation	-No for UCEP -For UC -Pre-registration & Annual assessment on structure criteria -self-assessment -site visit assessment for specialty service
Monitoring measures	Regulation on false claims -Warning -Admonition -Cancellation	NO regulation on false claims -Warning and return money

2. How we can apply them to the Thai Health care Finance system	3. What we want to learn in the future
Long term goal: -More stringent regulatory measures other than financial measure would be added Intermediate goal: -Single dataset should be designed and enforced -Should set up a statistical unit to be responsible for data survey and analysis used for improve benefit scheme performance. Short term goal: • Register individual medical doctors as health care providers to the insurer • Set conditions/criteria for pre-payment audit on each fee schedule items • Administration and financial performance feedback to providers	-Big data management and monitoring -Set up simple criteria and/or condition for audit

Source reference : 1. Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.

Flow Chart for future UCEP in Thailand



Source reference : 1. Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.

Learn More

Predictive models for Out-Patient service capitation budget allocation under the Universal Coverage Scheme in Bangkok

Khachon Mongkonchoo
National Health Security Office: Region 13 Bangkok, Thailand

Background

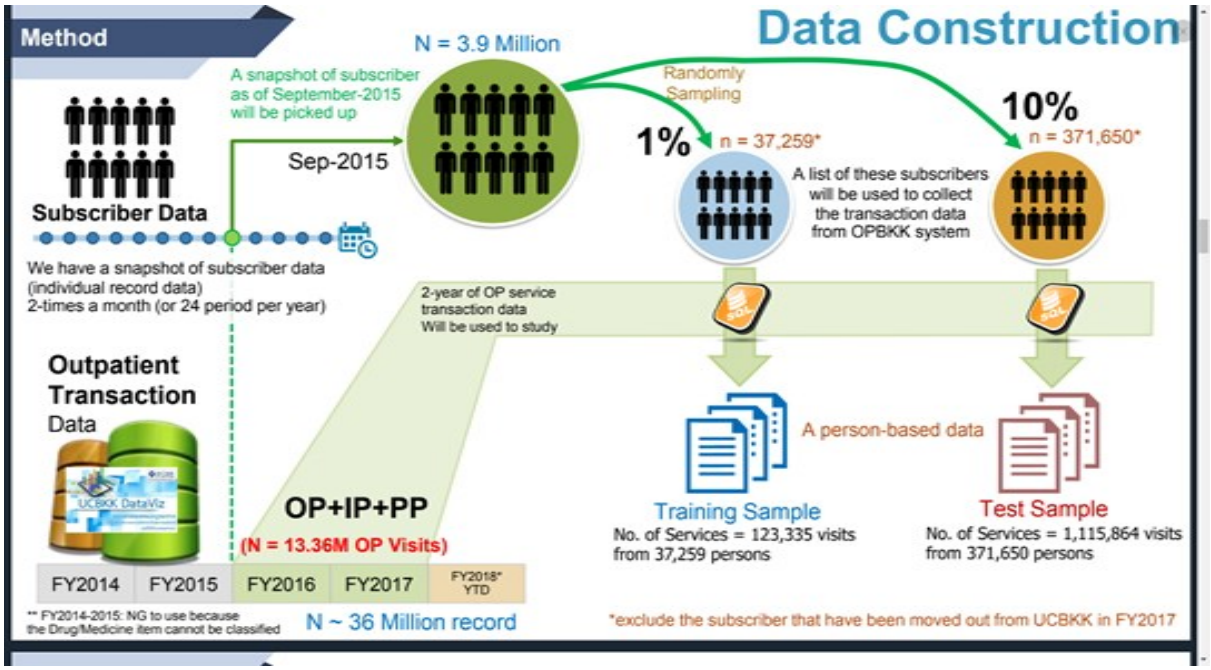
- **U**niversal **C**overage Scheme in **B**angkok Metropolitan area **(UCBKK)**, managed by **N**ational **H**ealth **S**ecurity **O**ffice: Region 13 Bangkok **(BKKNHSO)**
- **3.9 Million of subscribers** (people under UCBKK)
- **~400** of Health Facilities (Public/Private Hospitals, Health Center, Clinics)
- Total budget for Out-patient (OP) **~4000 Million Baht** per year
- BKKNHSO splits the OP budget for Capitation (70%) and Reimbursement system (30%)

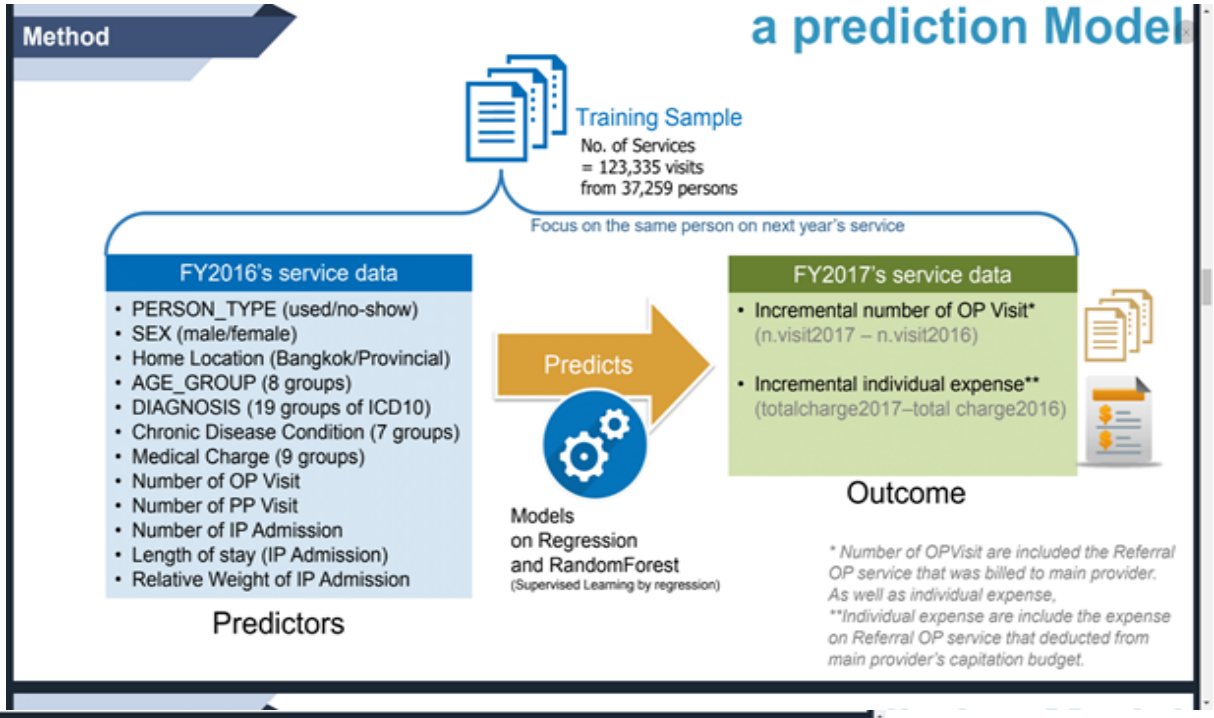
- **~270 facilities** that hold **UCBKK subscriber** are called **Main Contractor Facilities,** receiving the OP capitation budget. Most OP services are bundled.
- Each main facilities have a different capitation rate.
- Main facilities acts as a gatekeeper*

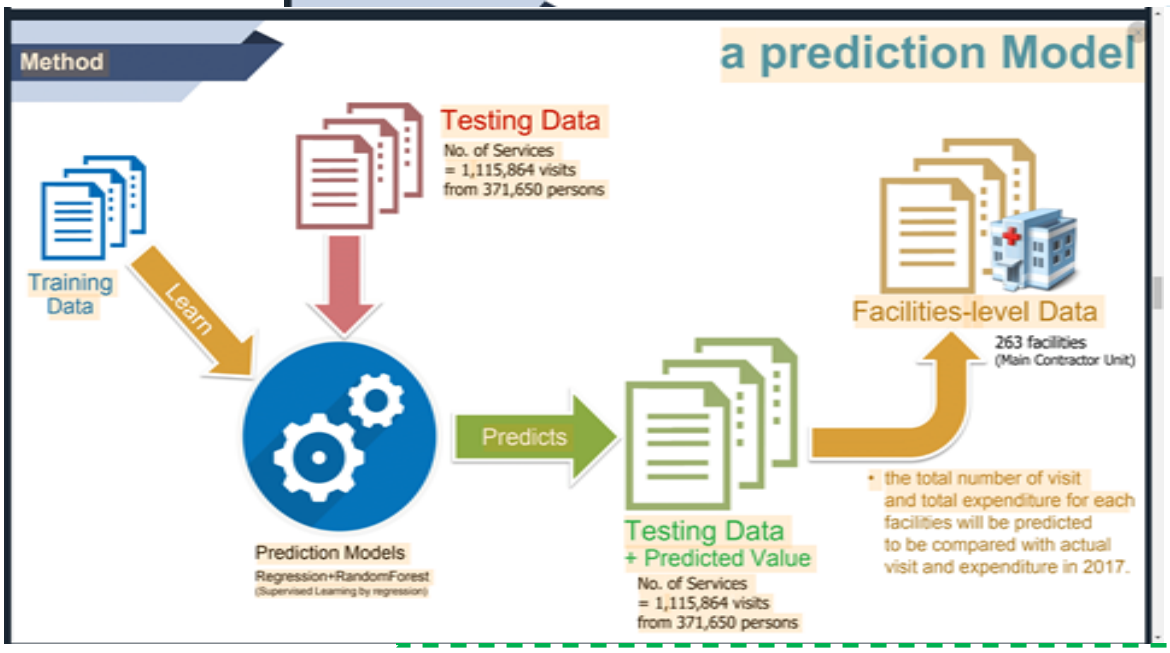
Objectives

To predict the total expenditure spent on Outpatient services and frequency of visit for each facilities under UC scheme in Bangkok by using medical charge and other relevance data in the preceding years.

Source reference : 1. Source reference : Presentation : JUNE 22th, 2018.





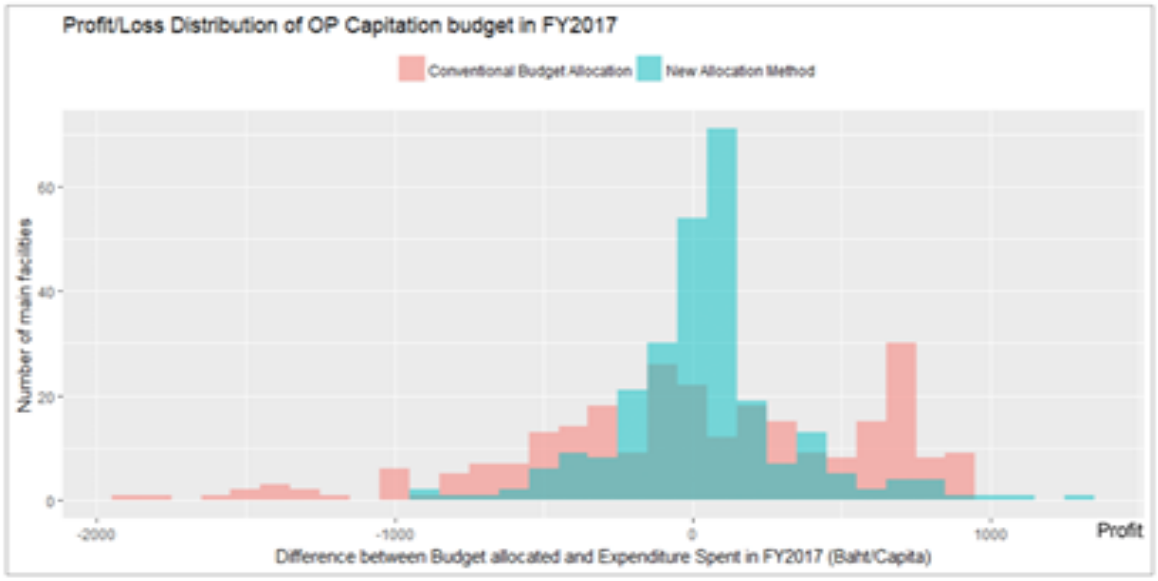


Source reference : 1. Source reference : Presentation : JUNE 22th, 2018.

Discussion

- This study can predict the next year's frequency of visit and individual expenditure on OP service well by using the bottom-up approach that constructs the person-based data from transactions.
- Machine learning algorithm can predict the next year's frequency of visit and individual expenditure on OP service more precisely than linear regression.
- The predictive model works fine on all type of facilities especially on clinics and heath center.

Discussion



- Due to the regulation that allow subscriber to change main service unit 4 times a year, **the subscriber's based data** can be used to agregated into facilities level better than summarizing from all transaction by facilities they belong to.
- So it might be improve the fairness of budget allocation if we use this prediction model as one input of allocation.

⚠ Limitation

- medical charge items were roughly classified, some items may be misclassified.
- cannot obtain medicine data, most drug items could not be classified into ATC* category. (we have a lookup data but not cover all item we used)

Remark:
* Anatomical Therapeutic Chemical (ATC) Classification System

Source reference : 1. Source reference : Presentation : JUNE 22th, 2018.

Dr.Yohsuke Moderator

Mrs.Nutchanat UME Representative

Mrs. Kiriya SAKURA Representative

Ms.Jaruwan TAKE Representative

Mr.Kachon Predictive model

Behind the scenes

Source reference : Presentation and Wrap up papers from training : JUNE 22th, 2018.

WHAT WE HAVE LEARN

Trip Report **17-23 June, 2018**

Project Benefits

By learning from the success of the Japanese operations. We can learn those knowledges and lessons to develop our work environment. The Ministry of Public Health, other organizations, and communities are planning to develop work more efficiently in the future. Thankfully for those the opportunities to continue to work for our local and global community.

Viewpoint

- An effective fee schedule is more a matter of getting the politics than the science right.
- Needs some participation by all stakeholders . Trust are the key to success.
- The change process supports more environmental factors, such as economic, financial, social and political.
- Institutional capacity for negotiation is key. Once the institutional capacity for negotiating is established, bigger policy changes. can be carried out
- The Japanese system is quite good for chronic care, particularly because it has so many older people. Along with appropriate medical care, Japan also provides long-term care to all older people who need it through a public insurance system.

View point is reference:

1.John Creighton Campbell U Michigan/U Tokyo/Japan-World Bank Partnership Program on Universal Health Coverage Workshop on Japan's Fee Schedule Thai National Health Security Office Bangkok: July 5, 2013

2.Textbook for the Knowledge Co-Creation Program (Country Focus) in Health Care Finance F.Y.2018 JICA

3. Japan Health System Review ,Asian Public Observatory on Health System and Policies,Vol.8 No.1,2018

"As we were given the opportunity to attend this training session over a period of one week, the team provided us with a wealth of knowledge and joy. Thank you to the management team of Japan, JICA Executive team, Executive team of Thailand , Dr. Suwit Wibulpolprasert , Dr. Winai Sawasdivorn , Dr. Jadej Thammatacharee and the team. Thanks to everyone who provide us support, encouragement, and learning together. We will continue to develop in the future for the high value service. "

- ***Dr.kasame Tungkasamesumran***
- ***Mrs. Nutchanat Viriyaprasit***

The first day of training **18 June, 2018**

Continue in the things we have learned

Go back home

WHAT TO DO NEXT

The last day of training [Certificate Ceremony] **22 June, 2018**

Plan to Improve Our Career Development

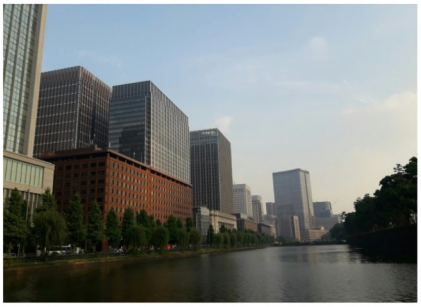
- Assessment of financial allocations are used for health service budgets: Statistical analysis of economic and financial factors to determine.
- To manage strategically advanced and running the most effective committee meeting.
- Working with schools, families and other group of service providers to improve and support long-term change in our communities.
- Planning and thinking about future health care.
- Assigning and managing policies that can help our organization to implement more effectively in a manner that supports our strategic goals.

Impression

Sensoji Temple (Asakusa Kannon Temple)

The Memory of Pictures

This city looks warm and contemporary.



- My colleagues, coordinators, and partners were really nice and friendly, so the working experience was very good.
- Accommodations were very comfortable and relaxing.
- Tokyo has a fascinating and multifaceted culture and friendly people.
- Evidenced based knowledge are needed to achieve a high level of competence (Aspects of research)

Dr. Kasame Tungkasamesamran

Last day of training

Mrs. Nutchanat Viriyaprasit

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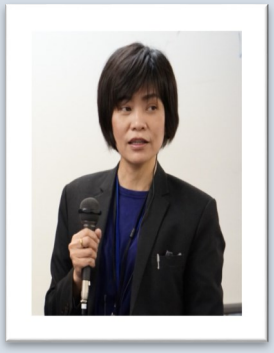


HOKKAIDO
Sapporo
Kushiro
Hakodate
Sea of Japan (East Sea)
Aomori
HONSHU
Akita
Morioka
Niigata
Shinano River
Sendai
Nagano
Fukushima
Nagoya
Mito
Japan
Kyoto
Mount Fuji
Tokyo
Hiroshima
Kobe
Fukuoka
Lake Biwa
Yokohama
Pacific Ocean
Osaka
Izu Archipelago
Nagasaki
Kochi
SHIKOKU
Miyazaki
300 mi
Kagoshima
KYUSHU
300 km
East China Sea
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