Summary report

"Thai Universal Health Coverage in Actions Course"

Contents

"Thai Universal Health Coverage in Actions"

A. Background

At least half the world's population still lacks access to essential health services. Some 800 million people spend more than 10 per cent of their household budget on health care, which is the threshold of catastrophic health expenditure that drives the households into financial difficulties, indebtedness or selling their assets to cover the medical bills. Almost 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses.

Member States adopted the Sustainable Development Goals (SDGs) to renew their commitment to promote the health and wellbeing of the population, underpinned by SDG target 3.8 for Universal Health Coverage (UHC) whereby all people and communities have access to needed quality health services without risk of financial hardship.

In view of UHC movement at global and regional levels, many countries in particular developing countries are struggling in translating global commitment on UHC into real actions. Thailand had achieved UHC since 2002. Along the journey of implementations, both success and failure lessons can be drawn and shared with other countries.

Thai UHC partners such as Ministry of Public Health, International Health Policy Program (IHPP), Health Intervention and Technology Assessment Program (HITAP), Thai Health Promotion Foundation, Hospital Accreditation Institute, and National Health Security Office (NHSO) organize a training workshop to share experience of Thai Universal Health Coverage under the training workshop "Thai Universal Health Coverage in action".

The training workshop aims at building capacity of countries with high political commitment to achieving UHC in order to apply Thailand's experience to real actions based on their context. Ultimately, the workshop also promotes South-South technical collaborations

B. Training workshop objectives

1. To share experience and lessons of Thai Universal Health Coverage in the real action.
2. To exchange experience of other countries on their movement towards UHC
3. To build up networking among participants and speakers

C. Expected outputs of the training workshop

1. The participants have an understanding on policy formulation, implementation and evaluation of Thai UHC and other countries' experiences on UHC.
2. According to participants' country context, the participants can apply Thailand's experience to develop/improve UHC implementation options based on their own country context.
3. Each participant would be developing networks with other participants and speakers

D. Date

19 – 30 August 2019

Course duration: 10 days

E. Venue

The training workshop will be organized at TK Palace Hotel, the National Health Security Office (NHSO), Sai noi district hospital and Wat Klong Kwang health center in rural area

F. Methods used during the training workshop

Several methods were applied to ensure that participants would gain maximum benefit from the workshop. These methods are:-

1. Presentation on each topic by Thai experts from several institutes.
2. Interactive discussion and exchange of experiences and perspectives by participants and speakers
3. Group work to discuss and brain storm on key issues: the way forward and plan
4. Field visit to see the real situation and implementation at district, and primary care levels
5. Essential materials for reading are provided to the participants
6. Experience sharing by each country: participants prepare a report about their country which focuses their health system development, health delivery system, health financing, health workforces, financial risk protection mechanisms and their national policy towards UHC

G. Focal points from Thailand

Name	Responsibility	Email
1. Ms. Wilailuk Wisasa	NHSO coordinator	wilailuk.w@nhso.go.th
2. Ms. Papitchaya Wattanakrai	NHSO supporter	papitchaya.w@nhso.go.th
3. Dr. Walaiporn Patcharanarumol	Course Manager	walaiporn@ihpp.thaigov.net
4. Dr. Warisa Panichkriangkrai	Technical coordinator	warisa@ihpp.thaigov.net
5. Ms. Parinda Seneerattanaprayul	IHPP coordinator	parinda@ihpp.thaigov.net
6. Ms. Waraporn Poungkantha	IHPP coordinator	waraporn@ihpp.thaigov.net

H. Overview of workshop program

The structure of this workshop is as follows;

Day 1	Day 2	Day 3	Day 4	Day 5
• UHC in Thailand • Thailand health systems • Country presentation	• UC scheme: governance, structure and functions • Expanding Population coverage ○ Beneficiaries enrolment ○ Consumer protection ○ CSO participation	• Expanding financial risk protection: Strategic purchasing ○ pooling revenue ○ budget formulation ○ fund allocation	• Strategic purchasing (Cont.) ○ payment methods • Audit systems ○ Quality audit ○ Medical audit	• Expanding services ○ Development process ○ Benefit package

Day 6	Day 7	Day 8	Day 9	Day 10
• Study visit: District health system ○ District hospital ○ Health center	• Monitoring UHC ○ Data platforms ○ Feedback loop • Quality accreditation	• Health services in Bangkok ○ Service provision: involvement of private providers ○ Fund management ○ Monitoring system	• Health promotion ○ ThaiHealth: Innovative financing ○ NHSO community matching fund • National Health Assembly	• Wrap up • Ways forward

I. Summary of Thai Universal Health Coverage in Actions course

Day 1 Monday 19 August 2019 at TK Palace Hotel

Time	Content	
0900-0915	• Welcome remarks and opening remark. • Briefing objectives of this training workshop	TICA MOPH NHSO NHSO & IHPP
0915-1015	**Session 1** Achieving of Universal health coverage and sustainable health development by 2030	**Dr. *Warisa* Panichkriangkrai** Researcher, IHPP
1015-1030	**Coffee break**	
1030-1200	**Session 2** Overview of Thailand's health system development and UHC • Two strands of development as solid foundation of Thai health systems	**Dr. *Warisa* Panichkriangkrai** Researcher, IHPP **Dr.*Weerasak* Putthasri**. Senior Researcher, IHPP
1200-1300	Lunch	
1300-1530	**Session 3 Country presentation** • each country: participants prepare a presentation about their country which focuses their health system development, health delivery system, health financing, health workforces, financial risk protection mechanisms and their national policy towards UHC (10 minutes/country)	***Dr. Viroj* Tangcharoensathien**, Secretary General, *IHPP* Foundation
1530-1545	Coffee break	
1545-1630	Workshop assignment	NHSO & IHPP
1630-1700	Summary and discussion	NHSO & IHPP

- **<u>Opening Remarks by Dr Jadej Thammatacharee, NHSO Deputy Secretary</u>**
    - Dr Jadej outlines the global push to translate the UHC rhetoric in reality. However, *"there is no blueprint to follow; each country must develop their path [to UHC] depending on their existing systems and structures."*

- **Session 1 – Sustainable Development Goals, Universal Health Coverage and Health Systems**

    - WHO defines Universal Health Coverage as "**all people** receive **health services** they need **without suffering financial hardship when paying for them**."
    - Over the years, countries have come together and endorsed the 'health for all' agenda which evolved into the millennium development goals (MDGs) and finally into the Sustainable Development Goals (SDGs)

Sustainable Development Goals

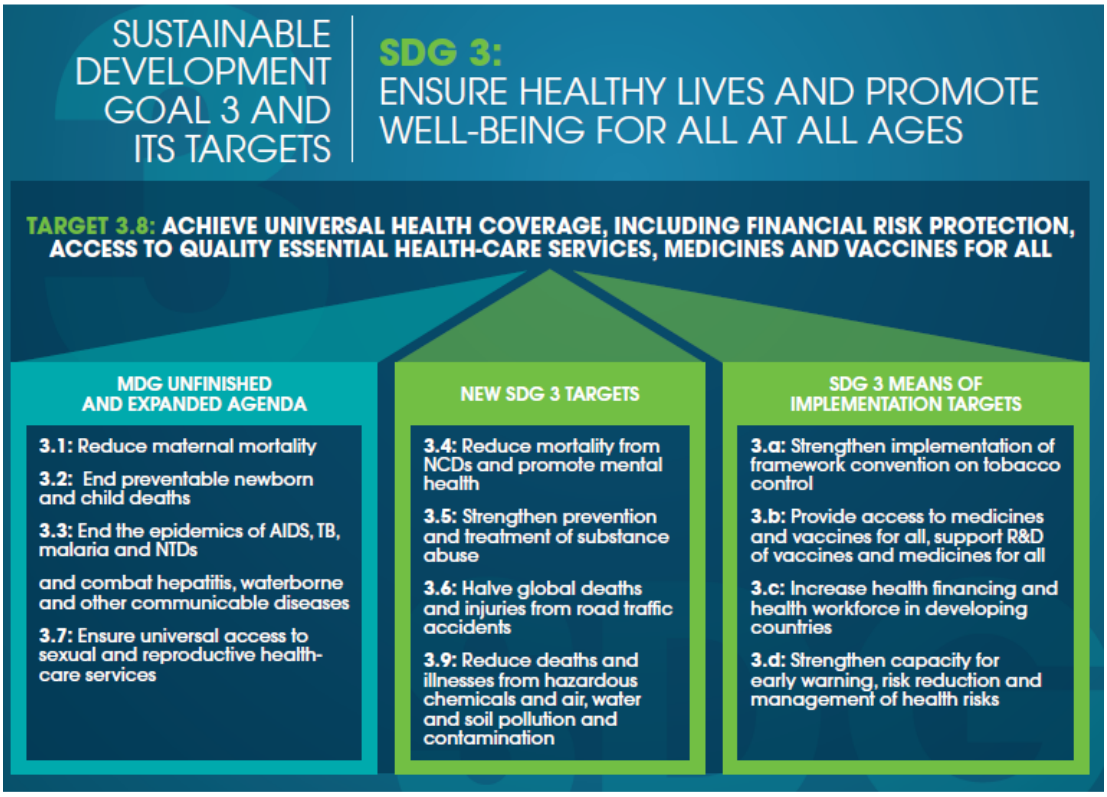
    - Health in the SDG era is enveloped in SDG 3 (good health and wellbeing for all ages). More specifically, SDG 3.8 translates to providing Universal Health Coverage.

- **Target 3.8** achieving universal health coverage (UHC), including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

- **Indicators**

  3.8.1 on coverage of essential health services

  3.8.2 on the proportion of a country's population with catastrophic spending on health

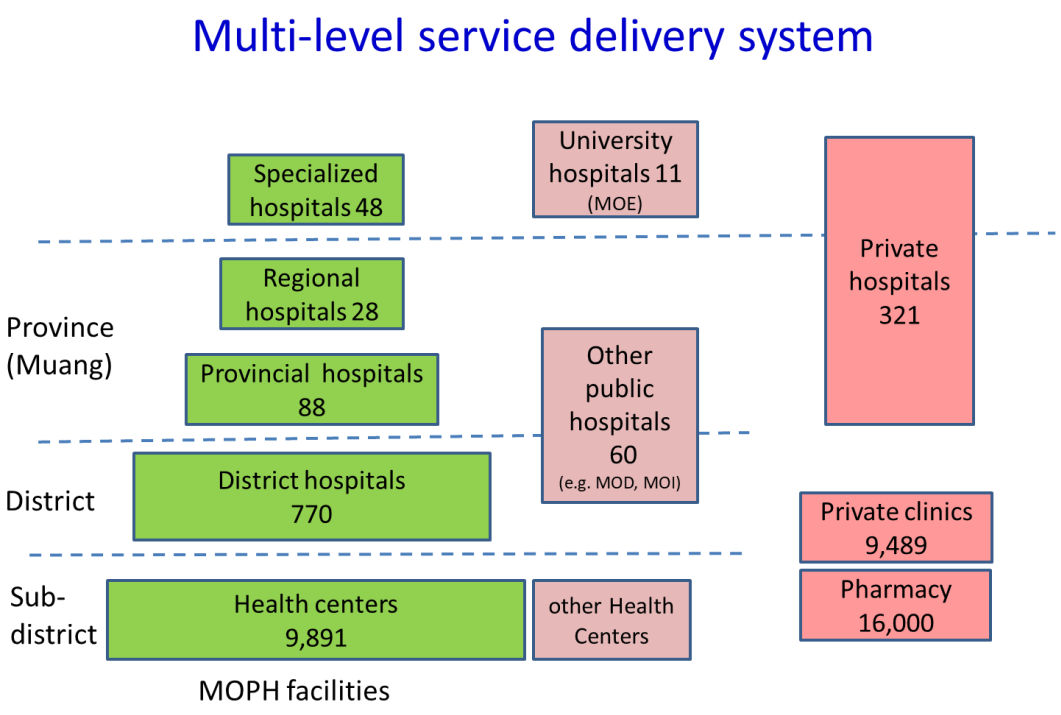


SDG3 and targets

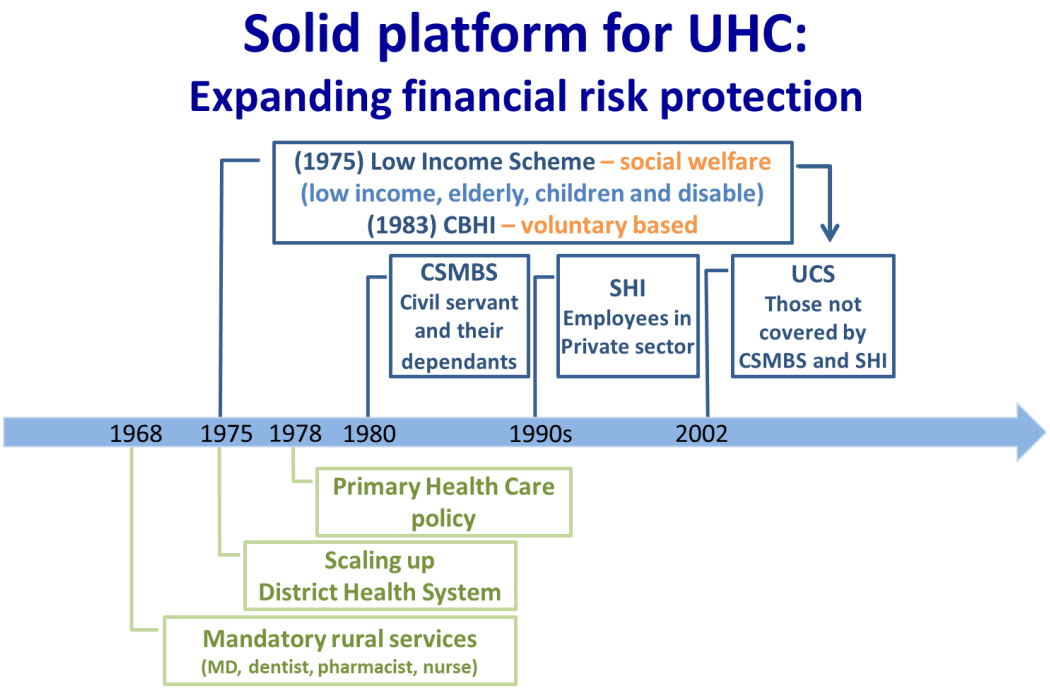
- Health system is foundation in achieving UHC which is heart of SDGs

Source: adapted from Kieny et al., 2017 WHO Bulletin *(13)*.

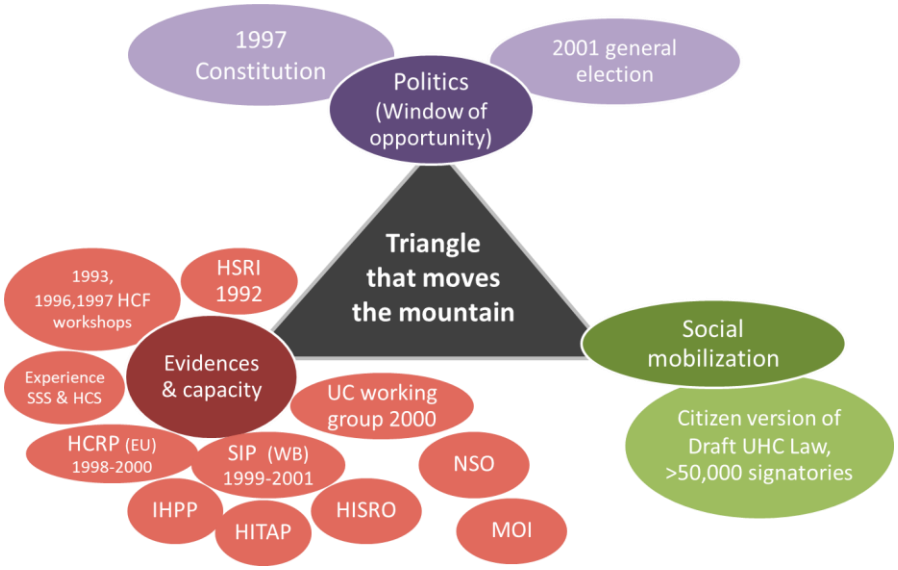
- **Session 2 – Health Systems in Thailand**
    - Thailand has 77 provinces, 878 districts, 7,256 sub-districts and 75,032 villages
    - Two main strands of development:
        1. Infrastructure development: Ensure equitable access to health facilities and equitable distribution of the health workforce.
        2. Expanding financial risk protection: by increasing coverage and expanding benefits package. Other details are in the slides, but key features are:
            - Rural health incentive programme – to incentivise newly qualified doctors to work in hospitals in rural regions.
            - The provinces in Thailand are arranged into different health districts based on regions
            - Health Centers (primary health facility) – only have a nurse and a public health officer – no doctor.
            - Government hospitals dominate in Thailand (more public hospitals than private hospitals in Thailand).



- UHC did not just start in 2002; there was a long history of laying the foundation for UHC in Thailand, e.g. In 1975 created the low-income scheme, for people on a low income, elderly, children and disabled.



- The triangle that moves the mountain
  - One: (politics/window of opportunity),
  - Two: (evidence and capacity),
  - Three: (social mobilisation).
  - Based on " Triangle that moves the mountain" model, UHC movement was greatly supported by the civil society groups.
  - UHC was an evidence-based policy option proposed by technocrats to politicians to demonstrate the feasibility



- Three public health insurance schemes: Civil Servant Medical Benefit Scheme, Social Health Insurance (SHI) and UHC scheme

99% of 69 million population			
	Civil Servant Medical Benefit Scheme (CSMBS)	**Social health insurance (SHI)**	**Universal Coverage Scheme (UCS)**
REGISTRATION	Royal Decree 1980	Act 1990	Act 2002
COVERAGE	6 mln pop	11 mln pop	51 mln pop
ORGANIZATION MNAGEMENT	Comptroller General Department, MOF	Social Security Office, MOL	NHSO (public independent body)
SOURCE OF FINANCE	Tax funded	Tripartite contribution	Tax funded
	Open ended budget	Close ended budget	Close ended budget
PAYMENT METHOD	Fee-for-service, DRG	Capitation, DRG	Capitation, Global budget and DRG, fee schedule etc.
PROVIDERS	Mainly public providers	Mainly contracted private providers	Mainly contracted public providers

- UCS used the gatekeeper scheme – one health centre allocated and one hospital allocated, cut down travel costs for a beneficiary but also prevent hospitals from overcrowding.

- Key success factors:
  - Relocated budget from primary health care development, rural development instead of tertiary care.
  - Health workforce – incentives to distribute and retain health workers (financial and non-financial).
  - Challenges remain in Thailand despite achieving UHC E.g. ageing population, epidemiological transition and an NCD burden

- **Discussion**
  - Q) Not many countries in the world have migrant health insurance apart from Thailand. Managing financial risk protection for them provides a challenge for many countries. What are some challenges faced in Thailand?
  - A) The perceptions, attitudes and practices of practitioners in the provision of healthcare services for migrants were mainly influenced by: (1) diverse cultural beliefs and language differences, (2) limited institutional capacity, in terms of time and/or resource constraints, (3) the contradiction between professional ethics and laws that limited migrants' right to health care. Nevertheless, healthcare providers addressed such problems by partially ignoring the immigrants 'precarious legal status, and using numerous tactics, including seeking help from civil society groups, to support their clinical practice.

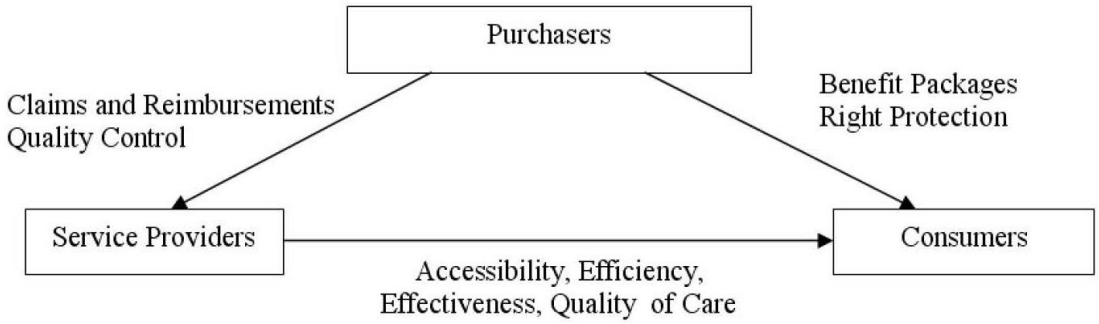
  - Q) Why was the 30 bhat scheme abolished?
  - A) 30 baht per admission (even if heart surgery). Cost of collecting the 30 baht much higher (e.g. cost of one accountant staff) than would be the cost to have no 30 baht collection. As the scheme didn't make financial sense, it was abolished.

  - Q)How is the private sector regulated?
  - A) In terms of managing the private sector, using financial incentives is more powerful than regulatory control (this does not work for the private sector because of a lack of capacity) — no quick-fix answers.

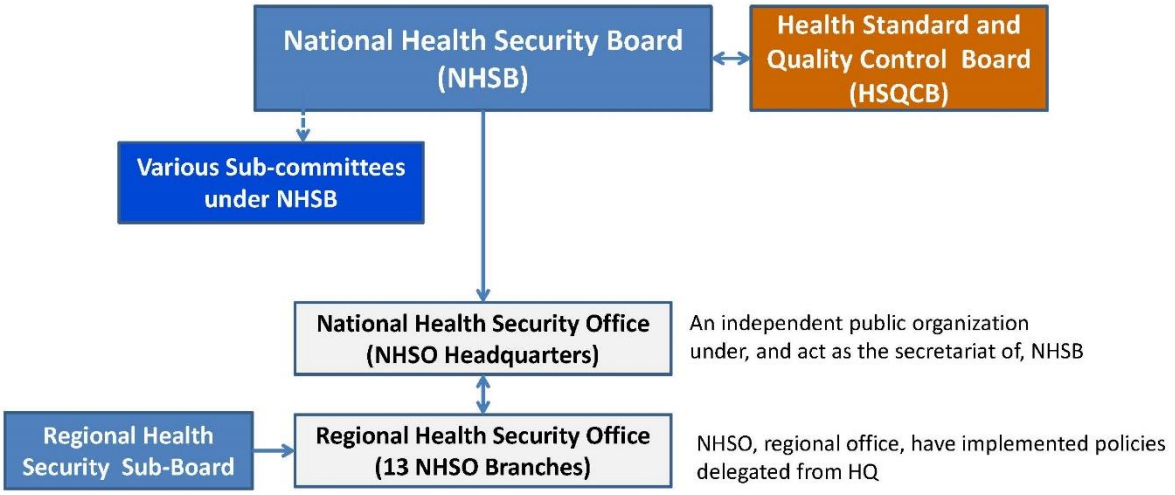
Day 2 Tuesday 20 August 2019 at National Health Security Office (NHSO)

Time	Content	
0815	Leave from TK Palace hotel to NHSO	
0900-0915	Welcome remark	
0915-0930	VDO presentation "Welcome to NHSO" and "Thai UHC"	
0930-1200	**Session 4 Governance of the UC Scheme: translating legislation into practice** • National Health Security Act B.E. 2545 (A.D. 2002), process in developing the Act • Introduction of UC Scheme • Governance structure, roles and functions of NHSO in managing UC Scheme • Core Business of NHSO	**Ms. Wilailuk Wisasa** Beau of International Affairs on Universal Health Coverage, NHSO
1200-1300	Lunch	
1300-1400	**Session 5 Expanding population coverage** • Right of people to access to health services • Beneficiaries enrollment using national citizen individual identification system • Data sharing on beneficiaries across schemes	**Col. Panomwan bunyamanop** Deputy Senior Director, Fund Management Cluster and Director, Bureau of Registration, NHSO
1400-1415	**Coffee break**	
1415–1530	**Session 6 Consumer Service and Consumer protection** • Consumer Service • Call Center 1330 NHSO call center tour	**Mrs. Doungnapa Pichetkul** Director, Bureau of Consumer Service and Right Protections.
1530-1600	• Summary and discussion	NHSO & IHPP
1715	Leave from NSHO to Songfangklong restaurant	

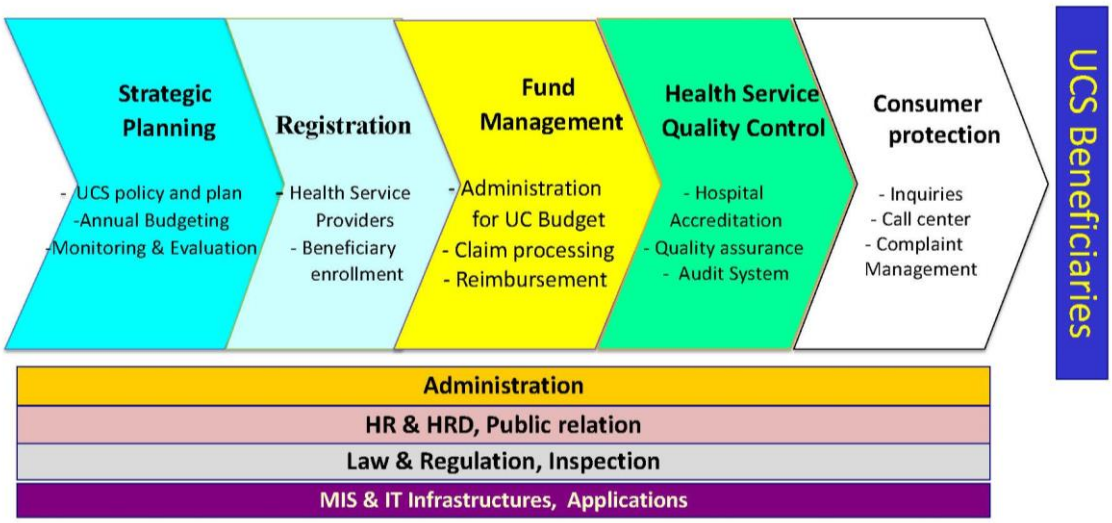
- **Session 4 – Goverenance of the UC Scheme: translating legislation into practice**
    - The National Health Seurity Act (NHS Act) was legislated and promulgated in 2002. It is the main legislative measure for implementing UCS in Thailand. The Act clearly addressed in section 5 that the Thai population shall be entitiled to health services with such standards and efficiency. The Act indicates establishment of two national committee: National Health Security Committee and Standard and Quality Control Committee, the National Health Security Fund and the National Health Security Office. From the Act, the National Health Security Office is the main agency to manage the the National Health Security Fund.
    - The concept of purchaser-provider split is adopted to make clear roles of each function;
        - Purchaser (NHSO) reimburses healthcare cost based on agreement to service providers and prepare benefit packer and right protection for consumers.
        - Providers (both contracted public and private hospitals) apply for reimbursement of healthcare cost and deliver effient and effective healthcare.



    - Multi-stakeholders' engagement has been promoted through governing bodies which stipulated in the Act including National Health Security Board (NHSB) and Health Standard and Quality Control Board (HSQCB). The National Health Security Board (NHSB) is chaired by Minister of Public Health. There are representatives from various sectors, including government sectors, non-profit private organization, and technical experts. The Health Standard and Quality Control Board consists of multi-stakeholders and chaired by an elected member. Its main tasks are setting and producing guildlines to ensure standard for health facilities and service quality. Lingkage between these boards and NHSO are ellustrated by figure below.



- Core business for UCS in NHSO outlined in figure below



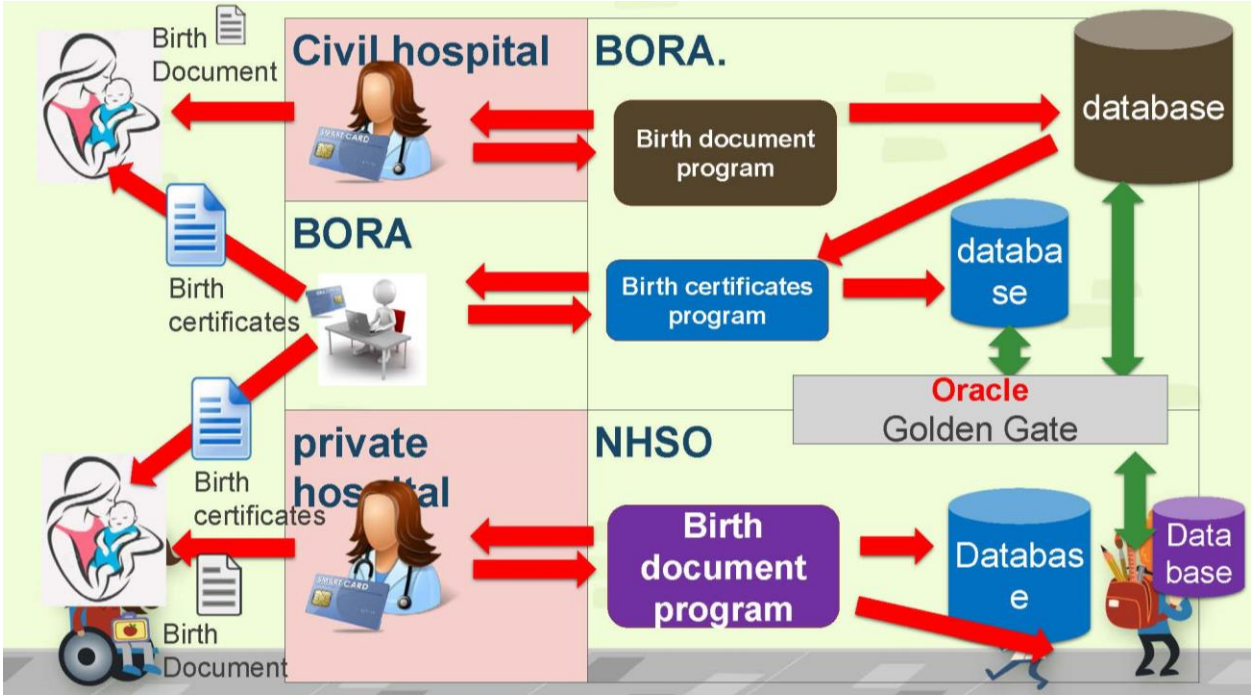
Discussion

- What's the different role of MOPH and NHSO on quality assurance?
- How the budgeting set up for different population group?
- There are gaps for satatisfactory between members of UCs and providers? And what 's the reason of peak in 2010?

Session 5 – Expanding population coverage

- To achieve the 2nd core business for UCS in NHSO, it is addressed in 3 goals that shall be accomplished: coverage, sustainable finance, and good governance. The presentation is mainly covered the population coverage. In 2018, there was 99.94 percent coverage by 3 main schemes, including CSMBS, SSS and UCS. The presentation provides how the Thai citizens registered to the health services and how to improve the population coverage. To improve populaiton coverage, it requires population database, status of health benefits of benefitceries and collaboration with other related government agencies who manage the information as outlined below
- Population database
  - The Bureau of Registration Administration (BORA), MOI
  - Department of Provincial Adminitration (DOPA), MOI
- Thai citizens who live aboard
  - Department of Consular Affairs, MOFA
- Health benefit status
  - The Comptroller General's Department (CGD), MOF
  - The Social Security Office (SSO), MOL
  - Department of Local Administration (DLA), MOI
  - Other small group of state agencies
  - Beneficiaries enrollment using national citizen indentification system and unique ID card (smart card) contains 13 digits which represent areas of living and status of Thai and non-Thai.

- All new born Thai will automatically have the UCS such the flow chart below, comparing how database shared between NHSO and civil and private hospitals



- After improving quality of registration data by integrating or link data with other governmental organization, the duplicated data was decreased to 0.003 percent in 2005.
- The data is centralized at NHSO from different governmental sectors, including Civil Servant Medical Services Scheme, Social Security Office, Ministry of Public Health, the Bureau of Registration Administration and other state agencies

- **Discussion**
  - How to identify poor person?
  - Who control the process for information systems?
  - How could NHSO deal with death persons? Still keep with capitation
  - For management, how does NHSO manage data,outsource or inhouse?

Session 6 – Consumer service and protection

- NHSO's consumer service and protection is operated to promote awareness and understanding of consumers' rights and duties, to ensure the accessibility of health services, to oversight standard and quality, to facilitate complaints,and to compensate for patients with adverse event from medical intervention.
- There are various channels for benefitciaries and health care providers to provide their complaint and asking questions for clarifications related to health care services, including NHSO call center 1330 (92.00%), NHSO regional branches

(2.89%), provincial health offices (1.08%), independent offices (2.17%) and UC service center within hospitals (1.84%).

- For NHSO call center 1330, there are control systems to ensure service quality. For example, NHSO provides standard of script, staff training, coaching and monitoring, and evaluating supervisors and call agents.
- Complaints that were received from consumers, some cases that cannot be solved by call agents, it will issue to the Consumer Protection Committee and later will refer to the Health Standard and Qaulity Control Board if cases cannot be solved that earlier stage.

- **Discussion**
  - Consumer protection, how to educate public to know their right?

Day 3 Wednesday 21 August 2019 at TK Palace Hotel

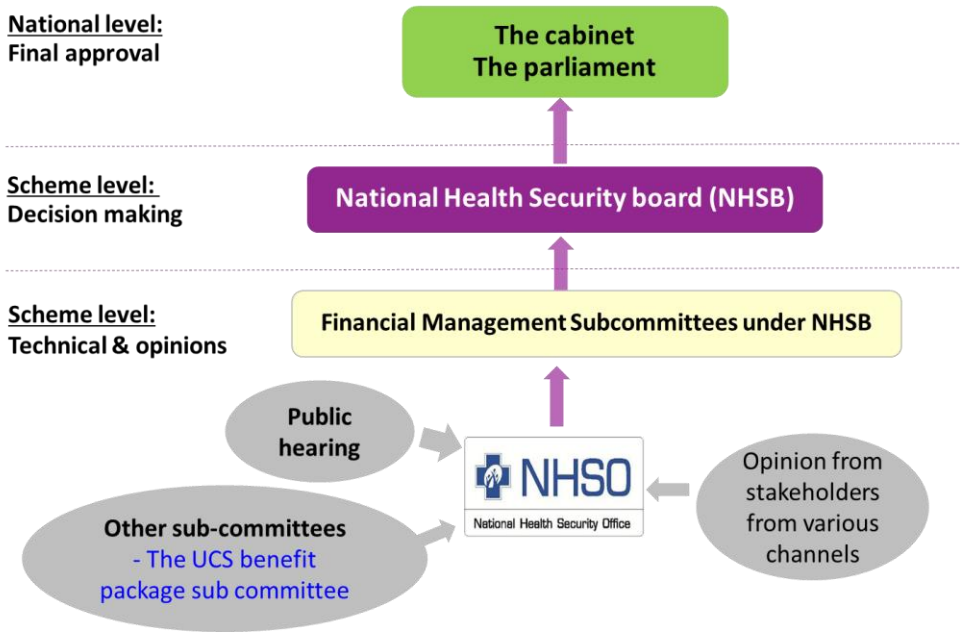
Time	Content	
0900-1200	**Session 8 Expand financial risk protection (Budgeting)** • Pooling revenue • Budget formulation	**Dr. Nantawan Kesthom (Keawpoonsri)** Manager, Bureau of Planning and Budget Administration, NHSO
1200-1300	Lunch	
1300-1500	**Session 9 Expand financial risk protection (financial Design)** • Fund allocation • How to design, enforce and monitor contractual agreement by organization	**Ms. Kanchana Srichomphu,** Manger, Bureau of Planning and Budget Administration, NHSO
1500-1515	Coffee break	
1515-1630	Experience sharing: Resource mobilization and Pooling revenue	Selected countries
1630-1700	Summary and discussion	NHSO & IHPP

- **Session 8 – Expanding financial risk protection & budget formulation**
    - Why is financial risk protection important and how it affects UHC?
        - Financial risk protection implies security from incurring catastrophic costs in case an insured event occurs.
        - A good health financing system raises adequate funds for health, in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them.
        - Impoverishment and catastrophic health expenditure are two indicators of financial risk protection.
    - Health financing functions and objectives

Function	Objectives
Revenue collection (where: domestic sources or donors; what: taxes, health insurance schemes, out of pocket payment, and other mechanisms; Who: the government or public agencies or directly by providers)	Raise **sufficient** and **sustainable** revenues efficiently and equitably to provide basic health services
Pooling (The practice of bringing several risks together for insurance purpose to balance the consequence of the realisation of each risk)	Manage these revenues to **equitably** and **efficiently** create **insurance** pools.
Purchasing or paying for health	Assure the purchase of health services in an **allocative** and **technically efficient** manner

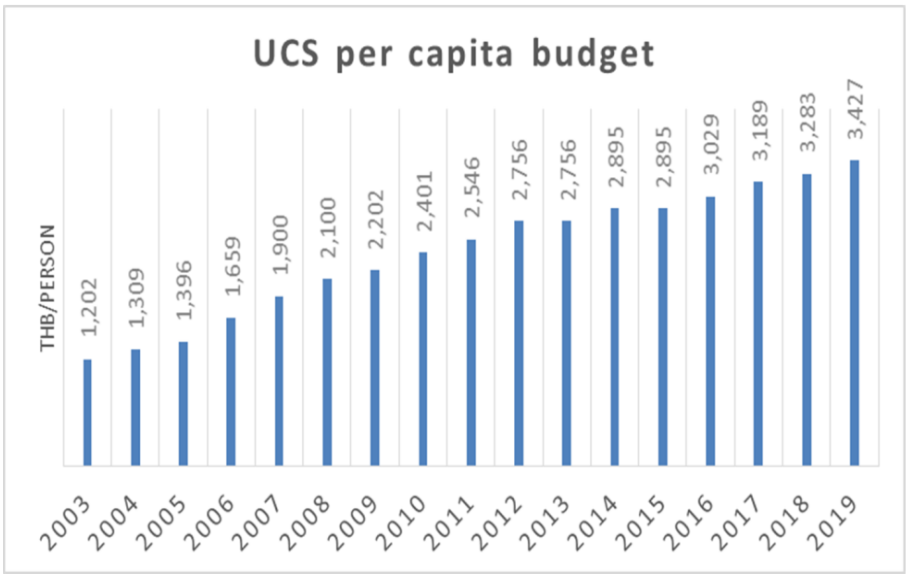
    - Other important considerations
        - The financing systems need to be specifically designed to provide all people with access to health services that are needed (including prevention, promotion, treatment, and rehabilitation)
        - Ensure that the use of these services does not expose the user to financial hardship
        - From the six building blocks of a health system: A good health financing system raises adequate funds for health in ways to ensure people can use needed services and are protected from catastrophic financial impoverishment associated with having to pay for them.

        - Monitoring SDG indicators on UHC,
            - Target 3.8.1: coverage of essential services
            - Target 3.8.2, monitoring financial risk protection and catastrophic spending on health.
    - Questions to ask: What is the source of the fund? How is the fund collected? And Who collects the fund?
    - Thailand's experience:
        - Three health insurance schemes, provide social security in Thailand UCS, CSMBS, and SSS
        - The tax generated from the population covers the three schemes.
        - Budget approval process:
            - 3 level
            - National level: final approval, the cabinet and the parliament
            - Scheme level: decision making, NHSB National health security board. Minister of Public health is the chair, permanent secretary of government ministries, experts from the fields, local government.
            - Scheme level: Technical and opinions, Financial management subcommittees under the NHSB.
            - NHSO as a technical team gathers opinions from hosts public hearings, other subcommittees (The UCS benefit package subcommittee), and from stakeholders from various channels
            - Opinions are sent to the financial management subcommittees under NHSB



- UCS budgeting:
  - Over the years from 2003 to 2019 the per capita UCS budget increased from 1,202 to 3,427 baht over 2003-2019
  - Additional benefits package especially high-cost care/interventions
  - Increasing of utilisation rate
  - Increasing of medical, labour inflation (6% per annum)

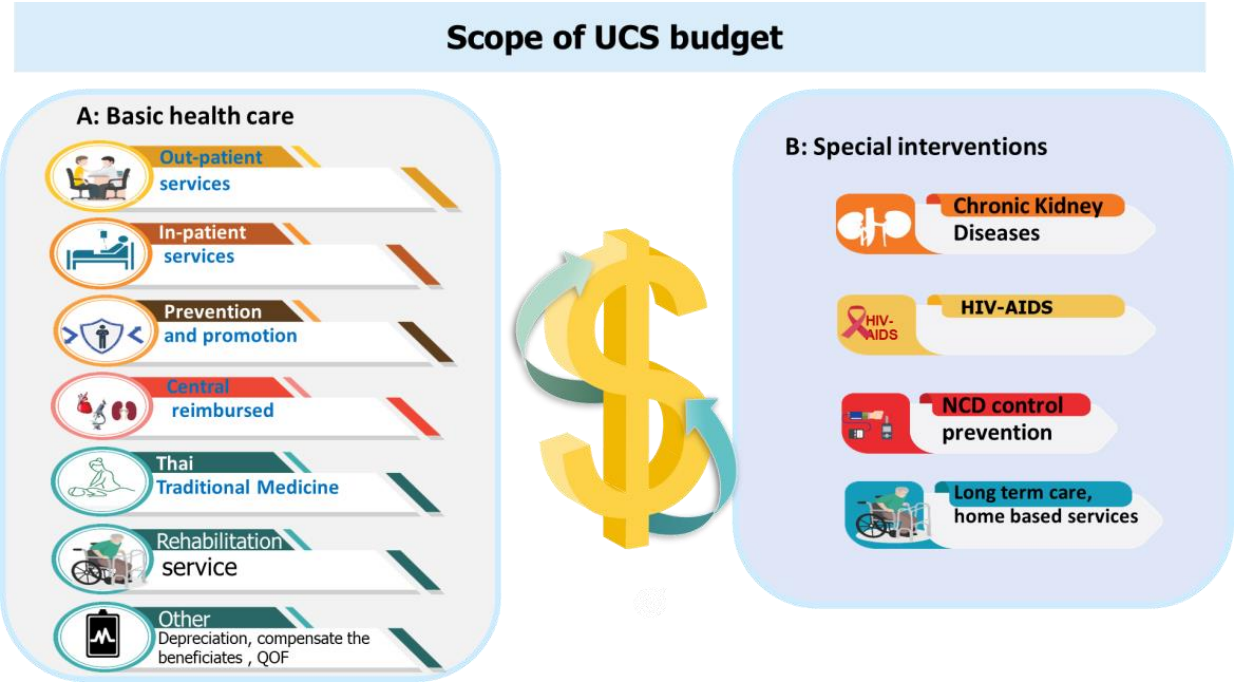
Per capita UCS budget, current price, 2003-2019, THB/capita



Factors of increases

- Additional benefit package especially high cost care/ interventions
- Increasing of utilization rate
- Increasing of medical, labor inflation (6% per annum)

- Scope of the UCS budget:
  - A. basic health care (outpatient services, inpatient services, prevention and promotion, central reimbursement, Thai traditional medicine, rehabilitation services, and others)
  - B. special interventions (chronic kidney diseases, HIV/Aids, NCD control and prevention, Long term care and home-based services)



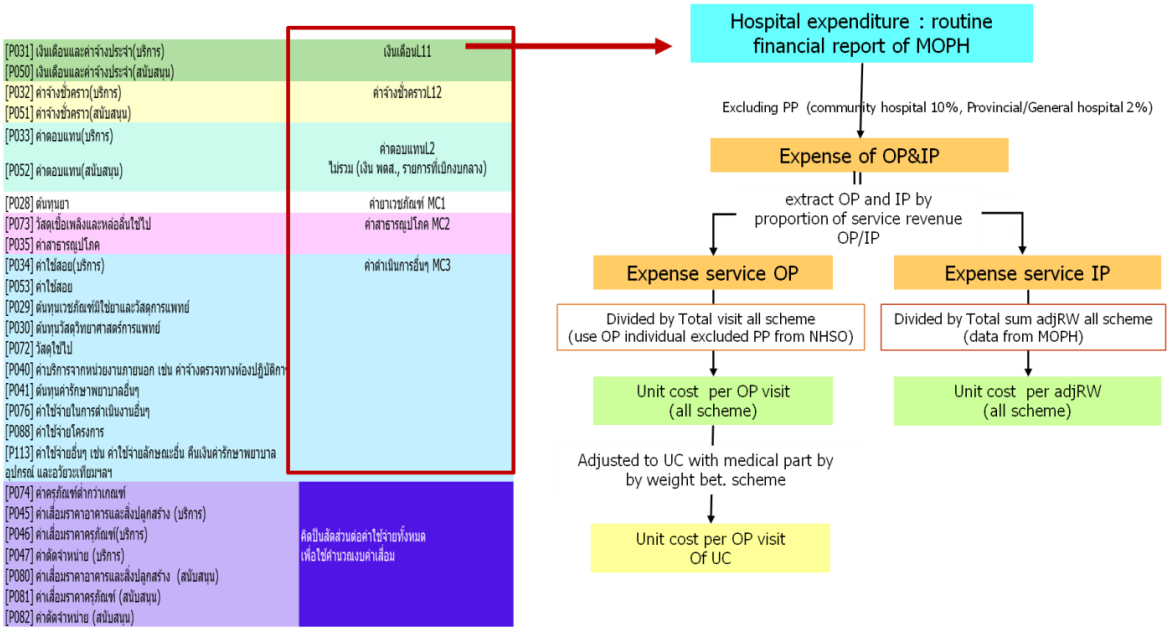
- The budget formulation for UC Scheme
  - Method 1: Price and quantity approach, PQ (price times quantity) Unit cost times use rate
  - Capitation (3,426 baht/capita) + specific intervention (311 baht/capita)
    - Item A, basic health care services 91%
    - Item B, specific/specialised interventions 9%
  - Method 2: activity-based (ABC) for health promotion and primary prevention
- UCS has a closed-end annual budget, the three factors that affect the budget: the price, quantity, and other
- Item A: basic health care services, budget per capita
  - Price: unit cost, inflation rate, medicine and vaccine price,
  - Quantity: service utilisation, coverage of prevention and promotion
  - Other: new benefits, and increasing leapfrog access

- For item B: specific intervention,
  - Price: unit cost and fee schedule
  - Quantity: prevalence and incidence
  - Other: new benefits, and increasing leapfrog access

Iten	methodology	calculation
1. Capitation budget		
1.1 Outpatient service (OP)	PQ approach	OP Utilization rate*POP*Unit cost per visit [by provider level]
1.2 Inpatient service (IP)	PQ approach	IP Utilization rate*POP*adjRW*Unit cost per adjRW [by provider level]
1.3 Central reimbursement	PQ approach	▪ Target volume*Unit cost per protocol
1.4 Health Prevention & promotion (P&P)	ABC	Standard activity*Standard Unit cost
1.5 Rehabilitation service (include disability)	PQ approach	▪ Target volume*Unit cost per service type
1.6 TTM service	PQ approach	Target volume*Unit cost per service type
1.7 compensate the beneficiates and provider who damage or injury caused by any service	PQ approach	Target volume*Unit cost per type
1.8 Quality performance base pay		% of OP+IP+&PP (by policy decision)
2. Special target group budget		
2.1 HIV&AIDS	PQ approach	▪Target volume*Unit cost per service type
2.2 Chronic renal failure		
2.3 Control chronic disease e.g.DM HT, chronic psychiatric		
2.4 Long term care service		

- General principle:
  - Per capita budget of the UCS is calculated based on:
    - The volume of services used by the type of service (OP, IP) and facility (health centre, district hospital, provincial hospital, another public hospital, university hospital, private hospital
    - The unit cost of services provided by the type of service and facility
    - Projection of increase in service utilisation and cost (inflation of labour cost and material cost)
  - Data availability:
    - Administrative database (OP and IP individual electronic records)
    - Hospital financial reports
    - Beneficiary registration database

Calculation unit cost per OP visit / per adjRW UC



- Policy direction:
  - Increase accessibility, the standard protocol of health services, new benefit package
- Data used in budgeting:
  - Population- Individual registration from NHSO
  - Utilisation OP- survey, Individual record from NHSO
  - Utilisation IP- survey, Individual records,
  - Prevention and promotion- Research data (cost), individual, reports
  - Central reimbursement- Individual record
  - Disease management- Individual data

- Q) Who consolidates this data on a daily base?
- A) NHSO, data set for services for OP and IP. Routine reporting for payments. The information comes from reimbursements, and the hospitals provide information on what services are provided. The hospitals provide every day if needed. Each patients chart has the details of the charge, the number of medicines, the laboratory, labour, unit cost of medicine.

- **Estimation of Prevention & Promotion (P&P) budget:**
    - New benefits: vaccines like rotavirus, pilot screening of down syndrome in pregnancy age <35 years
    - Quantity: calculated for all Thai people, this is unique as it covers everyone. Primary prevention for personal and family. Defined scope of benefits package by five age group
    - Quantity of service-coverage by activities requires the frequency.
    - Price Unit Cost: for 2020, the three main elements of PP budgeting:
        - Vaccine, P&P payment by the fee schedule, and activities by the core benefit package
        - Direct costs: vaccine, unit cost from technical papers of HITAP and other local studies, and expert opinion and committee from many branches department MoPH
        - Unit costs are adjusted by the cost inflation rate
        - Indirect costs are 30% of the direct costs
        - For new benefits, like rotavirus vaccine or pilot screening for women less than 35 years, we have developed a budget to estimate the costs.

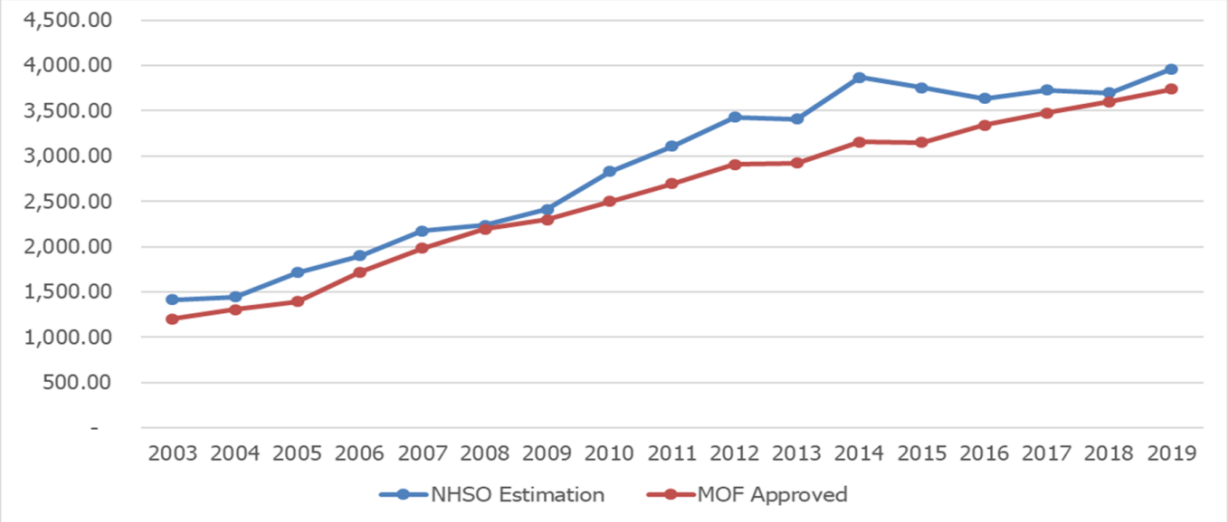
- The benefits package for P&P includes vaccination, services for pregnancy.
- The steps for estimation: the unit cost of direct and indirect (30% of DC) → frequency of activities → coverage → calculation P&P budget for all Thai people→ P&P per UC population
- Challenges:
  - There is no one size fits all approach
  - Budget constraint vs increasing demand for new interventions and technologies
  - Three insurance schemes applied a similar benefits package but paid the providers differently. Therefore cost containment needs to be applied to all three schemes.

- **Discussion**
  - Q) Regarding estimation for the unit cost for different costs in the health facility, who sets the cost for the unit so that the facilities don't have a different cost for the same services?
  - A) Comes from labour cost, medical cost, we use the hospital expenditure depending on the level of the hospital. Use average. The hospital can charge additional than the unit cost no more than 5%. Have a standard price from MoF, and hospital follows the set pricing.

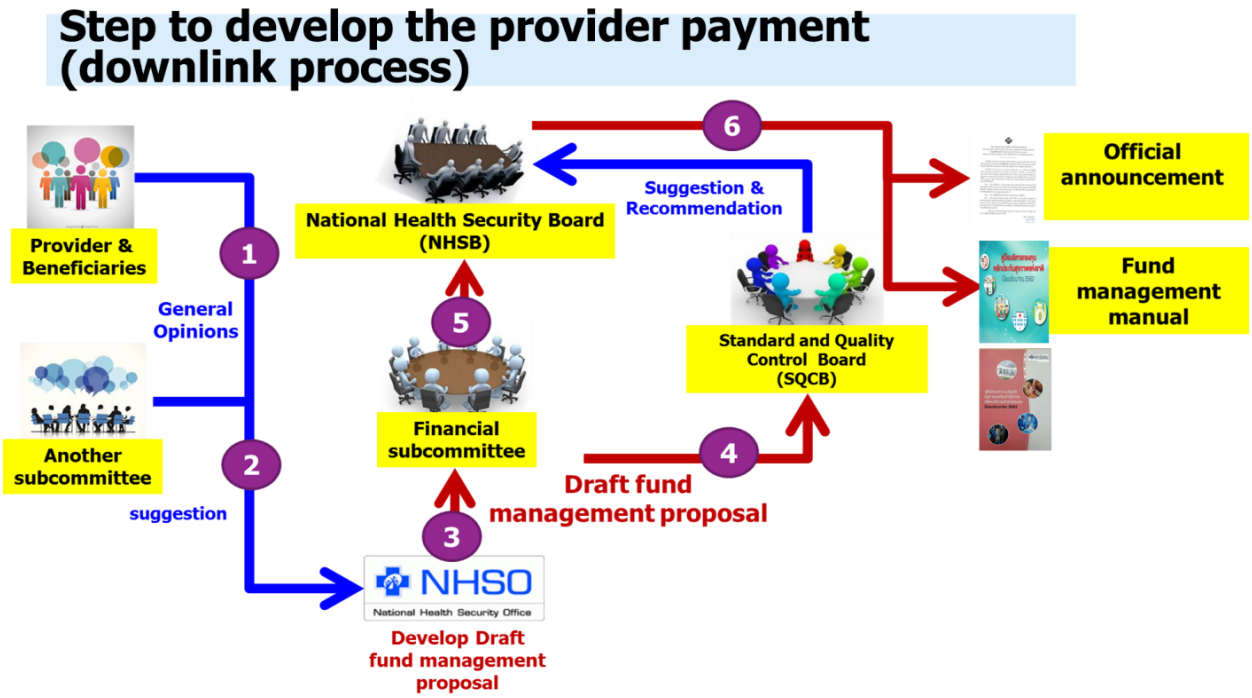
  - Q) At what level are these calculations done? At MOH? Alternatively, at NHSO?
  - A) The bureau works with working groups to show the evidence and subcommittees develop the costs.

    Q) When calculating labour costs, does it include professional fees (doctors charges?) or is it only salaries, for now, we use the hospital expenditure that includes salary?
  - A) Thailand doesn't use professional fees. Costs for each activity guidelines from WHO and Thai standards, identify the benefits package for P&P and then use the WHO guide for each activity

- **Session 9: Expand financial risk protection**
    - Three schemes in Thailand have different payment methods
        - CSMBS = FFS for OP; DRG for IP; FS add on high cost on the instrument and drug list
        - SHI in SSS = Capitation for OP and IP; DRGs for complicated IP
        - UCS = Capitation for OP & PP; DRGs with the global budget for IP
    - The budget approved by the Cabinet is lower that budget estimated by NHSO

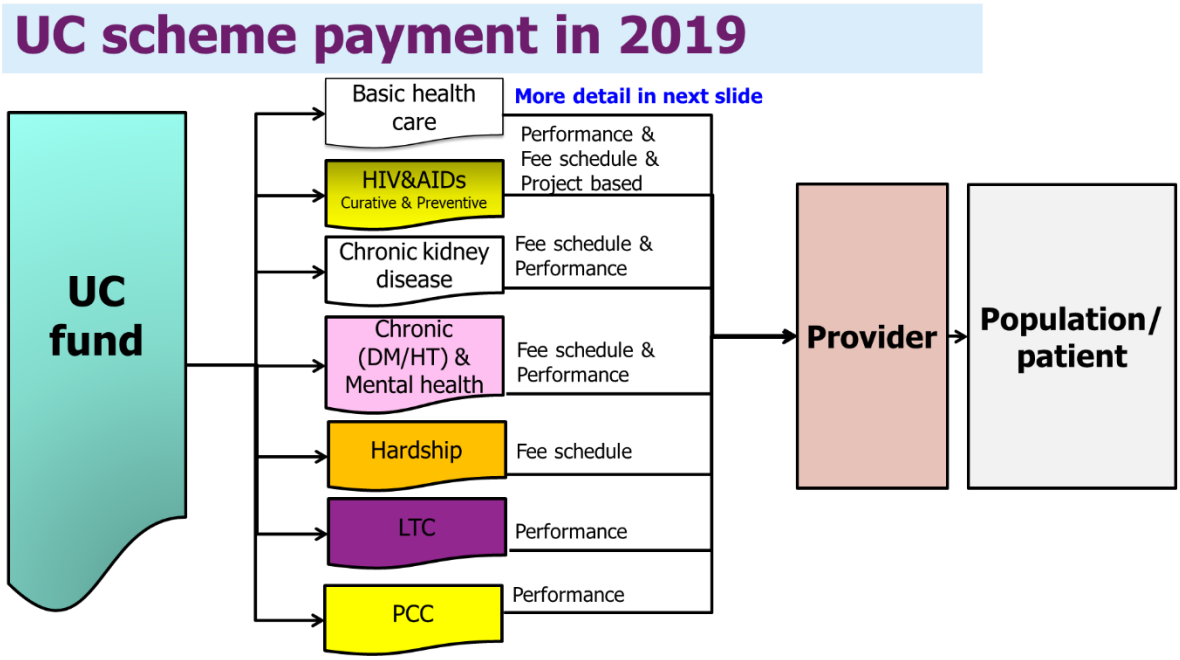


    - Step to develop the provider payment Downlink process: engage with healthcare providers
        - 1-provider and beneficiaries (general opinions)
        - 2-another subcommittee (suggestions)
        - 3-NHSO (develop draft fund management proposal)
        - 4-NHSO and financial subcommittee (develop fund management proposal, sent to standard and quality control board (SQCB))
        - 5-Financial subcommittee connect with the National Health Security Board (NHSB)
        - 6-The SQCB sends suggestions and recommendations to the NHSB

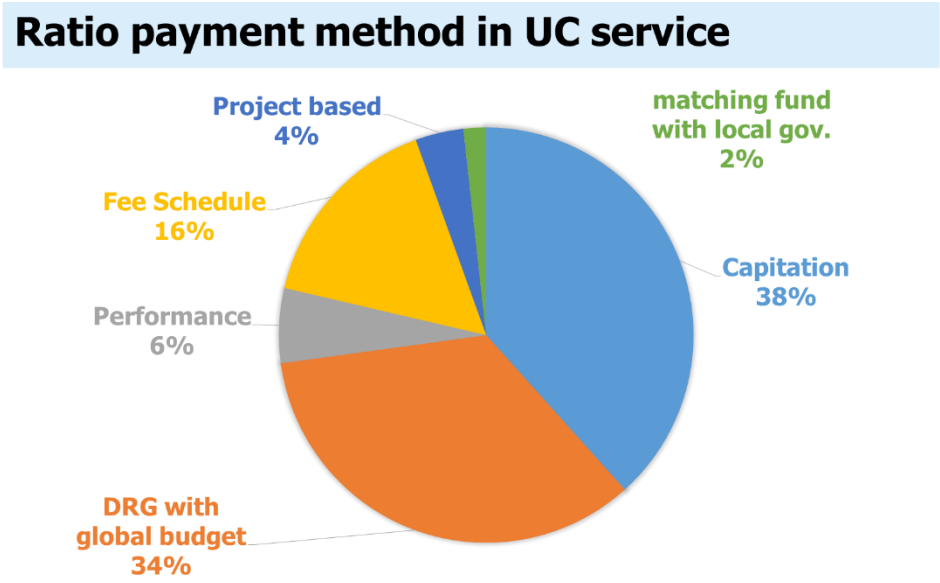


- Final outputs: official announcement and fund management manual
- Provider payment history of UCS:
  - Transition phase: early phase 2001-2 types inclusive and exclusive at CUP level
  - 2002: exclusive for public CUP at a provincial level, inclusive for private CUP
  - 2003 onwards, exclusive nation-wide: OP capitation, P&P capitation + performance-based, IP global budget + case base payment DRG, fee schedules payment for certain services
  - Seven service groups paid by NHSO to provide healthcare services, the main payment is fee schedule and performance
  - Payment of the nine types of basic healthcare services have many payment methods:
    - Outpatient: capitation and performance and project-based
    - Inpatient: DRG with global budget and performance
    - Central reimbursement: fee schedule
    - Health promotion and health prevention: capitation, fee schedule, performance, project-based, matching fund with local government
    - Rehabilitation: fee schedule, matching fun with local government
    - Thai traditional health service: fee schedule with a global budget
    - Investment budget: project of the investment plan
    - No-fault liability for health personal and patient: fee schedule

- Quality service: performance



- The ratio of UC budget in 2019, the highest % of spending was too basic services
- The ratio of payment method in UC Services: 3 main methods--Capitation, DRG, and fee for schedule



Payment Method	Main Advantages	Main Disadvantages
DRG with Global Budget	- Predictable expenses for fund holder, low administrative costs - Unified budget permits resources to be used efficiently	- No direct incentives for efficiency - Provider may under-provide services
Capitation	- Predictable expenses for the fund holder - Provider has incentive to operate efficiently - Eliminates supplier-induced demand	- Financial risk may bankrupt provider. Provider may seek to minimize risk by "cream skimming" - enrolling low-risk patients - Provider may under-provide services
Fee for Service with Fixed Fee Schedules	- Incentives to operate efficiently - Efficiency is greatly enhanced when combined with a global budget capitation	- Cost escalating: incentives for supplier-induced demand - Higher administrative costs (price controls must be established, revised periodically and enforced)

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- Central reimbursement (CR) program:
  - The concept and criteria used to set the list id CR item
  - Concept:
    - 1. Exclude the budget from capitation in OP service or DRG in IP service to pay by Fee schedule and move to manage the budget in centralised
    - 2. ensure it doesn't affect the quality of care, access to care, the financial burden in hospital, equity, effectiveness and efficiency management
  - Criteria for decision:
    - Risk pooling to ensure the patient can access quality services such as high cots services or for rare diseases
    - The efficiency of resource management (central bargaining and/or central procurement)
    - Ensure for certain services that are necessary, such as emergency services
    - Consider the differences in context in each area
  - Thai traditional health services, 564 million baht. Uses fee for service scheduled payment under the point system with a ceiling budget. Manage the budget at the central level.
  - Rehabilitation, 784 million baht. Matching fund from government of 243 million baht and pay for the performance of 541 million baht.
  - Four things we should be concerned with when designing the payment method: Increase access, quality of care, potential and availability of health care system, and efficiency management.
  - Before they used capitation and it was the easiest and draw effectiveness from the provider and eliminate supply induced demand.
  - Some payment methods help solve problems—for example, the fee for service with fixed dee schedule Is used to solve problems of waiting times.

- **<u>Discussion</u>**
  - Fund management is done annually, and all health facilities are invited. Q) What is the process of matching funds with the local government?
  - A) Initiative for NHSO to promote health promotion activities at the community level, the local government should provide the same amount as NHSO. The community will have its plan and have a public hearing on the activities based on the health problems of the district

- Q) What is the central reimbursement program?
- A) This is excluded from the capitation and DRG, and it is high-cost services and based on disease management. This program is managed centrally, and the hospital submits to NHSO in the central fund. There are three levels of fund: national, central, and hospital ** share consumer protection info with Kenya.

- Q) Process: when the subcommittee receives the draft from NHSO, what do they do? What is the composition of the financial subcommittee?
- A) Consists of many stakeholders: hospitals (private and public), academics, local performance fund management, NGO, Civil society. They consider the payment method for each service and a representative from the bureau of the budget is there too. We consider all dimensions and the impact of each stakeholder.

- Q) Project-based method payment: does the facility need to propose the activities for the next year? Alternatively, is it the same for all? Do they send the proposal to the central level for approval? For evaluation, do they need to send a report to the central level?
- A) Project-based payment is used to improve problems in the community, and the budget is approved by the local government under the community health fund. The fund is managed at the decentralised level in the sub-district. Each area has its committee. NHSO only monitors the projects and how much they do there is a reporting system, but the decision should come from local and helps to build the capacity for the community.

- Q) Capitation: what happens when a patient goes to a facility that they are not registered at? How do you manage the fund? For example, if they go to another province?
- A) The patient can change the hospital four times a year.

- Q) Kenya, in the Thai experience what is the incentive to get utilisation data from facilities in an accurate way?
- A) We have certain information that the hospital has to submit to the system, we incentives such as: pay for performance and quality assurance which has its criteria that we measure. NHSO monitors the utilisation that shows whether enough services are provided based on the estimated capitation provided.

- Q) Underutilization in capitation based on the number of people, what if it is because they were not sick, how do you decide? With reporting are you able to

categorically say what services and then are patients monitored to show if they received the services? At what level is the service provision measured?

- A) The patient chart shows the information. We also look at the burden of disease of outpatients in the district. Also, charges for the services show what was provided. MoPH requires that all public providers must submit the services provided. Contracting units manage primary care for the district. The chosen facility needs to meet certain standards. Public hospitals receive labour cost directly from MoF. Key point: In Budget, there are two main parts -salary and labour costs, the Social security for civil services office deducts costs for the operation costs and the health facility only sees the capitation they received. The national household survey measures the utilisation of public vs private.

- Q) For unplanned health costs that go beyond the ceiling for the individual, then who covers the cost?
- A) With the fixed budgets, they can get reimbursed by the DRG system for inpatient. For accident or case of emergency, they can access funds from another budget and can get services at any hospital.

- Q) Challenge in Kenya: as a disadvantage, under providing services due to the use of the capitation method, how do you address this in Thailand?
- A) We use many methods to monitor, utilisation rate from the information they submit, we set up a complaint system, we have an audit system and a committee who set criteria

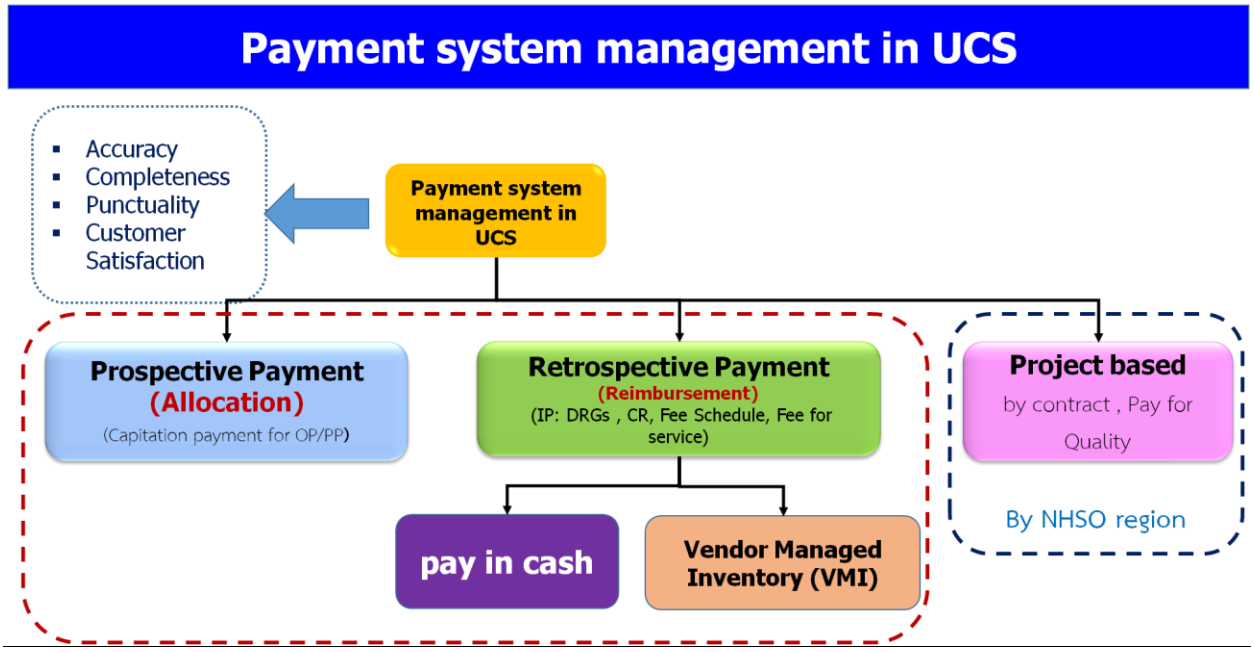
Day 4 Thursday 22 August 2019 at at TK Palace Hotel

Time	Content	
0900-1100	**Session 10 Strategic purchasing** : Medicine Pricing : Experience of Thailand Case study • Monopolistic power • Payment method • Central reimbursement: Cataract, etc • Medicine Pricing : Experience of Thailand	**Dr. Somruethai Supungul** Acting Director, Bureau of Medicine and Medical Supply. Management**,** NHSO
1100-1200	**Session 11 Budget allocation, Claim and reimbursement** • Budget allocation • Claim and reimbursement system	**Mrs. Benjamas Lerdchakorn** Director, Bureau of Fund allocation and Reimbursement, NHSO
1200-1300	Lunch	
1300-1400	Demonstrate the e-claim • E-claim workflow • Demonstrate the E-claim	Bureau of Fund allocation and Reimbursement, NHSO
1400-1630	**Session 12 Audit system** • Account Audit • Medical Audit • Quality Audit • Challenges for future Reforms • Case study of E-audit system	**Dr. Kriddhiya Sriprasert** Senior Director, Fund Management Cluster, NHSO
1630-1700	Summary and discussion	NHSO & IHPP

- **Session 10: Strategic purchasing**
    - National Medicine Policy
    - Procurement Process
        - Central procurement with efficient logistics for special medicines
        - Local procurement and competition law
    - National Medicine Policy: 1700 NLEM
        - Concept: Covers drugs needed for protection & treatment of health problems of Thai people at an essential level in an economical & cost-effective manner
        - Selection criteria:
            - Efficacy, effectiveness, safety, health need, compliance, frequency of drug administration
            - Efficiency based on HTA
            - Budget impact
    - The price negotiation working group
        - Tools for negotiation are
            - Patient access program
            - Price-volume agreement
            - Cost – capitation agreement
            - Voluntary licencing
            - Compulsory licensing
            - Pay-for-performance agreement: in process

- **Session 11: Budget allocation, claim and reimbursement system**
    - Introduction for the Bureau for Fund Allocation and Reimbursement
        - NHSO core business for the management of UCS funds:
            - Strategic planning: annual budget planning, M&E
            - Registration: Health service providers and beneficiary enrolment
            - Fund management: administration for UC budget, claims management
            - Health services quality control, hospital accreditation and audit systems
            - Consumer protection: provide information, complaints management, and bed coordination
    - NHSO uses many data for the management of funds. Therefore the electronic system and IT infrastructure is very critical to the work

- Service system for the beneficiaries of the UCS
  - Health financing strategies of the UHC policy: 30 baht or one USD co-payment, general tax, close-end provider payments, and promoting the use of primary care.
  - Enrolment and health service network: hospital registration and beneficiary registration → OP and IP service→primary care unit (health centre), the contracting unit of primary care (community hospital), and referral hospital (regional/provincial hospital)
  - Health service provider registration: all have to be registered and approved. Each has a unique hospital code, and it is related to the bank account number. All have to set up the bank account and IT system for recording patient registration. 2 main reference databases: the beneficiary registration and the hospital registration.
  - Fund holder primary care network: if you are referred by your doctor to a referral hospital then it's free of charge, but if you do a walk into the referral hospital then you pay the full amount with OOP.



UCs Allocation and Reimbursement

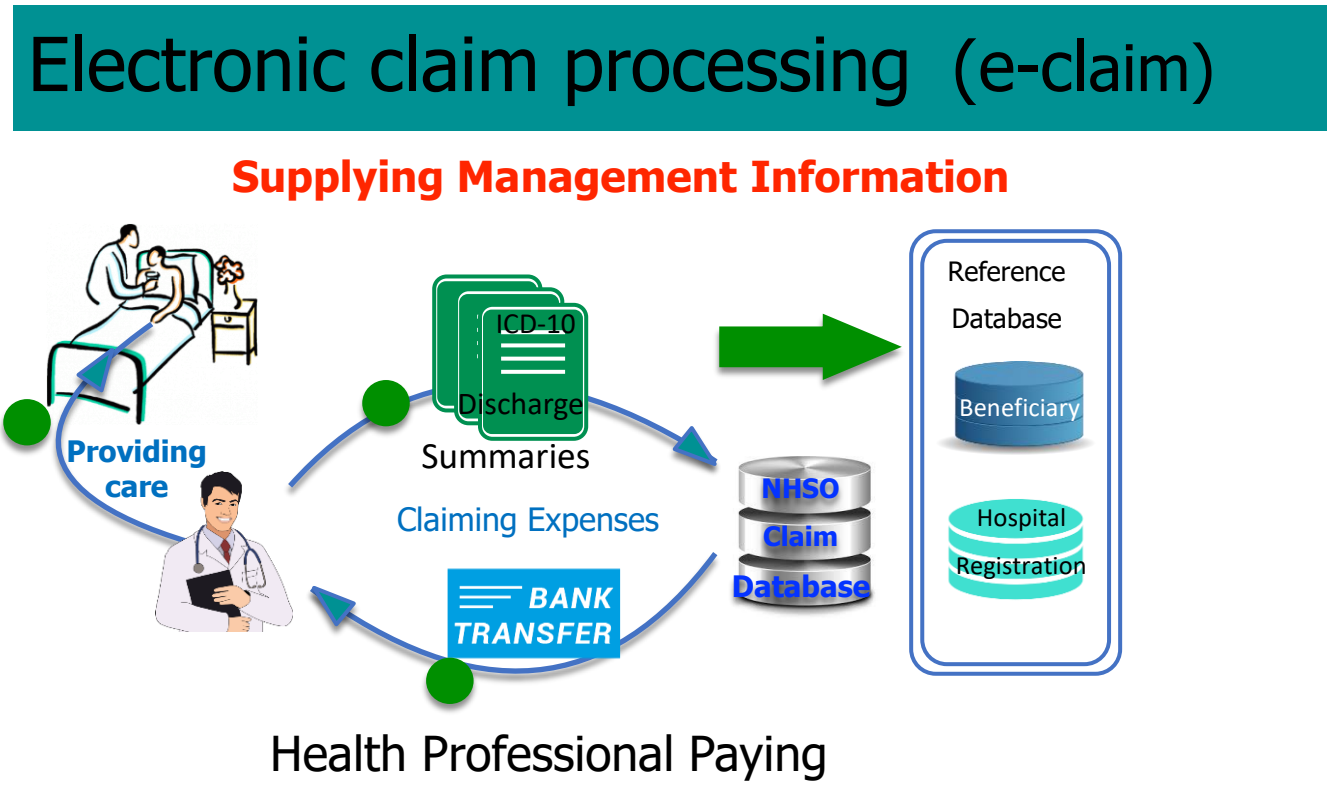
	Payment	Incentive (Central Reimbursement)
OP	Differential Capitation	Fee Schedule (Add-on OPHC & instrument)
		Point System under global budget (OPAE)
PP	Capitation	Pay for Performance (Quality and Outcome Framework)
IP	DRGs system with global budget using Relative Weight (RW) point	Fee Schedule (Add on instrument ,HD)
		DMIS

Dr.Karoon Kuntiranont,2016,"Service delivery, Quality, Safety and Efficiency",NHSO

- The payment system in UCS
  - Efficiency – best value for money.
    - Health promotion and disease prevention as a priority (goal>15% of UC budget)
    - Economic evaluation in the formulation of benefit packages with serious price negotiation
    - Central and regional bargaining and procurement
    - Capitation, bundled payment, and fixed fee schedule- with close end budget
  - Payment system management in UCS: accuracy, completeness, punctuality, and customer satisfaction.
  - The system is divided into three main methods:
    - Prospective payment/allocation of capitation payment for OP/PP
    - Retrospective payment/reimbursement of IP DRGS, CR, fee schedule, and fee for service
    - Project-based by contract, pay for quality

- HTA used to provide evidence for high-cost drugs, negotiate price for high-cost drugs, budget control, pay provider based on capped capitation budget and use closed-end budget, increase efficiency and control costs
    - Central reimbursement aims to provide more services and better quality
    - Age-adjusted capitation payments: 46% of UCS budget, capitation payment for outpatient and prevention and promotion services is allocated based on the number of beneficiaries register with a provider network (contracting unit for primary care CUP)
    - DRG payment of in-patient services. Clinical case captures clinical data of patients and personal characteristics and comorbidity, diagnosis and procedure. This information is grouped in the algorithm of respective DRG system with a set of coding standards and rules for assigning diagnosis and procedures to cases. The specific DRG is then assigned to a clinical case. This provides costs and also hospital activity
- FFS with ceiling price, fee schedule: First, defines which benefits to use a fee schedule, Second, set price and conditions for billing. Conditions for payment must be set and monitored (do not set conditions unless they can be monitored). Payment and conditions must be constantly revised (technology advances can increase or decrease costs)
- Cost containment:
    - Primary health care: a gatekeeping system to manage the utilisation of higher-level care
    - The close-end provider payment methods: capitation, DRG with a global budget, fee schedule, and fee for service
    - The national essential drug list, which includes medicines that are selected based on their effectiveness, safety, and cost-effectiveness.
    - High-price equipment and medicine, a central price negotiation system is in place to collectively bargain for best-priced items
    - Priority-setting for expansion of benefits
- Payment mechanisms: different for IP and OP
    - OP: fee for services with a fee schedule, Use this schedule for cataracts, radiotherapy, Capitation for OP and prevention and promotion:
    - IP: Fixed capitation system to reduce the cost below capitation level
    - Research of DRG happened with the health care reform 1990, a window of opportunity to implement UHC and the national DRG was ready to be implemented under the UC scheme
    - DRG needs to be constantly updated due to the change in the costs of medicines and medical devices
    - Conditions for payment review needs to be monitored and revised when there are changes in technologies and costs
    - Many methods to contain costs: 1-primary health care as a gatekeeper, 2-closed end provider payment method 3-pharmaceutical list is under the NLEM on effectiveness, safety, and cost- effectiveness, 4- high cost medicines use collective bargaining and negotiation

- Claim processing for reimbursement and report
  - Electronic data from health provider to NHSO
  - E-claim sent by the provider, NHSO uses the claim database system to send the reimbursement and the cost will not be different in the real-time. They use two different reference databases – beneficiaries' registration and hospital registration database
  - Reimbursement sent automatically to the provider bank account
  - UCS provider preparation for claim processing for reimbursement by e-claim:



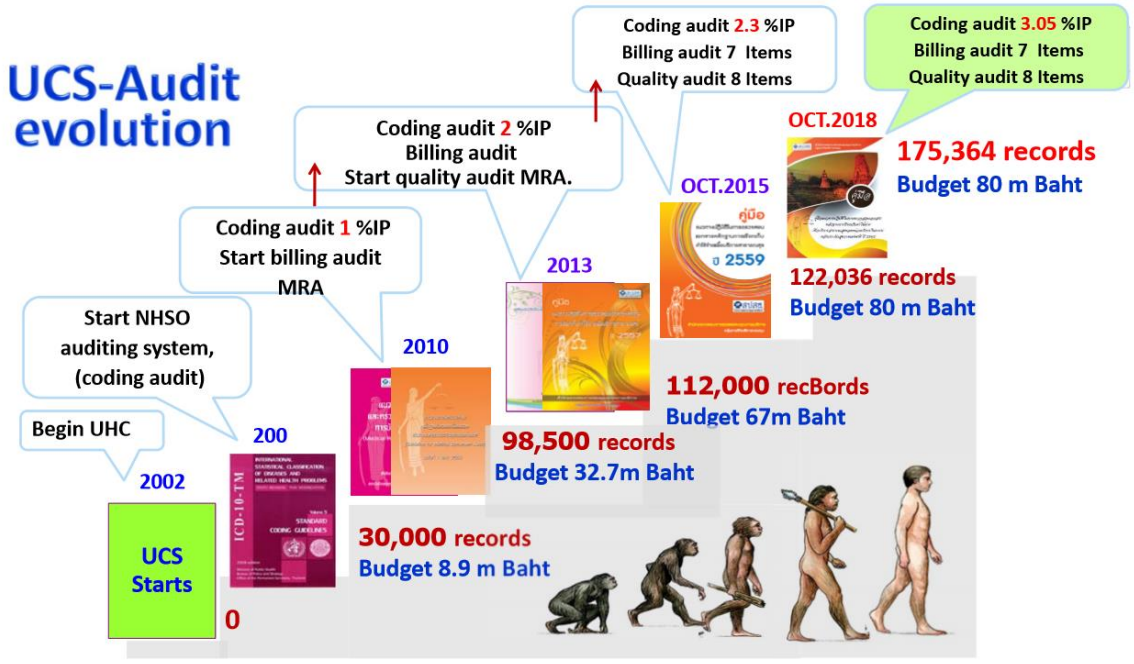
  - The following info is needed:
    - To provide coding for the classification of the disease by following the international statistical classification of diseases and related health problems from the WHO
    - To provide medical procedures and operation by following the international classification of diseases ICD-9CM in 2010
    - The UCS provider must prepare drug list and always update the list to be current then send to NHSO for data payment and use the updated guide for pharmaceuticals for dispensing,
    - The hospital receives the electronic claim summary with the status of each claim with denying or approval. Hospital has the chance to

appeal to cases and send extra data to NHSO.

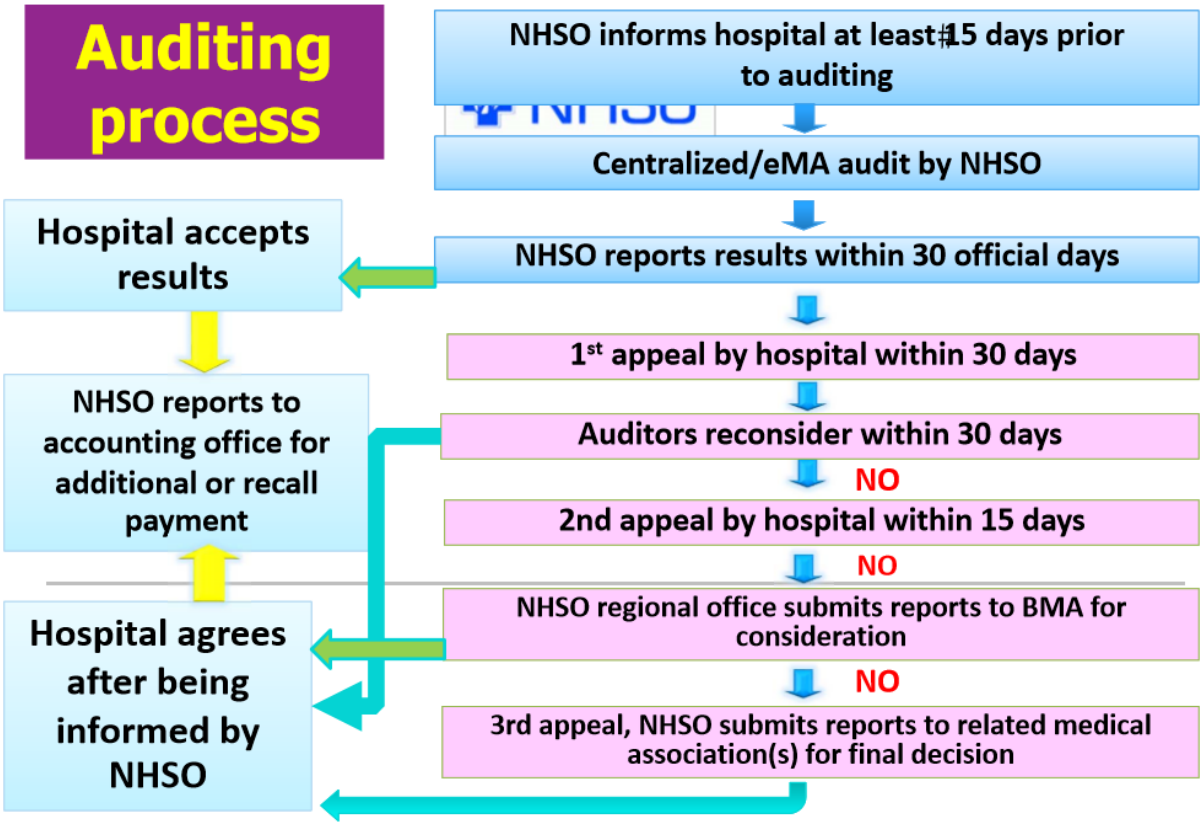
- E-claim screen: input patient info, diagnosis, procedure, P&P, medical expense etc.
- Reimbursement can be seen online by the period of claims.
- Statement screen shows the reimbursement sent by NHSO. Money is spent in 15 days after the statement is approved by NHSO, sometimes there is a delay by 1-2 months.

- **Discussion:**
  - Q) Explain claim processing:
  - A) 1st step-electronic automatic program runs the data sent by staff from the hospital computer and uses criteria that are set in the system. The output is accepted in A or not complete/cancel c with missing data or duplication and Deny with D, the reimbursement;
  - B) 2nd step post-audit, the NHSO staff manually check the problematic cases to see if the data matches the condition that was reported.

- **Session 12: Audit system of UC Scheme**
  - Why do we need a medical audit?
    - Reflect Good governance
    - Ensure transparency and quality
    - Verify correctness of reimbursement
    - Strengthen the accuracy of medical record-keeping

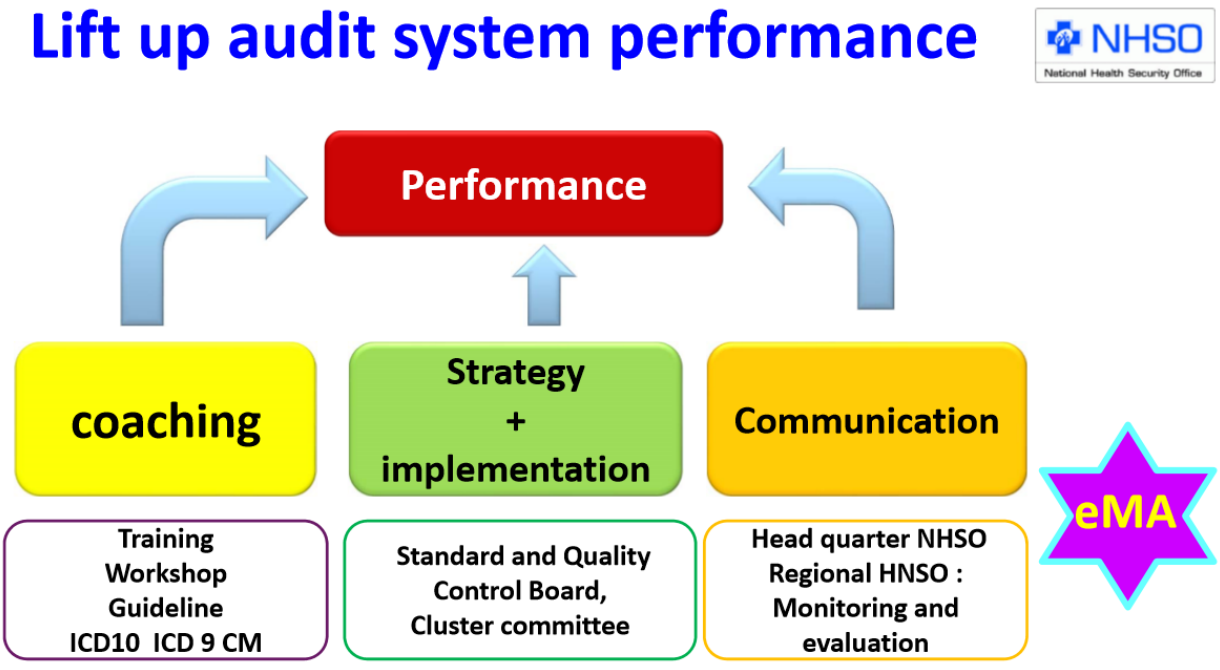


- Purposes: NHS Act
  - Article 5: Patient rights to standard care
  - Article 26: Authority of NHSO to supervise and audit
  - Article 45: Standard service from providers
  - Article 54: Effectiveness and efficiency in claim payment. Quality service according to medical standard
- BCMA, Core process:
  - Design: identified criteria to select abnormal data and to design the method of audit;
  - Operation: medical review by auditor teams consisted of BCMA staff and external auditors;
  - Report: to report results of the audit to the providers, fund manager and NHSO executive committee



- Types of medical audit: For both accounting audit and medical audit
  - Coding audit
  - Billing audit
  - The quality of clinical audit
  - Medical record audit: accuracy of the information in medical record

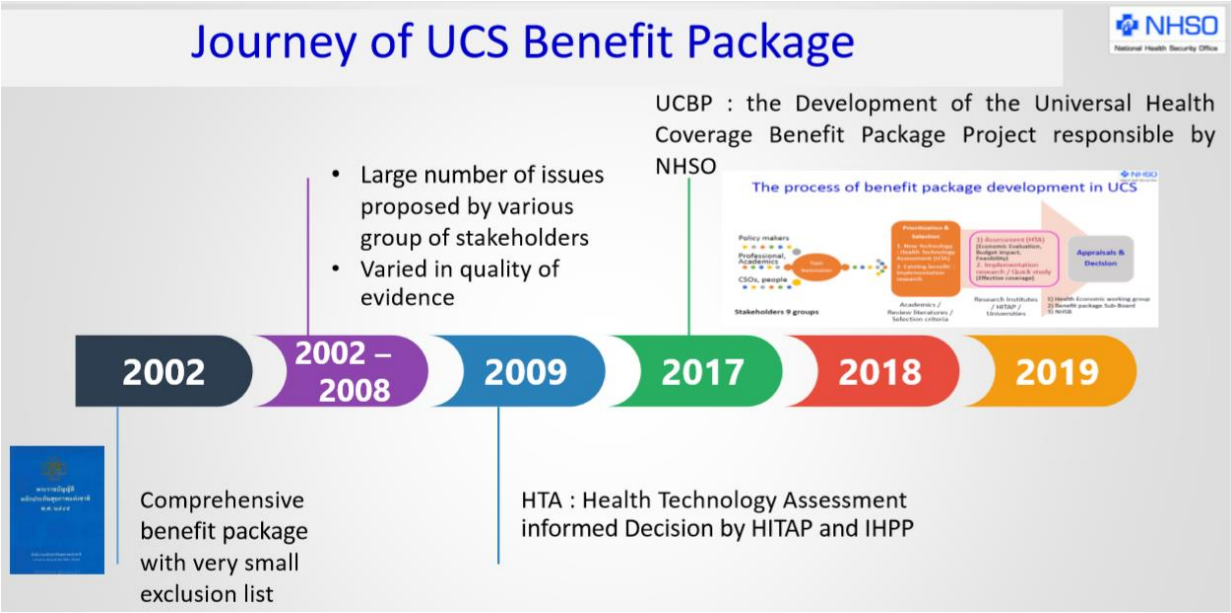
- Data selection criteria for audit:
  - Top 20 disease ranking by number of admissions
  - Top 20 diseases ranked by reimbursement (AdjRW)
  - Unrelated procedures with a principal diagnosis
  - High RW point but low admission days and low costs
  - Patients with SDx or severe complication but low admission days and discharged as cured
  - Sepsis (PDx or CC) with few admission days and discharged as "cured."
  - Shock with many causes for short admission length
  - Appendectomy with co-morbidity or sever complications etc
- Appeal process: Bound by law, regulations of NHSO in case of under or over the claim, published in Royal Gazette, item 6(1)(2). Financial arbitration committee, seven members; external experts. Providers may object within 30 days
- Audit outcomes:
  - Punishment: over the claim, money from hospital returns to NHSO; Reward: under- claim, NHSO pays hospital; Coders are empowered, capacity strengthening. Better information system of hospital and health system as a whole
  - Three core components:
    - Coaching: training, workshop, guideline, ICD10 and ICD9CM
    - Strategy and implementation: Standard and quality control, board, cluster committee
    - Communication: Headquarter NHSO, regional NHSO, and M&E



Day 5 Friday 23 August 2019 at TK Palace Hotel

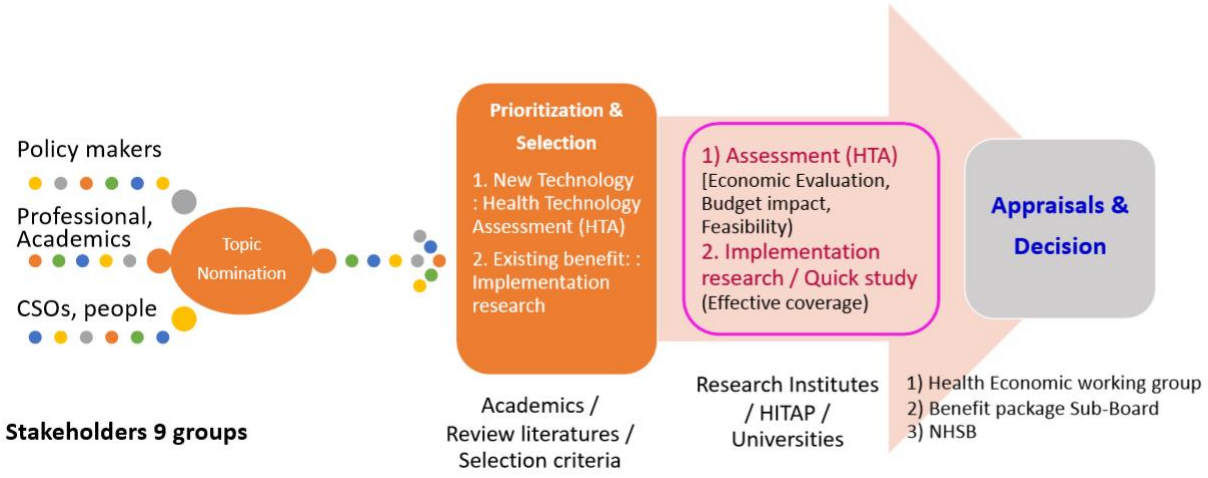
Time	Content	
0900-1045	**Session 13 Expand Services: benefit package management in action** • Benefit package management • Process of new benefit package development • System management for new benefit package	**Mrs. Narisa Mantharngkul**, Manager, Bureau of Strategic and Policy Development, and HITAP
1045-1100	Coffee break	
1100-1200	**Session 13 Expand Services: benefit package management in action (Cont)** Introduction to Health Technology Assessments and its role in achieving UHC	**Dr. Yot Teerawattananon** **Dr. Wanrudee Isaranuwatchai** **Ms. Saudamini Dabak**
1200-1300	Lunch	
1300-1415	**Session 14 Health prevention & promotion** • Health prevention & promotion in benefit package • Community Health Fund to promote health prevention &promotion	**Dr. Kanitsak Chantrapipat** Director, Bureau of Primary Care Management, NHSO
1445-1600	**Session 15 Primary Health Care** • Evolution of primary health care • District Health System and Family care team Inter-links between PHC and secondary and tertiary care	**Dr. Yongyuth Pongsupap** Senior expert on Primary Care, NHSO/MOPH
1600-1630	Experience sharing: Health prevention & promotion	Selected countries
1630-1700	Summary and discussion	NHSO & IHPP

- **<u>Session 13: Expand Services: Benefits Package Management in Action</u>**
    - UCS Benefit Package = Comprehensive care + Negative List (Unnecessary services: infertility, cosmetic surgery, services that are still under study; Services covered by specific budgets: for drug addicts, injuries from vehicle accidents)



    - Two components:
        - Non-pharmaceutical benefit package
        - Pharmaceutical benefit package
    - Criteria for priority setting and decision making
        - Eligibility criteria
        - Selection criteria
        - Decision-making criteria

The process of benefit package development in UCS

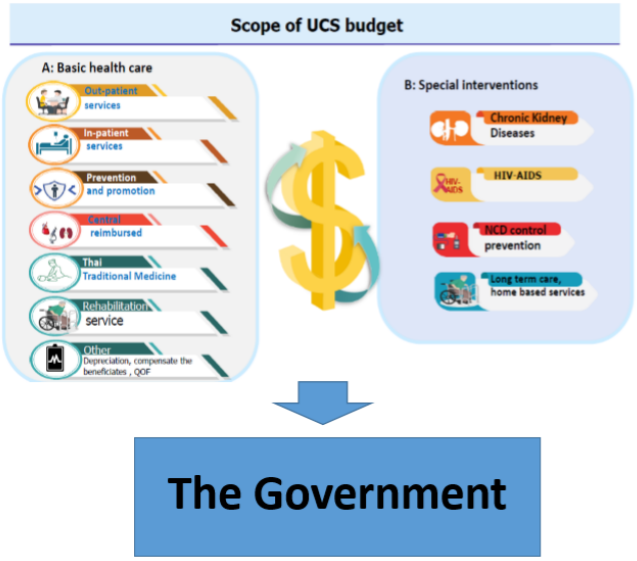


- Expansion of benefits package is done with the help of HTA, decision made by NHSO sub-committee for Benefit Package and Service System Development

Sub-committee for Benefit Package and Service System Development

- The Medical Council of Thailand (1)
- Permanent Secretary of Ministry of Public Health and Executives (3)
- Civil Servant Medical Benefit Scheme (CSMBS), Social Health Insurance (SHI) (2)
- Professional Councils (Pharmacy Council, Dental Council) (2)
- Civil Society Organization : CSO (3)
- Health Service Standard and Quality Control Board(2)
- Research organization and Experts in the fields (2)

UCS budget estimation



1. Per capita budget of the UCS is calculated based on
   - Volume of services and facility
   - Unit cost of services
   - Projection of increase in service utilization and cost
2. Data availability
   - Administrative database
   - Hospital financial reports
   - Beneficiary registration database
3. Policy direction -> increase accessibility , standard protocol of health services, new benefit package

- Monitoring and Evaluation: The WHO model is followed. Accessibility and Effective Coverage: ensure universal access to the comprehensive essential package.
- Future challenges:
  - Budget constraint = Challenge of fiscal space vs increasing demand
  - Effective coverage of the health benefit covered and some specific targets, e.g. vulnerable group, disease burdened – NCDs, TB, HIV etc
- Health Technology Assessment and its role in achieving UHC
  - Health care resource is scarce, and therefore, choices must be made.
  - The systematic evaluation of properties, effects, and/or impacts of health technology
  - A multidisciplinary process to evaluate the social, economic, organisational and ethical issues of a health intervention or health technology
  - The main purpose of conducting an assessment is to inform a policy decision making and to assist in the planning for sustainability and scalability.
- Economic Evidence: Cost-effectiveness: Creating a cost-effectiveness estimate; Showing the uncertainty around the estimate; Comparing to a decision rule.
- Cost-effectiveness Estimates:
  - Incremental Cost-Effectiveness Ratio (ICER): EXTRA cost for one EXTRA unit of outcome;

    - Incremental Net Benefit (INB): EXTRA net benefit of your program compared to usual care;
  - HITAP is a semi-autonomous, non-profit research unit (established in 2007) which conducts Health Technology Assessment.
  - All studies need to follow methodological and process guidelines (details in the slides)
  - Case Studies were explained, e.g. treatment of hepatitis C, Second-line treatment for CML, Other consideration (Off-label indications and social ethical issues), Refractive Error Screening, Impact of compulsory license.

- **Session 13 Expand Services: benefit package management in action (Cont)**
  - Health Technogoly Assessment (HTA) is the systematic evaluation which utilizes a multidisciprinary process to evaluate the social, economic, organizational and ethical issues of a health intervention or health technology.
  - The outcome derived from HTA will be informed to the policy decision makers.
  - There are several types of systematic evaluation varied in context matters.

Example Questions of interest	Type of economic evaluation
Compared to standard of care, is this new health program cost-effective?	• Cost Benefit Analysis (CBA) • Cost Utility Analysis (CUA) • Cost Effectiveness Analysis (CEA) • Cost Minimization Analysis (CMA) • Cost Consequence Analysis (CCA)
How much does the program cost?	• Cost Description
How will the policy affect the overall budget?	• Budget Impact Analysis (BIA)
What is an economic impact of a disease or health condition?	• Cost (economic) analysis

Day 6 Monday 26 August 2019 at District Hospital and Health center in Sai Noi District, Nonthaburi Province

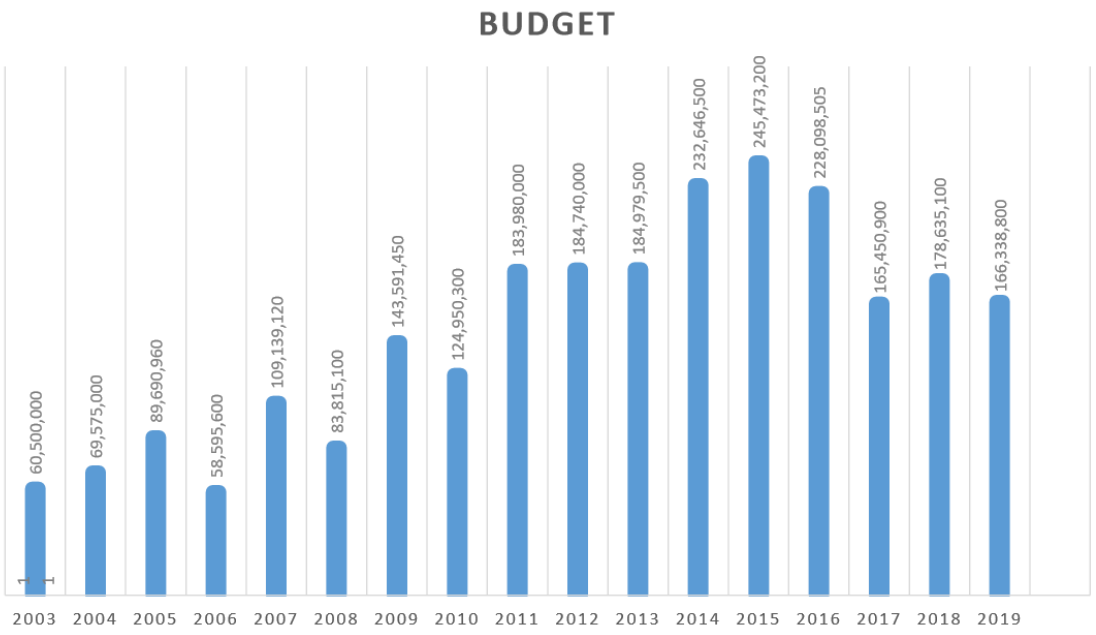
Time	Content	
0800	Leave from TK Palace Hotel to Sai Noi Hospital	
0900-1200	**Session 16 Study visit at District health facilities in Contracting Unit for Primary care (CUP) in action.** • District Health System (DHS) • Registration and data update for UC patients at contracting unit • Service delivery system: disease prevention, health promotion and curative services, including referral system • Flow of fund from national to provincial level and then to CUP • Payment within CUP and the province • Management system: patient record and claiming & audit process, • Interlinkages with district hospitals, technical and financial support • Hospital walk tour	**District hospital** **Sai Noi Hospital**, Sai Noi District, Nonthaburi Province
1200-1300	Lunch	
1300-1600	**Session 17 Study visit at Health Centre and community involvement** • Catchment area and management of health center • Intersectoral collaboration with local government, schools and other organizations • Registration and data update for UC patients/family folder and claim processing • Service provision in health center and (up and down) referral system focused on chronic disease management • Community Health Fund management and its activities • Role of village health volunteers	**Health Center** **Wat Klong Kwang health center**, Sai Noi District, Nonthaburi Province

Day 7 Tuesday 27 August 2019 at TK Palace Hotel

Time	Content	
0900-1030	**Session 18 ICT to support effective universal Health coverage UCS** • Information Architecture and system to support UCS system and management • Data sharing - standardization of data elements and data mapping to link data between schemes and healthcare facilities. • National data pooling of admission records using electronic transfer (web-based application)	**Ms. Siripan Muangsin** Bureau of Information Technology Management, NHSO
1030-1200	**Session 19 Monitoring and evaluating of UHC** • Data platform • Feedback loop	**Ms. Kanjana Sirigomon,** Director of Health Information and Outcome Evaluation, NHSO
1200-1300	Lunch	
1300-1430	**Session 20 Quality assurance and its role in achieving Universal Health Coverage** • Healthcare Accreditation (HA)	**Dr. Kittinan Anakamanee** The CEO of Healthcare Accreditation Institute
1430-1500	Coffee break	
1500-1630	**Session 20 Quality assurance and its role in achieving Universal Health Coverage (Cont)** • Quality assurance processes, credentialing, Health facility standards (including staffing guidelines) • Designed system for quality control Ensuring standard quality & Motivating providers & professionals to improve the quality	**Ms. Piyanuch Prongfa** Director, Healthcare Quality Management, NHSO
1630-1700	Summary and discussion	NHSO & IHPP

- **Session18: Effective IT for Universal Health Coverage Achievement**
    - IT Budget
        - IT budget accounts for 11% of the admin budget at THB 166 million (about THB 3.46)
        - Cost per data transaction is around USD 0.01

IT Budget per year



    - IT Infrastructure
        - Application for executive information system include (i) web base application, (2) application, (3) SAP business objective application;
        - The telecom is networked between central NHSO, NHSO branches and 1000 hospitals;
        - Investment in disaster recovery centre (DRC) with a recovery point objective within 24 hours and recovery time objective within 4 hours.
    - Application to Support Core Business include: Strategic planning, Health service provider registration, Beneficiary enrolment, Fund management, Health service quality control, Consumer protection
    - Data Utilisation

- Individual records in NHSO include disease management, prevention & promotion, emergency care, and OP & IP data
- Data is integrated by different levels of providers, i.e. community, primary and secondary using data lakes model
- Patient electronic record journey starts from primary care to acute & intermediate to long-term care and finally loops back to primary care.

- **Discussion**
  - Q) Reporting is a big problem in Africa, how to ensure timely and accurate reporting?
  - A) Payment by capitation and user registration, we can make sure the reporting is accurate. Since it is for reimbursement, they have incentive to timely report. The application team will work closely with manager to see what needs to be monitored and evaluated.

  - Q) How to perform data quality check systems within the IT system?
  - A) Validation criteria in every step for reimbursement to ensure data quality, if it doesn't pass the criteria it is sent back to the hospital for review e.g. for registration it will be validated with the national registry with Ministry of Interior.

  - Q) For IT architecture do you use the same software to integrate and link data for analysis?
  - A) Use standard data structure by all hospital to be sent to NHSO. We need to keep some medical records confidential e.g. HIV, and therefore in some cases we do want to link all the data/application. Application is only web-based to receive the data. Provide support to small health centres to build their app system.

  - Q) Is there biometric identification under consideration in Thailand?
  - A) It is expensive; therefore we use smart card; therefore, budget limitation, hospital has to implement the IT system from their budget, ID card also serves as identity validation at point of use.

  - Q) How are each hospital's IT systems at integrated with NHSO? Why still have paper-based system at Sai Noi?
  - A) Paper-based system for auditing purpose for National financial audit for at least ten years for both finance and patient record

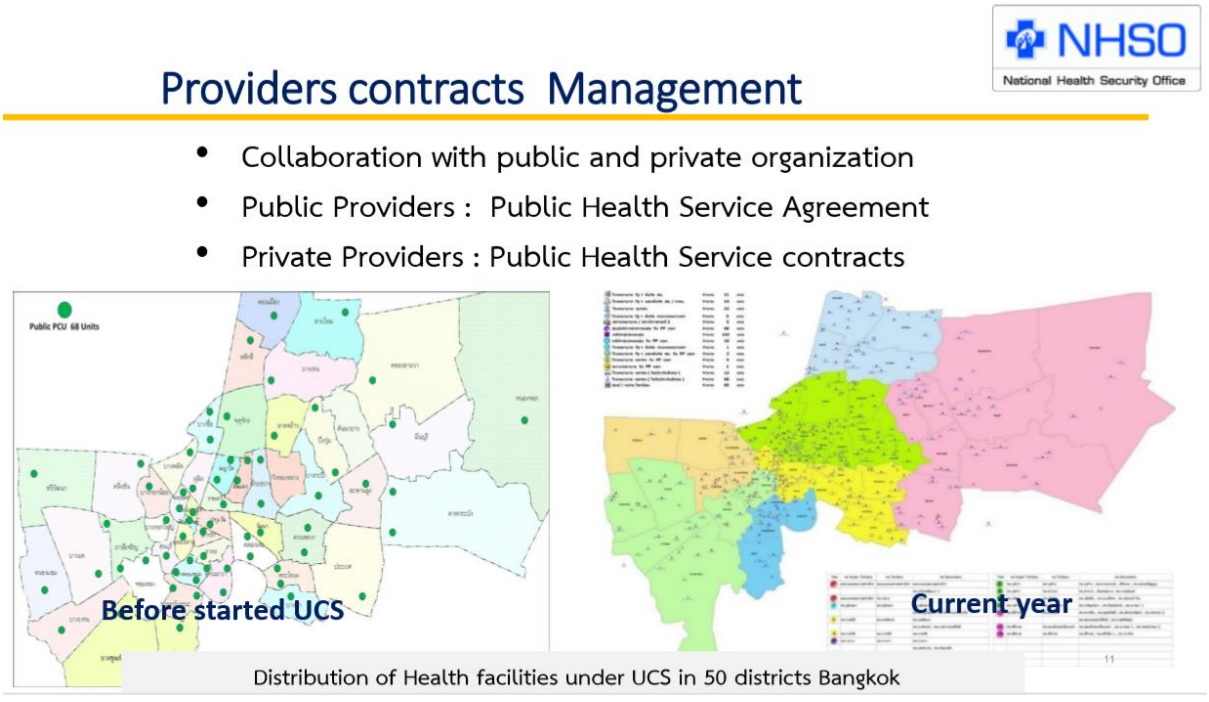
- **Session19: Monitoring and evaluation**
  - Using 100 core health indicators and health-related SDGs recommended by WHO
  - Monitor the (1) inputs and process (health financing, health workforce, health infrastructure, health information/governance), (2) output (service access and availability, health security), (3) outcome (coverage of interventions, risk factors and behaviours), and (4) impact (health status, financial protection)
  - Making most of the available data by using e-data source, data capability and survey

- **Discussion**
  - Health provider satisfaction decreasing, what are the parameters to measure this?
    - Workload
    - The burden of data collection
    - Insufficient budget etc
  - Reason for a civil servant for better access than UCS?
    - Payment mechanism as CSMBS (no primary contact point) use fee for service and they can use any public facility while UCS has contracted facility
    - It just means they have more options than UCS
  - Health satisfaction of UC beneficiaries for people comes from the household survey. The exit survey may only reflect the satisfaction at the hospital level, not community level.
  - Who analyses the raw data?
    - IHPP does the analysis upon request and authorisation from NHSO and encryption for data protection and privacy
    - IHPP the focal point for NHA and other outputs like catastrophic, impoverishment, health service analysis
  - The negative correlation between socio-economic status and satisfaction, in quality improvement, how do you take into account of this? Special focus on area?
    - Free movement to other health facility is not allowed
    - Long-waiting times
    - The items in the benefits package itself

Day 8 Wednesday 28 August 2019 at TK Palace Hotel

Time	Content	
0900-1200	**Session 21 Health services in urban area and Capital City: case study of Bangkok** • Service provision: involvement of private providers • Fund management • Monitoring system • Payment mechanism: Demonstrate	**Dr. Weraphan Leethnakul,** Director of NHSO 13 Bangkok and team
1200-1300	Lunch	
1300-1430	Experience sharing: Role of private sector	Selected countries
1430-1630	Group work: Role of private sector	
1630-1700	Summary and discussion	NHSO & IHPP

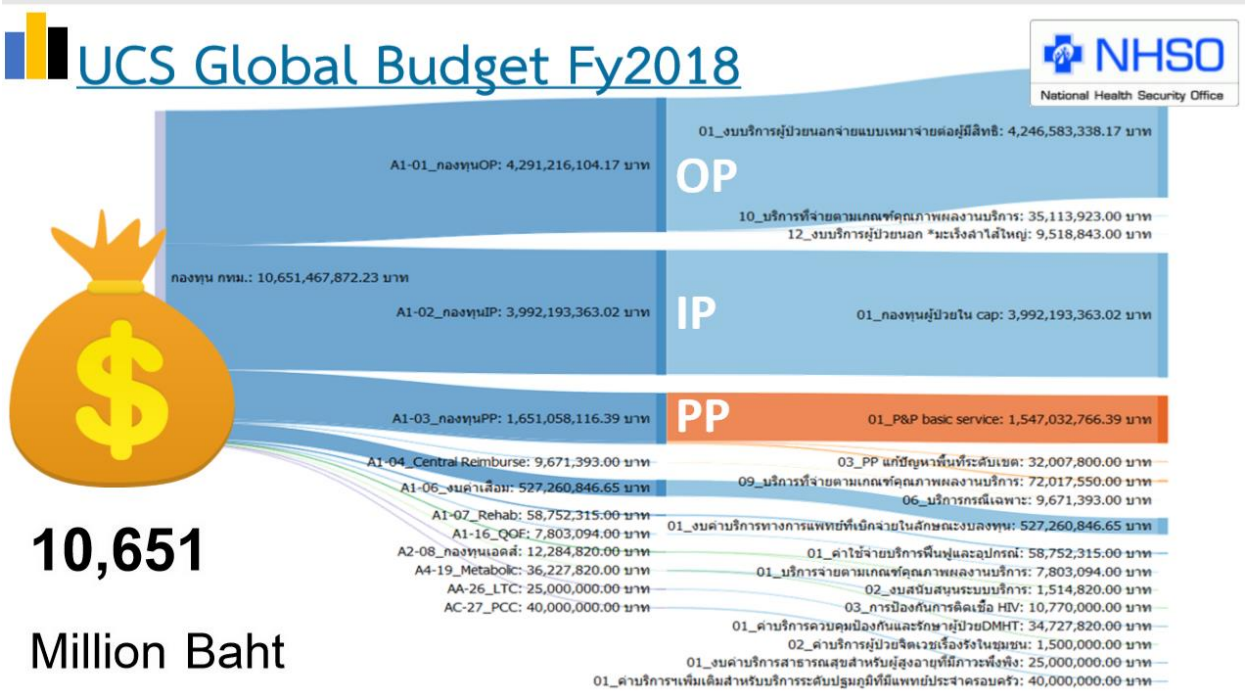
- **Session 21: Health Services in Bangkok**
    - Service provision:
        - There are about 2 million people who come into the city for work but are not registered in Bangkok.
        - The Bangkok Metropolitan Administration (BMA) area cannot afford to cover the 8 million people in Bangkok. Therefore, the private sector supports health provision.
        - Bangkok profile: 50 districts, 6 zones, and about 0.8-1.3 million people in each zone. One zone is related to 1 province in the rural area. 99% of the 8 million have UHC.
        - The UCS scheme only covers 50% of the people in Bangkok, but in the rest of Thailand, the UCS covers 70% of the people.
        - Healthcare providers in Bangkok: public health 23 hospitals and 68 primary care clinics. The private sector has 112 hospitals and 4,410 primary care clinics. Dental and drug stores were difficult to access, so they increased facilities for dental and drug stores in the UCS scheme, but are private providers.
        - Bangkok has tertiary care hospitals. Under the UCS there are different agencies under the health centre. MoPH has eight hospitals and one health centres. BMA has nine hospitals and 68 health centres. Moreover, here are 18 private hospitals. There are five university hospitals, 171 private clinics.



- Are health centres and clinics the same? In Bangkok the health centre has the doctor, the pharmacist, and dental provider. They are bigger in Thailand. Outside of Bangkok the health centres are smaller and have part-time doctors, nurse, and no dentists. In the rural, they take of animal health (e.g. rabies vaccination on dogs) and sanitary of the surrounding area.
- Define the clinics: Clinics are smaller and don't cover other auxiliary services.
- Primary care is clinic or health centre, secondary care is the general hospital, and tertiary care is large scale hospitals.
- Each private clinic has 10,000 subscribers. 66% of the subscribers are in private providers.
- Services approach network: 270 Primary care units. With 40 hospitals. With about 700 access networks. Note that each PCU has multiple secondary care providers between 1-4 hospitals.
- Your ID card when connected to the computer system will show that each beneficiary is allocated to a PCU and a hospital. This helps to show which hospital the patient can be referred to. Sometimes the hospital cannot provide the services, and therefore the patient can be referred to the tertiary care providers.
- The PCU is strengthened as they are the gatekeepers and to avoid congestion in the hospitals.
- Next year there is a rebranding project where the health centres in the US scheme will all look the same and as nice as private clinics.

- Registration system: Organize systems for registration of beneficiary service and their network. Registration units collaborate with BMA and public organisation. Each person will register to be a member of a main contracting unit near their home. 22 registration units around Bangkok: 19 unit at districts office under BMA, 3 unit at office of public organisation
- Fund management: Global budget for the Bangkok region. Last year was about 10,651 million baht, and most of the costs are in OP-4,200 mill, IP 3,990 million, and P&P 1,500 million. OP: 1,196.88 baht per capita. Capitation budget to the CUP 73% is paid monthly to the main facilities, which are the service providers and 27% for claim and reimbursement.
- Mutual fund for central reimbursement, this covers the risk-sharing to providers and protect the right to access service of subscribers.

- There is a problem with OP referrals due to differences in prices between the price from different providers. JICA is trying to support an initiative to try standardising the costs. We are trying to control the rice because it has been increasing over the years.
- IP: 1,294.94 per capita, the global budget of 3,992 million baht. DRG v.5
- P&P budget management 2018: 1,651 million baht, about 246.12 per capita - there are 4 subgroups: P&P basic services (fee schedule for each activity), P&P area-based (project-based), P&P quality and outcomes (pay for QOF, policy KPI), and P&P community (BKK local fun); PPB: 5 different programs by age group.



- **<u>Discussion</u>**
  - Q) How do you get/encourage the private sector to accept the scheme? Are the patients treated equally?
  - A) This is very difficult, there is no equality between the schemes, as they take better care of the people who pay more money. For example, even in the queue for some surgery, the people who pay cash are prioritised. The management sees that the UCS is for the poor, but in reality, only 5% of the beneficiaries are poor.

- Q) The drugstores or other facilities that are not registered by the schemes you have when such cases exist, then how do you say there is 100% coverage by the schemes? Please clarify.
- A) When we say 100% coverage In Bangkok, there is still out of pocket from the facilities that the patient selects to go to. There is a problem with 12-15% of out-of-pocket payments. The big hospitals are not distributed well and not enough, and this is why we encourage primary care, but the care in primary care is not enough. The referral system is still trying to address access to care.

- Q) Costing of services, e.g. for radiotherapy, do you have different prices depending on the hospital like private vs public?
- A) Price is the same

Day 9 Thursday 29 August 2019 at TK Palace Hotel

Time	Content	
0900-1200	**Session 22 Thai Health Promotion Foundation** • Innovative financing for health promotion • Structure and functions of Thai Health Promotion Foundation • Working with network at local level	**Ms. Milin Sakornsin** International Relation Officer Partnership and International Relations Section, Thai Health Promotion Foundation
1200-1300	Lunch	
1300-1500	**Session 23 Public participation in a policy process** • Roles of the government towards CSO on health development: "reach out them" or "let them in" • Health Assembly and Health Charter: participatory tools for CSO in supporting UHC	**Ms. Nanoot Mathurapote** National Health Committee Office (NHCO)
1500-1630	Group discussion: voice of people	
1630-1700	Summary and discussion	NHSO & IHPP

- **Session 22: Thai Health Promotion Fund**
    - Thai Health Promotion Foundation (ThaiHealth) is an autonomous government agency established by the Health Promotion Foundation Act in 2001.
    - Several factors contributed to the establishment of ThaiHealth. First, the 1986 Ottawa Charter for Health Promotion recognised the challenges of sustaining adequate funding for health promotion activities.
    - Second, lessons learnt from tobacco control showed that key barriers to effective interventions were small annual budget allocations and the health ministry's management of the budget. The lack of civil society organisations in programme implementation also hindered progress.
    - Third, senior public health leaders in Thailand recognised the potential benefit of using dedicated tax from tobacco and alcohol as an innovative financing mechanism for health promotion. They were inspired by the experiences of the Australian health promotion foundation, VicHealth, seven which used tobacco tax revenue to fund health promotion interventions. The funding was made possible through the Victorian Tobacco Act. The Act endorsed a tax increase from 25% to 30% of the wholesale price of tobacco products, and the revenue from the tax increase was earmarked to VicHealth.7
    - In 1999, a group of Thai public health leaders and health professionals established a working group and called for innovative government financing to address the increasing noncommunicable disease burden. After two years of political negotiations and legislative processes, parliament enacted the Health Promotion Foundation Act in 2001, which lead to the establishment of an autonomous government body, ThaiHealth.
    - Thailand experienced a rapid epidemiological transition in the early 2000s when the burden from communicable diseases, maternal and child conditions and malnutrition decreased and the noncommunicable disease burden increased.

- **Session 23 – Public participation in a policy process**
    - Thailand health landscape involves not only public organizations, but also multi-sector engagement. This due to to tackle social determinants of health, it requires multi-sector engagement. According to Institute for Clinical System Improvement (2014), population health is determined by healthcare approximately 20%. There are other factors that influence health such as socioeconomic factors, health behaviors (lifestyles), and physical environment respectively. Thus it is imposible that one responsible organization will improve this circumstance; there is the need for triangle that moves the mountain: 1) public participation, 2) muti-sector engagement, 3) evidence informed policy.

- Health assembly is the platform where a combination of hard power and soft power, which replicates process from World Health Assembly. Through National Health Assembly, it provides people participations through various steps, including proposing resolutions, public consultation,adoption of resolution. During Assembly, it also provides various activities, apart from consensus building of resolution, including progress report of resolution, exhibition to exchange case studies and technical side events.
- Health charter is a social commitment on the desired heath systems collectively developed by all sectors based on an area or an issue. In addition, a community health fund uses health charter, which is formed by people, as a framework for funding.

Day 10 Friday 30 August 2019 at TK Palace Hotel

Time	Content	
0900-1100	**Session 24 Summary of Lessons learned and ways forward** • Discussion: workshop assignment	NHSO & IHPP
1100-1200	**Session 25 Wrap up** • Final questions and answers • Conclusions and closing remarks	NHSO & IHPP

- **<u>Session 24 - Wrap up and key lessons from this workshop</u>**
  - Participants share thought to summarise key lessons learned in 5 areas:
  - Expanding population coverage by:
    - Focus on vulnerable groups who are the most in need and then expand to others
    - The triangle that moves the mountain
    - Different schemes for different population groups
    - ID system to monitor individuals and process the registration and the link to the insurance schemes. Data sharing is important and how we harmonise and manage
    - Increase equity through enhances access to essential services
    - Link between civil registration and insurance registration
    - Supporting systems like the district health systems
  - Lesson learned from Kenya: be clear on what the insurance coverage and what things are paid for out of pocket, knowing which population is not covered and how to expand the coverage to the population who are not insured. If your country can't support everyone, then you may go in stages and start with the vulnerable, then children and elderly, then everyone.
  - Laos agrees political and technical support. It is impressive in Thailand they prepare the foundation first before expanding the services. They had the facilities, technical support, financial support.
  - In Thailand yes, we started with the vulnerable, but if you look at the triangle, we work on the base first, and in some groups it's easier to identify the groups. The informal sector is hard to define. We start with the top and bottom, and then UC scheme covered the remainder.

- **Expanding financial risk protection:**
  - Strategic purchasing and using evidence
  - Sin-tax for health promotion
  - Harmonising the schemes
  - Bhutan: The preferential benefit that the civil services get, if all schemes can go under one, it would bring everyone together. Bhutan does not have preferential rights no matter if you are a villager or a top bureaucrat.
  - In Thailand, it would be quite difficult; each group has its reasoning, for example the civil society scheme gets more benefits because of the lower salary – only 5 million people and they spend half of the health budget.
  - In Thailand, the efficiency between the schemes is different as the competency of who manages the scheme, and their interests are different.
  - In the Maldives: it is easier to give equal (equity) services to all, but it's not sustainable. To manage inequality takes more effort and planning on specific needs of different populations. When the public is enjoying services it is difficult for the government to minimise or remove from the package. Keywords: consistency, collaboration, commitment, multi-stakeholder involvement,
  - In Thailand the planning is better, you use evidence, and you give what you can base on the recourses.

- **Expanding population coverage**
  - Primary care and health promotion should be the biggest focus and in the long run, can reduce the number of patients
  - Using evidence and HTA to inform the benefits package and drug lists
  - Private sector to fill in the gap if the country has unmet needs, NHSO encourages them, but they need to meet standards
  - Community and civil society involvement
  - The hotline 1330 to receive complaints and suggestions from beneficiaries

- **IT system for data, quality control, legislation, governance**
  - Inclusive IT system to closely monitor finances and support evidence-based decisions
  - Legislation that has clear missions and actions that drives NHSO work
  - Big data to monitor and to evaluate the progress and performance of health providers
  - Governance system is important
  - Sri Lanka: the compulsory rural services helps ensure that that the rural areas have enough health care providers and access to services

- What are the key lessons learned in the roles of other sectors in supporting UHC implementation?
    - Academia and technocrats who provide timely research and relevant research and evidence to the policymakers. Policymakers can also propose research questions, and it is up to us to develop recommendations.
    - Involving community to raise awareness of UHC
    - Autonomous bodies play
    - Intersectoral approach and multisectoral involvement.
    - Health volunteers and local governments

- **<u>Country experience sharing</u>**
    - Philippines: Thailand has the champions who help push the agenda and influence policy. We also need young ones to grow and build capacity of young researchers.
    - Bhutan: investment in HR in primary health care, like the Philippines we can have two years of training like the Philippines, involvement of religious leaders and community leaders to increase trust in the primary health care. When it comes to budgeting systems P&Q, you are still able to bring down the costs, we can think of using the P&Q system. Think about HTA for investment and disinvestment. The strong mentoring culture in Thailand is a strength. The national health bill in Bhutan is being drafted, so we will think about community participation as an option to add. The health promotion and using the auspicious months to discourage consumption of alcohol.
    - Cambodia: 21 countries participated, in the training there has been immense learning.
    - Egypt: 1 - general health expenditure and comparing Thailand's and the US. 2 - Public satisfaction and the healthcare system. 3 - population coverage. All three show it's not all about money, it's about how you manage your finances. There are four key points: economic efficiency, smart financial management, internal and external communication, local community engagement and support from local leaders. What can be included in Egypt: community health management, HTA institute to ensure sustainability, central procurement policy for supplies and distribution. Annual forums where you bring stakeholders together to have a mutual agenda.
    - Guinea Bissau: government and structural roles of NHSO, the management of the schemes, health-promoting and prevention is a big experience from me, and the management of alcohol and tobacco, the multisectoral involvement and everyone is fighting to bring health for the entire Thai population. The volunteers and family

care team are appreciated. The role of the health assembly in health promotion. We can adopt some of the Thai strategies in my country.

- Iran: role of volunteers, using evidence for decision making.
- Japan: Learnt practical things: 1-expanding role of healthcare volunteers, as there is a crunch of skilled labour in Japan. 2-HTA and Japan don't have much experience with this.
- Kenya: Healthcare financing and costs, the budgeting process, insurance schemes, how can we collapse them and still cover everyone, equity vs inequality, application of HTA for the benefits package, system strengthening, prevention and promotion, engagement with private sector, who will be in the primary healthcare network, M&E needs to be strengths, inpatient data and how it feeds to the reimbursement system, quality, role of the quality accreditation system, issue of mentoring, having the quality health care learning centres and peer review of health centres, enhance public participation.
- Laos: Solid foundation for capacity building, we don't have much evidence or research required for fund allocation, quality of care and develop hospital accreditation, strong stakeholder engagement in policy process, prevention and promotion to be included in our package.
- Maldives: what works here may not work in our country. However, involvement in primary healthcare as a gatekeeper. The health care providers who have not been used, there are facilities, re-orient the health services to make primary health care the focus. The referral system is a learning point.
- Mauritius: strengthening primary health care, reallocation of the budget, reallocation of health workforce to community, add health volunteers, reduce abuse of system and shopping around by having the gatekeeper system, regular inspections to monitor facilities, research and evidence and institutions for policymaking process, IT system for enrolment and catchment area to help with referral system, consider and include all stakeholder, public participation.
- Montenegro: complex decision-making system, but also have a simple system to assess the health services. We have full coverage and the comprehensive benefits package, but accessibility to the health facilities is a challenge. Primary health care is a good model to focus on volunteers, NGOs, and religious groups and involve all stakeholder. Institutionalising HTA.
- Morocco: we have many reforms that are similar to the UC scheme in Thailand, national management body which is in charge of the resources and expansion of the low-income scheme. Our takeaway is the establishment of the unique identification of the population, stakeholder engagement in all steps of implementation, Capitation and DRG payment, referral care system for all

schemes, strengthening of the standards and norms, the evaluation and audit using KPI.

- Nigeria: the will from the health providers, strengthen primary health care system and linkages between the levels of care, effective manage of resources and fiscal space, mobilisation with the triangle that moves the mountain
- Philippines: Capacity building and the research unit, increasing investment in IT to have evidence and data, a clear framework of the implementation of more stakeholders.
- Samoa: improve healthcare fund management, planning and purchasing, M&E, services, accessibility, utilisation, E-health system to be developed
- Sri Lanka: UHC will be achieved by strengthening the primary health care system - the implementation is a tough job. The compulsory rural act that needs to be implemented and evenly distribute human resources. The private sector for services, consumer protection mechanism, audit system and trained staff to do coding, HTA, value for money and M&E, participatory involvement for decision making and include beneficiaries, health promotion.
- Uganda: a strong focus on M&E, incentives and family caregivers, health promotion is a large component of UHC and campaigns, insurance schemes and the different departments, motivation of health workers by giving them housing.
- Vietnam: emphasis on primary health care, strengthening the capacity of grassroots level, health promotion and prevention services, move the mountain triangle components, we have the magic triangle, dialogue between purchaser and citizens, using evidence for policymakers and convincing them for new services, payment methods and which service it applies to
- Thailand: learned from other countries, ageing society and discussion with Vietnam and information system, huge countries like India. It is inspiring to see that countries are taking the goal of UHC in all seriousness.