NHSO
Annual Report
2008

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National Health Security Office

NHSO
National Health Security Office

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List of abbreviations

ADJRW	Adjusted DRG Relative Weight	DRG	Diagnosis Related Groups
AE	Accident and Emergency service	EMS	Emergency Medical Service
CSMBS	Civil Servants' Medical Benefit Scheme	HC	High Cost service benefit
CHF	Congestive Heart Failure	HSRI	Health System Research Institute
COPD	Chronic Obstructive Pulmonary Disease	IP	Inpatient service
CUP	Contracting Unit of Primary Care	LOS	Length of stay

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MoPH	Ministry of Public Health
NHSO	National Health Security Office
NSO	National Statistical Office
OP	Outpatient service
PP	Health promotion and disease prevention services
PCU	Primary Care Unit
PUC	Pre-registered Universal Coverage scheme
PWA	People with AIDS
RW	DRG Relative Weight
SSS	Social Security Scheme
UC, UCS	Universal Coverage Scheme
VCT	Voluntary Counseling and Testing

Philosophy

According to the 2003 Constitution of the Kingdom of Thailand, health is declared a fundamental human right of the citizen. This implies that the national health system must be strengthened for the enjoyment of the entire population and Thai government is accountable to ensure that health care is one of the priority tasks. Within the health system, the health security system serves as a fundamental life security which gives a person confidence that they will be able to indulge in appropriate health behaviors and get access to any health activities and services needed without obstacles. Health security system should provide quality health care to all citizens--rich and poor, young and old, regardless of health conditions or socio-economic status.

Health care financing is a key function to generate appropriate service provisions. Financing mechanisms could provoke fair distribution of resources in the health care system. With dynamic participation of the civil society, health services can prosper under the citizen stewardship. Community participation and involvement is another indispensable component that helps to steer the focus of health actions towards a community-based and demand-driven approach. As a result, equitable access to health care responsive to the people needs is likely to be realized.

Vision, Missions, and Goals

Vision

"Health security system that ensures equitable accessibility, public confidence and provider satisfaction"

Missions

1. Promote and develop quality health care system with public confidence and provider satisfaction.
2. Promote the participation of civil society and local administration organization in health security development.
3. Promote and protect the people's right to health security as well as reinforce the learning process of the public in realizing their rights and duties.
4. Manage the health security funding and the utilization of the fund in the manner of sufficiency and efficiency.
5. Establish an organizational management system which is of high standard and promote continuous development towards a learning organization.

Goals

- Equitable health services provided at reasonable cost and with people satisfaction
- Access of beneficiaries to high standard health care services
- Efficient health security fund management
- People's participation in health security management and activities including those from local administration organisations, professional bodies and private sectors
- Systematic, integrated and high standard health security implementation on the basis of decentralisation to regional offices in line with efficient monitoring and evaluation
- Teamwork and continuous collective learning process

Message from the Secretary-General

For more than half a decade of its existence, Thailand's universal health care coverage has been strengthened and promoted through strenuous efforts from the National Health Security Office and its stakeholders. With an ultimate goal of equal access to quality health care for all as stipulated under Section 3 of the 2002 National Health Security Act, it is NHSO every endeavour to develop an accessible health care system which is responsive to the people's need with strong networks of public and private participation. We need to ensures that Thai people are protected from catastrophic situation caused by health expenses exceeding their financial capacity. NHSO therefore initiates programs that offer many sets of benefit packages for high-cost care, such as coverage for renal replacement therapy, kidney transplantation, kidney dialysis, peritoneal dialysis, heart surgery, cancer treatment, cataract extraction and lens replacement, treatment of haemophilia and treatment for cleft lip and cleft palate. We seek to provide prompt and greater access to health care so that the people's life quality is enhanced and their livelihood is guaranteed.

NHSO is well aware that the development of an efficient health care system and quality service means greater responsibility and obligation to the health care providers. NHSO aims to support these providers and come up with effective solutions for existing obstacles, especially the shortage of human resources and some inefficiency in the system. Some of the actions already put in place are the increase of budget for the providers executing good services and the flexibility introduced to budget utilization. Our mandate is to develop more mechanisms that support the work of the health care providers and stimulate quality services at "public confidence and provider satisfaction."

For the past six years, it is fair to say that the universal health care coverage in Thailand has been through many changes and it has progressed considerably. However, in the face of the world economic crisis, globalisation and changes in the world's epidemiology, there are inconsiderable tasks to be accomplished by NHSO and all stakeholders. Primary health care is one of the most important areas that require immediate attention and it shall be the focus of NHSO for the next phase of development.

I would like to take this opportunity to extend my sincere thanks and appreciation for the support and cooperation from the involving governmental agencies, private organisations, local administration organisations, professional bodies, our partners and networks and, above all, the Thai citizens. We hope that this productive support will continue indefinitely.

(Winai Sawasdivorn)
Secretary-General
National Health Security Office

The National Health Security Office

The National Health Security Office or NHSO is set up according to the 2002 National Health Security Act, with two governing national Boards, namely the "National Health Security Board" and the "Health Service Standard and Quality Control Board." The National Health Security Board is responsible for policy setting and system development. In principle, the development of benefit packages, health care service standard, criteria for fund management and no-fault compensation as well as regulation frameworks for contracting providers are decided. As stipulated under Section 13 of the 2002 National Health Security Act, the National Health Security Board is chaired by the Minister of Public Health and consists of members from various public and private organizations. The board members include the permanent-secretary of related ministries, namely Ministry of Defense, Ministry of Finance, Ministry of Commerce, Ministry of Interior, Ministry of Labor, Ministry of Public Health and Ministry of Education as well as the director of the Bureau of the Budget. Representatives from health professional bodies, municipalities, local administration organizations and non-profit organizations working on children, youth, women, elderly and other vulnerable groups are also included as the board members. In addition, experts in health insurance, medical sciences and public health, Thai traditional medicine, alternative medicine, finance, law and social sciences are appointed board members by the Cabinet. NHSO secretary-general is designated as the board secretary.

The Health Service Standard and Quality Control Board is responsible for controlling, monitoring and supporting standard and quality of health care providers. The Board also provides comments on standard fees for treatments, regulate no-fault liability payment, support public access to UC information and give response to consumer complaints. The board members include the heads of many health care institutes such as the Department of Medical Services, the Food and Drug Administration Office, the Hospital Development Accreditation Institute and the Medical Registration

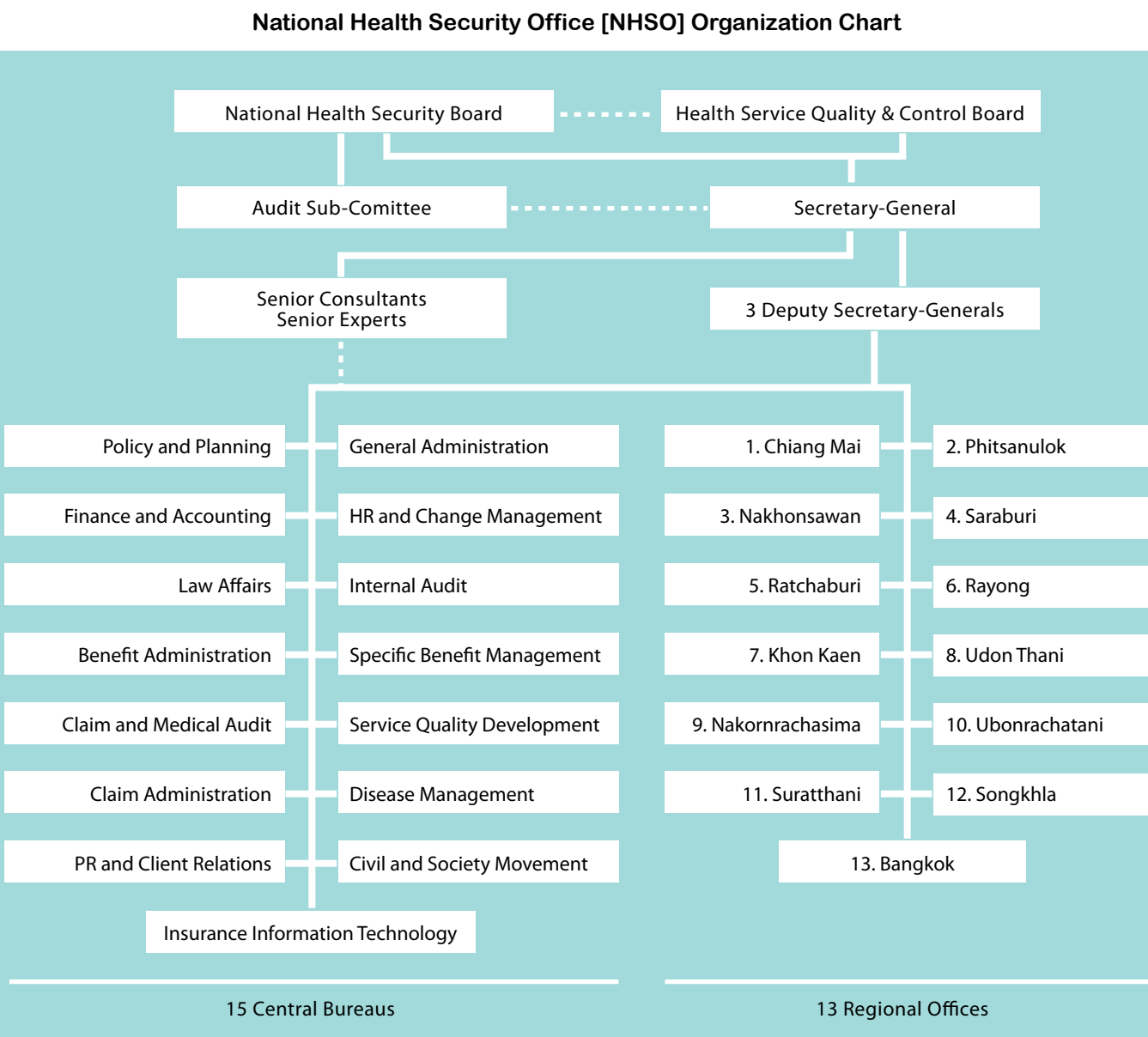
Division. Representatives from professional bodies, private hospitals, health care professionals, Royal Colleges as well as municipalities and local administration organizations are also included as board members. Representatives from non-profit organizations working on children, youth, women, elderly and other vulnerable groups are elected as members. Six qualified experts in tropical family medicine, mental health and Thai traditional medicine are appointed as board members by the Minister of Public Health. NHSO secretary-general is also designated as the board secretary.

With regard to good governance, an audit sub-committee appointed by National Health Security Board will function as internal auditors. The audit sub-committee is to closely inspect into the system whether internal operation, especially financial management, complies with the laws and regulations. Regular reports are submitted to the National Health Security Board on a quarterly and annual basis.

NHSO is an autonomous organization acting as a secretariat office for both national boards to manage and ensure the attainment of universal coverage for all. The internal operation in NHSO is divided into two main sections, the head quarter and regional offices. The head quarter office consists of 15 bureaus responsible for policy and planning, system support as well as monitoring and evaluation. 13 regional NHS Offices take responsibility for administering and monitoring the fund management at the regional level. The regional offices will ensure that health security implementation is responding to the local health needs. In order to accomplish this goal, co-operation and participation of stakeholders in decision-making process and health-related activities are required. In each regional catchment area, there is the number of population of 2.3 to 5 million.

Organization structure

Figure 1 Administrative structure of the UC, 2008



Public Health Insurance Systems in Thailand

At present, there are three main distinct public health financing schemes covering the entire population. The Social Security Scheme covers employees in formal sectors, whereas the Civil Servant Medical Benefit Scheme covers government employees and their dependants. The rest of population is covered by the Universal Coverage Scheme. The main characteristics of these three main schemes are summarized in Table 1.

Table 1 Main characteristics of health financing schemes in Thailand, 2008

Scheme	Target population	Coverage in 2008	Source of fund	Payment method
Civil Servant Medical Benefit Scheme Since 1963	Government employee, retires and dependants	8%	General tax, non-contributory	Fee for service retrospective
Social Health Insurance* Since 1990	Private sector employees	16%	Payroll tax tripaite contribution	Capitation and price list payment
UC Scheme Since 2002	Rest of population	76%	General tax, non-contributory	Capitation for OP and P&P. global budget and DRG for IP

Remark: Total Thai population in 2008 = 62.55 millions
Source : Bureau of Policy and Planning, 2008

The Universal Coverage Scheme

UC Scheme has been implemented since 2002. To improve the health of all Thai people, the provision of equal access to quality care in accordance with health need of population is extremely needed. UC offers coverage for all Thai citizens not covered by any other public health insurance schemes. To fulfil the enjoyment of health care, beneficiaries can get full access to health services provided by designated area-based networks of providers with free of charge. The current extensive system is proved to be able to protect them financially from catastrophic situations.

Entitled beneficiaries

The entitled beneficiaries are all Thai citizens, excluding those already under public schemes e.g. CSMBS and SSS.

Benefit packages

UC offers comprehensive benefit package which includes health promotion, prevention of diseases, curative care and rehabilitation services (except traffic accident cases which are already covered by traffic accident insurance scheme). Beneficiaries are systematically required to visit the registered primary care facility as the first point of contact. In case of severe conditions, they will be referred to secondary and tertiary care facilities, respectively.

Contracting unit for primary care

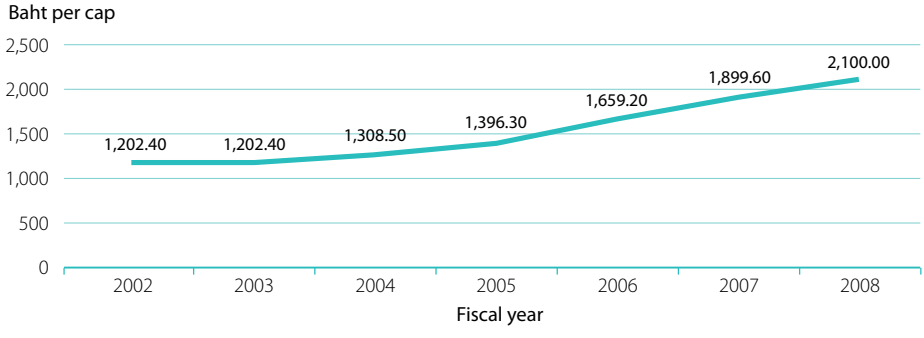
Contracting Unit for Primary Care (CUP) include both public and private health care facilities. They provide primary care services and act as gatekeepers. Services provided must emphasize on individual and family health care encompassing curative care, health promotion, preventive care, rehabilitation and community service within the service facility and in the community. On the basis of referral system, any public and private hospitals could be contracted as unit for secondary or tertiary care. Patients requiring care at secondary or tertiary level will be referred to the respective health care facilities.

These health care facilities are distributed throughout the country, covering all urban, rural, and remote areas. In 2008 registered providers comprise of 836 hospitals of Ministry of Public Health (including more than 10,000 health centers), 75 other public hospitals, 55 private hospitals, 93 public primary care units (PCU) and 150 private clinics.

Sources of finance

The UC scheme is financed by general tax revenue. NHSO proposes the annual budget by per capita calculation mainly according to unit cost of services provided and utilization rate. The capitation comprises labour cost, material cost, public utility cost, and depreciation. Since launched in 2002, the approved capitation was 1,202.40 Baht in the first two years and rose to 1,308.50, 1,396.30, 1,659.20, 1,899.69, and 2,100.00 Baht in fiscal year 2004, 2005, 2006, 2007 and 2008, respectively.

Figure 2 Approved budget, 2001 to 2008



Source: Bureau of Policy and Planning, 2009

Budgeting and provider payment mechanisms

In 2008, total budget of 76.598 billion Baht was separated into UC global budget and budget for HIV/AIDS (72.216 and 4.382 billion Baht respectively).

The UC global budget was divided into 12 subcategories: outpatient general services (OP); inpatient general services (IP); health promotion and disease prevention services (PP); central reimbursement (high cost care and accident & emergency care); emergency medical services (EMS), service for the disabled; capital replacement; flexible fund for specific facilities; no-fault liability; health personnel injury compensation; pay for performance and budget for alternative & traditional medicine.

The detail of each payment categories are as follows:

1) Almost all general OP budget was paid prospectively on a capitation basis with age adjustment to the contracting units of primary care (PCU). Referred OP cases would be reimbursed by PCU according to fee schedule or contracted agreement with referral health facilities. Some high cost items would be reimbursed under subcategories 4. The rest of the budget was for the development of out-patient clinical and financial information system of as well as quality improvement of outpatient care.

2) The general IP budget was reimbursed by Diagnosis Related Group (DRG) version 4 under global budget at NHSO regional level. Baht per adjusted relative weight was not guaranteed. Only the referral cases across regions were guaranteed at 9,000 Baht per adjusted relative weight. Some high cost items would be reimbursed under subcategories 4.

3) The PP budget was paid for health promotion and disease prevention services for all Thai people. It was divided into four parts. The first part was managed at national level for vertical programs e.g. national immunisation programme. The second part was for prevention and promotion of community-based services. The third part was for health promotion and illness prevention at health care facilities e.g. annual medical check-up. The forth part was for regional specific health prevention projects.

4) The central reimbursement budget was reimbursed for specific high cost items of OP and IP services e.g. coronary angiography and prosthetic heart valve. Accident and emergency care would also be reimbursed under this subcategory to the providers.

   - Point system with ceiling under global budget was applied to the reimbursement of accident and emergency care after calculating from charge prices.
   - point system with ceiling under global budget was applied for high cost services which was additional payment using NHSO fee schedule for medical instruments.

- NHSO fee schedule according to specified payment criteria was paid for disease management initiatives and special services. Those were Leukemia, lymphoma, cleft lip & cleft palate, open heart surgery, haemophilia, cataract extraction, surgery in epilepsy patients, urgent treatment in stroke fast track, bone marrow transplantation in children and secondary prevention for Diabetes Mellitus.

5) The EMS budget was initiated to increase accessibility to pre-hospital care that was poorly developed. A part of the budget was for EMS system development, and the other part was for claim reimbursement using fee schedule.

6) The disability budget was aimed to increase access to rehabilitation services for the disabled. Fee schedule under global budget was adopted for payment of services, instruments, and prosthesis. It also covered system development.

7) The capital replacement budget was administered mainly for maintenance. Therefore, at least 75 percent of this subcategory was allocated for the preventive maintenance and the replacement of the durable goods and building. The rest was allocated to minimize inequity of resource distribution, improve quality of excellent center services, and improve quality of primary care services. The allocation for minimizing inequity of resource distribution was considered to fall in to other budget line outside NHSO in the next fiscal year.) Fund for specific facilities was designed as an additional payment in response to higher cost of services in some specific areas such as areas with less number of people registered as well as a financial incentive for health personnel working in risky or remote area.

9) The no-fault liability fund was a fund developed under Section 41 of the National Health Security Act comprising no more than 1% of the total health security fund. In case of any medical injuries, patients could apply for compensation to the provincial committee. The compensation would be paid in accordance with the criteria established by the National Health Security Board.

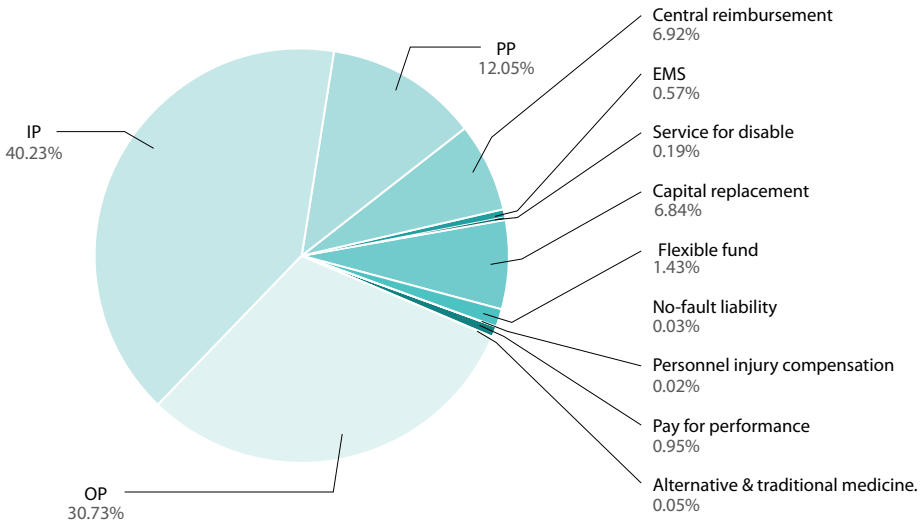
10) The health personnel injury compensation fund was set as a preliminary compensation for the health personnel suffering from injury and illness due to their medical service provision and performance.

11) The pay for performance fund aimed at the quality improvement of health facilities in primary care level and upper level. Composite scores of key performance indicators were collected to assess the performance.

12) Alternative and traditional medicine budget was designed to support Thai traditional medicine e.g. Thai massage treatment and physical rehabilitation

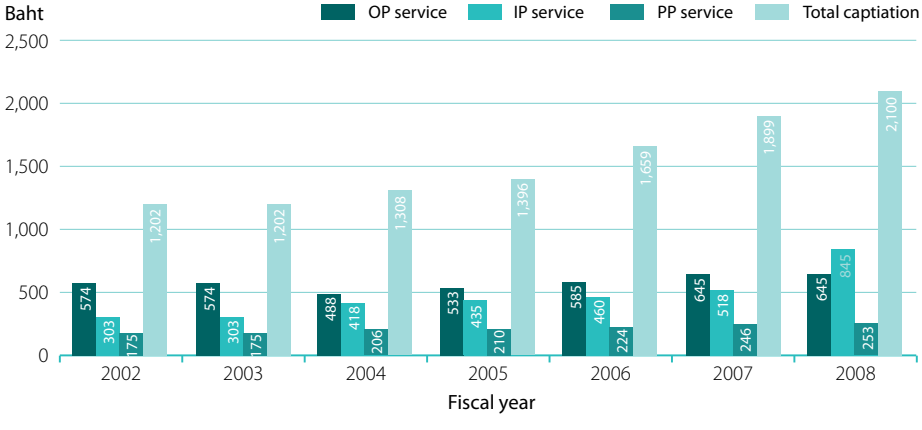
The proportion of each sub-category illustrated in Figure 3

Figure 3 Proportion of each sub-category of UC fund in 2008



The three largest share of UC fund during 2002 to 2008 was OP followed by IP and PP, respectively. The proportion of OP fund varied between 31% and 48%, IP budget was between 25% and 40%, while PP budget was between 12% and 16%, respectively. It has to be noted that in 2008, due to the integration of some subcategory funds, especially the IP fund, accident service, emergency service and some items of high cost care. Therefore the IP fund was the highest growth rate (179% from 2002 to 2008). On average, the total number of fund increased 12% per year.

Figure 4 Baht per capita of OP, IP, PP and total budget between 2002 to 2008



Source: Bureau of Policy and Planning, 2009

Besides the global UC fund, AIDS fund is established to ensure that all PWA in UC scheme can access to anti-retroviral treatment. The budget is designed as additional payment to providers which covers HIV/AIDS treatment and care services including strengthening of service system in facilities. The treatment and care include antiretroviral treatment, treatment of hyperlipidemia, HIV laboratory services, counseling services and condom use promotion. In 2008, 4.382 million baht was exclusively allocated to AIDS fund to support those activities.

Utilization review and clinical audit

In order to develop strong and effective benefits administration, a comprehensive utilization review and clinical auditing system covering coding, billing and quality control is put in place to strengthen and accelerate the claim and payment process under verifiable, measurable and transparent principles. NHSO claim and re-imbursement system is designed to regulate the accuracy of service data and quality standard. NHSO monitors and conducts quality control according to service delivery professional standard and verifies medical records of the UC beneficiaries focusing on in-patient care.

NHSO conducts financial and clinical audit to the health care providers according to the service utilization data submitted electronically by all of the providers ranging from small hospitals to medical schools. The development initiatives in fiscal year of 2008 are as follows:

1) **Development of guideline for financial auditing**
   The auditing starts from the utilization review of submitted claims from health care providers. The claim requests are scrutinized for any irregularities, considering the relevant information on disease diagnosis, treatment and procedures, LOS and amount of fees and expenses for the treatment.

2) **Medical record audit management at regional level**
   NHSO headquarter is responsible to manage medical record audit in each region with technical support from Bureau of Claim and Medical Audit. Selected health care personnel in each region will be trained to be auditors. Medical records are selected according to criteria from utilization review, and audit procedure is conducted at the health care facilities.

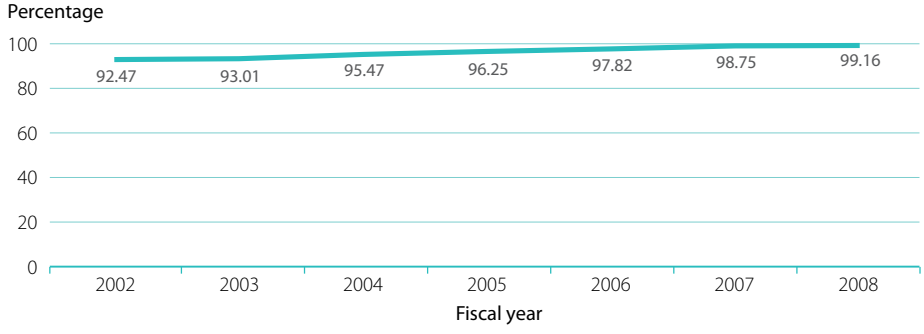
Outcomes & Achievements

To achieve the UC ultimate goals of equitable accessibility for all Thais and protection of catastrophic situations from high cost care, several mechanisms are put in place. Payment mechanism is one of the essential tools to efficiently utilise health resources and enhance sustainable health care system. It is also purposively designed to correct inequitable distribution of health resources and reinforce the behaviour of utilising resources in an efficient way. Since the commencement of UC, better quality of care has been provided significantly by both public and private settings and people's confidence in the policy has been increased. The effortless cooperation from the partners from different sectors is considered an invaluable contribution to UC success.

Coverage and accessibility

In 2008, UC scheme gave 99% of the total 63 million Thai populations an access to public health insurance. Only 0.8% of the entire Thai population is currently not covered by any public scheme. This is due to several causes such as temporary layoff, transition period to UC scheme for the dependants of civil servants, newborn under SSS etc.

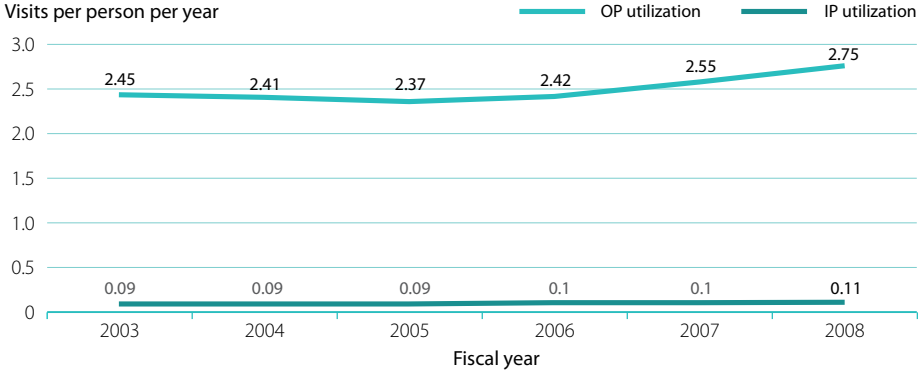
Figure 5 National coverage of insured persons by public health insurance schemes, 2002 - 2008



Source: Bureau of Insurance Information Technology, 2008

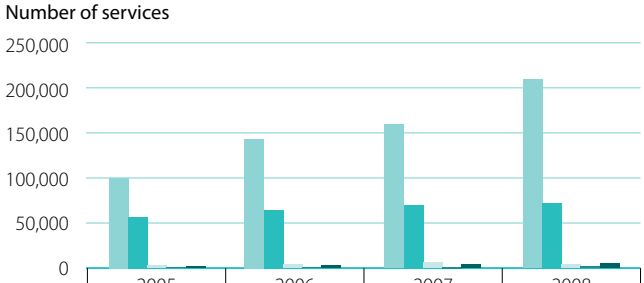
One of the greatest achievements in this new public health and medical care system is accessibility. Both out-patient and in-patient care utilization slightly increased over the past few years. Health promotion activities and disease preventive services are implemented under a policy focusing on community involvement and participation. The system efficiency is also strengthened by the promotion and support given to primary care providers with the hope that health service utilization would shift to appropriate care level with primary care as gatekeeper. These sets of evidence are illustrated in Figure 6 to Figure 9

Figure 6 OP and IP utilization, 2003 -2008



Source: 1) OP utilization analyzed from database of 0110 report 5, 2003 - 2008
2) IP utilization analyzed from IP individual record, 2003 - 2008

Figure 7 Improving access to high cost care, 2005 - 2008



	2005	2006	2007	2008
OP with chemotherapy/radiotherapy	100,203	143,287	158,993	209,883
IP with chemotherapy/radiotherapy	56,812	63,701	69,837	71,411
Heart surgery	2,865	4,212	6,411	6,345
Coronary artery bypass graft	926	1,094	1,278	1,462
Percutaneous transluminal coronary angioplasty	1,530	2,625	3,811	5,078

Source: Bureau of Claim Management, NHSO, 2008

Figure 8 Improving access to referral service, 2002 - 2008

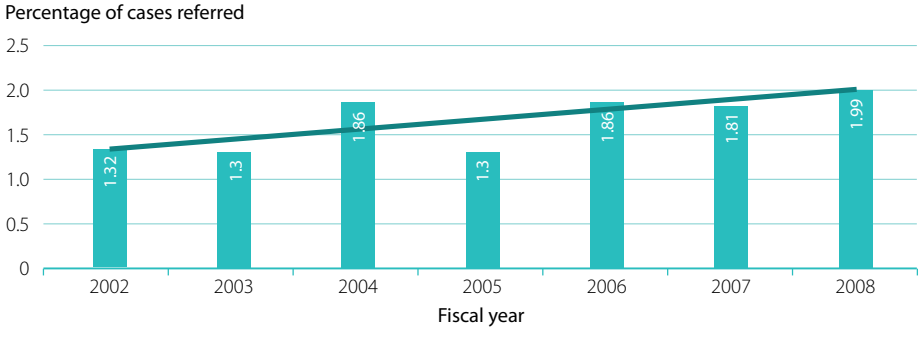
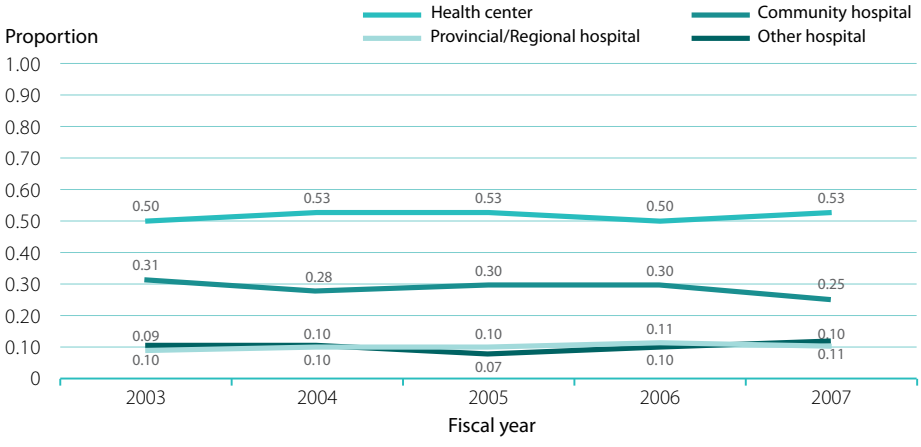


Figure 9 Health care facility utilization from 2003 - 2007

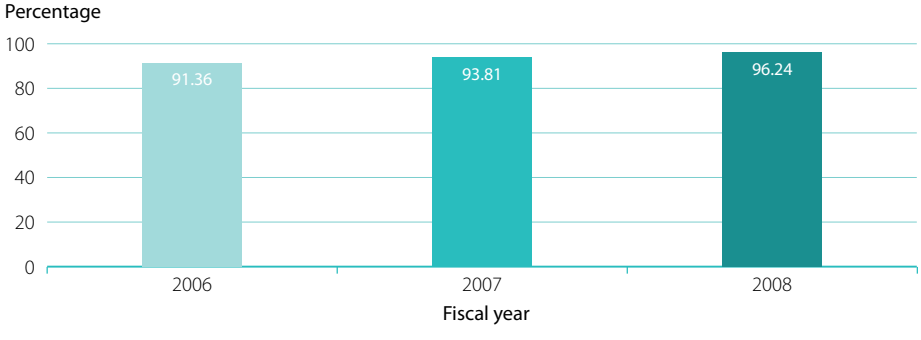


Source: Analysis of database from National Statistical Survey, National Statistical Office, 2003 - 2007

Quality of service

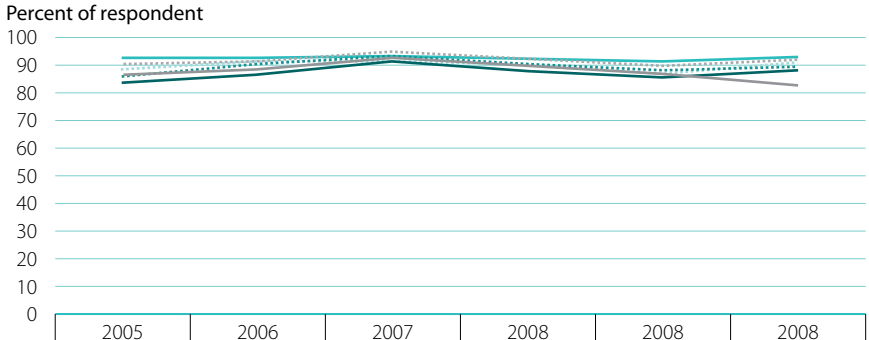
There is an increasing number of certified and accredited health facilities registered under UC as presented in Figure 10. Moreover, the users' satisfaction towards service quality increases in all aspects, except the "convenience," as illustrated in Figure 10.

Figure 10 Percentage of accredited hospital in all levels, 2006 - 2008



Source: Bureau of Service Quality Development, NHSO, 2008

Figure 11 Users' satisfaction towards service quality at UC health care providers from 2003 - 2008



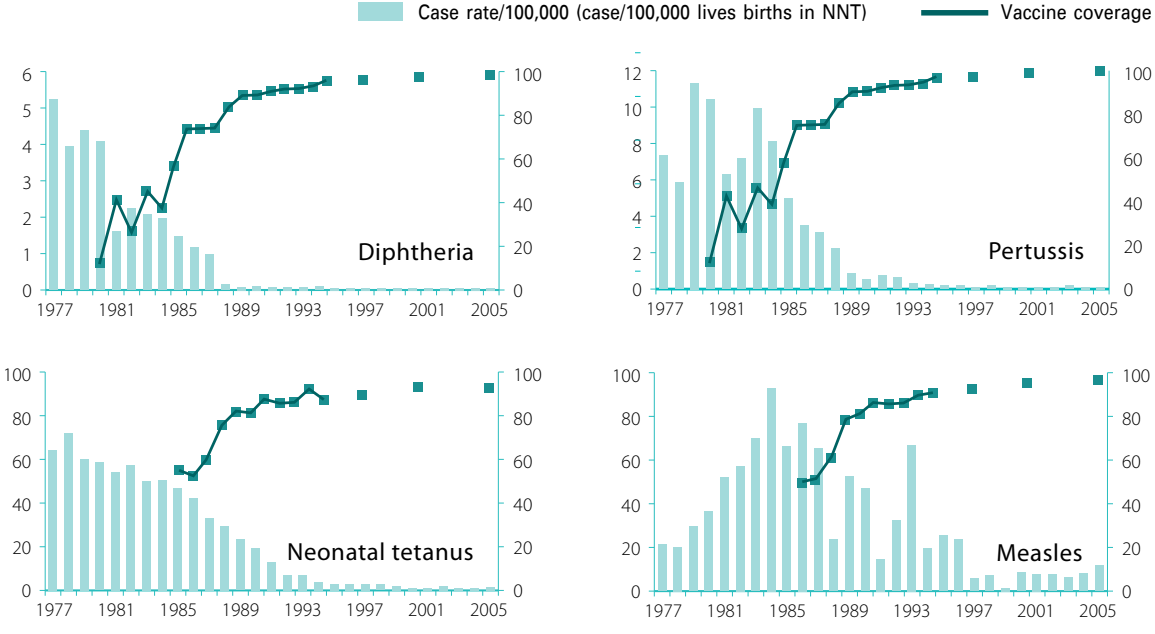
	2005	2006	2007	2008	2008	2008
Physician	92.9	92.9	93.3	92.2	90.9	93.6
Nurse	89.4	91.2	92	90.5	87.6	91.6
Drug	83.3	86.6	91.1	86.8	85.9	88.8
Medical equipment	85.8	90.4	92.9	90.2	88.5	89.4
Convenience to get service	86.1	88.3	91.3	89.5	87.5	82.2
Treatment outcome	90.2	91.8	94.4	91.7	90.0	92.0

Source: Perception survey on peoples' satisfaction towards UC, by ANCHOR, Assumption University, 2008

Health outcome from health promotion and disease prevention service program

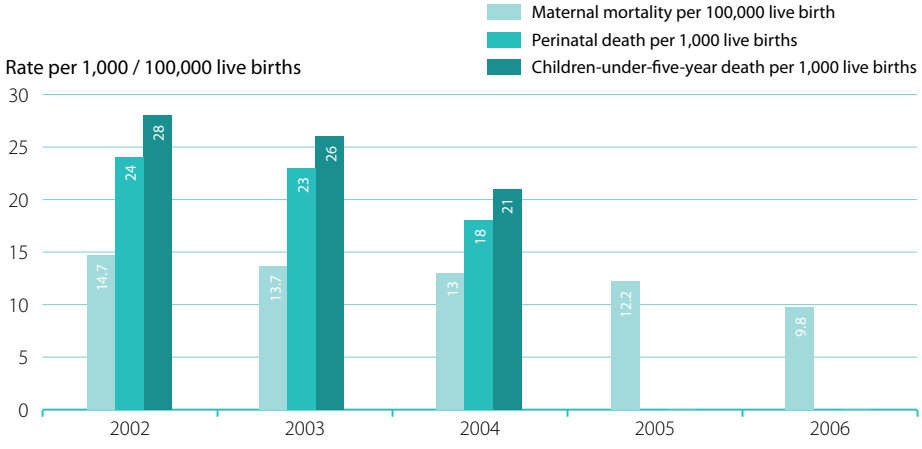
The success of health promotion and disease prevention implementation derived from the contribution from many sectors and partners. The most important partner is the Ministry of Public Health. The success indicator is reflected through an increase in coverage for preventable diseases by vaccination that, in turn, affect a rapid decrease in disease incidence (Figure 11), and the reduction of maternal mortality rate, perinatal death and the death in children under five (Figure 12) . In addition, the decreasing rates of low birth weight and birth asphyxia are stated (Figure 13).

Figure 12 EPI vaccination coverage rates and disease incidences, Thailand 1977 - 2008



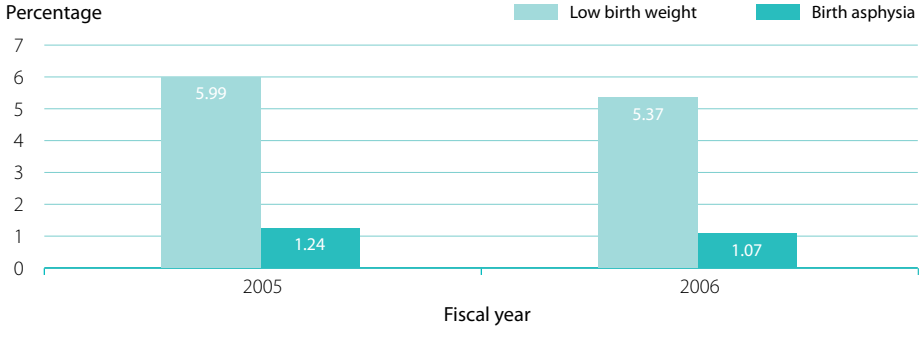
Source: Disease Control Department, MoPH, 2008

Figure 13 Maternal mortality, perinatal death, children-under-five-year death, 2002 - 2005



Source: Thailand Health Profile, 2005 - 2007

Figure 14 Low birth weight and birth asphyxia from 2005 to 2007



Source: Individual medical record analysis, Bureau of Service Quality Development, NHSO

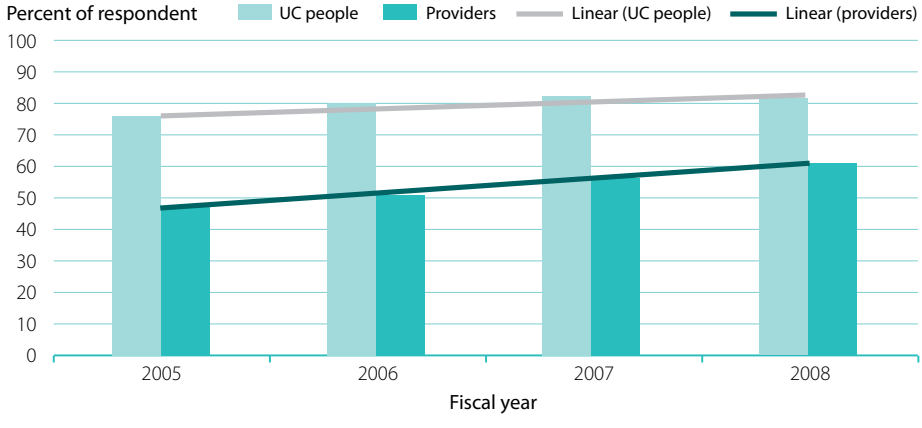
Promoting equity in health

According to the study of "How do the poor benefit from the Universal Healthcare Coverage Scheme? Thai experience, 2008" by Pongpisut Jongudomsuk (Jongudomsuk. P, 2008), many features of the UC promote equity in health. Empirical evidence shows that Concentration Index (CI) of general tax revenue in 2002 was 0.6996 which indicated the rich contributed a larger share than the poor. Recent study on benefit incidence analysis found that for ambulatory services, the government subsidy was pro-poor at district health system. The CI was - 0.3326 and - 0.2921 for health center and community hospital, respectively. It was slightly less progressive at general and regional hospital level (CI = -0.1496). For in-patient care, it was more progressive in favor of the poor at community hospital, the CI was -0.3130 in 2001 and -0.2666 in 2004. It was less progressive in favor of the poor at general and regional hospital, the CI was -0.1104 in 2001 and -0.1221 in 2004.

Satisfaction of stakeholders

A survey data on people's satisfaction towards UC in 2008 conducted by the Academic Network for Community Happiness Observation and Research (ANCHOR), Assumption University, illustrates a slight increase in the users' and the providers' satisfaction towards the scheme as shown in Figure 15.

Figure 15 People's and providers' satisfaction towards UC, 2005 - 2008



Remarks: Satisfaction percentage calculated from respondents' indication of "satisfied" and "very satisfied"

Source: Perception survey on people's and providers' satisfaction towards UC, by ANCHOR, Assumption University

Consumers' Right Protection

Following the declaration in the Thai constitution of "Human dignity, right and liberty of the person shall be protected" and "A person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from public health centers of the State…," several measures to guarantee the right to health for all Thais have been developed as follows:

1) Public awareness on consumers' right and participation as well as complaint feedback

- Dissemination of public relation materials through various channels such as television, radio and print media
- Hotline service of 1330 call center for information inquiries and acceptance of complaints and appeals
- Interconnected complaints and appeal management system with other organisations for example, 1111 hotline, the Office of His Majesty's Principal Private Secretary, the Prime Minister Office, Damrongdharmma Center and other media organisations.
- Establishment of information and complaint service centers within the facilities, such as regional hospitals, general hospital as well as possible extension to some community hospitals, which will help to strengthen the awareness in service system development and bridge the gap between providers and users

2) Complaint and appeal management procedures

- For the violation of the right to health care, according to Section 57 and 59 of the National Health Security Act, such cases will be investigated by the investigation sub-committee on the following issues:
  - Service fee charged by health care providers on services under UC benefit package
  - Inconvenience in access to care
  - Substandard of health care service

3) No-Fault Compensation

- According to Section 41 of the National Health Security Act, in case of injury due to services under UC, the patients are entitled to submit a request for no-fault compensation. The request will be considered by the provincial sub-committee. In case the patients seek to bring the case forward to an appeal, the case will be passed to the consideration of the Health Service Standard and Quality Control Board.

4) Patient Referral Center Initiative

- The centers for referral are established to improve the efficiency of referral system. In principle, the Patient Referral Centers are based at the regional level. The stakeholders will work together to manage referral system efficiently and to strengthen referral network.

Stakeholder Participation and International Cooperation

Participation from stakeholders is one of the most crucial factors to the achievement of UC mission. Vitalizing cooperation between different organizations from public and private sectors has been carried out by NHSO. These stakeholders include the civil society, local administration organizations, professional bodies as well as government agencies and private organizations. Stakeholders need to be encouraged to involve in the design and management of health security activities and implementation. Representatives from each area are appointed as the board members of the National Health Security Board as well as the regional health security sub-committees. In addition, partnerships and alliances with relevant organizations are also strengthened in order to efficiently implement such health insurance activities for the entire population. Some of the important co-operations and partnerships are:

Cooperation with civil society and local administration organizations

Civil society and local administration organization are the voices of the beneficiaries. NHSO endeavour to support them in health security participation in order to ensure demand-driven approach in management, right protection, people capacity building as well as awareness raising.

Cooperation with health care providers

NHSO is well aware that health care provider plays a vital role in developing health security in the nation. NHSO has made strenuous effort to coordinate with and involve health care providers in both academic and management areas. The effort is put in both public and private sectors.

Cooperation with professional bodies

NHSO is committed to promote the sense of ownership by means of participation in health security policy planning and monitoring among the professional bodies such as the rural doctor society, royal colleges, health institutes and medical schools as well as health care societies and foundations.

Cooperation with other public health insurance schemes (CSMBS and SSS)

Sharing of resources is the key to this cooperation. The three schemes focus on synchronising health care standards and practices in a close collaboration manner.

National technical cooperation

NHSO joins hands with the institutes under Health System Research Institute (HSRI), National Health Foundation (NHF), the Foundation of Thai Gerontology Research and Development institute (TGRI) and Naresuan University (NU) in developing proper provider payment mechanisms for intermediate care and long term care in support of the aging population. NHSO is also cooperating with the National Blood Center of the Thai Red Cross Society, Thai Haemophilia Foundation, the Government Pharmaceutical Organization (GPO) and WHO experts to conduct a study on FVII concentrate production in Thailand in support of the haemophilia patients.

International cooperation

NHSO realises the fruitfulness of technical cooperation and experience sharing internationally. Up to the present time, the recent international cooperation projects and activities are as follows:

1) International Labor Organization (ILO) in collaboration with the three public insurance schemes (CSMBS, SSS and UC) implemented health care financing model development to strengthen the budgeting and financing system of each scheme. The implementation is expected to be completed within fiscal year 2009. A collaborative training and model maintenance activities are also put in place on a regular basis.

2) A lesson-learned extraction project on Thailand's health security situation under "Country Development Partnership in Health (CDP-Health)" is conducted by the World Bank in collaboration with NHSO and MoPH. A completed research under this project is "Trend of Cost and Service in Thai Health Delivery Systems."

3) Collaboration with World Health Organization, especially the South East Asia Regional Office, is conducted on a regular basis in order to achieve and promote quality health care.

4) NHSO nominated its experts to participate in regional proposal development with the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP). During the fiscal year 2008, two proposals launched are "Development of Health Systems in the Context of Enhancing Economic Growth towards Achieving the Millennium Development Goals in Asia and the Pacific" and "Promoting Sustainable Social Protection Strategies to Improve Access to Health Care."

5) The European Union, NHSO and MoPH entered into a technical cooperation agreement on "Thai-European Health Care Reform Project" where technical assistance is provided to the Royal Thai Government on health care reform for a term of five years. The objectives of the project are to strengthen health care reform through four key components, namely, 1) Primary Health Care Development, 2) Health Care Financial Management, 3) Hospital and District Health System Management and 4) Advocacy. The technical assistance provided includes doctorate and master degree as well as short-course scholarships on related health issue, study visit on health care system in European countries as well as technical input from contracted national and international consultants.

6) NHSO and Social Security Office are members of the Asian Social Security Association (ASSA). Currently, there are 19 member organizations in total from ASEAN countries, except Myanmar (Burma) and Cambodia. The Secretary-General of NHSO is recently appointed as the vice president of ASSA.

7) Cooperation with overseas organisations and institutes for study visits at NHSO. The details of the study visits are shown in Table 2

Table 2 Overseas organizations paying a visit to NHSO in 2008

Topics	Country
HIVQUAL project implementation, results and lessons learned in Thailand	Cambodia
Expansion of National ARV Access into National Health Security System	Bhutan
Universal Coverage for Health Care Program	Indonesia
Study on Tsunami disaster of the year 2004 in Thailand	Japan
Expenditure on Health of Universal Coverage Scheme	Bangladesh
HIV/AIDS	Maldives
Background of the Universal Coverage Scheme (30 Baht)	International students
National AIDS Program and Quality Improvement System	India
Universal Coverage for Health Care Program	Indonesia
Background of the Universal Coverage Scheme (30 Baht)	Bangladesh
UC from policy to implementation	World Bank
Compulsory Licensing	WHO
Social Health Insurance & Health Care Financing	Bangladesh
Study Visit NHSO on UC overview/claim/provider contracting/customer service	Indonesia
Public Policy and Economics of Health System Development	International students
Universal Coverage for Health Care Program	Indonesia
Overview of Health care system & Customer service	Bangladesh
Expenditure on Health of Universal Coverage Scheme	Palestine
Developing and Implementing the DRG system for payment of health care services in Thailand	Vietnam
Health Security Scheme in Thailand: Universal Coverage	International students

Source: Bureau of Policy and Planning, NHSO, 2009

Improving Efficiency in Health Care Management

Several initiatives have recently been implemented to improve efficiency in health care management.

- Introduction of disease management approach to improve system efficiency on specific disease control. The diseases under this initiative include some chronic diseases such as Diabetes Mellitus, tuberculosis, and some high-cost disease such as leukaemia, lymphoma, and open heart surgery.
- The rational drug use program aiming to reduce drug cost, to secure continuity of their supplies, and to increase accessibility to care. Several strategies have been carried out such as central procurement, Vendor Management Inventory, and collective bargaining for drug purchase.
- Community health promotion fund established at sub-district or municipal level and co-financed by Local Administration Organizations and NHSO. This initiative aims to sustain health care system at local level.
- Promotion of Primary Care Unit (PCU) is launched to improve the capability of front line health care system in joint cooperation of NHSO, the Royal College of Family Physicians of Thailand (RCFPT), and Thai Nursing and Midwifery Council. The main focus is capacity building for primary health care team, i.e. health personnel, family doctors, and nurse practitioners.
- Friendship Support Promotion Center, promoting humanized care has been initiated through peer to peer patients suffering from chronic diseases such as cancer, hemophilia, chronic renal disease, heart-surgery patients and people living with HIV. The center activities are aimed not only at physical treatment but also mental support and it is closely advised by health professionals. Volunteer from either patients and their relatives or health professionals and other interested people can take part in the activities. The center is promoted at all health facilities nationwide.

Major Concerns

Despite the improvement of health care provisions following the commencement of UC stated in a number of research findings, some major concerns on the scarcity of health resources and inequitable distribution of health facilities, particularly in remote areas still exist. Two significant constraints are inaccessibility of deprived people and over-workloads of providers.

Future Challenges of UCS

Even though there are several successful UC programs in terms of improving accessibility, protecting the poor from catastrophic expenditure, improving people's satisfaction, and increasing stakeholders' participation, considerable actions to improve the system still need to be taken. The policy development and program designs should be evidence-based. Fair distribution of resources for accessibility, health equity and financing equity shall be given priority to and the following management should be implemented:

- Standardize provider payment mechanisms and benefit package in the three main schemes.
- Balance the use of financing mechanisms and other measures to harmonize interactions among purchasers, health care providers and consumers.
- Develop a more equitable plan of health care delivery and put it into practice.
- Ensure the sustainability and equity of UC financing.
- Develop effective health care purchasers at central and local levels, and promote local purchasers of health care authority into practice
- Promote participation of communities and local governments
- Ensure quality of primary care services responsive to people's needs.

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Appendices

Table 3 Number of disease screening for persons having risk behavior in 2008

Total screening	Categories			
	Diabetes mellitus	Hypertension	Stroke	Obesity
9,112,925	2,859,513	3,890,032	2,443,130	3,439,018

Table 4 Number of persons having disease risk entering into behavior changing program

Categories	Number of persons having disease risk	Number of persons entering into behavior changing program	%
Diabetes mellitus	2,859,513	583,553	20.41
Hypertension	3,890,032	601,414	15.46
Stroke	2,443,130	310,209	12.70
Obesity	3,439,018	410,250	11,93
Total	12,631,693	1,905,406	15.08

Table 5 OP and IP utilization in 2003 - 2008

OP/IP	Categories	2003	2004	2005	2006	2007	2008
OP	OP visits	111.95	112.49	111.64	114.77	119.29	128.73
	OP utilization rate	2.45	2.41	2.37	2.42	2.55	2.75
IP	IP admissions	4.30	4.16	4.34	4.73	4.88	4.95
	IP utilization rate	0.09	0.09	0.09	0.10	0.10	0.11
	Average Adj. RW	na	0.87	0.89	0.91	0.95	0.99

Table 6 Number of patients accessing to some high cost care services in 2004 - 2008

Items	2005	2006	2007	2008
OP with chemotherapy/radiotherapy	100,203	143,287	158,993	209,883
IP with chemotherapy/radiotherapy	56,812	63,701	69,837	71,411
Heart surgery	2,865	4,212	6,411	6,345
Coronary artery bypass graft	926	1,094	1,278	1,462
Percutaneous transluminal coronary angioplasty	1,530	2,625	3,811	5,078

Table 7 Medical services for HIV/AIDS patients in 2008

Medical services	Amout
VCT (time)	254,516
New cases registered (person)	37,546
Current registered (person)	154,320
Current followed up (person)	105,674
• CD4 tested (time)	129,567
• Current follow up with ARV (person)	101,027
• ARV drug - first line formula (person)	98,146
• ARV drug - second line formula (person)	2,881
• Viral load tested (time)	59,730
• Blood chemistry tested (person)	63,106
• Drug resistance testing (time)	2,450

Table 8 Number of patients registered in disease management program in 2008

Disease program	Number of cases registered
Diabetes mellitus	70,456
Tuberculosis	45,152
Cataract extraction and lens replacement	54,193
Open heart surgery	3,344
Luekemia & Lymphoma	1,448
Cleft lip and cleft palate	1,604
Continuous ambulatory peritoneal dialysis	781
Haemophillia	566
Epilepsy	99
Stroke	52
Bone marrow transplant	17

Table 9 NHSO budget in 2003 to 2008 (Unit: million, Currency: Baht)

Categories	Fiscal year					
	2003	2004	2005	2006	2007	2008
Total UC population	46	46.82	47	47.75	46.07	46.48
Total UC fund including providers' salary in public hospitals	56,091.23	61,212.39	67,482.6	82,023	91,366.72	101,984.1
UC fund excluding providers' salary in public hospitals	30,538.40	33,572.87	40,789.95	54,428.63	67,364.06	76,598.8
• Medical service	25,538.40	29,727.54	35,796.62	36,870.6	63,508.46	72,216.4
• AIDS budget	0	0	0	2,796.2	3,855.6	4,382.4
Management budget	1,600	1021	625	647	811	807.65

Table 10 No-fault compensation in 2007 - 2008

Categories	2007		2008	
	cases	Baht	cases	Baht
Number of claims filed to the provincial sub-committee	511		658	
• Not met criteria	78		108	
• Met criteria	433		550	
• Dead/Disable	239	38,090,000	303	49,722,000
• Organ lost	74	7,570,535	73	7,720,000
• Injured	120	4,527,000	174	6,406,148
Number of claims appealed to the Health Service Standard and Quality Control Board				
• Appealed cases	55	1,990,000	74	1,010,000
Total paid	433	52,177,535	550	64,858,148

Table 11 Health personnel injury compensation in 2007 - 2008

Item	2007		2008	
	cases	Baht	cases	Baht
Number of claims filed to the provincial sub-committee and regional sub-committee	235		562	
• Not met criteria	38		89	
• Met criteria	197		473	
• Dead/Disable	2	280,000	2	
• Organ lost	4	300,000	2	240,000
• Injured	191	2,966,500	469	8,351,800
Number of claims appealed to the appeal board	2	-	19	815,000
Total payment	197	3,546,500	473	9,406,800

NHSO ANNUAL REPORT 2008

First Printing September 2009

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Distributed by Bureau of Policy and Planning
National Health Security Office (NHSO), The Government Complex
120 Moo 3 Chaengwattana Road, Lak Si District, Bangkok 10210
Tel : 66 2 141 4056 Fax : 66 2 143 9730

Printed by T.Film Co.,Ltd.

Designed by Srisopa Nimvijit

ISBN

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