Quick Health Financing Stats for Thailand

Basic statistics (2013, WHO Global Health Observatory)*	Thailand
Population	67,010,000
GDP per capita (USD)	$5,977.4**
Total health expenditure per capita (USD)	$658
Total health expenditure as % of GDP	4.6%
Government health expenditure as % of total government expenditure	17%
Government health expenditure as % of total health expenditure	80.1%
OOP spending as % of total health expenditure	11.3%

* 2013 data from WHO's Global Health Observatory
** Data from World Bank 2014

DEMAND-SIDE PROGRAMS

In this framework we define demand-side UHC programs as programs that aim to reduce economic barriers and expand access to more and better services.

Many major national, demand-side health system programs either target a specific population (*poor and vulnerable people*, the *non-poor informal sector*, or the *formal sector*) or have distinct design features depending on the beneficiary's economic and work status. Therefore, this matrix includes questions specific to the program's design features for each specific population.

		Universal Coverage Scheme (UCS)	Social Security Scheme (SSS)	Civil Servant Medical Benefit Scheme (CSMBS)
Identify each major, nationwide program / system that aims to reduce economic barriers and expand access to more and better health services for the population, and when the program started or was reformed. List one program per column.		• Social Welfare Scheme • Public integrated model(ILO 2008) • Began in 2001 • Institutionalized in the National Health Security Act in 2002 • 45 million now covered by UCS (of 70 million Thai) (UNICO-World Bank 2013)	• Established in 1990 for private sector employees • Compulsory Scheme	• Established in 1980 for civil servants, permanent employees, pensioners, and up to two dependents • Fringe benefit scheme • Largest civil servant scheme. Local governments and other state enterprises have benefit packages; similar to the CSMBS, with much smaller membership.
Population Covered: • How are beneficiaries identified and targeted? • What are the eligibility rules?	Poor/vulnerable (UCS) Non-poor informal sector (UCS) Formal sector employees (SSS and CSMBS)	• Together the UCS, SSS, and CSMBS examine multiple citizen registries (civil, house, national ID numbers) to determine CSMBS/SSS eligible recipients. UCS targets remaining population, including poor and informal sector, but also small business members in private formal sector. • UCS enrollment is automatic, but registration is required. Registration happens at health centers, hospitals, or health offices. Members must specify registered providers (can change main providers four times per year). • The National ID system, under the Ministry of Interior, is an important system when targeting beneficiaries. UCS uses the National ID card for registration/membership card. • Targets all people not covered by the SSS	• Together the UCS, SSS, and CSMBS examine multiple citizen registries (civil, house, national ID numbers) to determine CSMBS/SSS eligible recipients. • Targets formal private sector. Reluctant to extend insurance to small enterprises (less than 10 people) (UNICO-World Bank 2013). • Private employers with more than one employee must participate. • Must use contracted hospitals or its network with referral line, registration required. • Only covers adults 15-60 years of age (excludes dependents who would be eligible to receive UCS)(WHO 2012). • Requires annual provider choices to be selected; choices of provider when ill are limited to registered contractor hospital and its network; free choice for accident or	• Together the UCS, SSS, and CSMBS examine multiple citizen registries (civil, house, national ID numbers) to determine CSMBS/SSS eligible recipients. (UNICO-World Bank 2013). • Target formal public sector including civil servants of the central government, pensioners and their dependents (parents, spouse, children- up to two children who are younger than 20) (ILO 2008). • Offered as a fringe benefit. • Free choice of providers and no registration required.

		Universal Coverage Scheme (UCS)	Social Security Scheme (SSS)	Civil Servant Medical Benefit Scheme (CSMBS)
		and CSMBS schemes. Also, targets coverage for children under five and adults over 60 (WHO 2012). • UCS annually add or remove beneficiaries by cross-referencing registries if members switch to CSMBS or SSS (UNICO-WB 2013). • Target self-employed as well with flat monthly contribution though not enforced (Tangcharoensathien 2013).	emergency services (Tangcharoensathien 2014).	
Services and Benefit entitlements: • Summarize the services or benefit entitlements for each population group. • Specify whether the services or benefits are defined in the form of a positive list, a negative list, or not explicitly defined. • How are benefit packages selected? • How are they updated over time? For example; health technology assessment.	Poor/vulnerable (UCS) Non-poor informal sector (UCS) Formal sector employees (SSS and CSMBS)	• Comprehensive coverage focusing on primary care, including inpatient, outpatient care, prevention and promotion, and rehabilitation. • Has a positive and negative list that specifies health conditions or clinical procedures covered or excluded. Mostly applies negative list concept (Tangcharoensathien 2014). • Benefits package refers to National Essential Drug List that classifies meds into categories based on effectiveness and cost-effectiveness characteristics. • The NHSB Committee on Benefits Package uses 2010 guideline requiring Ministry of Public Health MOPH inputs from the Health Intervention and Tech Assessment program and International Health Policy Program to supply evidence to committee on effectiveness and cost effectiveness of potential new interventions. These considerations are taken into account before new interventions are added to benefits package during annual review. • Before adding to the benefits package, important criteria including ethical considerations, budget impact/cost effectiveness, and feasibility are considered. (Tangcharoensathien 2013).	• Comprehensive package including outpatient, inpatient, accident and emergency, high cost care with minimal exclusions. Covers non-work related illnesses and conditions. Offers maternity (WHO 2012). • SSS covers some rehabilitation and curative services (Thammatach-aree 2011). • Prevention and health promotion activities not covered by benefits. Must pay for these services out of pocket (OOP). No annual physical provided; does not cover private bed or special nurses in in-patient care (ILO 2008). • Beneficiaries receive services at registered contractors' hospital with more than 100 beds, public or private, and mostly in Bangkok and urban areas (Thammatach-aree 2011). • The SSO is split into an Internal Audit Group and Management System Development Group (MSDG). Within the MSDG there is a Financing, Accounting and Investment Bureau, Information and Communication Tech Bureau, and Benefits Bureau. Within the Benefits Bureau, the benefits package is reviewed and updated by the Policy and Planning Division. They use a similar process of assessing important considerations including ethical considerations, budget impact/cost effectiveness, and feasibility.	• Enjoys the best Benefits package of the three schemes (UNICO-WB 2013). Expenditures are four times higher because fee for service payment creates provider incentives to diagnose and provide prescriptions to patients (WHO 2012). • Comprehensive Coverage includes: public ambulatory services, private and public emergency in-patient services, allows free choice of providers, maternity benefits, annual physical checkups, comprehensive package for many conditions. • Does not include: prevention health promotion services unless it is a public decree, does not cover specialty nursing; does not cover beautification treatments, and will not cover some contraception. These are OOP expenditures (ILO 2008). • CSMBS beneficiaries can seek services at any public hospitals. • There is Fee for Service payment on outpatient service and diagnostic related groups (DRGs) on inpatient services. (Thammatach-aree 2011).
MANAGING MONEY/ FINANCING UHC				
Financing sources	• Government source of revenue (e.g,. taxes) for this program? Earmarked taxes, sin taxes, general taxes? • Mandatory contributions by formal sector workers (payroll taxes)? • Beneficiary premiums? • Beneficiary cost sharing at the point of service?	• Financing for health mostly from government revenue (general tax-based financing). As of last NHA in 2008, central government pays for two-thirds whereby local government contributes 4%. Remaining 31% comes from households and formal private businesses. • Progressive tax financing (i.e., the rich pay more income tax - 37% net income & 30% corporate net income) than the poor, used to	• Payroll tax financed (not general tax), tri-partite (employee, employer, government) contribution (1.5% salary equally by employer, employee, and government (WHO 2012). • 4.5% payroll (Tangcharoensathien 2014). • OOP expenditures required for some benefits, and beneficiary cost-sharing at point of service.	• CSMBS accounts for 16% government spending. • General tax based revenue, non-contributory scheme. • Costs continue to rise (UNICO-WB 2013).

		Universal Coverage Scheme (UCS)	Social Security Scheme (SSS)	Civil Servant Medical Benefit Scheme (CSMBS)
	• Provide specific information about any separate features of the beneficiary contribution model covering poor and vulnerable people, the non-poor informal sector, and the formal sector (if applicable). • Summarize how each source of financing is collected.	generate revenue (Health Insurance Research Office 2012). • Sin taxes on beer, spirits, and tobacco used to generate revenue. • Import duty taxes on cars and luxury goods used to generate revenue. • Central government contributions mostly fund UCS. • As of 2012, required 30-baht co-payment for patients receiving prescriptions who are willing to pay, though not actively enforced. Exemption of co-payment for 21 beneficiary groups including poor, elderly, children under 12 (UNICO-WB 2013). • Costs per capita continue to rise.		
Risk pooling	• Is there one national pool, separate national risk pools for distinct beneficiary groups, or subnational level pools? • Are the poor cross-subsidized by higher income people? Discuss for each program.	• 80% of national health spending goes through fund-pooling mechanisms. UCS is biggest funding pool mechanism (one-fourth or 25% of government health spending) and targets informal and poor beneficiaries. • Universal benefits provided and pro-poor targeting used. • Higher taxes by the rich contribute to coverage.	• SSS is pool for formal private sector. Accounts for 7% of government spending.	• CSMBS is a pool for public employees or civil servants. Accounts for 16% of government spending. • Because three pools exist, per-beneficiary expenditure is highly skewed because of lack of redistribution across the schemes (Reich 2015).
Financial management	• What institution manages the program? • How does the program remain solvent? • Are there mechanisms in place, such as caps or utilization review, that maintain the financial viability of the system?	• Established in 2002, under the authority of the National Health Security Board (NHSB), the National Health Security Office (NHSO), a state autonomous agency with monopsony purchasing power registers beneficiaries and providers and pays claims according to regulations set by the NHSB (UNICO-WB 2013). • The MOPH is chair of the NHSB and the Permanent Secretary of MOPH is member. NHSB includes members from civic sector, professional bodies, academia, etc. • Standards and Quality Control Board also governs UCS, responsible for quality control. • An ongoing problem, with roots in DRG payment analysis requiring global budget cap, are delayed payments to providers. To mitigate, NHSO disburses early payments based on historical utilization with the final amount adjusted in last annual financial transfers. • Government provides NHSO with UCS budget based on number of beneficiaries covered (capitation rates per person). NHSO estimates capitation cost on unit cost studies and number of yearly covered beneficiaries. The government cabinet annually approves this rate. However, budget provided has at times been lower	• Social Security Office (SSO) runs SSS. • The SSO is split into an Internal Audit Group (IAG) and Management System Development Group (MSDG). Within the MSDG there is a Financing, Accounting and Investment Bureau, Information and Communication Tech Bureau, and Benefits Bureau. Within the IAG there is Contribution Bureau, Medical Service Management Bureau, and Inspection Bureau. • Tripartite contribution by employer, employee, and government help maintain solvency. • They use a mix of provider payment mechanisms including DRG and capitation. See provider payment section below.	• Comptroller General Department within the Ministry of Finance is the financing body. • Spends more on branded drugs and has higher caesarean rates and longer hospital stays for most DRGs. • Many financial viability challenges cited including: age of beneficiaries, irrational use of drugs, high OOP costs, and fraud/waste.

		Universal Coverage Scheme (UCS)	Social Security Scheme (SSS)	Civil Servant Medical Benefit Scheme (CSMBS)
		than projected capitation coverage needs. • Use of closed end provider payment methods (DRG and capitation) with caps on provider payments ensures better cost containment (Tangcharoensathien 2013). • Also NHSO monopsonistic purchasing and negotiation power has helped ensure cost containment.		
Financial protection	• Financial protection for households: are there caps on cost sharing or other safeguards that protect households against impoverishment due to health costs?	• Targeting poor at risk, but ensuring spouse and children are connected to membership. • Pro-poor subsidies. • Overtime NHSO has sought to expand coverage to a number of illnesses that cause catastrophic costs for households (Tangcharoensathien 2013). • Overtime have seen statistically significant reductions in catastrophic health expenditure and medical impoverishment.	• Similar to UCS by covering a number of illnesses and conditions that cause catastrophic household costs.	• Similar to UCS by covering a number of illnesses and conditions that cause catastrophic household costs.
Provider payment	• Describe the payment mechanisms used to pay primary health care (including preventive and promotive care). • Describe the payment mechanisms used to pay for hospital level care. • Are payments tied to quality of care, and if so, how does this work? • Do the systems contract private providers or private health plans? If so, describe the payment mechanisms incorporated into contracts.	• To encourage efficiency and cost containment, NHSO uses age and gender adjusted capitation for paying facility outpatient services and uses DRGs for paying in-patient services (consuming 78% of the budget in 2012). • To counter under-treatment of patients as a result of cost-containment strategies, UCS uses additional payment mechanisms for specific high cost diseases and procedures (see below). • For high cost clinical conditions a pre-assigned fee schedule is used. • Fee schedule is used for priority services (like cataract surgery) to increase access to under-used services. • Incentive payments used for some prevention and promotion services to encourage detection and care of NCDs (e.g., diabetes/hypertension) (10% of budget in 2012). • Funds for specialized services like the Antiretroviral and Renal Replacement funds pay providers using pre-defined fee schedules (less than 3% each of budget). • Use a capital depreciation replacement budget to support providers (6% of budget for capital depreciation replacement). • Financial incentives in place to encourage desired provider behavior including quality improvement (QI) and on-time reporting of utilization data (UNICO-WB 2013). • NHSO contracts with the MOPH's network of hospitals (Provincial Health Offices are the Authority and contract with District Health Networks). Hospitals can have sub-	• Inclusive capitation for outpatient and inpatient services (WHO 2012). • DRG used for inpatient. • Fee schedules for selected conditions or services (Tangcharoensathien 2014). • Co-payments for maternity/emergency services (ILO 2008). • Contracts with both public and private competing contractors.	• Fee for service, direct disbursement to public providers for outpatients (WHO 2012). • Use DRG to reimburse for in-patient care (WHO 2012). • Fee schedule for room/board and artificial organs. • Fee for service for high cost drugs. • There is mandatory co-payment at private hospitals for in-patient care (ILO 2008). • Different reimbursement methods for public and private facilities.

		Universal Coverage Scheme (UCS)	Social Security Scheme (SSS)	Civil Servant Medical Benefit Scheme (CSMBS)
		contractors including health centers and private clinics that provide prevention and promotion services. Creating a network of services and greater access to district services. Little competition for sub-contracts in rural areas. • NHSO (including regional NHSOs) also contract private providers through contracting process requiring financial deposit. However, diminishing number of private hospitals participating citing low capitation and DRG payments as reasons for withdraw of UCS (UNICO-WB 2013).		

SUPPLY-SIDE PROGRAMS

In this framework we define supply-side UHC programs as nationwide programs that aim to reform and upgrade the production of health services.

		Program 1	Program 2	Program 3
Identify each major, nationwide program / system that aims to reform and upgrade the production of health services. List one program per column.				
Human Resources	• Summarize design features of programs aiming to improve distribution of health workers, retention of health workers, or outreach by health workers.	Human Resources for Health (HRH) in Thailand managed by MOPH which sets salary scales and mixes of staff at various levels. There is a National HRH Commission looking at improving distribution of HRH. From 2001 onward, workforce recruited locally by facilities and employed as temporary staff with no access to attractive benefit packages (WHO 2010). • To increase intake of students from rural places into med/nursing schools there is a rural recruitment policy with three different programs targeting doctors and nurses. • Three year compulsory service in rural areas for medical, dental, and pharmaceutical graduates from public universities. Penalty payment for medical graduates who don't serve the full three years. • Special contracts for nurses to work with public providers that are driven by quotas. • Financial incentives (including higher pay) given to doctors, nurses, dentists, pharmacists who agree to work in remote areas. Also non-financial incentives for professional training, task-shifting, supervision used to motivate those who work in remote areas (UNICO-WB 2013). • UCS's capitation system for District Health Systems established to facilitate health workforce distribution and allow for financial incentives to attract and retain workers (WHO 2010).		
Managerial Flexibility	• Do managers of facilities or at subnational level have the flexibility to hire and fire, manage money, procure commodities? Summarize design features of programs aiming to improve managerial flexibility in public facilities.	• UCS and local government co-fund sub-district interventions to test innovative efficient and equitable public health activities (UNICO-WB 2013). • UCS contributes to a community health fund but only when there is matching local government funding. • MOPH manages a network of providers under UCS (UCS funds these networks). MOPH maintains stewardship of rules and regulations and health oversight • Provincial Health Offices (PHOs) run NHSO provincial offices, thus they are accountable to both MOPH and NHSO • Since 2006, PHO's have devolved purchasing power to sub-contract and oversee hospitals and clinics connected to hospitals (Health Insurance Research Office 2012).		

		Program 1	Program 2	Program 3
Private Providers	• Summarize design features of programs aiming to increase participation of or oversee quality of private providers.	• The UCS and SSS do not have their own providers, but rather purchase services from public and private providers. • UCS can contract with private hospitals and private clinics can sub-contract with public hospitals at subnational levels. • Private providers have over time dropped out of UCS citing poor capitation and DRG rates. • Private providers are often not equipped to provide comprehensive coverage UCS requires (WHO 2012). • Most services (hospital and health center) provided by public providers. However, private providers including pharmacy, primary and secondary are commonly used in urban areas (UNICO-WB 2013).	• The UCS and SSS do not have their own providers, but rather purchase services from public and private providers. • Public and private providers compete for contracts with SSS. • Private providers are active part of the SSS plan with payment arrangements including co-pays and fee schedules.	• Purchase most services from public providers
Health Care Provision / Accreditation and Other Regulation of Quality	• Summarize design features of programs aiming to accredit health facilities or regulate quality of service provision in another way.	• Because District Health System (DHS) often singularly provides care in rural areas, DHS's often receive contracts even if they aren't accredited by the Healthcare Accreditation Institute (HAI). Thus a strict accreditation requirement for entering into a contractual agreement with NHSO was not reasonable (Tangcharoensathien 2014). • In 2007, HAI introduced a stepwise accreditation system, and NHSO offered incentives to engage. Three steps to accreditation include risk identification, quality assurance/QI in place, and achieving full accreditation or re-accreditation every two to three years (Tangcharoensathien 2014). • NHSO earmarked funding to boost QI. • UCS has incentive funds to give to providers who are screening and providing care for diabetes and hypertension. • Offers incentives for providers to complete prenatal services by protocol (UNICO-WB 2013). • Performance requirements are in place for contractors to receive funding (Health Insurance Research Office 2012). • Major concern in UCS is under-provision of services by clinical staff. Thus, NHSO regularly analyzes utilization rates, administers household surveys, undertakes clinical audits and		

		Program 1	Program 2	Program 3
		adjusts capitation by age group to ensure quality health services are maintained.		
Health Care Provision / Integrating the Health System	• How is beneficiary care coordinated across levels of care? Is there a system of referrals and counter-referrals and the information system to manage this? Please describe.	• Gate-keeping system used by USC. Patients can't go directly to general or regional hospitals without a referral from district hospital (unless it's an emergency or paying OOP). • PHO coordinates collaboration between district and provincial hospitals. • UCS designed to ensure proper referrals between sub district, district, and regional levels	• Gate-keeping system used by SSS. Patients can't go directly to general or regional hospitals without a referral from district hospital (unless it's an emergency or paying OOP). • PHO coordinates collaboration between district and provincial hospitals.	• No gate-keeping/referral strengthening functions. • Lack of harmonization between three systems exists, and room to grow for information harmonization (Health Insurance Research Office 2012) and benefit harmonization. CSMBS defends its generous benefits to compensate low paid civil servants. • Policy movement toward more harmonization across insurers. • There is cooperation among call centers, there is cooperation/sharing of beneficiary databases (Health Insurance Research Office 2012).
ACCOUNTABILITY IN THE HEALTH SECTOR				
Other Institutional Details		• UCS, SSS, and CSMBS require an extensive information system to register beneficiaries and provider payments and for monitoring and evaluation of the health system. • UCS's NHSO relies on the following existing systems and actors: – Central Office for Health Care Information is independent nonprofit that developed standards and information sharing network for reporting utilization statistics from providers, especially DRG statistics (SSS, CSMBS and UHC). – Thai Case Mix Center was recently established to develop tools and standards for case-mix payment system to support all health insurers (SSS, CSMBS and UHC). – NHSO has internal information system and online claims system. – Health Insurance System Research Office is independent non-profit research agency to conduct research and development on health financing and service system development (also researches CSMBS and SSS plans). • NHSO also conducts audits of electronic records and data from online reporting system. When there are suspicious errors, in depth assessment takes place. Inspectors can visit at any time. • Annual external review of NHSO performance using key performance indicators. • UCS also has system for questions, complaints, and appeals from members or contractors (hotline). Complaints are to be followed up within one month (in 2011 94% were resolved in allotted time period). • The National Health Security Act has also introduced policy aimed at reducing the trend of medical litigation that had been increasing in Thailand in last 10 years (UNICO-WB 2013).		