A decade of

Thai UCS implementation

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Universal Coverage Scheme Assessment of the first 10 years :

UCS implementation

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Assessment of a decade of Thai UCS implementation

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Aims and Characteristics of the UCS Reforms

Official guidance on the management of the Universal Coverage Scheme (UCS) during the initial implementation period stated that: "the UCS aims to entitle equally all Thai citizens to quality health care according to their needs, regardless of their socio-economic status" (Ministry of Public Health 2001: p 1). Three main policy objectives were set; the expansion of health insurance coverage to protect all Thais, a single standard for benefits and care, and the creation of a sustainable system (Ministry of Public Health 2001; Jongudoumsuk 2002). The reforms shared certain characteristics of the original Beveridge universal coverage model by utilizing tax-based finance, a single standard benefits package, and primary care gatekeeping. However, they also incorporated certain New Public Management elements (Hood 1991; Manning 2001), including a purchaser-provider split, a mix of public and private providers, decentralized fund management by an agency at arm's length from the MOPH, a contracting model using a closed-end payment method, consumer protection and choice, and modern quality assurance techniques. The original reform plan called for the merging of the existing public health insurance schemes (Ministry of Public Health 2001; Jongudoumsuk 2002; Siamwalla 2001), but this proposal had been diluted by the time of promulgation of the National Health Security Act 2002, which contained the more limited requirement that the three public schemes should be administered by a single agency (articles 9 – 12). Even so, implementation of this provision was delayed, so that the new UCS has operated alongside the existing Social Security Scheme and the Civil Servant Medical Benefits Scheme.

The centrepiece of the reforms was the proposal to replace of the old arrangements for channeling funds from the Ministry of Public Health to the administrative tiers and service units, with a purchaser/provider system in which a new agency. The National Health Security Office (NHSO), would purchase care from local contracted units. The contracted units would deliver primary care services and arrange the referral of patients to secondary care services in autonomous hospitals. The policy intention had been to increase transparency, responsiveness, and accountability by involving a wider range of agencies and stakeholders in the allocation of health care resources, but many of the changes required by the reforms proved to be controversial and difficult. During the first three years the NHSO contracted with the MOPH rather than MOPH service units (so that the MOPH retained substantial influence), and the plan to establish autonomous hospitals did not progress beyond a single pilot institution. The Ministry of Public Health (MOPH) steered the new system through the initial implementation phase, but has evolved to become the manager of a network of MOPH providers under the UCS. Although the NHSO was established in 2003, full financial power over MOPH facilities was not transferred to the new agency until

2006. This led to conflict between the two organizations, some slowing of the planned reform time-table and various difficulties in UCS implementation discussed below. Even at the present time, the precise division of labour between the NHSO and MOPH remains unclear. The NHSO set up 13 regional branch offices, which cooperate with the MOPH's Provincial Health Offices (PHOs) in translating policy into practice.

The UCS incorporates a public contracting model together with a closed-end payment method for arranging the purchase of health services from both public and private providers. The scheme reimburses providers for the cost of tertiary, secondary, and primary care services as well as disease prevention and health promotion (P&P) activities. It employs capitation to pay for ambulatory care and weighted DRGs under a global budget for inpatient care. The reforms heralded a shift from traditional supply side financing to demand side financing. The intention was that money should follow patients (or at least registered members), so that finance reflected the distribution of the population and need for services across the nation rather than the (skewed) historic allocations to the administrative and service units. The new capitation-based funding stream that went to Contracting Units for Primary Care (CUPs) aimed in part to allocate health resource more equitably across urban and rural provinces. The Thai healthcare system had long suffered from an over-concentration of material and human resources in the central region and the large urban centres. The reforms left hospitals or provinces with a relatively high concentration of staff with financial deficits, while those with fewer staff received surplus funding, albeit monies that proved difficult to use to generate additional services (Srithamrongsawat and Torwatanakitkul 2007; Hughes et al. 2010). This led to much controversy, and the MOPH removed salaries from the capitation-based allocation in the second year of implementation. The plan to use the UCS budget to redistribute the salaries budget was partially undermined because it ran counter to the existing civil service workforce allocation arrangements, and implementation of the reforms was not assisted by a lack of clear policy from the MOPH on human resource distribution (Srithamrongsawat 2005).

The NHSO used its financial power to gear the service delivery system to meet the health needs of its beneficiaries and improve efficiency. Thus the NHSO required all contracted hospitals to set up a primary care unit for every 10,000 – 15,000 registered beneficiaries, and active management of some specific unmet but necessary services, such as cataract removal, open-heart surgery, acute myocardial infarction, and the administration of thrombolytic agents for stroke. UCS members are automatically assigned to the CUP linked to their local district hospital (based on their address as specified in their house registration document), and therefore have little or no choice of provider. However, certain mechanisms to protect beneficiaries were established, including a '1330' Gold Card hotline for the UCS, a patient complaints service, tougher hospital accreditation requirements, and a no-fault compensation fund.

The implementation of the UCS was affected by various constraints, originating from both inside and outside the health sector. Factors outside the health sector affecting UCS implementation included other cross-cutting government policies (such as ongoing civil service reforms and the 1999 Decentralisation Act) and a degree of opposition within the public sector bureaucracies. Factors inside the health sector included a limited health budget, the skewed geographical distribution of health resources, and the fact that the MOPH is often a local monopoly provider of health services, especially in rural areas. Confronted with these challenges, the UCS has evolved over time so that some elements of the original design have been dropped and others implemented in modified form. Even in respect of the basic purchaser/provider split structure, the direction of travel has not always been clear. For a time the term "system manager" was preferred to "purchaser", and the concept of "commissioner" has been recently debated. Establishment of regional offices as arm-length offices of NHSO was another example where tensions

surfaced between the NHSO and MOPH, and local arrangements have been adapted to reflect the dual loci of power. Although still operating as the local arms of the MOPH, the PHOs have developed an important role as mediators between the NHSO branch offices and administrative and service units in the local health care system.

At present the Social Security Scheme and the Civil Servant Medical Benefit Scheme continue to function as separate public health insurance funds, overseen respectively by the Social Security Office and the Comptroller General's Department. Fragmentation of the current public schemes leads to inefficiency and inequity within the systems. Recent studies report continuing inequity in the public subsidy provided to the different schemes (Thammatach-aree 2009). Moreover, the use of different reimbursement methods and payment rates resulted in variations in service provision (Limwattananon et al. 2009). Even though articles 9, 10, and 11 of the National Health Security Act (NHSA) 2002, state clearly that the three public health insurance scheme will be administered by a single public agency once ready, this provision looks unlikely to be implemented. Recent attempts to introduce step-by-step moves to harmonize the three schemes have provoked strong opposition in some quarters. A committee to coordinate policy across the three public schemes was established in 2004, but worked mainly on technical issues concerning a framework for coordination rather than substantive moves towards harmonisation. In recognition of the continuing problems arising from fragmentation of the public health insurance schemes, a National Healthcare Financing Development Office was established in 2010 with a remit to explore avenues for harmonization.

In considering the problems and issues thrown up during implementation of the UCS reforms, this report will focus on policy surrounding the purchaser-provider split, the conception of the public purchasing role (strategic purchasing), and the moves to harmonize the three existing public health insurance schemes. All were part of the original reform blueprint, and all represent unfinished agendas requiring further reform.

Research Questions

How far have the three main reform components - (a) the purchaser-provider split, (b) strategic purchasing, and (c) harmonization of the three public health insurance schemes – been implemented as planned and what constraints applied? How far have the arrangements in each area evolved in response to complex real-world pressures and how well have they worked?

Objective

- To examine progress and problems in the implementation of the three main reform components (purchaser-provider split, strategic purchasing, and harmonization of current health insurance schemes), considering the responses of relevant central and local organizations, and how well the system has performed.

Specific objectives

- To assess how the Thai UCS purchaser-provider split model has been implemented during the past decade, paying attention to:
    a. Institutional arrangements within purchasing organizations at central and peripheral levels including their functions and responsibilities;

    b. contracting styles and relationships with public providers and their evolution;
    c. the engagement of professional groups, private providers, local administrative organizations, and civic groups in health care;
    d. constraints on policy implementation.
- To assess the extent to which a strategic purchasing model has been adopted by the UCS including:
    a. the degree to which the NHSO has engaged in active commissioning of services (needs assessment, priority setting, planning, and active contracting);
    b. how far the NHSO and MOPH and the local offices have utilised economic levers to bring about health service improvements;
    c. the evolution and unbundling of payment methods of the UCS for different services and the implications of changes in reimbursement methodologies;
    d. how far purchasing has taken account of issues of access and rights protection for UCS members.
- To assess progress and problems in moves to harmonize the current health insurance schemes over the last ten years, including:
    a. the harmonization framework of the National Health Security Act (article 9-12);
    b. the committee established to coordinate policy on the three public health insurance schemes;
    c. the role of the National Healthcare Financing Development Office (NHFDO).

Framework for assessment

The design of the Thai UCS incorporated several features that resembled New Public Management (NPM) reforms adopted elsewhere. Since the 1990s the NPM concept has influenced many countries that sought to build elements of markets and competition into their public systems with the aim of improving efficiency, accountability, and responsiveness (Polidano 1999; Manning 2001; Sarker 2006). Hood (1991) has suggested that NPM reforms rested on seven main principles; hands-on professional management in the public sector, explicit standards and measures of performance, greater emphasis on output controls, a move to disaggregate units in the public sector, greater competition in the provision of public services, stress on private sector styles of management practice, and greater discipline and parsimony in resource use. In general, NPM involves an increasing emphasis on performance, outputs, and customer orientation, decentralized management of public services, and the disaggregation of integrated public systems through provider pluralism, contracting out, and the creation of internal markets.

The concepts of a purchaser-provider split and contracting for health services have been adopted in designing the UCS. The National Health Security Office (NHSO) was established in 2002 according to the National Health Security Act (NHSA) to act as a purchaser, and thus in legislative terms automatically separating the purchaser and provider functions. The model of a purchasing or overseeing organization arranging the provision of health care services for members also broadly fits the other two schemes left in place by the 2002 Act: the Social Security Scheme (SSS) for private employees in the formal sector, and the Civil Servant Medical Benefit Scheme (CSMBS) for civil workers and their dependents. The Universal Coverage Scheme (UCS) fills the gap by covering the rest of the population.

The analysis of implementation processes contained in this report rests on three main theoretical influences. The overarching conceptual framework is based on Gill Walt's (1994) policy process approach, which examines implementation actions in terms of contexts, content, process, and actors. But, in an

attempt to better understand the role of actors at different levels the report also draws on debates concerning top-down and bottom-up influences (Hogwood and Gunn 1984; De Roo and Marse 1990) and the interaction between central and local actors in policy implementation. Additionally in light of the importance of well-developed policy networks in the Thai case, and the significant evolution of the UCS reforms over time, certain ideas from the advocacy coalition framework proposed by Paul Sabatier (1986; 1993) have also informed the analysis. Sabatier examined how actors at lower as well as higher levels become involved in implementation, and described a policy subsystem comprising a range of public and private organizations and actors who are involved in concerted action but are often in conflict. Over time competing advocacy coalitions emerge which support particular policy positions. Shifts in policy positions may often involve compromises between coalitions supported by key actors or agencies – Sabatier's 'power brokers'. Sabatier (1993) proposed the framework of policy change based on four basic premises: (1) that understanding the role of policy change requires a time perspective of a decade or more; (2) that the most useful way to think about policy change over time is through a focus on interaction of policy subsystems; (3) that those subsystems must include all levels of government; and (4) that public policies can be conceptualized in the same manner as belief systems. Three factors that crucially affect successful policy implementation are: the presence of relatively stable parameters in the policy environment, external events, and the policy subsystem.

Below we outline a framework for the assessment of UCS implementation based on Walt's policy-process approach. Crucial aspects of context affecting policy implementation include: the bureaucratic system, other cross-cutting government policies (e.g. downsizing the public sector, decentralization, promoting Thailand as a medical hub), the wider political policies of the governing party, health system constraints (insufficient and inequitable distribution of human resources), and widespread geographical monopoly provision by MOPH hospitals and service units. Turning to a concept from Sabatier, the relatively stable parameters present during the implementation process were the senior administrators in the MOPH, and the continued role of the MOPH and the NHSO (and their arm's-length units) as the major agencies overseeing the reforms; the legislative framework created by the National Health Security Act, the continuing influence of medical professional groups, and the involvement of local government organizations (whose power was set to increase under the provisions of the Decentralization Act 1999). In respect of harmonization of public insurance schemes, the major actors were the three main public schemes - the UCS, CSMBS and SSS - and a new body set up by the National Health Commission known as the National Health Care Financing Development Office. Evidence on the performance of UCS implementation related to the key issues will be explored, including: issues of accountability and responsiveness vis-a-vis the UCS, the implications for governance of the overall system, and the degree of convergence and continuing divergence observable in the management of the three health insurance funds.

Contents	Contexts	Actors	Implementation	Performance
What are the intended objectives of purchaser-provider split and the system as designed?	• What were the contextual factors affecting implementation of the purchaser-provider split?	• MOPH and NHSO and their arm's-length units • Other providers • NGOs	• Institutional arrangements • Contractual relationships between purchaser and providers • Encouraging participation of other sectors	• Accountability of NHSO • Engagement of stakeholders • empowerment of UCS members • Implications for governance of the system
What are the intended objectives of strategic purchasing and the system as designed?	• Health system constraints affecting the purchasing function	• MOPH and NHSO and their arm's-length units • Other providers • Professional groups	• Planning and budgeting • Shift to demand side financing • Contacting • Evolution of payment methods • Using financial mechanism to drive health system development	• Access to care • Quality of care • Rights protection
What are the intended objectives of harmonization and the system as designed?	• Legal framework • Political drive • Decentralization	• NHSO, SSO, CGD NHC, Labour unions, political parties	• Articles 9-12 NHSA • Coordinating Committee for 3 funds • National Healthcare Financing Development Office	• Convergence and divergence in benefit packages, scheme management, and payment mechanisms

Methodology

This evaluation of the UCS implementation process involves a policy analysis, literature review and small-scale empirical study. Official documents and international and Thai language publications relating to the three key areas were identified and reviewed. Areas not examined in sufficient depth in the existing literature were investigated via new in-depth qualitative interviews with key informants. In total interviews were completed with 14 informants, comprising: the former deputy minister MOPH (a politician), three current senior administrators from NHSO, two former Permanent Secretaries of the MOPH, two current senior MOPH administrators, three researchers from TDRI, HSRI, and a university, one senior administrator from the Comptroller General's Department (CGD), one senior administrator from SSO, and one from a consumer protection group. The interviews took an open ended form, loosely based on prepared interview guide questions, but with different items included to reflect the particular role of the respondent (see below).

Key informants	Purchaser-provider split	Strategic purchasing	Harmonization
Politician (1)	√		√
CGD (1)			√
SSO (1)			√
NHSO (3)	√	√	√
MOPH (4)	√	√	√
Researchers (3)	√	√	√
Civil society group (1)	√		√

Findings

Table 1 summarises chronological events related to UCS implementation. Implementation of purchaser-provider split and strategic purchasing could be divided into three phases; (1) first year of UCS implementation prior to the promulgation of the National Health Security Act (NHSA), (2) a transitional period spanning the first three years of the NHSA (2003-2006), and (3) a post transition period when the National Health Security Office (NHSO) was fully in charge as purchaser of the UCS. Similarly, movements toward harmonization of the current health insurance schemes could be divided into three phases; phase I covers the first year of implementation of the NHSA when there was strong political support to establish a single management unit for all public health insurance schemes, phase II started in 2004 when a Coordinating Committee of current health insurance schemes was set up in order to harmonize certain aspects of the financing and coverage of the schemes, and phase III started in 2011 when a National Healthcare Financing Development Office (NHFDO) was set up following the decision of the National Citizen Health Assembly in 2010 to recommend a more strategic approach to the harmonization of the current health insurance schemes.

1. Purchaser-provider split model

1.1 Aim and objectives

Theoretically, the purchaser-provider model aims to introduce market incentives into publicly managed systems by assigning managerial responsibility for the functions of demand and supply to distinct institutions (Street 1994). The production of services becomes the sole concern of providers which no longer hold a budget or decide how it should be spent. Purchasers are not usually consumers but purchasing authorities established to buy health services on behalf of the service users, and which are responsible for commissioning services so as to secure improvements in health for defined populations. In order to do so, purchasing authorities have to assess the health care needs of their population, determining the most effective means of meeting these needs, and contracting with providers to supply the services required.

The National Health Security Act, 2002 was promulgated according to the principles of the 1997 Constitution, which stated that all Thais have an equal right to received standard health services and public health services must be equitably distributed and efficiently provided (Royal Thai Government Gazette 2002). Moreover, under the provisions of the Act, a National Health Security Office (NHSO) was established as a semi-autonomous body responsible for managing the UCS and executing other duties specified in the legislation. Thus there was a firm legal basis, deriving from both the Constitution and the NHSA, for the NHSO to act as the purchaser of services on behalf of UCS beneficiaries, to ensure their

Table 1 Chronological evolution of UCS implementation during 2002-2011

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Purchaser-provider split	Under MOPH management	Transitional phase NHSO channeled monies through MOPH but directly contracted with other public & private CUPs				NHSO contracted centrally with MOPH CUPs, non-MOPH public CUPs, private CUPs, contracting units for secondary or tertiary care. Soft contractual arrangement was employed.				
• Institutional arrangements	MOPH & PHO	+ NHSO, +NHSO BKK office	+ NHSO Khon Kaen Office	+ 11 NHSO regional offices	+ Piloting Local Health Funds (LHF)	Expansion of LHF to cover more Local Administrative areas			Piloted commissioning in 2 regional areas	
Strategic purchasing										
• Capitation rate (% increase)	1,202	1,202	1,308 (8.8)	1,396 (6.7)	1,659 (18.8)	1,899 (14.5)	2,100 (10.6)	2,202 (4.9)	2,401 (9.0)	2,546 (6.0)
• Subtraction of salaries	At CUP or province	Pooled nationally				Pooled at provincial level with some adjustments				
• Allocation of capitation budgets	Flat rate	Flat rate	RH 300, GH 410, DH490	Adjusted for age, workload, hospital type, hardship	Same as in 2006	Adjusted age and utilization +budget for specific settings	Same as in 2007	+Fixed cost for DH CUPs and health centres according to number of UCS members, and with extra payment for border area or remote area		
• DRG payment	**DRG v2.0**		**DRG v3.0**				**DRG v4.0** x1.32 for DH			
• Purchasing targeted services	High cost (9 items)		+RW>3	RW>4, new borns	Disease management (6 items)	+ P&P (6 items) + ARV	Disease management (11 items)	+RRT	P&P (10 items)	Disease management (8) drugs (7)
Harmonization of current public health insurance schemes		Phase I	Phase II Coordinating Committee							Phase III
		Strong push single unit	Coordinating committee		Shared beneficiary databases	Shared call centre			Joint claims auditing	NHFDO
Other related reforms and policies										
• Other public policies	Public sector reform Decentralisation	Medical hub					Dec 08 new allowances for DH then for RH & GH in 2009	CL		
• SSS	Firms with 1 employee can join									Attempts to cover dependents
• CSMBS			Directly disburse OP chronic		Directly disburse OP pensioners	Directly disburse OP all +DRG				

right and access to standard services, and (by implication) to over-ride any opposition from the MOPH. The creation of a NHSO, separate from the MOPH, established new lines of accountability and the legislation placed a duty on the new agency to be responsive to its beneficiaries.

The separation of the purchasing and providing functions was expected to increase equity in resource distribution and improve the efficiency of the system by introducing a capitation-based financing mechanism whereby money would follow patients and human resources would be distributed more evenly across the nation. Moving away from supply-side financing to demand-side financing would provide greater incentives for providers to manage service provision so as to increase efficiency. Moreover, it was initially expected that capitation-based financial allocations would result in a more even geographical distribution of human resources, since the allocations would include salary costs.

It was also expected that the NHSO would be able to recruit private and other public providers, including service units managed by local government, to deliver services under the scheme, especially in areas where there were limited MOPH facilities. Policy makers had concluded that, without a purchaser/provider split, it was likely that MOPH would operate the system using its own existing facilities and be reluctant to recruit outside providers.

Moreover, policy makers perceived that the separation of functions would shift power away from MOPH providers who had previously held most of the public health budgets, and established the NHSO as a countervailing power protecting the interests of UCS members, and empowering the members by setting up new mechanisms such as the gold card hotline and a complaints system.

> *".....the separation between purchaser and system manager (purchaser) is crucial. The purchaser must stand on the people's side while the MOPH stands on the provider side. Following the separation, this reduced the provider's power in holding the money and making decisions on how to use it.....If there was no such separation, there is no one to safeguard and protect the people's right to health care...However, how well the purchaser performs depends on the vision of the office, including a system design that ensures good governance...."*
>
> Executive, NHSO

> *"..to have a clear means to monitor quality of service provided by providers...and more important is to shift from a supply-based allocation to be demand-based according to the number of people - this should be the heart of capitation and the purchaser-provider split, which has not been successful yet..."*
>
> NGO Administrator

However, it should be noted that competition between providers was not mentioned as an explicit aim of the reforms. In part, this was because many areas are served by local monopoly providers. The MOPH facilities are sole providers in all rural areas, while private providers are mainly located in Bangkok and larger urban areas. Moreover, neither purchaser nor providers had any choice regarding whether to enter the 'market': they were both public institutions mandated to comply with government policy. By a cabinet resolution, all public providers are automatically providers under the UCS.

1.2 institutional arrangements

Fundamental to the purchaser-provider split is the process of service contracting, designed to encourage competition among providers. For competition to work, individual providers must be able to manage and control their own resources, and where they are in the public sector a degree of decentralized autonomy is required. A UCS reform proposal and implementation plan was developed by a UC working group in the Health Systems Research Institute (HSRI) prior to the introduction of UCS in March 2001 (Working Group on Development of Universal Health Insurance Coverage Policy 2001). The main components of the proposal included a purchaser-provider split, decentralization, transparency and accountability, and participation of all stakeholders in managing the system. The reform blueprint devised by the Working Group is shown in Figure 1 below.

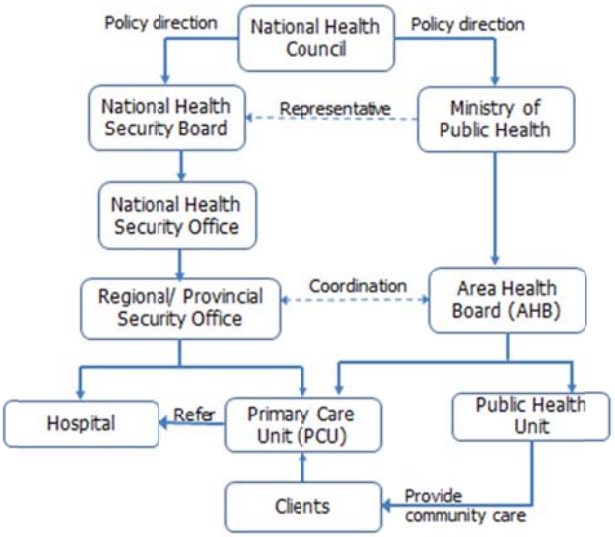

Figure 1 Proposed structure of the UCS and relationship with healthcare system

Source:Thammatach-aree and Jongudoumsuk (2004)

The Working Group envisaged a change in the role of the MOPH, so that it ceased to be at the head of the line-of-command, and instead became a national policy body and policy regulator. Most of public health services were expected to be decentralized. In the event these plans were not realized: in practice, the management of public health services and human resources has remained the responsibility of the MOPH.

Before the promulgation of the National Health Security Act in 2002, a temporary management structure was created within the MOPH to oversee UC policy implementation. A core team for policy development was formed to take forward the provisional plan and debate policy options. Additionally the MOPH set up 10 working groups, comprising representatives from the public health care sectors, consumer groups, and private health care providers, to formulate detailed policy outlines, which was used as guidelines for policy implementation(Ministry of Public Health 2001). Many functional departments within the MOPH were involved and played a role in translating UC policy into an operational reality. One crucial development was the establishment of a committee, known as “War Room”, and chaired by the Deputy Minister of Public Health, to coordinate and monitor activities pertaining to policy implementation and solve emerging problems (Thammatach-aree and Jongudoumsuk 2004).

The initial reform plan, as reflected in official guidance at this time, envisaged that the purchasing function at provincial level would be devolved to Area Health Boards (AHBs). The AHBs were to be established in accordance with the Decentralization Act B.E. 2542 (A.D. 1999) to perform as local purchasers, and also to promote the integration of personal health care and public health programs. However, both because of logistics and opposition from some quarters within the MOPH, building the capacity of the AHBs proved to be very difficult. Finally it was decided to decentralize the fund management to the Provincial Health Office (PHO), leaving the AHB with only an advisory role. Consequently the PHOs became provincial branch offices of the NHSO, while simultaneously functioning as line-of-command organizations in the tiered MOPH structure.

The NHSA made provision for the MOPH to manage the UCS within MOPH hospitals and service units for a three year transitional period (2003-2006)[1]. In formal terms the NHSO purchased health services from the MOPH by transferring funds to the Ministry, as opposed to directly to the service units, according to the terms of a memorandum of understanding (MOU) between the NHSO and MOPH. Informally, this meant that the MOPH continued to be the main conduit for funding the public system. The PHOs, now operating in the dual roles of MOPH bodies and branches of the NHSO, managed and allocated monies to MOPH providers in the provinces. During this period the NHSO had little direct engagement with MOPH providers, but from 2003 onwards it began purchasing health services from non-MOPH public providers (such as the military hospitals) and private providers.

These arrangements provoked considerable controversy and a good deal of tension between the MOPH and NHSO, particularly regarding different approaches to the implementation of the UCS at provincial level. Some onlookers detected a conflict of interest in employing the MOPH as the implementer of reforms that were intended to reduce central power. Thus Siamwalla (2001: 228), in his account of the Working Committee on the UCS, stated that "the real difficulties ahead lie in the manner in which the Ministry of Public Health has captured the initiative and ploughed ahead with its plans, without consulting with other agencies". But other policy commentators believed there were some advantages. The existing skills of PHO staff could be used in the registration of beneficiaries, there was fast and smooth coordination between the PHO and MOPH providers, there was an easy mobilization of resources among MOPH providers to secure performance targets, and the MOPH system was able to integrate public health activities to focus on local problems (Leesmidt et al. 2005).

The NHSO began to contract directly with individual MOPH providers in fiscal year 2007. Figure 2 shows the current organizational structure and relationships under the UCS. At the national level, there are the National Health Security Board (NHSB) and the Service Standards and Quality Control Board (SQCB). The NHSB is chaired by the Minister of Public Health and is made up of thirty representatives drawn from related public organizations (9), local government (4), civic groups (5), professional bodies (5), and technical experts (7). It should be noted that the Permanent Secretary of the MOPH is a member in the board. The NHSB is responsible for formulating policies, guidance and rules, and determining the benefits package and reimbursement mechanism. The SQCB is chaired by an elected member and comprises representatives from related public organizations (4), professional councils (5), local administration organizations (4), NGOs (5), professional groups (10), and technical experts (6). The SQCB is responsible for setting standards and producing guidelines on service quality and required standards for health

[1] The transitional phase ended in May 2006 (midway through 2006 fiscal year) and the National Health Security Board (NHSB) agreed to allow the MOPH to continue managing the UCS budgets for MOPH facilities under the Permanent Secretary's Office (provincial hospitals, district hospitals, and health centres) as planned until the end of fiscal year 2006.

facilities. Its remit includes the administration of the complaints system relating to quality of care and medical errors. In order to manage the system, the NHSO has set up various subcommittees to assist in policy and system development, including, for example, the subcommittees on financing, benefit package development, and civic and local government involvement.

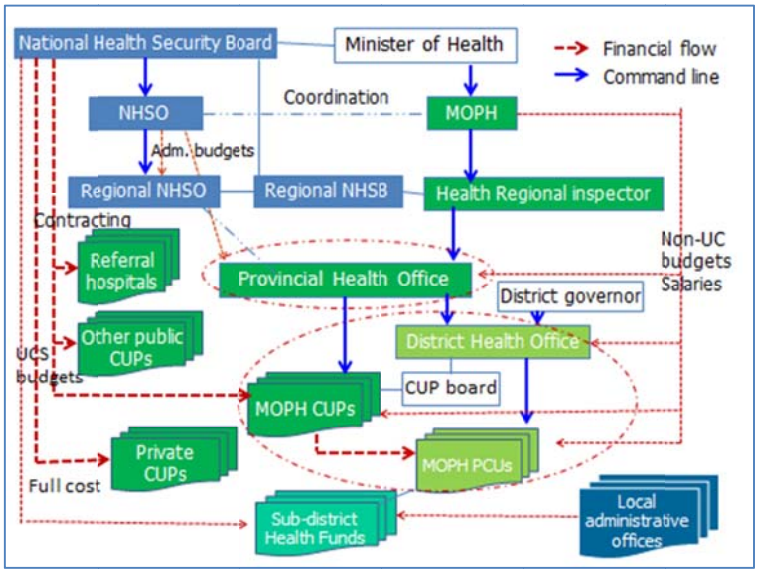

Figure 2 institutional arrangements of purchaser-provider split of the Thai UCS

Rather than relying on the PHOs to act as the decentralized branches of the NHSO, it was eventually decided to create branch offices at regional level. The Bangkok branch office was established at the time of the creation of the NHSO, due to the lack of an arm's-length unit to deal with the many providers in the capital, which could not be managed by a PHO as in other provinces. (NHSB resolution of the 3/2002 meeting on December 23rd 2002). The Khon Kaen branch office was established in 2004 (NHSB resolution of the 5/2004 meeting on May 3rd 2004) following ongoing conflicts between the NHSO and MOPH that led the NHSO to conclude that it needed regional offices to coordinate contracting with local providers. Another 11 regional branches were approved for establishment in February 2005. Thus, there are currently 13 NHSO regional offices. The regional offices are linked to Regional Health Security Boards (RHSBs) chaired by a local elected board member, usually a retired health administrator. The Board membership normally includes the Provincial Chief Medical Officers (PCMO) of all provinces in the region, representatives from local administration offices, a representative from a non-MOPH public hospital and one from a private hospital, representatives from civil society groups, selected experts, and the director of the regional office. The MOPH Regional Inspector is an advisory member of the regional board and the regional office acts as a secretariat for the board. The regional officers of the NHSO oversee relations with local providers, and are involved in strategic planning and performance management. At present, the purchasing function for most acute services remains centralized at the NHSO. So far only a few services have been decentralized to be managed at the regional level, mainly in relation to area-based prevention and promotion budgets (part of the P&P component of the UC budget).

Below the regional level, the NHSO continues to utilize the PHOs as its local arms, coordinating their activities with the relevant Regional Branch Office. The director of the health insurance division of the PHO acts as secretary of the Provincial Health Security Committee, which is chaired by the Provincial

Chief Medical Officer (PCMO). Members of the Provincial Health Security Committee include representatives of providers (provincial hospitals (PH), district hospitals (DH), health centres, non-MOPH public hospitals, and private hospitals), district health officers, local administrative officers, civil society groups, and the medical profession. Research suggests that engagement of representatives from outside the health sector was limited due to a lack of knowledge, information, and ownership (Leesmidt and Oon-ob 2007).In fact the PCMOs are also officers in the line-of-command MOPH system, so that the PHO, potentially at least, is charged with dual functions, as both purchaser and provider. However, the research evidence suggests that in practice most PHOs perceive themselves as managing authorities within the provinces, rather than purchasers of UCS services (Lapying et al. 2010). The central NHSO contracts directly with CUPs based in private hospitals and non-MOPH public hospitals, but allows the PHO to advise on the number of beneficiaries allocated to each hospital. This has provoked allegations regarding conflicts of interest and possible PHO bias in limiting the number of beneficiaries assigned to private hospitals (Leethongdee 2007).

MOPH facilities are major providers under the UCS, accounted for 73, 79, and 95 percent of the main contracted hospitals (CUPs), secondary or tertiary care hospitals, and primary care units respectively in 2009 (National Health Security Office 2010). All public hospitals are required by the government to participate as UCS providers. The main local contracting unit – the contracting unit for primary care or CUP - is almost always based in a hospital, mostly a district or provincial hospital, and oversees a local service network which includes health centres and other service units. Most health centres are organized in clusters as primary care units (PCU), although other variants such as hospital-based community medical units (CMUs) also exist. Management of service provision and the UCS budget within the CUP is undertaken by the CUP Board, which is usually chaired by the director of the district or provincial hospital. The degree of support given and the formula used for allocating budgets to PCUs varied substantially, both between CUPs and provinces (Srithamrongsawat et al. 2010). Local patterns of resource allocation appear to depend largely on how power is distributed among members of the network and the relationships between key actors (Chamchan 2007; Hughes et al. 2010; Intaranongpai et al. n.d). In some localities, there was a problem of "equity of distribution", whereby curative services were prioritized over prevention and promotion activities. This sometimes resulted in conflict between hospital and PCUs. In some provinces this caused concern among MOPH and PHO administrators, who produced additional guidance for MOPH CUPs in allocating UCS budgets to health centres. Some PHOs earmarked or 'top sliced' specified proportions of UC prevention and promotion budgets for disbursement to health centres (Hughes, Leethongdeee et al. 2010). However, a more recent study suggests that the degree of technical, material, and financial support to primary care has increased substantially as a result of the UCS reforms, even in CUPs where conflict was reported (Srithamrongsawat et al. 2010).

In 2010, the government launched a new policy to encourage the establishment of "Sub-district Health Promotion Hospitals". This aimed to renovate and upgrade the capacity of health centres to deal with unmet needs and solve the problem of overcrowded outpatient departments in MOPH hospitals, arising in part from patients with chronic conditions. The MOPH allocated additional budgets to 75 PHOs to upgrade health centres. However, shortages of human resources, especially in terms of qualified doctors and nurses, remains a major obstacle to implementation of this proposal (Community Health Research and Development Office 2011; Suriyawongpaisal et al. 2011).

Another innovation launched in 2006 was the "Sub-district Health Fund" or "Local Health Fund" (LHF). This is a fund made up of matching contributions from the NHSO and local government, which aims to improve health promotion and prevention activities including community health, and to empower local administrative officers and community groups. In rural areas the relevant local government organization

is the sub-district administration organization (SAO), while in urban centres it is the municipality. Initially the NHSO allocated 37.5 Baht per capita of UC funding to the fund, and the SAO or municipality provided a matching allocation of not less than 10, 20, or 50 percent of the NHSO contribution, depending on the size of the organization. The per capita budget allocated to the fund increased to 40 Baht and the proportion of contribution from the SAO and municipality was raised to 20, 30, and 50 percent in 2010. The fund is chaired by the chief executive of the SAO/municipality and includes representatives from the SAO/municipality, village heads, community groups, and health personnel. Early assessments of the LHF found that successful implementation depended on the degree of coordination and cooperation between local government and health personnel. Moreover, studies have shown that the fund is a crucial mechanism for empowering local administrative officers and community groups. The efficiency of fund management is still problematic and requires improvement (Wongkongkathep et al. 2010; Srithamrongsawat et al. 2011).

The UCS enters contracts with both public and private providers, not only MOPH health facilities. However, the vast majority of providers are MOPH facilities, including nearly 10,000 health centres spread across the nation. Private hospitals are major providers in Bangkok and its vicinity. The UCS assisted many contracted private hospitals to survive the Asian economic recession that had started in 1997 and was continuing as the UCS was introduced. Initially the relatively low capitation rate was offset by the attraction of a reliable cash flow. Moreover, the utilization rate of UCS members in private hospitals remained relatively low in the early 2000s, so that costs could be contained. However, the decline over time in the numbers of private hospitals illustrates that capitation rates were not high enough to maintain participation of the UCS in better times. It must be noted though that this pattern is not uniform across all types of private health facilities, and that the number of private clinics (as opposed to hospitals) operating as primary care providers for beneficiaries in Bangkok has been increasing. Local government hospitals and community medical units are other choices for UCS beneficiaries in urban settings.

Table 2 Number of contracted providers of UCS, 2003-2010

Type of main contractor	2003	2004	2005	2006	2007	2008	2009	2010
MOPH hospital	822	818	825	826	830	836	839	844
MOPH Community Medical Unit		3	3	4	4	13	9	13
Other public hospital	71	74	74	72	73	75	74	75
Other public Community Medical Unit		40	40	76	80	80	11	6
Private hospital	88	71	63	61	60	55	50	49
Private clinic		89	105	116	152	150	167	169
Local government hospital								2
LG Community Medical Unit								10
Total	981	1095	1110	1155	1199	1209	1149	1155

Source: National Health Security Office

The role of local government in health care has been growing, and the numbers of Local Health Funds (LHFs) have been increasing quickly with 71 percent of local administration organizations supporting LHFs in 2010 and an NHSO projection that virtually all sub-districts will have LHFs by the end of 2011 (Table 3).

Table 3 Numbers and coverage of Local Health Funds, 2006 - 2010

	2006-7	2008	2009	2010
Numbers of LHFs	869	2677	3935	5508
% of local administrative organizations with LHF		35	51	71

Source: NHSO

1.3 Contractual relationships between providers and purchaser

The concept of the 'purchaser-provider split' was prominent in the early policy discourse, including in the deliberations of the HSRI Working Group (Siamwalla 2001) and has been adopted by the NHSO. However, the term 'purchaser' has never been used in official guidance, and NHSO has sometimes used the term 'system manager' instead (Leesmidt et al. 2005). The term 'system manager' has been used by several reasons. First the terms "purchaser" and "provider" were unpalatable to medical professionals who argued that it undermined a professional ethos whereby care was provided to patients according to need, rather than according to what a purchaser buys. Second, the NHSO recognized that a straightforward concept of purchasing did not capture the complexity of a system in which health resources are not equitably distributed and essential services are not available in some areas. In such a situation there was a strong pressure for the NHSO to intervene to assist in developing system capacity and build new services. Third, there had been serious conflict between the NHSO and MOPH at the beginning of UCS implementation when the NHSO had sometimes bypassed the MOPH and communicated directly with the PHOs and MOPH hospitals. This defacto widening of the NHSO's role was also reflected in the renaming of the "Bureau of Purchasing" as the "Bureau of Development and Support" in October 2004. Even at the present time there is a widespread perception in policy circles that the division of labour between the NHSO and MOPH – or the purchaser and provider - requires clarification in order to reduce the conflict between them.

> *"..the term provider or seller was strongly opposed by professional groups. They argued that they do not provide care according to what purchaser bought but rather they performed their professional function…."*
>
> Academician

> *"..our mission is to ensure and enable access to essential necessary care for our beneficiaries. If there are any known services that our beneficiaries don't have access to, then it is our duty to manage the system in order to let them get access…Thus it is inevitably that we have to manage providers in such cases. For example, when we adopted peritoneal dialysis for Renal Replacement Therapy in the UCS benefits package, we could not simply buy services from providers, since there was no such service available in the system. Consequently we had to set up the system - i.e. providing support in training CPD nurses and so on….The reason why we didn't let the MOPH do this instead is that the MOPH does best within its own boundaries, not with the other public or private hospitals"*
>
> NHSO, executive

> *"… I wonder what is the position of the NHSO; a purchaser? If yes, then what really is the mission of a purchaser? Whether the NHSO knows what they would like to purchase within a limited budget? Are there any service targets?"*
>
> MOPH, executive

"..The NHSO holds the budget but the MOPH has the health facilities…The NHSO should set the service targets and let the MOPH manage the system to meet the targets…."

MOPH, executive

Conflict between purchaser and providers, especially in the MOPH system, has continued throughout the last decade. It has centred on the issue of allocation of UCS budget including the salaries subtraction (details in section 2.2), and attempts by the NHSO to intervene to manage providers, even though this seems less common in recent years. The tensions reflect the shift in power that followed the transfer of control of budgets from the MOPH to NHSO. But an exacerbating factor was probably the tone of NHSO policy statements as UCS implementation went ahead. For example, the use of language such as "squeezing fat" or "get rid of fat in the system" to justify changes in patterns of resources allocation went down badly in the tertiary hospitals and large facilities in central region. This turned some professionals and senior administrators against the NHSO.

"..We used the wrong approach at the beginning, 'squeezing fat'. This implied that they were the problem and needed improvement. We enjoyed too much power to deal with them… In the later phases, we changed the message to 'the overall system needs improvement' and adopted a "participatory approach" with professional groups. Then we got a better response from them…."

"..We were quite successful in developing hospital care, especially for tertiary services, but not so successful in primary care which was under the control of the MOPH…"

"..To be successful in reforming the health care system, we need at least three reforms - a financing reform, a provider reform, and a management reform… Having only the financing reform without the other two has limited its success…."

NHSO, executive

In recent years a further alternative to the term "purchaser" has emerged as policy makers have begun to use the term 'commissioning'. This appears to have been influenced by a visit made by members of the NHSB to study the United Kingdom's NHS, and suggests that the purchaser function needs to go wider than the mere buying of services. Health care commissioning includes the work of assessing needs, planning services, priority setting and disinvestment, deciding on a purchasing strategy, contracting, and dealing with complaints about contracted services (∅vretveit 1995). The purchasing role is not static, but requires refinement in relation to resources available, changes in health needs, the changing epidemiology of disease, and developments in clinical services and treatments. There is some convergence here with the recommendations of a recent project which argued that area health systems needed to be strengthened in the areas of governance, health service planning, financial management capacity, arrangements for service monitoring and evaluation, better relationships between the centre and periphery, and improved local leadership (Leesmidt and Pannarunothai 2010).

The commissioning concept has been associated with the idea of decentralization of purchasing and management of the system via regional areas, which has been piloting in two regions, Bangkok and Nakhon Ratchasima, since 2010 as a research and development project (Leesmidt 2011).

"I don't think there is a real purchaser..I prefer the term "commissioning" because, first, our health resources are not equitably distributed to ensure equitable access for our populations, i.e. there are many heart centres in Bangkok while there is very little

in the other regions, and since services are not available then we have to work closely with providers to make particular services available for our populations. Second, many of us in the NHSO came from MOPH so we don't have only a finance perspective. Probably our perspective on provision is greater than on finance…."

NHSO, executive

Commissioning implies some softening of the purchaser/provider split since planning, service development and priority setting are more likely to be successful if both sides take part. In Thailand there is a growing recognition that a strategic partnership between the NHSO and MOPH is needed in a situation where the Ministry is a near-monopoly provider of health services in many localities, and the NHSO has no option but to deal with it on an ongoing basis. The term 'strategic partnership' was mentioned by some directors of NHSO regional offices in the assessment on area-based health prevention and promotion (Lapying et al. 2010).

2. Strategic Purchasing by the NHSO

Health care commissioning is closely associated with the notion of strategic purchasing. Strategic purchasing is a methodology used in many businesses and organizations to maximize benefits while still effectively managing costs. Strategic purchasing in health aims to increase health system performance through the effective allocation of financial resources to providers (Busse et al. 2007). This process involves three sets of explicit decisions: which interventions should be purchased in response to population needs according to health priorities and evidence on cost-effectiveness, how they should be purchased, including the contractual mechanisms and payment systems employed, and whom they should be purchased from, taking account of quality and costs. Strategic purchasing should lead to a maximization of overall health gain from available resources. The World Health Report 2000 emphasized that the objective of strategic purchasing is to ensure that there is a coherent set of incentives for providers, whether public or private, so as to encourage them to offer priority interventions efficiently. Selective contracting and the use of multiple payment mechanisms are needed to create incentives for better responsiveness and improved health outcomes (WHO 2000). Strategic purchasing requires a continuous search for the best interventions to purchase, the best providers to purchase from, and the best payment mechanisms and contracting arrangements to pay for such interventions. In this section, three aspects of strategic purchasing are explored: planning, budgeting and contracting, selective contracting of targeted services, and payment methods.

2.1 Planning and budgeting

In general, the calculation of the size of the UCS budget was based on an analysis of previous utilization trends and the projected utilization rate of the target year, multiplied by the unit cost of the previous year with an adjustment for inflation. The approved capitation amount was usually based on an annual negotiation between the NHSO and the Bureau of Budget. The capitation budget of the UCS has increased substantially in the past 10 years as shown in Table 4. The capitation rates set during the early phase of UCS implementation were criticized as too low by some commentators (Pannarunothai 2001), and even then there were delayed in the allocation. There were a number of reasons for the sharp increase of capitation budgets in 2006. The government finally acknowledged that the scheme was underfunded, perhaps because of the personal interest taken by the then Prime Minister, Thaksin Shinawatra. Thus, the NHSO met with Shinawatra three times in 2004 to discuss the capitation rate

Table 4 The Rising UCS Capitation Budget, 2003-2011[1]

Items	2003	2004	2005	2006	2007	2008	2009	2010	2011
1. Basic capitation (Baht/ capita)	1,202.40	1,308.50	1,396.30	1,659.20	1,899.69	2,100.00	2,202.00	2,401.33	2,546.48
• Outpatient services (OP)	574.00	488.20	533.01	582.80	645.52	645.52	666.96	754.63	795.39
• Inpatient services (IP)	303.00	418.30	435.01	460.35	513.96	845.08	837.11	885.94	954.72
• Additional budget for specific settings[2]		10.00	7.07	7.00	30	30	72.25	72.25	64.09
• Prevention & promotion services (P&P)	175.00	206.00	210.00	224.89	248.04	253.01	262.06	271.79	312.5
• High cost & disease management	57.00	86.00	124.21	244.38	260.58	145.26	187.08	205.70	211.70
• Capital replacement	83.40	85.00	76.80	129.25	142.55	143.73	148.69	148.69	148.69
• Emergency Medical Service (EMS)[3]	10.00	6.00	6.00	6.00	10	12			
• Rehabilitation services		4.00	4.00	4.00	4	4	5	8.08	12
• No fault compensation		5.00	0.20	0.53	0.53		1		2.68
• Health personnel compensation for work related injury					0.4	0.4	0.85	0.78	0.97
• Pay for performance					20	20	20	40	25
• Compensation for abolition of 30 Baht co-payment					24.11				
• Thai traditional medicine						1	1	2	6
• Incentives for primary care development								10.63	11.24
• Incentives for targeted tertiary care development								0.84	1.5
2. Anti-Retroviral Therapy				58.56	83.70	94.29	63.45	58.66	62.46
3. Renal Replacement Therapy							32.54	30.81	67.22
4. Secondary prevention of chronic diseases								6.45	13.14
5. Supporting targeted psychiatric care									4.24
Total (Baht/ capita)	1,202.40	1,308.50	1,396.30	1,717.76	1,983.39	2,194.29	2,297.98	2,497.24	2,693.54
US $ (34 Baht : 1 US$)	35.36	38.49	41.07	50.52	58.33	64.54	67.59	73.45	79.22
% growth		8.8	6.7	23.0	15.5	10.6	4.7	8.7	7.9

Source: NHSO

Notes:

[1] it should be noted that the number of budget items in this table are greater than those of the approved upstream budget; however, the total capitation rates are the same figures. The budget categories in this table had been used by the NHSO for downstream budget management.

[2] Additional budgets for MOPH health services units in specific areas i.e. remote areas, CUP or PCU with a small registered population (less than 30,000 and 2,500 respectively), risk-prone areas, and border areas, as well as fixed costs for some district and small provincial hospitals in more recent years.

[3] The Emergency Medical Service budget under the UCS was terminated after the establishment of the Emergency Medical Institute of Thailand (EMIT) in 2009

(Srithamrongsawat, 2007). Additionally, more reliable information about utilization and cost of the scheme became available. The 2007 fiscal year was the first year when the NHSO had hard evidence on service utilization from administrative databases (as opposed to estimates from survey data), and this put the

Office in a strong position to negotiate a higher UCS capitation rate with the Bureau of Budget. Furthermore, it was also the first time that budgets for targeted services were calculated separately from general capitation, e.g. ARV (2007), Thai traditional medicine (2008), and RRT (2010). In general, the drivers behind rising UCS costs include inflation of labour costs and medical supplies, increasing utilization rates for OP & IP, and the inclusion of additional benefits for members, such as ARV and RRT (Table 4 and Table 5). However, negotiations in policy circles and high-level political support were crucial in determining the approved capitation budgets.

Table 5 Utilization rates for OP and IP services, 2004-2010

	2004	2005	2006	2007	2008	2009	2010
OP UR (visits per person per year	2.41	2.37	2.42	2.55	2.75	3.12	3.22
IP UR (admission per person per year)	0.089	0.092	0.100	0.105	0.110	0.112	0.118

Source: NHSO

However, planning and budgeting for some specific services has increasingly been undertaken separately. This mostly concerns high cost services, which are likely to be underprovided if the budgets are bundled with the general OP and IP budgets. Separation of the budgets for these services is a way to ensure access to the specified high cost or emergency services. In the early days of the UCS reforms, the budget categories utilized included only a few high-cost services and accident and emergency services. However, the numbers of services covered by separate budgets have been steadily increasing. The addition of new services has usually been proposed by professional groups concerned about access to care and the unmet needs of UCS members, rather than following from any systematic assessment of health needs by the NHSO. Services in this category include; haemophilia drugs, chemotherapy for cancers, leukemia and lymphoma, renal stones, asthma, stroke fast-track services, thrombolytic agents for ST-elevated myocardial infarction, and high-cost drugs. Apart from high-cost and accident & emergency services, some specific prevention and promotion services have also been separately managed, again usually as a result of initiatives by departments within the MOPH. The separation of budgets for these services has been criticized by some providers on the basis that it automatically reduces UCS budgets for general IP and OP services. This is because the earmarked budgets are not identified and separately calculated at the time when the UCS capitation rate is negotiated, but deducted from the approved budget at a later stage. However, the NHSO claims that "upstream" and "downstream" budget lines will be the same for the 2012 fiscal year budgets.

> *" ..Purchasing of services could be categorized into two groups, basic services and prioritized services which are centrally managed….The latter focus on expensive services with low frequency [of utilization]. However, some services are not expensive but remain underprovided, like dentures for the elderly, cataracts etcetera."*

> *" ..selected or targeted services for purchasing came in various ways. Sometimes they were selected from areas of high case mortality rate care, such as cardiovascular disease, cancer, and trauma. Sometimes they came from available "know-how" about managing particular conditions, like corticosteroid management for pediatric asthma. And sometimes they came forward because of the readiness of the participating team.*

For example, professional groups have proposed packages of services that effectively manage groups of patients such as STEMI, stroke fast-track etcetera…"

NHSO, executive

2.2 Moving toward demand side financing: management of salaries under the UCS

The architects of the universal coverage reforms had envisaged that capitation would be the main funding mechanism and that most monies would be channelled to service units through the CUPs (Siamwalla 2001; Nitayarumpong 2005). Money would follow patients (or registered members) so that the reforms represented a major shift from supply-side, facility-based funding to demand-side funding. But only in the first year of full UCS implementation (2002) was this form of demand-based allocation via capitation-based payments to CUPs utilized. Against the background of disagreements among senior policy makers about how to implement capitation funding, the MOPH elected to allocate UCS budgets to the 75 PHOs outside Bangkok and allow them to decide on the preferred approach. Provinces could choose to allocate and pay the salaries of their personnel at either the CUP level or the provincial level. Moreover, they could also choose to arrange the payments for inpatient (IP) hospital care, either using an IP-inclusive system where the CUP disbursed IP payments in line with referrals, or an IP-exclusive system where IP budgets were pooled at provincial level and paid by the PHO (Pokpermdee 2005). Only for that proportion of CUPs funded using the inclusive approach without salary subtraction, was the "pure" capitation funding model advocated by policy makers such as Nitayaraumphong implemented. But the shift to capitation funding, and particularly the inclusion of salaries in capitation-based budgets, resulted in major changes in the distribution of resources across the nation. As had been anticipated in some quarters (Siamwalla 2001), it meant a major reduction in the income of large hospitals, particularly those hospitals in central region where there was a relatively high density of staff. The degree of professional opposition and organizational turbulence engendered was such that a special contingency fund was required to support the capitation-losing provinces and hospitals, and the impact of capitation funding became a major preoccupation in the MOPH's "war room".

Table 6 Summary of categorization of provinces by types of payment

Salary deduction	Type of payment			
	Exclusive	Inclusive	Mixed	Total
CUP	11 (14.6%)	27 (36%)	2 (2.6%)	40
Provincial	18 (24%)	13 (17.3%)	1 (1.3%)	32
Proportion	0	3 (4%)	0	3
Total	29	43	3	75

Source: Pokpermdee 2005; p 88)

During the transitional implementation period (2003 - 2006), the NHSO had little direct contact with MOPH providers and purchased health services only in the sense that it transferred that part of the UCS budget allocated to the public system to the MOPH centrally. In 2003, in order to solve the problem of system instability in the capitation-losing provinces, the MOPH switched to a more supply-based allocation by deducting salaries at the national level prior to allocation of UCS budgets to the 75 PHOs. Disbursement of UCS monies at the provincial level was undertaken by the PCMO according to the NHSO guidelines. However, the formula used for budget disbursement for outpatient care (OP), inpatient care (IP), and prevention and promotion services (PP) to CUPs varied substantially, both across provinces and over time (Pitayarangsarit et al. 2008). Coincident with the move to subtract salaries at national level, the MOPH determined that the IP-exclusive system would be used as the single payment method for IP

services, thus reducing the influence of the CUPs on the spending of the IP budget and bringing this more under the control of the PHOs. The change was part of a general trend towards more conservative policies in the MOPH under a new Permanent Secretary, but derived some support from research that had found evidence that the IP-inclusive system was resulting in delayed treatments and fewer referrals as CUPs hung on to IP budgets (Na Ranong et al. 2002). Later assessments of the impact of the different reimbursement methods confirmed that the payment regime influenced hospitals in clinically significant ways. Exclusive capitation and salary deduction at CUP level were associated with higher quality of care than inclusive capitation and salary deduction at provincial level (Pokpermdee 2005). The non-salary operating budget was allocated to each CUP based on equal capitation in 2003 and with some adjustment for type of hospital in 2004 (300 Baht per capita for regional hospital (RH), 410 Baht per capita for general hospital (GH) and 490 Baht per capita for district hospital).

Box 1: The micro politics of policy implementation: the salaries subtraction

Prime Minister Thaksin Shinawatra yesterday defused a potentially explosive conflict at the Public Health Ministry by giving disgruntled Deputy Minister Surapong Suebwonglee more power to supervise the health-care scheme and allowing a review of recent top-level reshuffles. Surapong, who had threatened to quit, vowed to work on after he, Public Health Minister Sudarat Keyuraphan and Permanent Secretary Winai Wiriyakijja held a two-hour meeting with Thaksin at Government House. "Conclusions made at the meeting convince me that I can work more effectively," said Surapong, who had indicated that Sudarat and Winai side-stepped him in making important decisions as well as carrying out the reshuffles (...) He will head the health-care scheme's operation center, the so-called "war room", and "will have the final say regarding the programme's key policies," he |said. He added: "Resolutions that come out of the war room will be final and I'm empowered to give ultimate implementation directives." (The Nation, 2001).

The personnel issue of the administration was not the key issue. What I worried about was the whole system - how the idea would be changed from the first idea that we had implemented. (...) I could understand because we got many criticisms from the doctors in the big hospitals at the time (...) When we faced the problem about the salaries, that's one thing that the Prime Minister tried to re-think: could we reform aggressively as we would like to do, or we have to just slow down? Many of the key persons in the Ministry of Public Health provided information to the Prime Minister – that's why we had to conclude that we had to split the salary from the capitation. (Interview, 2011)

Following the Prime Minister's rare intervention in health affairs, Dr Suebwonglee's position within the war room was strengthened, but he was forced to concede that the change in capitation funding proposed by the MOPH conservatives would stand.

From 2007 onwards the NHSO has purchased health services directly from MOPH CUPs as well as non-MOPH public and private hospitals. Salaries were again deducted at provincial rather than national level[2]. However, the redistributive impact of this change has been limited by compensating changes in UCS budget allocations. Since MOPH facilities are major providers under the scheme, the NHSO has to take into account of financial viability of MOPH hospitals in the allocation of UCS budgets. The uneven distribution of human resources (and salary costs) across hospitals combined with the lack of a clear

[2] In practice, the NHSO could not manipulate the salary allocation determined by the MOPH since this is protected by law and within the MOPH's remit. What the NHSO was able to do was to manipulate the non-salary operating budgets, which are under NHSO control, to make some compensatory adjustments. Thus the NHSO calculated full capitation for each province in such a way that provinces with relatively high salaries allocations would get relatively less under their non-salary operating budgets.

MOPH policy on redistribution of personnel are problems that the NHSO cannot solve but must take into account. The NHSO has tried to make allocations more equitable by making adjustments to prepaid budgets (OP, PP, and general IP) to reflect population age structure, providing extra funding for hospitals and health centres with small numbers of beneficiaries or a historically high density of staff, and paying fixed costs for small district hospitals and currently for small provincial hospitals. The fairness of the salary subtraction arrangements is an ongoing issue, and in the 2011 financial year the NHSO imposed a floor and ceiling on the salary deduction so that it was not greater or less than average salary ± 1 standard deviation. However, some critics believe that the NHSO's efforts to deal with historic problems is making it act more like a system manager and less like a purchaser. Details of managing salaries in the allocation of UCS budgets are provided in the appendix.

> *"The separation of purchaser and provider in Thailand is not perfect since there is monopoly of service provision by the MOPH, we have no choice. Another problem is the scheme has relatively less purchasing power compared with the other two schemes…the centralized monopoly of MOPH facilities caused difficulties in following the concept of 'the money follows the patient', and providers will follow the money… Without a clear explicit MOPH policy on human resource deployment, the concept does not work…"*
>
> NHSO, executive

> *"…we deducted salaries at the CUP level in the first year with the intention of providing a disincentive for overstaffed facilities to recruit new staff. Redistribution of existing staff is difficult. If the facilities receive additional staff then salaries of the new staff would be on their shoulders…but it could be done only for one year due to its serious implications for the mismatch of resources….."*
>
> NHSO, executive

> *"….handling the salaries in the allocation is always problematic due to the mal-distribution of current human resources. However, we tried to ensure their financial survival and make them operationalize [the policy]… I can't say whether what we did was good or not, and recognize that what we did moved a bit to supply-based [funding] to keep the balance of the system…Moreover, according to our experience in nearly a decade, it let us recognize that it is impossible to reform a health care system by solely employing financial mechanisms. Then there were two possible things that we could do, first step back a little bit, or move further with an agreement with the MOPH to reform the system, particularly on human resources…"*
>
> NHSO, executive

> *"…it is too much of a burden on the NHSO to do things if the MOPH does not cooperate….. The UCS budget is a major source of funding for MOPH hospitals. If there are hospitals that are in financial deficit for any reason, the NHSO is always the first target for blame….It is as though we cannot throw a snake from our neck."*
>
> NHSO, executive

Despite these limitations, demand side financing has been utilized successfully with post-paid budgets where payments depend on the volume of services provided by each facility. This has happened, for example, in the areas of high-cost services, accident and emergency services, some items of P&P,

rehabilitation services, ARV, RRT, secondary prevention of chronic diseases, and special drugs (further details will provided later in the strategic purchasing section).

2.3 Contracting for health services

Publicly-administered purchaser/provider systems around the world use a variety of contract forms ranging from relatively formal and "complete" contracts resembling the legally binding documents utilized in the business sector, to less detailed agreements which do little more than establish a framework for managing transfer payments between organizations that remain part of a unified health care system. The NHSO employs a soft contract approach more towards the latter end of the spectrum. Thus the contracts signed by NHSO and providers contain only general statements, without a detailed specification of outputs, or quality standards. There are few detailed requirements regarding the management of subcontracts, following referral within a provider network. In contrast to the classical image of contracts as voluntary agreements by which enterprises in private markets manage risks, the contracts are "imposed" in the sense that all public facilities are obligated to participate as providers. Private providers wishing to enter contracts with the NHSO must be accredited, but the details of the contracts are similar to those of public hospitals.

There are certain threshold requirements before providers can contract for UCS work, such as the need to set up a primary care unit (PCU) for every 10,000 – 15,000 registered members, but again these are more usually enforced by bureaucratic command as opposed to contractual clauses, at least within the public system. With hospitals in the public system the NHSO has made efforts to steer provider behavior by using financial incentives to encourage providers to improve services, but to date these are enforced by management processes rather than contractual governance *per se*. There is an absence of the detailed penalty and incentive clauses found in contracts in systems like the English NHS, though the Thai contracts do contain general requirements to use specified reimbursement mechanisms, which according to the detailed provisions of NHSO guidance do have some incentive based-elements. There is no contractual requirement for hospital accreditation in the NHSO's agreements with private providers, but they have to meet the threshold requirements mentioned above.

Most contracts are between the NHSO and the CUPs, whether based on provider networks centred on public or private hospitals. The NHSO also enters contracts with specialist public treatment centres - for example, cancer centres, thoracic hospitals and cardiac centres operating as Contracting Units for Secondary Care (CUS) or Tertiary Care (CUT). Similarly, some private hospitals may contract as CUSs or CUTs and must then accept the payment rate set by the NHSO. Additionally, the NHSO contracts with accredited solo clinics in Bangkok and vicinity, and MOPH, local government, and other medical centres in urban settings, which act as the main contractor for OP services with a referral hospital backup. For MOPH health centres, the NHSO has allocated part of the UC budget to actively support the development of primary care, for example, by improving basic infrastructure and capacity, strengthening management and support of CUPs, service model development, incentives for primary care providers, and improved training.

Contract monitoring remains relatively under-developed. Claims auditing has been performed only for high-cost services. The NHSO directly manages e-billing and reimburses hospitals via itemized fees schedule-based payments. There are no formal sanctions for either public or private hospitals found to have made inappropriate or false claims: the usual practice is merely to require return of the monies paid. For medical record audit, the NHSO to date has only investigated certain chronic conditions – for example, diabetes in 2006 and 2007 - and found major problems in the delivery of required quality

standards. This resulted in the introduction of a separate program on secondary prevention for chronic conditions in fiscal year 2010.

With regard to information systems, the NHSO maintains substantial administrative databases on OP, IP, and selected or targeted services. However, these are used mainly for reimbursement, not for monitoring and evaluation. Moreover, the capacity of NHSO staff at the national and regional levels to analyse such large databases remains limited and the transaction costs in doing so are prohibitively high.

In order to protect UCS beneficiaries, the NHSO set up mechanisms for beneficiaries and providers to access information and make complaints. The gold card "1330" telephone hotline was set up and operated 24 hours for seven days per week. The numbers of calls and complaints have been increasing over time, reflecting growing public awareness of this communication channel. A no-fault fund was also set up to compensate patients and health personnel who suffered damage of their health, and again it was found that the numbers of patients and health personnel receiving compensation has been increasing year on year (Table 7). Moreover, the NHSO sought to counter problems in arranging hospital admissions in Bangkok by setting up a bed management service to channel patients towards vacant beds. In general, only 70 percent of requests led to a bed being successfully arranged, and only a minority of these were beds in UCS-contracted hospitals. The majority of the arranged beds were in contracted hospitals, but some were arranged in hospitals under special contracts with the NHSO, which offered higher than normal payments for specific conditions, such as brain surgery and neonatal intensive care. This is due to the problem of limited supply for specific conditions in some areas.

Table 7 Numbers of calls, complaints, compensation awards, and bed arrangements for the UCS, 2004-2010

	2004	2005	2006	2007	2008	2009	2010
Provide information for beneficiaries (x1,000)	495.6	831.6	788.4	720.5	755.3	728.9	777.8
Provide information for providers (x1,000)	17.4	24.3	30.1	66.3	96.7	40.2	31
Complaints	1,490	1,864	2,945	2,796	4,239	4,298	4,186
Compensation awards for patients	73	178	371	433	550	660	704
Compensations awards for providers	11	46	48	197	473	664	686
Requests to arrange bed				3,137	3,770	3,905	3,234
Bed arranged				2,386	2,673	2,723	2,158
% Beds in UCS-contracted hospital					88	93	

Source: NHSO annual reports for relevant years

2.4 Purchasing new targeted services

As mentioned earlier, NHSO purchasing is sometimes problematic because many of required services are not available; therefore, the NHSO invests resources in service planning and supporting service development in areas of unmet need. Soon after its establishment, the NHSO used part of its capital replacement budget to support development of centres of excellence for cardiac disease, cancer, and trauma, which were major causes of death in 2002 (compensating in part for the lack of a capital investment budget in the MOPH). This project continued during 2003-2006 but widened to encompass not only capital projects but support for provider development and incentives for service improvements. It was found that the cardiac centres of excellence were particularly successful in improving the

accessibility and geographical spread of services. A decline in mortality rates of trauma cases in the trauma centres of excellence was also observed, but there was less gain from the cancer centres, which may have suffered from a lack of good referral networks (Srithamrongsawat et al. 2008).

Some services do not need additional investment in facilities but rather better management. For example, the NHSO concluded that this was probably the case in the areas of cataract surgery, haemophilia, leukemia & lymphoma, cleft lip and cleft palate. In these areas the NHSO concentrated its efforts on developing appropriate clinical guidelines, and also set up higher than average payment rates which made it more attractive for providers to offer these services.

Purchasing of targeted services is closer to the concept of active purchasing than is the case with routinely-purchased services, because the former might not otherwise be provided whereas the latter generally depend on historic levels of funding that tend to be rolled on from year to year. The prospect of

Table 8 Performance of targeted and non-targeted health services within the UCS, 2004 - 2009

	2004	2005	2006	2007	2008	2009
P&P non targeted services						
% coverage health examination 0-5 years old	91.85	94.95	71.92	64.13	55.21	52.31
% child 0-5 years old malnutrition	5.99	7.21	13.49	15.03	18.49	22.8
% child 0-5 years old with obesity	2.71	6.38	0.86	13.08	16.05	19.1
% coverage health examination 6-14 years old	19	27	24	43	38	36
% child 6-14 years old malnutrition	7.95	6.39	5.56	9.38	11.48	16.4
% child 6-14 years old with obesity	7.71	3.68	8.64	6.15	7.11	9.58
P&P targeted services						
% coverage of screening for metabolic syndrome 15+					17.48	20.56
% coverage of high risk group engaging in behaviour modification program					8.9	8.8
Curative targeted services						
Open heart surgery		21,162	23,936	26,505	29,959	32,233
RRT					972	10875
ART				74841	106798	116382
Cataract	13,553	42,191	88089	122130	128880	120247
mobile services			13266	48697	53587	34149
normal services			74823	73433	75293	86098
Haemophilia			483	718	889	927
Leukemia & lymphoma new cases			1079	1831	1448	1582
Cleft lip & cleft palate			1226	1828	2692	2779
Quality & Efficiency						
Maternal mortality/ 100000 live births		22.34	16.82	20.8	17.56	16.04
% teenage pregnancy		24.5	25	26	27.2	28.2
% caesarean section		17.7	19.7	21	21.9	22.8
% early stage CA cervix		22.2	22.45	21.18	22.22	21.6
% Low Birth Weight				9.4	9.37	9.93
% UCS members satisfied with the scheme	83.4	82.4	84	83	88.4	89.3
% Providers satisfied with the scheme	39.3	47.7	51	56.6	60.8	60.3

Source: NHSO annual report, 2009

"new" monies creates an incentive to provide targeted services which is reflected in the increase in the numbers of such services shown in Table 8. The NHSO adopted a similar approach in primary care, in relation to prevention and promotion services with inadequate demand. However, there were at least four major consequences of channelling funding via targeted services. First, it usually brought a substantial additional data recording burden, especially when it was adopted to pay for high frequency but low cost primary care services in under-staffed health centre. Moreover, some programs required web-based data entry that caused problems for health staff, especially in rural areas. Second, it might crowd out non-targeted services as observed in Table 8. In addition, because reimbursement depended on data returns some primary care facilities might put more emphasis on data entry than provision of services. Third, the financial incentives for maximizing the volumes of recorded activity raised questions about the reliability of the databases. Moreover, the transaction costs that would be incurred in verifying and auditing these databases are high, particularly as such systems are not well established in the NHSO. Finally, itemized payments for primary care services threatened to undermine a holistic concept of primary care which stressed the comprehensive, integrated, and continuous nature of service provision.

2.5 Payment methods

The main reimbursement methods employed in the UC scheme from the beginning are capitation for OP and P&P services, and weighted DRGs under a global budget for IP. The capitation payment system could be implemented without major difficulties due to a well-established citizen registration database and housing database, which made it possible to calculate populations within CUP catchment areas. Those who migrate to work outside their house registration area can identify themselves at an available CUP in their new place of residence, and their name will be transferred to the new CUP without the need to transfer their house registration to the new location. Past experience from the Social Security Scheme, and the (now defunct) Medical Welfare Scheme and Health Card Scheme, helped the planning of the new system. DRGs first came to Thailand in 1993 as part of a research project. The first operational version of DRGs was unveiled in 1997, and used to pay for high-cost services under the Health Card Scheme. Moreover, piloting of capitation payments for OP and weighted DRGs under a global budget for IP in six provinces under the 2001 Social Investment Project (later re-badged as the first phase of the UC reforms) gave policy makers confidence that these could be adopted when national rollout of the UCS went ahead the following year.

In the early 2000s the sharing of the capitation payment between different health care organizations, services and departments - the so-called unbundling of UCS budgets – occurred as part of the downstream resource allocation process. It was necessary from the beginning to specify certain sub-budgets at the central level so as to safeguard access to high cost services, and accident & emergency services. However, as discussed earlier, there has been a growing trend towards earmarking a higher proportion of the UC budget for targeted services. The payment method employed for targeted services was the itemized fee schedule as shown in Figure 4. The consequences of unbundling UCS budgets were discussed in an earlier section.

The current DRG system is version 4. Generally the later iterations of the methodology have resulted in an increase in the number of DRGs: there were 511 groups in the first two versions, which increased to 1,283 groups in version 3, and 1,920 groups in version 4. The increase in the number of groups was intending to better reflect cost variations of more and less complex treatments. However, critics have pointed out that unbundling of DRGs generally favors the larger hospitals, especially tertiary care hospitals, which have a more complex case mix that attracts higher payments. It was observed that the average case mix index (CMI) has been increasing steadily overtime, as shown in Figure3. The average

CMI increased sharply in most types of hospitals in 2008, largely due to the change from DRG version 3 to version 4. Moreover, there seems to be evidence of "DRG creep", which may be related to the limited capacity of hospitals in coding ICD10 and ICD9CM (National Health Security Office 2007). Critics saw DRG version 4 as a technical move that reflected the micro-political agenda of certain professional and MOPH interest groups who wished to reverse the redistribution of resources from tertiary/secondary to primary care that the UCS had encouraged. However, without better data on hospital costs it is difficult to assess whether the additional allocations to the larger hospitals are excessive.

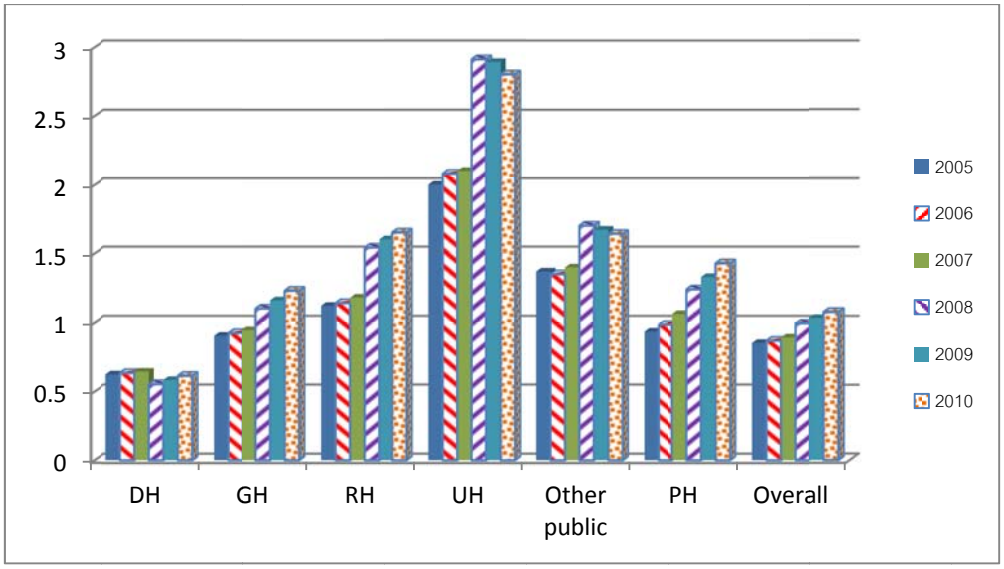

Figure 3 Average case mix indexes for inpatient cases of UCS by type of hospital, 2005 - 2010

Note: DH = district hospital, GH = general hospital, RH= regional hospital, UH = university hospital, PH = private hospital

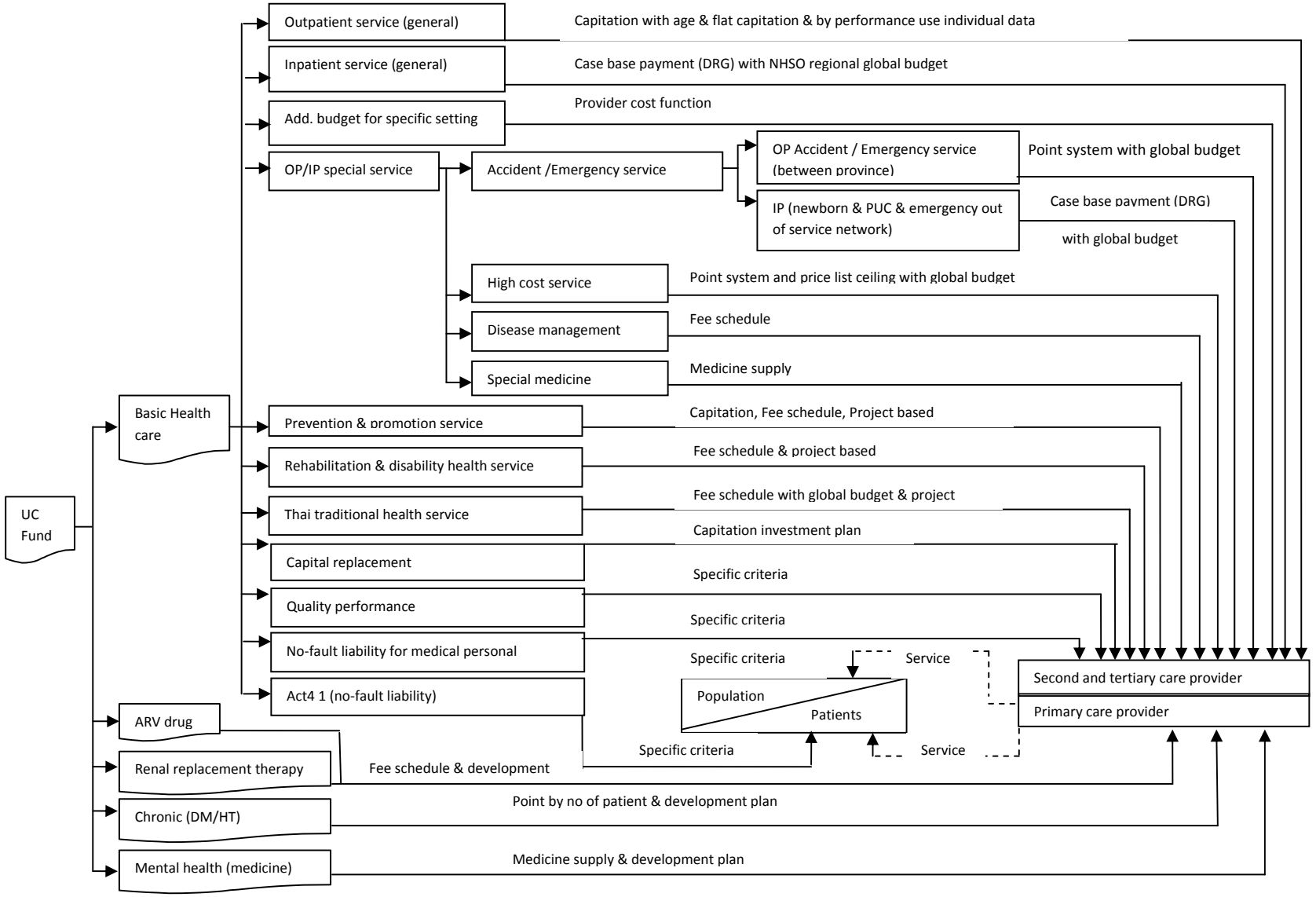

Figure 4 UCS payment mechanism by service type as of year 2011

3. Harmonization of health insurance schemes

3.1 Policy rationale and controversies

Harmonization of the public health insurance schemes remains an issue for hot debate in Thai society ten years after the inception of the UCS. The lack of equity between the three schemes continues to raise questions about whether entitlement to universal health care means entitlement to health care of a similar standard for all Thai people. Mills et al. (2005) noted the sharply differing views of the different stakeholders and identified a number of issues needing resolution. First there was controversy about how to devise a non-discriminatory insurance system and meet the needs of both the formal and informal sectors. Second there was a problem of perceived competition between the SSO and NHSO over whether informal sector workers/home workers should be covered by an expanded SSS or by the UCS. Third there was the possibility of prioritizing certain harmonization topics - such as benefit packages and information systems. Fourth, there was a strong case that the medical component of the Traffic Accident Protection (TAP) scheme should be the first program to merge with the UCS since it duplicated the health service coverage in the other insurance schemes, but no progress had been made regarding this first step (Mills et al. 2005).

Recent studies found inequity in the access to essential care offered by the different health insurance schemes, including differences in benefit packages, payment methods and payment rates, and provision of expensive drugs and high-cost procedures (Limwattananon et al. 2004; Limwattananon et al. 2009; Thammatach-aree 2009).

The architects of the UCS reforms originally envisaged that universal coverage would be achieved through the creation of a single fund (Working Group on the Development of the Universal Health Insurance Coverage Policy 2001; Jongudomsuk 2002; Siamwalla, 2001). However, during the Parliamentary process of drafting the NHSA, this idea evolved to that of managing the three existing schemes via a single administration agency. This signalled a fundamental ideological change. The rationale for merging the funds was to create a single system within which equity could be guaranteed, while the idea of having a single management unit aims to reduce duplication and improve the efficiency of the system, but not necessarily to reduce inequity between schemes. The dilution of the plan from a merger of schemes to setting up a single management unit appears to have resulted from the intense controversy sparked by the reform proposals, and the compromise agreed among the contending groups as the Parliamentary drafting process proceeded.

> *"..the original intention was to create a single fund, not just a single management. The Act distorted this vision. According to the Act, it is similar to just outsourcing of scheme management from the SSS to the NHSO. Then the NHSO acts as only a clearing house unit of the system."*
>
> *Academician*

The compromise solution of a single management agency was incorporated in the Act, but continued to provoke significant opposition, which exists to the present time and has prevented implementation of this component of the reforms. During the 10 year life span of the UC reforms there has not been sufficient political or high-level administrative support for either the merger or single management proposals to advance significantly.

"We need strong leadership, strong leadership with good opportunity and strong support from major parts of the society. For the current government, the Prime Minister needs sometimes to strengthen her strong leadership. So with a controversial issue like this I don't think that the current policy community would implement it."

Politician

"The current situation is not suitable to push SSS towards harmonization. I think we can only do harmonization of the benefits package with the CSMBS, which has a very large gap"

NHSO, executive

"The harmonization cannot happen because of the lack of leadership."

Academician

The concept of harmonization remains confused so that there is no consensus about its meaning. Senior administrators of the SSS were said by our respondents to be reluctant to agree to change, partly because of the long struggle they had faced to win improved benefits for workers and reluctance to jeopardize the gains made in the Social Security Act and more recent extensions of entitlements.

"From my own experience, SSS had strong ownership… They felt that merging to a single management would destroy the strength of the scheme. For example, choice of provider, when the UC scheme has very limited choice"

NHSO, executive

"I have a question about the efficiency of the single management scheme. I don't know the net result of increasing efficiency and less competition between schemes."

SSO, executive

"However, the number of funding agencies might not be the main concern if some elements such as benefit package, information system, payment method, claim system, audit system could be harmonized."

Academician

3.2 Strong political support for a single management unit

The single administration proposal was strongly supported by the government during the early phase of UCS implementation. The government forced the other schemes to open negotiations by using the provisions of the National Health Security Act 2002. Meetings between executive officers of the three schemes were organized to discuss a way forward. However, there was strong resistance from both the CSMBS and SSS. The politician interviewed for this evaluation suggested that there were concerns about how far government could be trusted and a suspicion that there might be a more radical hidden agenda behind the single management agency plan, In particular there were fears that the plan for full merger of the funds remained alive and that the Government planned to use SSS monies to subsidize the UC scheme. From the CGD side there was a worry that Ministers had already signaled a wish to reduce

CSMBS expenditure, and that the new proposals might have the aim of reducing the level of support for the scheme.

> *"It is difficult. …the Ministry of Finance and Ministry of Labour did not want to… They were afraid of [change] and said that civil servants work for the government with relatively low salaries so they would like to receive higher health care benefits. Even though I said that they would get all the same benefits, we do not cut anything. We just try to make it more efficient. They did not trust us. They thought that we try to bring their budget to subsidize the UC scheme. Even the Ministry of Labour, …in the first year they expressed the idea that the UC scheme cannot be reliable. So, we would need the money from the Social Security Scheme, and that was may be their misunderstanding."*
>
> Politician

> *"Employee groups were afraid that the government needed the SSS budget to subsidise the UC scheme."*
>
> SSO, executive

Pressure to push the policy towards early implementation deepened suspicions and strengthened opposition from beneficiaries of the CSMBS and SSS.

> *"We were not clear how the government would manage if they were merged to be a single fund. Can we go to any hospital when we get sick as usual or do we have to go to a health centre first like under the UCS? This was the problem of misinterpretation of information."*
>
> Comptroller General Department official

> *"Employees felt that they could propose a new benefits package to the provider and negotiate to solve problems of service. They were afraid of losing this power if the management had moved to the NHSO"*
>
> SSO, executive

3.3 Coordination committee process

Against the background of the limited progress made in implementing the single administration proposal, a coordination committee of the three public insurance schemes initiated by the NHSO was set up on 19 April 2004. Its remit was to coordinate and support the harmonization process. The objectives specified for the committee included: (1) to cooperate in mobilizing registration data of beneficiaries between schemes; (2) to support the development of standardized data that could be shared between schemes; (3) to develop a common audit system (4) to support data exchange for monitoring and evaluation of the health insurance system.

The chairmanship of the committee rotates every year among the executive officers of the three schemes, but the NHSO always plays an active role. Committee membership is limited to staff of the three public health insurance schemes, and is not open to external stakeholders such as civil society groups or academicians. A review of the minutes of meetings during the six years period between 2004 and 2010 undertaken for this report found that none of the meeting agenda items were related to the specific harmonization issues set out in sections 9 – 12 of the National Health Security Act.

However, the work of the committee brought at least three successful outcomes. First, there has been cooperation between the telephone call centres of each scheme in providing information, not only in relation to the individual scheme but the other schemes too. Second, there has been improved cooperation and sharing of beneficiary databases between schemes with regular updating to record individual entitlements and prevent duplication. Third, a joint audit system has been established.

However, it should be noted that there have been both convergent and divergent changes in the SSS and CSMBS during the last decade, as shown in Table 1. Competition between the UCS and SSS was observed in several areas. The SSS expanded its coverage to cover enterprises with at least one employee in 2002, the first year of UCS implementation. Moreover, a proposal to extend coverage to spouse and dependents of SSS members was discussed by the Government in 2010/11, but not implemented. Conversely the CSMBS has made changes to bring it closer to the UCS. The introduction of a direct disbursement system for OP services will make it easier to utilize capitation for the CSMBS in the future, since this requires beneficiaries to register with their preferred hospitals. Moreover, the adoption of DRGs as a payment method for IP services in 2007 also opens the way for harmonization of payment methods in the future, even though the rates of payment differ significantly between schemes.

3.4 Improving the governance of the health insurance system

Lack of progress towards harmonization and research evidence of practice variations and inequity between schemes brought this issue on to the agenda of the National Citizen Health Assembly in 2010. A new mechanism was proposed to address the lack of an overarching governance framework in the current system. Each health insurance scheme had its own governance body and rules. Moreover, in its six years of existence, the coordination committee had moved towards harmonization only in regard to technical and not policy issues. The Assembly's proposed solution was to create a regulatory body standing above the three public health insurance schemes, with responsibility for the governance of the health care financing system.

The Assembly's proposal led the Government to establish a new organization, the National Healthcare Financing Department Office (NHFDO). This agency will have only a temporary existence, and has been assigned to work for three years. Its remit is to develop a long-term plan and roadmap for the harmonization of the three public health insurance schemes. The office is managed by a board chaired by the Prime Minister. As a step towards the development of the plan and roadmap for harmonization, there is a proposal to set up a number of working groups based on centres to study case-mix, data standards, audit, and data management.

Most of our key informants were sympathetic to the concept of a new organization above the three insurance schemes.

> *" I agree with having an organization above the three insurance schemes to agree a core benefits package for all the schemes…This three years period might determine the permanent functions of a new organization in the future…I think that each scheme can have additional benefits dependent on the background of the scheme"*
>
> MOPH, executive

> *"This new office strategy aims to keep all schemes in the system, not to merge them into a single management."*
>
> NHFDO, executive

However, our key informants differed in their views about the sustainability of this process. One believed that this might be the model for a future organization to take harmonization forward. Another suggested that the office would only bring about minor changes.

> *This new office is only a minor movement to reduce the gap between benefit packages… I don't think this office can do more than build up knowledge for future developments"*
>
> NHSO, executive

> *"The pressure of changing the SSO to be part of an independent organization might have the benefit of increasing efficiency, which would support the sustainability of all the health systems"*
>
> NHSO, executive

Currently several NGOs are concerned about what they consider to be the unfairness of requiring SSS members to pay twice if the care available to them after paying employment-based contributions is only the same as that provided by the tax-financed UCS to members who make no additional contributions.

> *"We question why we don't get the same core benefits as an NHSO member, even when we pay more. We need to have the same benefits without having to pay double, the same as the UC scheme"*
>
> NGO administrator

> *"There are three schools of thought in the SSS. First is the group who want to move to the UC scheme. This group requires the government to subsidize the health care service so they can use their money for other benefits under the Social Health Insurance. The second group is the group who want to keep the status of fund management by the SSO. The third group is the group that wants to change schemes to have greater benefits, like they'd get in the CSMBS."*
>
> SSO, executive

> *"The movement towards harmonization in section 10 of the National Health Security Act seems to be biased towards the NHSO. According to the Act, there is neither a representative from the employers nor the employees on the National Health Security Board. This leaves them afraid of and against the movement towards harmonization."*
>
> SSO, executive

Discussion

Evidence from a decade of UCS implementation indicates that financing reform alone could not transform the health care system to achieve all the desired outcomes. The separation of purchaser from provider made the system more accountable to the Thai people, gave them more rights and better protection (through the work of the NHSO), and gave them better access to health care services. However, the continued centralized management of MOPH facilities, and the Ministry's near monopoly over provision in many localities resulted in a lack of provider reform. In a situation where government requires public

purchasers to take part in the UCS, and contracting with the NHSO is mandatory, there is little chance for market levers to work or even for NPM-style bench-marking and performance review. The MOPH continues to function as a command and control bureaucracy managing its system of providers, and this has limited the ability of the NHSO to move from supply-based allocation to demand-based allocation as the original reform blueprint required. Salaries allocation, in particular, remains a problematic issue, and the possibility of using this as a mechanism to counter the existing mal-distribution of the workforce has been constrained by Ministry opposition and the safeguarding of existing arrangements under the Public Salaries Act.

The interviews conducted for this part of the evaluation showed that MOPH executives agreed that purchaser should be separated from provider. However, there was a widespread perception that clarification of the purchaser and provider roles and functions is needed. There is a recognition that purchasing in an emerging economy like Thailand cannot simply mean buying services. Not all necessary services are currently provided in all provinces, and there is a need for a push from above to establish priorities and develop new services. The unclear boundary between purchaser and provider roles has exacerbated the tensions and conflict between MOPH and NHSO. The difficult relationship between the two bodies arose partly from attempts by "conservatives" in the MOPH to slow the pace of reform, but was worsened by the some NHSO statements which struck an unnecessarily critical and adversarial tone.

After a rocky start, the NHSO has been able to improve its relationship with the medical profession over time. The participatory approach employed by the NHSO in giving doctors a central role in the selection and development of targeted services led to better co-operation and reduced professional negativity towards the NHSO. This approach also probably worked to reduce conflict between the NHSO and MOPH. There is growing interest in the concept of "strategic partnership" in recent years, reflecting a recognition that the two bodies will need to work together for the foreseeable future. Improved relationships might be expected to translate into better coordination of planning and service delivery. The term "commissioning" has entered the policy discourse in the last year or two, and also suggests a need for better relationships across the purchaser/provider split which will allow co-operation in needs assessment and service planning. Nevertheless, at the time of writing continuing tensions are manifest between the NHSO and MOPH, between pro-reformists and conservative factions in the MOPH, between organizations at different levels of the system, and between different sectional interest groups within the civil service and the medical profession.

Purchasing, in the sense of active purchasing, only operates in the area of targeted services. The lack of provider competition and the relatively low purchasing power of the UCS, mean that the NHSO has little scope to use the lever of purchasing to change patterns of services or secure quality improvements. But the relatively attractive payment scale for targeted services let the NHSO bring in a wider range of providers, including private hospitals providing tertiary care for UCS members and may allow the NHSO to select between providers. This has opened up a wider range of services for UCS patients. However, when a similar approach was adopted to purchase certain specific primary care services, the gains were less certain. Even though the NHSO requires providers to submit substantial administrative data, the Office uses these mainly for reimbursement purposes. Use of these data for monitoring and evaluation was limited due to lack of capacity and the high transaction cost of doing this centrally.

The introduction of the new reimbursement mechanisms required for the UCS was facilitated by the experience of implementing previous insurance reforms in the shape of the SSS, HCS and MWS. The existence of a citizen registration database and the experience of past beneficiary registration made it feasible to introduce capitation funding with minimal delay. A DRG system, adapted to Thai needs, had been developed nearly ten years prior to the introduction of the UCS, and so was ready for use. The

substantial preparation and capacity-building exercise that preceded universal coverage reform in Thailand meant that the initiative was built on firmer foundations than most comparable reforms in lower middle-income countries (Tangcharoensathien et al 2004). One lesson that can be drawn from the Thai reform experience, and especially the rapid rollout of coverage in the first two years, is that adequate system capacity is an important prerequisite for success.

Sectional interests, a lack of consensus and uncertainty about the scope of reform probably explain the failure to move towards harmonization of schemes, even in the limited way set out in the NHSA. From the perspective of administrators who had fought long and hard to improve scheme entitlements in the SSS and CSMBS, harmonization represented a potential threat without compensating gains for members. Moreover, it is unclear how far Thai society understands and values the concepts of social solidarity and equity. Existing scheme members have remained generally unreceptive to arguments about the greater good. It is unclear how successful the new NHFD office will be in advancing the harmonization agenda, especially when the current government is not from the same political party that set up the office.

What next?

Further reforms are needed in order to enable effective implementation of the purchaser/provider split. One enduring problem since the inception of the reforms has been the tension between the different organizations, interest groups and stakeholders involved. Many of the policy adjustments made as the reforms have bedded down have involved swings of power between the Ministry and the NHSO, or organizations at different levels such as the PHOs and the CUPs, and central intervention has sometimes been needed to control the behaviour of particular actors. One recurrent problem, at all levels from the Ministry and NHSO to the CUP provider networks, has been the lack of appropriate checks and balances needed to bring stability to the system. Achieving a better balance of power among organizations and actors is likely to be crucial for longer-term stability.

Such a balance of power is likely to involve a degree of decentralization and greater devolution of decision making authority to organizations in local areas. Currently local government is beginning to play a bigger role and, together with the NHSO branch offices and PHOs, is part of an expanding administrative infrastructure at regional and provincial level. However, the mixed arrangements that are emerging carry a risk of excessive system complexity and even a degree of organizational fragmentation, so that there is a need to take stock regarding the organizational framework needed to delivery universal coverage.

Commissioning by area-based health authorities is one possible solution that warrants further investigation. Health boards, with or without a hard purchaser/provider split, have been utilized successfully in several universal coverage systems (Ashton, T. et al 2008; Lomas, J. 2001). They provide a means of planning area-based services at arm's length from the central agencies, and can act to support a common national strategy, while retaining flexibility to plan local services according to local needs. Strong area-based bodies might have more success at strategic purchasing than the NHSO has achieved at national level. Of course, any such move would require further reform of MOPH workforce allocation policies and need strong political will to implement. Moreover, such a reorganisation would require substantial preparation for the transfer of functions from the present NHSO branch offices, PHOs and local government organizations. In particular, purchasing and commissioning capacity would need to be developed substantially, especially in areas such as planning, needs assessment, priority setting, and monitoring and evaluation of local health systems.

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Appendix: Managing salaries in the allocation of UCS budgets

The technical basis of the calculation

1. The UCS total capitation rate was calculated to include the full cost (labour cost, material cost, and depreciation cost) of services provided to an average member in a given year. The approved capitation rate announced would cover the full cost of service for a member for a year. However, although the salaries component was included in the UCS rate calculated for public facilities, this was not allocated directly to downstream organisations as part of UC budgets.
2. This is because salaries of government employees are protected by the Civil Service law. The Comptroller General Department channels salary budgets through the provincial treasury offices on a monthly basis. The salaries are then disbursed into employees' bank accounts near their place of employment.
3. In general only the non-salary components of the UCS budget are available for direct allocation to public facilities[3], with actual allocations bring calculated by reducing the total budget to take account of salary payments already received via the provincial treasury offices. This process is subject to negotiation between the NHSO and the Bureau of Budget regarding how much salary can be allocated to UCS-related work, since providers also have other non-UCS duties. Thus over the 10 years of the UCS, allocations to public facilities have been calculated as follows:

[3] It should be noted that the value of the salaries deducted from the capitation rate was based on the figures agreed in negotiations between stakeholders and the Bureau of Budget and approved by the cabinet.

For MOPH facilities under the Permanent Secretary's Office (provincial hospitals, district hospitals, and health centres), which covered 90% of UCS members.

a. Fiscal year 2001-2003;
   Available UCS budgets = total capitation budget minus 100% of salary budget[4]
b. Fiscal year 2004- 2006;
   Available UCS budgets = total capitation budget minus 79% of salary budget[5]
c. Fiscal year 2007 onward;
   Available UCS budgets = total capitation budget minus 60% of salary budget[6]

For other public hospitals (MOPH hospitals outside PSO, other ministries, and university teaching hospitals) which cover only 6 % of UCS members[7] a different approach is used whereby a notional deduction from the capitation rate payable (rather than in respect of salaries) is made to reflect the amount of non-UCS work undertaken.

a. Fiscal year 2002-2003; available UCS budgets = 0.55 (1 - 0.45) of capitation rate
b. Fiscal year 2004; available UCS budgets for other public primary, secondary, and tertiary facilities = 0.6702 (1 - 0.3298), 0.6338 (1 - 0.3662), and 0.6858 (1 - 0.3142) of capitation rate respectively
c. Fiscal year 2005-2010; available UCS budgets for other public primary, secondary, and tertiary facilities = 0.6702 (1 - 0.3298), 0.6154 (1 - 0.3846), and 0.6858 (1 - 0.3142) of capitation rate respectively.
d. Fiscal year 2011; available UCS budgets for other public hospitals, and university hospitals = 0. 7361 (1 - 0.2639) and 0.8248 (1 - 0.1752) of capitation rate respectively.

4. Private facilities received full capitation for OP, IP, and P&P with adequate demand (or P&P facility based) [8].
5. In practice, salaries were deducted from the capitation budget only for OP, IP, and P&P with adequate demand, not from other budget heads that did not include labour costs.

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[4] The rationale for the 100% deduction was that all public facilities already received salaries direct from the CGD; moreover, since MOPH facilities were major providers of UCS services then it was assumed that all salaries of MOPH facilities were included in the calculation of the UCS total budget.

[5] Against a background of financial deficits in many MOPH hospitals and after the MOPH failed to increase the capitation rate to the expected level, it was argued that MOPH facilities also provided services to CSMBS and SSS members, so that it was unfair to load the full salary costs onto the UCS. After negotiation it was agreed that only 79% of salaries of MOPH facilities would be allocated against the UCS.

[6] The above approach was adopted again. Given the political difficulty of securing a large increase in the capitation rate and the need to safeguard the financial viability of MOPH facilities, it was agreed to deduct only 60% of salary costs from the total capitation budgets for MOPH facilities

[7] A different approach was adopted for other public facilities because services provided to UCS members shared only small portion in these facilities. Similar to that of MOPH facilities, the level of salary deducted from the capitation rate was based on the figures agreed in negotiations between stakeholders and the Bureau of Budget and approved by the cabinet.

[8] The P&P budget was divided into 3 categories, P&P vertical programmes (8%), P&P with adequate demand (60%), and P&P area-based (32%). The first category includes central procurement of vaccines, MCH & school health logbook, and national priority programmes. The second category includes services with adequately demanded by the populations i.e. maternal and child services, vaccination, family planning services, school health program, health screening and behaviour modification programme. The third category includes budgets supporting the local health funds, supporting outreach services, solving of local health problems, and monitoring and evaluation of P&P activities.

Salary subtraction of MOPH facilities under the Permanent Secretary's Office and its allocation

	Salaries	Subtraction of salaries	OP	P&P with adequate demand	General IP
2002	Salaries of public employees are protected by the civil service law. The Comptroller General Department channels salaries through the provincial treasury offices on a monthly basis. The salaries are then disbursed into individuals' bank accounts near place of employment on a monthly basis.	100% of MOPH facility salaries were deducted from budget allocations at Provincial or CUP level	Each province received UCS budgets = (number of UCS members x capitation rate) – 100% salaries of MOPH facilities within the province or particular CUP depending on the financing mechanism chosen. Provinces could choose whether they would adopt an IP-inclusive or IP-exclusive capitation payment		
2003		100% of salaries deducted from budgets at National level	Equal non-salary operating budgets per head allocated to all CUPs		Global allocation at national level
2004		79% of MOPH salaries were deducted from total capitation budget at national level (available operating budget = (capitation rate * number UCS members) – 79% MOPH facility salaries	A differential capitation rate for non-salary operating budgets (OP+IP+PP) set at 490, 400, and 300 was allocated to district hospitals, general hospitals, and regional hospitals respectively.		Global budget at national level
2005			A formula based on UCS population, age mix, social disadvantage and workload was employed to allocate available operating budgets		Global budget at national level
2006			The transitional phase ended in May 2006 (midway through 2006 fiscal year) and NHSB agreed to allow the MOPH to continue allocating the budgets as planned, similar to those of 2005		Global budget at national level
2007		60% of MOPH salaries within a province were deducted from the calculated capitation budget for each province. (available UCS budget for each province = total calculated budget – 60% of salaries of MOPH facilities within the province)	The capitation rates for OP, IP, PP were adjusted by age structure of UCS members served, utilization rate, plus additional budget for specific settings [9] (remote area, size, and high risk areas)		Global budget at regional level
2008			Same as that in 2007		DRG v4.0, adjusted 1.32 for DH[@], Global budget at regional level
2009			Adjusted age structure for general OP budget. Allocating additional budget to those with specific settings (remote areas, size, border areas, and fixed costs for district hospitals (except DH>30 beds not located in border or remote areas)		Global budget at national level[#]

[9] This is a separate budget line under the UCS capitation allocated to specific settings i.e. health facilities located in border areas, remote areas, high risk areas, CUPs with small population size (<30,000), and health centres with populations less than 2,500.

	Salaries	Subtraction of salaries	OP	P&P with adequate demand	General IP
2010			Adjusted age structure for general OP budget. Allocating additional budget for specific settings as fixed cost to district hospital CUPs which were calculated according to size of registered populations of CUP and health centre, remote areas, and border areas		Global budget at national level except two regions, Bangkok & Korat.
2011			Same as that in 2010		Global budget at regional level
2012		Limited the ceiling of salaries deduction from each province not to exceed mean of actual salaries +-1 SD	Adjusted age structure for general OP budget. Allocating additional budget for specific settings as fixed cost to district hospital CUPs and small general hospital CUPs, which were calculated according to size of populations registered with CUP and health centre, remote area, and border area		Global budget at regional level

Source: summary from NHSO guidelines for managing Universal Coverage Scheme fund in various years.

Notes

It should be noted that: (1) a common criterion used in all years was that no facility should receive a budget less than that received in the previous year; (2) a part of the budget was reserved as a contingency fund to assist hospitals faced with financial problems during the year; (3) the PCMO was allowed to readjust the budgets for each CUPs within the province but could not vary them by more than 20% of the calculated budgets**.**

[@]In order to mitigate the negative impacts of DRG v4.0, the aggregated sum of the adjusted relative weights of district hospitals was multiplied by 1.32. This was done only in 2008.

[#]It was decided to hold the global budget for IP at the national level in this year largely as a result of canvassing by the Rural Doctors Association, which argued that equity would be improved if a single rate was introduced for all.