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Health Care Financing in Thailand:

Learnings in the Theory and Practice of Universal Health Coverage

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Introduction:

The purpose of this note is to describe the policy and practice of health care financing in Thailand, the approach to building its health system it has chosen and to understand how the Thai health care financing strategy fits into the international understanding of progress towards Universal Health Coverage (UHC). The note also briefly discusses the lessons of the Thai experience for India and her efforts to achieve universal access to health care[1].

This note is divided into five parts. The first part presents a brief overview of the institutional structure of Thailand's health care system and the mechanism of health care financing. The second part contains a detailed description of financial flows of the Universal Coverage Scheme (UCS). This includes two case studies- one of a district hospital that serves as a Contracting Unit for Primary care and another of a primary health center. The third

[1] This note is based on a trip Thailand in April 2014, which includes visits to District Hospital; the Contracting Unit for Primary Care and to a primary health center contracted by it, discussions with the leadership of the National Health Security Office (NHSO), and the National Health Foundation. The note also draws on presentations by the NHSO, and on six key publications, made available to us by NHSO., and referenced in the note.

part analyses the strengths of the Thai system that led to Thailand being acknowledged quite widely as a success story in health outcomes, health systems performance and financial protection against the costs of health care. In the fourth part we look at how well the Thailand experience fits into or is explained by the main UHC discourse with its emphasis on provider –payer split, competition and choice. In the final concluding part we briefly consider how the theory used to analyze and guide health sector reform influences the choice of strategy for further progress towards UHC in Thailand, in India and in other third world nations.

Part – I

Health Care Financing in Thailand:

Institutions that handle public financial flows for health:

At the National Level –

1. **The National Health Security Office Organization (NHSO)**: This is a public agency established under the National Health Security Act of 2002, and its main purpose is to manage the financial flows of the Universal Coverage Scheme (UCS). Its Governing Board, called the National Health Security Board, is chaired by the Minister of Public Health. The Secretary General is selected by a committee appointed by the board for a fixed four year term- that can be extended once only. The 29 member Board brings together all key stakeholders within the national government (8 representatives) and local governments. (4 representatives) with representatives of civil society and professional organizations, academics etc. The National Health Security Board has 15 sub-boards under it. There is also a separate board, called the Standard and Quality Control Board, established by the National Health Security Act (2002) and its mandate is quality assurance (section 48, 52 of the Act). *The sole function of the NHSO is managing the Universal Coverage Scheme.* The funds of UCS flow largely to public health care facilities- and to a small percentage of private providers who supplement it. To the extent that financing can influence priority setting and performance, the NHSO also has a role in the design, implementation and outcomes of the public health system. This scheme covers 75% of the population.

2. **The Ministry of Public Health (MOPH):** This guides all elements of health policy, and manages the provincial and district health offices, which in turn manage the administration of the hospitals and primary health centers. The salaries to all public health providers in the facilities and most administrators at provincial and district health office levels are paid through the MOPH. The MOPH is also in charge of all preventive and promotive activity at the community level, (distinct from similar activity at the individual and family level, which is managed by the UCS.). The Preventive and Promotive (P&P) activity under MOPH includes programmes such as vector-borne disease control, disease surveillance, and promotive activities under reproductive, maternal and child health programmes etc.
3. **The Ministry of Labour – Office for Social Security Scheme (SSS).** This scheme is a tripartite scheme with one third contribution from the employee as a pay-roll tax (1.5% of the salary), a matching contribution by employer and by the government. This excludes dependents and covers about 16% of the population. (This is similar to the Employees State Insurance Scheme (ESI) in India)
4. **The Civil Servants Medical Benefit Scheme(CSMBS):** This provides insurance coverage to all government employees and their relatives which accounts for about 9% of the population. (Similar to the CGHS- Central Government Health Scheme in India which covers all employees of the federal government.)

Institutions at the Province and District level:

Contracting Units for Primary Care* (C*UP)-: The CUP is defined as the district hospital for the district. The original design was that the district hospital would be an autonomous agency and it would be paid on per capita basis for all primary care in the district, which in turn would contract in private and public primary care providers within the district. Of the 700+ districts, only one has converted thus. All the rest are contractees only in name. There are some districts where a part of the district has been given to a private provider, especially in Bangkok city. Here the CUP contract is directly with the national NHSO office, by passing the district health office. If we exclude these 40 to 50 private hospital CUPs, the CUP for all practical purposes is synonymous with the district health system.

District Health Office*:* This is an office under MOPH, which supervises all government health care facilities, and health programmes of MOPH. It is synonymous in most instances with the CUPs, and exercises its authority through a CUP Board.

***Provincial Health Office**:* This is an office under the MOPH, which has a contract with the regional /national NHSO. It thus acts as the NHSO's monitoring agency over the MOPH CUPs and as the capacity building and support agency of the MOPH for all its programmes. Salaries from all MOPH providers go through this office.

Health Care Facilities:

Thailand has a population of 67 million, which is distributed across 6 regions, 77 provinces (including Bangkok) and 867 districts (excluding Bangkok city) and 74,963 villages.

A pyramid of health care facilities under the Ministry of Public Health provides health care for this population. At the apex are 96 general hospital or regional hospitals, with about 150 and 500 beds, respectively. At the next level are 787 Community Hospitals (referred to as District Hospitals), catering to districts with populations ranging from 10,000 to 100,000. Some districts have general hospitals in lieu of the smaller district hospital. A district hospital would typically have 30 to 60 beds. At the next tier are 10973 primary health centers, each covering a population of about 5000. At the bottom of the pyramid, closest to the community are over 80,000 community managed health centers each catering to about 800 population.(table 1).

There are also some other tertiary hospitals under the Ministry of Public health such as the Chest Hospital, the Children's Hospital and the Mother and Child Hospital, which serve as referral hospitals.

There is also a robust private sector, which accounts for about 38% of all providers, but it is located mainly in the cities, and caters to about 23% of outpatients and 19% of inpatients- most of whom can afford it, and pay out of pocket or through private insurance.

<u>Financing</u>

The main form of health care financing in Thailand is through tax-based general government revenue. About 65% of total health funding comes from the central government. Local government contributes 4 percent, and the rest is a direct contribution from households or private firms. (1)

Of the total public health expenditure by the center, about 38 % goes to the Universal Care Scheme (UCS) which pays for health care of 75% of the population, about 26% goes to the Ministry of Public Health (MOPH) for public health activities and administrative functions, another 25% goes to the Civil Servants Medical Benefits Scheme (CSMBS) which provides coverage for 9% of the population, and perhaps about 5 to 7 % goes to Social Security Scheme (SSS) which provides coverage for 16% of the population. (1). The relative costs to the government of the three schemes are 79$ per capita for UCS, 367 $ per capita for the CSMBS scheme and 71$ per capita for the SSS scheme.

Part -II

Understanding Financial Flow of the Universal Coverage Scheme (UCS):

We discuss this in four sections-

1. Flow from the Ministry of Finance (MoF) to the NHSO:
2. Financial releases from NHSO to the Provincial Hospitals and CUPs
3. Case Study- Fund Flows at a CUP
4. Case Study- Funds Flows at a PHC.

1. Release of funds for the Annual Health Budget (from Ministry of Finance to NHSO)

The major part of the health budget is for the UCS and all of it flows through the NHSO. Every year around the month of February, the NHSO submits to the cabinet , through the " bureau of the budget" a request for grant. After cabinet approval, the grant request is placed before Thailand's National Parliament- which accords the final approval, by April or May of that year.

The budget request is made under two major heads – Capitation Budget and Special Target Group Budget. The latter accounts for only 5.8%of the budget. The main budget request is on capitation basis.

The Capitation budget item has 8 sub-heads. These are shown below along with the mechanism of calculation of each:

	Capitation Fee- budget request heads	Method of computation
1	Out-patient Service (OP)	OP utilization rate * population * Unit cost per service(by provider level)
2	In-Patient Services (IP)	IP utilization rate* population*unit cost per admission(by provider level)
3	Disease Management and Special Service (DMI)	Target volume* unit cost per protocol* financial incentive
4	Health Prevention and Promotion	Standard Activity* standard unit costs
5	Rehabilitation Service(including disability)	Target Volume*unit cost per service type* development cost
6	Capital Replacement.	7.4 % of (OP+IP+DMI costs)
7	No-Fault Liability (art.41)	Target Volume* Unit cost per type
8	Quality Performance base Pay	% of OP+IP+PP by policy decision
	Table Foot notes	
	The rates are based on the previous year's utilization rate and forecast to the fiscal budget year (normally this is a two year lag time). Recognizing that certain diseases cost more to manage, and a capitation based system could lead to inadequate resource allocation and care for diseases that have a higher unit cost to treat, a top-up is added on. The same applies for rehabilitation services.	

	Capital replacement and quality performance is provided as a percentage of total capitation pay-outs. Article 41 of the National Health Security Act mandates that 1% of money to be given to health care units for beneficiaries who have damage or injury due to any services provided. Note: The justification for the budget request by NHSO, need not be literally adhered to while making allocations to CUPS or other agencies. However allocations downstream must broadly be aligned with this logic.

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The special target group budget pays for ARV drugs (for HIV treatment) , for renal transplantation, for psychiatry drugs , secondary prevention of Diabetes and Hypertension.

This form of budget request breaks with the usual practice (of activity wise, inputs based justification of budget requests)- to an output based justification. In many nations, such as India, each year's budget allocation is often made by an addition or decrease to each line item of the previous year's budget - (historical precedence) and each line item denotes an activity or input- whose connect with the output is never very clear.

The UCS approach to budget requests makes it easier to measure performance against expectations and is more convincing to the MoF/Cabinet. In this case where the request is made and budget provided in anticipation of the activity-taking place and the expenditure being actually incurred, the use of terms like purchasing or demand side financing could be misleading to readers who do not know the entire context. Calling it "Budget Request and Allocation linked to Outputs" communicates it more clearly and precisely.

A panel agrees upon the system of calculating unit costs, and institutions in the chain of decision-making vet the calculations presented. Most important is that when this comes up for discussion in Parliament or outside the public is able to get into the discussion, and there is clarity in what is being paid for. All funds and attention are not focused on a few vertical programmes, but a well-balanced financing mechanism to support and develop the health systems to serves all health care needs, with some prioritization built in as appropriate.

In the year 2011, the NHSO budget could be expressed as Thai Baht Bt 2693 per capita- of which 35.8% was against the budget head "outpatient capitation", 41.9% was for in-patient capitation, 10.4% was for prevention and promotion, 5.5% was for capital replacement, 0.1% for no fault liability and 0.2% for quality based pay and 5.8% was for the four special category diseases taken together (see table 2 for details).

2. Flow From NHSO to CUPs (Districts and other agencies):

In 2013, the NHSO disbursed the budget as follows:

- 93.5 % of the budget was allocated by NHSO to its CUPs for service provision.
- 1.5% of the budget went to Local administration (Municipalities etc) for investing in health promotion activity- usually community level activity. This allows local governments to get involved, feel that they are involved and is useful to mobilize communities .
- Another 0.5% of the budget went to provincial health offices again for area based health promotion activity.
- 3.2% of the budget went for purchase of drugs and vaccines and other supplies needed for specific high cost of care diseases like HIV, renal replacement.
- A final 0.3% of the NHSO budget went to MOPH for purchase of vaccines, and some special drugs at the national level.
- In addition to the above, the NHSO gets a separate budget for administration. The administrative budget is excluded from the capitation budget and is over and above it. (Section 29 of the Act). This budget pays for the administrative support for NHSO at the national level and NHSO branches at the provincial level. NHSO branches at the provincial level are synonymous with MOPH provincial health offices. A very small part also goes to district health offices which, for the most part are synonymous with CUP. However they are important for they pay for supervision.

Distribution of the budget to the districts(CUPs):

There are rules that govern the distribution of the NHSO funds between the different CUPs. The fund received as capitation is allocated from NHSO to CUPs for "basic health care" under 11 budget heads. The fund received as "special target groups" is allocated in the same four heads as it is received.

The basis of allocation to CUPs, differs in some other ways too from the basis of its grant to NHSO. One part of the capitation fund is deducted for the payment of salaries, another part is cut back to create pooled funds that are kept with NHSO for different uses like paying for emergency ambulance services, or paying for purchase of some high value tertiary care services which are within the package and not provided by CUPs, incentive schemes to improve access etc.

The amount that can be deducted for salaries is capped through a process of negotiation. In 2012 it was around 24% of NHSO budget, or 60% of the salary of health personnel under MOPH. (about 32,795 million out of total budget of around 140,600 million). This is paid to MOPH, which then pays the salaries through its provincial and district offices, with the salaries being directly transferred to their bank accounts. These salary payments are independent of output functions and depend on number of persons deployed and their salary eligibilities. The administration costs are paid to provincial and district level NHSO offices which for the most part are synonymous with MOPH provincial and district offices. The rest of the funds are paid as explained in the table below

Table B: Basis of Disbursal from NHSO to CUPs

			Basis of Calculation
1	Outpatient Services	Capitation Fee	Flat rate calculation: Capitation adjusted for age structure* number of OP cases attended to in previous year
2	In-Patient Services(General)	Case Based, DRG based payments	Based on reimbursement rates for each DRG- but capped by total funds available in global regional budget.
3	Special budget for special area	Provider cost function	This item is like a redistribution process, from pooled all hospital allocation to hardship hospitals. Initially this was deduced from the OP and IP allocations, but since 2014 this is an additional fund from the government. These are used to provide incentives for increasing access and utilization.
4	OP/IP special services	1. Accident & Emergency 2. High Cost Services 3. Disease	1. For OP additional funds on points and for IP- use of DRGs 2. A sum is deducted from OP capitation of CUP and paid to a central pool for purchase of some high cost low probability disease treatment. 3. Incentives – fee schedule- tops us capitation 4. Supplied as medicines purchased centrally.

		Management Incentives 4. Special Medicines	
5	Preventive and Promotive Service	Capitation Fee – project based	For individual and family level care- like immunization, antenatal care delivery. Some part for community level has to be projectised and submitted.
6.	Rehabilitation and Disability health service	Fee schedule and Project based.	
7	Thai traditional health service	Fee Schedule and Project based.	To the district hospital- and some PHCs
8	Capital Replacement	Specific Allocation:	Allocation to districts largely aligned to % of capitation fee- but topped up by an Allocation within the district against a capital investment plan.
9	Quality Performance	Specific Allocation based on quality scores	A systems of points scores every facility- and available sum under this head gets distributed to districts and within districts according to the scores.
10	No fault liability for medical personnel	Specific criteria	
11	Act- 41 No fault liability	Specific Criteria	
	Table Footnote:		
	When estimating capitation fee payments an additional top-up or increased rate is provided for population below 5 and those aged over 60. (see table 3 for details) One part of the OP capitation fee payable to CUP is deducted and used as financial risk pool at the NHSO to pay for treatment of some diseases of high costs and low probability. Another part of each CUP's allocation used to be deducted and pooled for providing incentives to special areas- though since 2014, this is provided by government as separate budget.		

One problem that was anticipated with outpatient payments fixed on a per capita basis and DRG based payments for in-patients capped within a global budget for all in-patients in the region, was that those facilities which managed more complex problems would be at a disadvantage, and that facilities would therefore have an incentive to avoid such services. Hence these are paid for by the special target group budget which pays for ARV drugs (for HIV treatment) , for renal transplantation, drugs for mental illness and secondary prevention of Diabetes and Hypertension.

There were however some diseases with even higher costs and no specific probability of occurrence. Deducting a sum from the capitation fees and earmarking these funds for specific high cost diseases created a separate budget head called Disease Management Initiative (DMI). Payments to providers from this fund are on a fee-for service basis.Moral hazards of over-diagnosis are not likely in these diseases.

Non- CUP Flows: The purchase of tertiary care:

Increasingly funds from NHSO, under DMI, are used to pay for services purchased from private or university hospitals or even larger tertiary care public hospitals. They are typically for clinical events of low probability and very high cost. The classical examples being cancer therapy, or a renal transplantation or a coronary bypass, blood dyscrasias like hemophilia and tuberculosis, etc.

There are two ways of purchase, namely fee for services or DRG based transfers. In the first, costs are reimbursed based on each item of expenditure subject to some ceilings. In the latter (DRG based transfers) an average cost per diagnostic entity forms the basis of payment. The general strategy now, is to first pay with fee for service payments, and gradually learn and shift to DRG based payments. Currently only about 5% of payments are on fee for service mode.

The number of hospitals registered for disease specific procedures and the amount of expenditure incurred on this continues to grow as the list of procedures is added on each year. In 2006, open heart surgery, cleft lip and palate and leukemia new cases were added. In 2008 stroke, STEMI for coronary artery disease and cataract by mobile units was included. In 2009 cornea transplantation and bone marrow transplantation and in 2010 treatment of urinary tract calculi was included. In 2012 liver transplant and heart transplant, when done under some conditions was included

To manage payments for such high cost care, a central financial risk pool has been created by deducting from the capitation based resource allocations of the CUPs. This financial risk pool is then used for the purchase of high cost services- in effect the role of the classical insurance agency. But here the

classical insurance systems are embedded within a larger comprehensive health care system and used where insurance is most effective- for very high cost , very low probability events with little or no moral hazards and with the public systems acting as gatekeepers.

Clearly much of this is paying for tertiary care and for a type of specialist services which are not possible within the district health system. However, purchase by a central agency is able to negotiate more advantageous costs and better services and is used strategically for low frequency, high cost events. However we note that in such a design, tertiary care costs are only in the range of 5% of total costs, which is what is desirable.

3. The Bangpa-In Case Study: Case Study of Fund Flows at a CUP

Financial Flow as seen from a CUP:

Having described the fund flow at the national office, we next examine the fund flow at the district level or CUP. In between there is a provincial level that we are skipping over, since much of the function there is intermediary. The basic unit of sanction and expenditure is the district. The CUP we visited was typical of almost all CUPs, in that it is a government district hospital, which in turn is linked to a network of 20 PHCs.

To the CUP manager funds come in from a number of heads of which budget provided by NHSO is only a part. CUPs, by rule are allowed to retain funds obtained from any source as income. These funds obtained from many sources are pooled and allocated to a number of activities that take place in the district hospital, in the primary health centers and in the community. The rules allow them to use this money to hire personnel or/and to invest in equipment or buildings, within some boundaries.

One important feature here is that each CUP can make its own rules for internal allocation, provided they stay within certain guidelines. NHSO only requires details of outpatients and inpatients and activities undertaken. The guidelines within which they can exercise their discretion are laid down by MOPH.

It is possible that different CUPs have made very different rules for internal allocation of the resource envelope provided to them, and that guidelines are followed or breached at least at the margins, depending on contexts. There is no study or published information on this that is readily available. Quite correctly (in our view) the NHSO does not think that it should monitor this- but it certainly would be useful to encourage cross sharing of experience and learning on this aspect.

Description of Bangpa-In :

Bangpa-In District has a population of 91,982. The CUP in this district is the district hospital. Of this population, 57,815 are registered under the UC scheme, 23, 275 under the SSS scheme, and 6003 under the CSMBS scheme. About 481 who are double registered. There are 1289 under private insurance, not registered here and 23 in-migrants and 1801 whose “names were not found”. The CUP keeps track of this break-up.

Double registration occurs because some dependents in a family could be working in government and private industry, with CSMBS or SSS coverage respectively from that job. However they are permitted to use only one of these.

This 1801 “names not found” tells a story about the process of identifying a beneficiary. Every individual has a National ID number registered by National Registration Office of the Ministry of Interior. NHSO is linked to this database. This database is updated with births and death every midnight, and NHSO then provides this information to all hospitals online. Information updates from SSS and CSMBS registration are sent to NHSO every month, and transmitted to each hospital/CUP. Those who reside here and are covered by SSS and CSBMS are counted and then excluded from calculation of their capitation based allocation so as to ensure that no double counting takes place.

All names sent to CUP have to be verified and registered proactively by the corresponding health center and then their names sent to CUP. Unless this process is complete they cannot receive capitation fee for them. Thus there are 1801 names whose national ID shows them as resident in Bangp-In CUP but who were not found and registered here. Thus they cannot receive capitation for this category.

In the process, in-migrants not on the population census of that area have to be registered but those missing due to out-migration or any other reason get struck off the capitation fee count. In other words, registration is census based but actively confirmed by the health care facility. Registration also implies a minimum set of preventive services and visits to each individual, and a case folder for the person in the PHC.

Bangpa-In district hospital is located in the district headquarters town and has 60 beds. It has 20 primary health centers linked to it. The district hospital employs 220 personnel- of which 10 are doctors, 78 are nurses, 5 are pharmacists, 4 laboratory technicians, 3 are dentists, 1 is a traditional Thai medicine practitioner, 3 work on rehabilitation and 2 are counselors. The rest are administrative and non-technical support staff.

The 20 PHCs together employ 70 health workers each of whom have a 4-year degree in public health and 20 to 30 nurses (average one nurse and three health workers in each PHC). Each PHC caters to about 5000 population.

The OP load of the district hospital is about 400 patients per day and the IP load is over 100% bed occupancy. The district hospital provides comprehensive primary care, which includes most elements of what we would consider secondary care, except for major surgeries. Major surgeries including C-sections used to be performed, till three years ago, but the problem of retaining specialists and the confidence to do surgery at the district level, is leading to a withdrawal of these services to the provincial hospital. Blood transfusion however is still available- based on blood storage with about 2 to 3 bottles being transfused every year.

Revenue Receipts at Bangpa-In CUP

(see table 4 for details)

Last year (2013- Thai year 2556) Bangpa-In CUP got a total of 116.7 million Bt of which 49,14 m Bt was towards capital expenditure (mainly on the building), and the rest 67.56 million Bt was towards revenue expenditure. Of this 67.56 m Bt, roughly m Bt (67 %) was from NHSO under the UCS , 4.11 m.Bt under the SSS, 7.66 m Bt was under the CSBMS scheme, and 0.167 m Bt was from accident fund. Clearly the UCS is the main income source accounting for 68% of all funds received for revenue expenditure and 100% of funds received for capital expenditure. The other two insurance schemes- SSS and CSBMS together with the accident fund amount to only about 17 % of the funds received. Various forms of services charges and local enterprises make up the remaining 15 % of incomes.

What were these service charges? About 7.87 m Bt was charges made to non registered patients, and about 0.85 m Bt was from voluntary 30 Bt co-payments. Other innovative services like medical checks ups also brought in some money. Bank interest, rentals charged to entrepreneurs for hosting ATM machines or other local enterprises also brought in some money. Such funds, though small were useful. There was also a small grant from local government and some incentives for completing registrations on time.

In year 2013 Bangpa-In received 49 m Bt for a new building from NHSO which included infrastructure maintenance/depreciation and another 180 m Bt from the national infrastructure funds through MOPH. Bangpa-In in the year 2012 received 27.6 m Bt.

Within the receipts from NHSO fund of 45.56 m Bt in the year 2013, 50% came as outpatient capitation, 20% from in–patient payments, 13.2 % for P & P (prevention and promotion) and the rest as payments for disease specific services (for dental health, for mental health, for rehabilitation, for HIV, for diabetes), and for traditional Thai medicines. There were also top-ups of the per capita rates for quality of care. In 2014 the payments for quality were re-organised and increased as payments for Quality of Care as measured by a standard scoring system with separate measurements for quality in IP,OP, PP services(table 4)

Salaries, administration and ambulance services are not part of the capitation fee based allocation made by NHSO to Bangpa-In (though they are part of the capitation fee based budget request by NHSO and grant from the MoF to NHSO).

Salaries of all workers, (about 36 mBt) flow directly to the facilities/providers from/through MOPH funds. MOPH also provides some categories of drugs in kind, and hardship allowances and other categories of pay top up, which need to be added to get a full picture of Bangpa-In's revenue sources. The amount the CUP received for administration was 40 m Bt.

Expenditure at Bangpa-In:

(refer to table 5 A for summary and 5 B for details)

What did Bangpa- In spend its money on?

The major expenditure, of about 37% in the Bangpa-In CUP is on human resources, and this does not include the core salaries. This HR expenditure has three forms. The largest is additional allowances for regular staff, which is calculated on the basis of a number of parameters that adjust for difficulty of posting, years of services, overtime work done etc. The second item of expenditure is for hiring contractual staff locally, paying for their salaries and their coverage for medical insurance under the workmen's compensation Act (SSS). The third is a small outlay on training and scholarships for higher studies, relevant to the center.

The second largest head of expenditure is medicines, which accounts for 27% of the expenditure. Diagnostics accounts for about 10% of the total expenditure and the money is spent as paying for outsourced tests as well as for supplies for tests done in-house.

Infrastructure maintenance and running costs related like all manners of repairs, electricity bills, water, communications, cleaning, and maintenance and some purchase of equipment together account for about 13 % of the costs. Of the total, about one tenths is the amount disbursed to the PHCs and the rest is spent at the district hospital(table 5 A &B).

Not included in the above are salaries- which are paid separately by MOPH, or administration costs. Also not included are ambulance services, whether for emergency rescue or inter-facility transfers or drop-back home. When an ambulance is required a call is placed and the trip documented- and the cost gets then shifted electronically to the ambulance services which are paid through a central arrangement.

For medicines and supplies, each CUP places orders with the public sector owned GPO (Government Pharmaceutical Organization). The GPO is a State Enterprise under the Ministry of Public Health mandated by the Government Pharmaceutical Organization Act, AD 1966. The GPO manufactures, sells, and supplies pharmaceutical products and medical supplies mainly to MoPH hospitals and health care facilities. It is a mechanism to ensure competitive price levels for pharmaceutical products and medical supplies that the public health system needs. It is government regulation that public hospitals have to purchase the product from GPO if it has that product. The GPO buys drugs both from public sector manufacturing units and private sector manufacturing units as appropriate, and supplies them to the facility. There are times when the GPO is not able to supply it at once, but on the whole there are no stock outs of essential drugs. The GPO also runs its own retail outlets in select sites.

There are rules governing both allowances and hiring of staff for HR- but within this there is some flexibility as well. The flexibility comes from the number of allowances admissible. Thus a newly recruited doctor would get a basic salary of 17,000 bt. But in Bangpa- In he/she would qualify to get another Rs 5000 as non-practicing allowance, another 2000 as a fixed monthly allowance for that locality, plus a Rs 20,000 for a difficult area allowance- making the take home pay close 45,000 Bt. Another doctor after 15 years of services would get about 50,000 Bt as the monthly allowance and 10,000 as non practicing allowance making for a take home pay of almost 100,000 bt per month as the take home pay.

No payments are made for work-related outputs, in other words, the classical understanding of pay for performance.

Additional funds provided to Bangpa-In after having been successfully accredited for quality of care had in practice been used for training programmes, for provision of scholarships for upgradation studies of select staff and for furnishings, but not for financial incentives in cash or kind.

Who makes this resource allocation between these heads. The CUP Management in coordination with the district health office makes it. A framework of rules , provided by MOPH defines the boundaries, but within these boundaries the CUP can make decisions on what it would spend and on what it would save on. The NHSO does not have to be informed.

Resource Allocations from CUP to Primary Health Centers:

There are 20 PHCs under the Bangpa- In CUP. Though the language is of "contracting-in," in practice there are no contracts between the PHC and the District Hospital. Officials from NHSO refer to it as provider network-, not as contracts. Health care facility managers perceive it as the public health system. There is a district health coordination committee which combines the CUP and the district office and which is accountable for making the allocations.

Each PHC is more or less contiguous with a *tambon*- the latter being a sub-district administrative unit. Exact governance mechanisms at the CUP level and at the level of hospital and PHC need to be understood further.

The resource allocation to PHCs is approximately 110 Bt per capita, or about 6 mBt for Bangpa-In' s 20 PHCs taken together. The per capita calculation is based on the UC registered population, not the total district population. But there is some flexibility in allocation of this 6 mBt between the 20 PHCs.

In 2013 all PHCs had got the same amount for electricity and water supply (40,000 Bt), for cleaning (30,000 Bt), for office equipment (15,000 Bt), and for other expenses (10,000 Bt). Only three PHCs got funds for dental services (30,000 Bt). For medical equipment, the allocation was need based, and 200,000 Bt had been divided across the 20 PHCs in a range from 5000 Bt to 25,000 Bt ac. (see table 6 for details).

What varied considerably across PHCs was the expenditure on medicines. Medicines are supplied in kind but booked to their account. Another budget head is called OT meaning overtime. This is a resource allocation made at the beginning of the year to PHCs based on their OP service utilization in the previous year and recognizes that some PHCs have higher case loads and therefore the health workers sit longer hours and should be given more money. Thus there is some small range of flexibility in local allocation, which is otherwise well bound by rules. However, this flexibility allows a great deal of recognition and enables higher inputs for quality of care in those facilities which are doing more work.

4. Talad Kreab - Case Study of a PHC

The Talad Kreab PHC, one of the 20 PHCs, is located in a *tambon*. Under the PHC's catchment area, is a population of 3400 (census). Of this 2800 are registered with UC, 340 are covered by SSS, and 150 with CSMBS, with 110 "persons not found". This PHC has 5 staff - a director, one nurse, two health workers, one data entry operator/statistics persons.

There are also 43 Community Health Volunteers each of whom are paid a sum of 600Bt per month. (A Bt is about two rupees). Each CHV has a population of about 65 to 70 persons to provide services for. A newly appointed health worker gets about 11,000 Bt which after a decade of services rises to about 20,000 bt per month. They have a four year B.Sc in public health degree. The Director of the , PHC, too is of this qualification- but with more years of experience.

The services provided in the PHC, include immunization, Reproductive and child health , non communicable disease, communicable disease and preventive, promotive and rehabilitative services. The PHC does not provide delivery or midwifery services, the first available site for this service, is the district hospital !!

The persons resident in the *tambon* are necessarily registered with the PHC in Taled Kreab. Even in Bangkok city, registration is, as a rule, with the nearest government PHC. There is provision that a beneficiary can change her/his site of registration upto four times a year, but the purpose of this is to enable

continuity of care for the seasonal migrant, rather than as a mechanism of choice between facilities. A person moving to a new PHC area will need to provide proof of his residence near that area, apply through a health facility and then after about 2 weeks to a month his or her registration is shifted accordingly.

The total budget received by all 20 PHCs of this CUP under the UCS in the year 2013 was 5.6 m.Bt or about 2023 Bt per capita registered under UC (1726 Bt if one uses the entire existing population as denominator). Of this about half was the value of medicines and supplies consumed. and the rest was given to the faciltiies in two instalments (see table 6 for details). Of this Talad Kreab got 0.6 m Bt - over 10% of the total. This was because Talad Kreab had spent more on medicines and got more overtime allowance than most other PHCs- as its case load had been higher. The distribution of the funds on overtime is a facility level decision on who worked more. Talad Kreab also shows up an additional 50,000 Bt expenditure under miscellany- but that is an adjustment for some necessary expenditure at the district level, which cannot be booked elsewhere.

In addition to this the 20 PHCs together received a further 300,000 Bt for payment to CHWs and salaries of the 5 staff. They also get a further top up of 120,000 Bt for quality points earned the previous year. The money earned for quality is spent on some more essential human resources, hired at contractual terms at the center.

The allocation of funds at the local level has considerable flexibility, but the flexibility is bound by another set of rules made at the higher levels and which they need to abide by.

Part III.

Understanding Thailand's Successful UHC:

Thailand's health care system is undoubtedly one of the most successful in the third world, and in terms of cost-efficiency in achieving UHC it is one of the most successful anywhere in the world. This is uncontestable, and can be evidenced in many ways. It can be supported by data on child and maternal mortality and life expectancy and by figures of utilization of outpatient and inpatient services.

In terms of progress towards UHC, Thailand provides, along with Brazil, the most comprehensive care package anywhere in the third world (LMIC). Its share of public health expenditure in total health expenditure is one of the highest (70 to 75%). Thailand also has also sharply declining incidences of catastrophic health expenditure and impoverishment on account of health expenditure. Catastrophic health expenditure rates, dropped amongst the poorest quintile from 6.8% in 1996 (prior to universal coverage) to 2.9% in 2009, and amongst the richest quintile from 6.1% to 4.7%(4). The incidence of medical impoverishment is low and decreasing, as measured by the additional number of people falling under the national poverty line because of health payments; this reduced from 11.9% in 2000 (prior to universal coverage) to 8.6% in 2002 and 4.7% in 2009. (this is still significant- and is attributed to continuing out-of-pocket expenditure are UCS members choosing private hospital inpatient care not covered by the UCS or bypassing the referral system and hence bearing the full cost.). (4)

In terms of the comprehensiveness of the package, the effectiveness of social protection and public share of total health expenditure, the Thailand achievement is matched or even bettered by at least some OECD nations. However, what is unique is that Thailand achieves this at 4% of the Thai GDP whereas the nearest any OECD nation does so, is at over 8% of their GDP. The per capita GDP in terms of PPP per capita is much higher in every OECD nation as compared to Thailand. This is why understanding the success of Thailand is so important for all LMIC nations, and even for OECD nations struggling to cap their health care budgets- now rising to beyond 15 % of the GDP.

For nations like India with public health expenditure at 1% of the GDP, the – Thai model, is what is feasible in the here and now, especially in states like Kerala, Tamilnadu, Himachal Pradesh, Punjab, and Sikkim where the comparability in many parameters is so similar to the Thai situation, that these states could quickly catch up with Thailand- if we read the lessons right.

So what are the main features of the Thailand model? We have chosen to describe it without recourse to UHC terminologies like provider – payer split, purchasing of care, coverage, package of services etc, since there are so many meanings made of these terms and also because this description provides a simple, clear and equally valid understanding of what is happening in Thailand.

The Thailand health care approach to universal health coverage and universal access to care could be described as being based largely on public health care provisioning with public health care financing, with some marginal but essential supplementation by purchase from the private health sector. It can also be described as a system of comprehensive primary care provision by the public health system, where the state assures health care for all by providing it through a network of health care facilities operated by it and closing critical gaps in provisioning by purchase from the private sector.

The central question, then becomes understanding the factors that contribute to such effective public health care provisioning, as compared to the experience of other LMICs- especially of India ? How does it manage to provide good quality of services and better access through public providers?

- *Adequate Human Resources in the public health system:* The first and foremost feature of the Thai health care system is that there is a well-paid, regular, salaried workforce which is adequate in numbers. Thus in a population of 100,000 in Bangpa-In there are 10 doctors, over 140 nurses plus 4 year trained public health workers (providing considerable clinical primary care) and about 120 to 240 support staff and about 1400 CHVs. In Tamilnadu in a similar population of 100,000, we have about 10 doctors , 75 nurses and perhaps about 70 or fewer less support staff and no community health volunteers. (if it were Kerala, we could also include 100 CHVs). Most other Indian states would have only half to one third of this staff, and that too as contractual staff. There is no pay for performance of any sort, but there are incentives for working in difficult areas. Quality of care is not incentivized by more incomes. ("We do not believe quality of care can be assured by money"- was a repeated refrain.

- *Comprehensive and not selective primary care:* The second reason is the clear commitment to *comprehensive* primary care. In India, even in a state like Tamil-Nadu the commitment is only to a small select range of RCH services . For the rest of the states, those who visit are welcome, but there is no population-based programme (though this is changing now in some states) for anything other than care in pregnancy and immunization. In India for example, the package of care available is far too narrow and set by donor priorities instead of local needs, leading to their loss of credibility.

- *Innovative Financing of Public Health Services :* The third and perhaps the most important lesson, is a much better system of health care financing for public health facilities, where the flow of funds is far more responsive to needs and requirements. The central challenge of all state run and managed systems is understanding how to effectively decentralize **and** ensure responsiveness in resource allocations, so that financial flows match needs, requirements and expenditure patterns while accounting for equity and quality concerns. The comparison is much more stark for a visitor from India working in its National Health Mission. The NHM budget from centre to state, and state to district is sanctioned in a budget format with over a 1000 lines with almost no flexibility for further reallocation between them, even though only a limited range of RCH services are being provided. Till recently every facility received the same amount of un-tied funds, irrespective of case loads, distances, package of services provided and there were serious mis-matches between the inputs provided and the services delivered. As the package of services provided increases, such centrally determined line by line budget allocation becomes impossible and transaction efforts and delays and mismatches act as huge constraints on fund absorption.
- The heart of the success of UC Scheme lies in the system of health care financing that it has developed. We can discuss it as being made of six positive features.
- a) The first positive feature is what has been described so far. The NHSO transfers large amounts to every public facility in just one or two installments every year, for a much greater diversity of services, factoring in equity and quality in just about 24 budget lines. The skillful mix of capitation based payments, with DRG based reimbursements and top-ups of many sorts on this through which this is achieved has been described in the first section.

b) The second important feature of such responsive public financing is the institutional arrangements at district and sub-district level that allow for flexibility in using these funds without compromising objectives. By calling the district health office a Contracting Unit for Primary Care (CUP), the only change is the clarity about measurable outputs in terms of quantum and type of services they would deliver. There is no formal contract either between the District Health Office and NHSO or between the District Hospital and the primary health centers- all of which are MOPH owned. In the few exceptions where private hospitals play this role, there are of course contracts, but these account for only 5.7% of UCS memberships.

CUPs are allowed to decide how best to make internal allocations guided by a set of rules that MOPH and not NHSO have given to them. But within these rules there is enough flexibility for them to be truly responsive to the health care needs- not as decided by some distant and obtuse burden of disease estimates, but by actually measuring and catering to those who knock on their doors and those who need care when their army of family health workers knock on each family's door.

Also since their resource envelope is fixed there is every incentive to generate the maximum value for the available resources and local managers have the powers, the capacity and the motivation to do so.

c) The third positive feature of the public financing strategy is that there is a clear link between financial flows and visible, directly attributable system outputs. In India budgets could flow rigidly down the 1000 + budget lines which describe inputs and there is no way to track the relationship between expenditure and performance. Distant indicators which are impossible and irrational to attribute to inputs- like IMR and MMR are used even at district level, instead of simple outputs like no of outpatients seen, number of diabetics managed etc. Also the indicator set provides for over 200 indicators related to reproductive health and immunization and almost no indicators for the remaining 90% of health care needs. As a result management information systems are totally disconnected from financing- which is not so in Thailand. The other benefit of this direct and visible link between financing and output in terms of services is that the budget document can be understood and is a matter of negotiation. There is effective public pressure at every level including the parliamentary debates over the national budget.

d) A fourth positive feature of public financing is the policy on user fees and service charges and out of pocket expenses. In 2002, the 30 Bt scheme was launched wherein every single service- however large or small, complex or simple was charged 30 bt only. The scheme was immensely popular. While one would wonder why today, it must be remembered that at that time, the logic of user fees was cost recovery to allow market principles to operate. So 30Bt reduced OOPEs for most patients (though it could in some cases, increase it). In 2006, as UCS was increasingly re-positioned as tax- funded insurance, even this was removed. The 30 Bt co-payment was re-introduced in 2012, but as a voluntary payment – the rationale of which is discussed later.

e) A fifth positive feature of public financing is how integration has been achieved between the three insurance programmes. At the national and provincial level the flows are separate. But at the level of the CUP and the PHC, the members covered by the other two schemes are identified and excluded from the list covered under the UC scheme. However at the primary care level (that includes district hospital) those who seek care there get the same care as under UCS but the CUP gets reimbursed from CSBMS or SSS schemes. Thus there is no duplication in the budget at any level.

f) The sixth feature of the financing strategy is that where there is a gap or there are services that the primary care system cannot provide, there is no hesitation to supplement by direct purchase of the services from a private provider- without involving transfer of investments from public to

private hands, without compromising equity concerns, without substituting care available within the public system and most important without any danger of moral hazards since the “high-costs items” that are chosen are such that none would likely fake such conditions.

There is no ideological or policy drive to push public private partnerships but there is enough space for private sector participation. . A recent World Bank Study (Piya Hanvoravongchai, Health Financing Reform in Thailand: Toward Universal Coverage under Fiscal Constraints;UNICO Study Series 20; The World Bank, Washington DC, January 2013) records that *“NHSO regional office has the authority to contract with the non-MOPH providers in their regions. There are certain standards that must be followed to be an eligible contractor, including a requirement of a nominal financial deposit. There are more than 70 other public hospitals that are NHSO contractors. The NHSO also contracts with private hospitals, but the number of private hospital contractors continuously declined—from 71 in 2004 to 44 in 2011 (NHSO 2012, 26). Relatively low capitation and case-based payments are cited as a reason for private hospital withdrawal from the UCS. A limited beneficiary base to adequately pool health care risks is another alleged reason, since UCS members were enrolled first to MOPH providers. In addition to hospital contracts, the NHSO also contracts directly with private clinics in Bangkok for primary care*.”

On querying the Director, NHSO about this, his perception was that though their role as CUPs had declined, private hospitals were interested and more were partnering for specific high cost disease managements on fee for service basis. Whatever the reason, at the primary care level only about 5.3% of the population have enrolled with a private provider. What it means is that in effect this is a system of complete public provisioning with the willingness to close critical gaps with private partnership- which is a far cry, from a situation like India, where the discourse of health sector reform pushes PPP as the main solution.

Work Culture and its determinants: If an adequate salaried workforce, a commitment to comprehensive care and the public financing strategy are three major reasons for the Thai success; the fourth must definitely be the work culture. For undoubtedly, there is a very positive work culture. What is the work culture attributed to? One factor that emerges from the dialogue is no doubt the better terms of remuneration and job security that the system offers- with top-ups provided so that there is a sense of fair play. A second is the importance given to quality of care including accreditation. By 2010 60% of hospitals had achieved level 2 accreditation and 20% had achieved level 1% accreditation. These quality processes emphasize training and organization of work processes, patient satisfaction surveys etc as important elements of quality of care- and no doubt contribute to the work culture.

But the positive work culture is also because provider-patient relationships are consciously built around trust and where personal profit is excluded from the equation. Changes in clinical decision will not have any implications for income of either the hospital or the individual provider- it is free from moral hazards. That does not mean an absence of monetary incentives, but these take the form of top-ups to salaries for working in more difficult areas, or doing substantially more work. Such top-up allowances acts as social recognition and demonstrate non-discrimination. This is not the same as the P4P logic where more income is considered as the driving logic of better performance. Indeed at each of the three levels visited, there was a rejection of the idea that increased income or monetary incentives could push better quality or better performance even in quantitative terms.

Even the recent international independent evaluation of UCS concedes this aspect of the work culture. To quote: *" Recently there has been increasing interest in using the term " commissioning" to address the negative connotations associated with the term purchasing. In Thailand there is a widely shared view that health care professionals do not sell services to a purchaser, they are professionals acting in the best interests of their patients. Commissioning also implies close cooperation between purchaser and providers and might open the way for a more collaborative, non adversarial version of purchasing, better aligned to Thai Culture."* (Thailand's Universal Coverage Scheme: Achievements and Challenges; An Indpendent Assessment of the first ten years- 2001 to 2010, Synthesis, Report, Health Insurance System Research Office, Nonthaburi, Thailand pg 59).

This was quite evident during all interviews, with interviewees preferring substitution of words like "purchase" with "money provided to facility" or of "contracted agency," with a "member of our provider network" etc.

One interesting exchange recorded in the interview relates to the re-introduction of 30 Bt since 2012, and the collections that hospitals were making through this. When asked if it were not a reverse of the no-user fee policy of 2006, employees were at pains to explain that the 30 Bt collection was truly voluntary and meant to show appreciation and trust- a contribution that would help providers improve services better- and not an user fee. It was mentioned, that when 30 Bt was introduced in 2002, it was a very popular reform because it was reversing a policy of cost recovery based on user fees. Whereas earlier there was a fee for service which had to be paid out of pocket, it was replaced by a flat 30 Bt payment for each visit- which was a major step in withdrawal of user fees. There was exemption for those who were poor. But as the policy thinking shifted further away from user fees, in 2006 this token 30 Bt was withdrawn. However in 2012, the political party that had gained immensely from the introduction of 30 Bt came back to power, and re-introduced it, but this time, its interpretation was different. It is a token payment re-positioned as

voluntary, with perhaps some salutatory action to cap over-consumption of OP – care, but largely as citizen contribution to building what is now a new "common property resource."

Community Participation: One area of inquiry was about community participation, which figures in some narratives, as a positive characteristic contributing greatly to the success of the Thailand story. There is no doubt some engagement with the community- but it is not community led, much less directly governed by community as some descriptions refer to. [2] All providers in the facility and officers interacting had difficulty in describing or even recalling local, regional and even national health assemblies or the forms of community engagement that are institutionalized. The most important forms seems to be a contribution made from NHSO to local administrations for community level preventive and promotive action and the local administrations facilitation of the functioning of the district hospital and primary health centers- along with some minimal financing contribution. However these are very preliminary observations, and we need to study the role and actual influence of such community processes in shaping the Thai model .

What certainly is bringing around a very high level of community engagement however is the huge density of volunteer deployment and their closeness to the community and the facility- at one per about 30 to 50 households- clearly the highest density anywhere in the world. Closely related to this is the institution called the community primary health center, run by health volunteers in the village, which can provide basic drugs, screeing for hypertension, diabetes, and BMI, nutrition and health education etc. One has not heard much of this institution in other descriptions of the Thailand health care system. Are these a site of community health workers' interaction with service users? How does the community participate in these? How effective are these? These are some open questions for future study.

This is not to say, that the facilities and systems are not community friendly and responsive. But responsiveness flows out of the institutional design, where funds can match needs and requirements and local managers have the space to make the necessary decisions, without reducing the guiding role of the national offices.

[2] The reference here is to the dialogue on community participation role in UHC in India in the National Advisory Council and in the HLEG.

Grievance Redressal: One interesting innovation is in accountability and the seriousness given to assured services. Article 41 of the National Health Security Act mandates compensation for injury or damage due to any services provided. A grievance redressal and helpline call center operates from NHSO office with a commitment to complete the process of redressal or other adequate response within 30 days. Over 704 beneficiaries and 686 providers received compensation in 2010(2)

Political Will? : Most narrations of the Thai success story also attribute success to political will. No doubt if 12% of the national annual budget is being spent on health, there must be political will. But the political process of governance in Thailand is as raucous and contested as any third world nation. Frequent coups, high degrees of animosity between opposing political forces, charges of corruption against those in power, court interventions, street violence are all evident. But the key health institutions seem insulated from this turmoil, and the health agenda stands outside the arena of political contestation- with an enviable continuity across political and administrative changes. How exactly did the sharp political contestations that characterize the last 15 years of Thailand history, shape the development of the Thai approach to UHC- and how was the continuity maintained. This is certainly another area that needs further study.

Sovereignty: Another area where Thailand has had an advantage, is that even when it comes to the swings in international discourses on health care, and changing fashions and priorities amongst the international aid community, Thailand has largely maintained a continuity in its practice. Does Thailand adapt by rapidly adopting the latest idiom and theories in English, while maintaining internal continuity at the level of practice in Thai language? In the nineties along with Brazil, Thailand was one of the very few third world countries that did not shift from comprehensive to selective care- the prescription of the World Bank and almost every international aid agency. Now that there is a world-wide push for insurance, the Thais have absorbed the push to insurance by merely calling their 30 Bt UC scheme as insurance when it suits the occasion, but persisting with their basic design, just taking on those features from the international discourse, which they think appropriate to absorb. The leadership of their national institutions is well exposed to international scholarship and there is an active programme of learning from the leading public health schools in the west, but there is also a diligence in applying it to their context, building on what they already have on the ground.

India's Mahatma Gandhi would have approved. His famous quote, that seems to fit this case study remarkably well. reads : "I do not want my house to be walled in on all sides and my windows to be stuffed. I want the cultures of all the lands to be blown about my house as freely as possible. But I refuse to be blown off my feet by any."

Part IV.

The International Discourse on Thailand's Universal Coverage Scheme:

But this is not the only way that the success story of Thailand can be told. In the mainstream international discourse on UHC, when Thailand is presented as a case study for UHC, the facts are the same but some of the factors that have been analyzed in the sections above as contributing to success, are seen as constraints. Other features, which have found limited or no space in the narrative above are given more prominence or even projected as having been key to the success of the Thailand model. A list of such features would include: the projection of UC Scheme as an insurance scheme; the importance of provider-payer split; the capitation based payment seen as specific form of purchasing care; pay for performance approaches to financing facilities and individual providers leading to better productivity and quality; successful contracting-in of private providers into primary care as being key to improving access; the amalgamation of public and private providers into a single network with the public having a choice between these two, and such choice leading to better quality of care and so on. All these features in the list above are seen as key desirables of health sector reform in the international universal health coverage discourse.

We examine below how applicable some of these concepts are to the UCS.

1. Is the Thailand UC Scheme- an example of universalization of health insurance coverage? Could it be called a tax- financed, publicly financed insurance programme- the only difference being that the providers are reimbursed on a capitation basis and not on a fee-for-service basis.?

Discussion: That it is universalized is true enough. But is it insurance? Though it could be made to fit into a definition of insurance, it is not insurance as would be commonly understood and therefore it is disingenuous to call it so. There is no notion of premium to be paid, or of sum assured. There is no package of services- provision is comprehensive and assured. If one diabetic requires 100 visits per year, and another needs only one, the same qualities of services are assured- with no cap on it. And most important- everything is covered- only small lists of exclusions are notified.

This is financial protection certainly – but financial protection is through the provision of free care by public facilities with some supplemental contracts with private providers to close critical gaps. Also one must note that coverage is achieved by administrative order- everyone who is not already covered by two other insurance schemes is declared a beneficiary with entitlement to free care in the public hospital. The key difference from the usual public facility in a country like India, is that every facility in the network has to demonstrate active registration of and comprehensive primary care delivery to each family/individual within its catchment area.

While it is true that insurance schemes can be based on buying a composite health plan from a health management organization rather than on a fee for service mode- the capitation fee mechanisms we see under NHSO are not forms of purchase. They are forms of making rational and equity sensitive budget allocations for outpatient care, in patient care and preventive care to public facilities, in a manner that is responsive to different contexts and caseloads. For public facilities this is over and above payments of salaries, infrastructure, and administration that goes through traditional fixed supply side routes. And public facilities account for 95% of care provision. No doubt there are lessons that UCS has taken from insurance-based systems, and for some high cost, low probability, low moral hazard medical events, there is insurance like mechanism built into the UCS. But for all that, UCS is not an insurance scheme.

2. *UCS is a success because there is a split between providers and payers- between provision and purchasing. One recent publication that theorizes the health sector reform in Thailand approvingly quotes an unnamed NHSO manager as saying: " The separation between provider and system manager 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 peoples 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." In this understanding-*
    a. providers, even salaried government providers, are driven by their own vested interests – and it takes a disinterested purchaser to safeguard peoples right to health care.
    b. purchase of care and the separation of provider from payer brings efficiency and lower costs by the mechanisms of competition amongst providers and consumer choice. This is expected to improve quality of care because consumers have choice from multiple providers and can exit the public provider if need be. This would discipline the poor quality public provider, and reward the good quality public provider who would have more clientele and therefore more resources. Underlying this understanding, is the admission, that competition and choice do not work well in the health services because of information asymmetry and

> because the individual client cannot make an informed choice. But, according to this theory, if the state (or insurance companies) act as a purchaser and offers a choice of providers to the client this handicap is overcome. In countries like USA, there is in addition to the market in providers, a market in purchasers as well, and the individual can choose amongst competing private insurance companies with different schemes with the state stepping in only for the poor who cannot pay.

Discussion: This same publication and chapter from which the above quote is taken, concedes in the next few paragraphs that such a provider-payer split met with considerable resistance and could not be implemented fully, but attributes the situation to tactical failures related to poor negotiation. This discourse concedes regretfully, that in Thailand, Hospitals and CUPs did not become autonomous units competing with each other. (2)

But this is no mistake. This is a conscious decision by the government. There is rule making it mandatory to register with your nearest provider, and within this preferably the public provider. In Thailand one is allowed to change providers upto a maximum of four providers per year- but that flexibility has nothing to do with choice (as portrayed in some case case studies on Thailand). It is primarily perceived and explained as a flexibility for the needs of seasonal migrants to maintain continuity of care.

The characterization of MOPH as a provider, aligned only with provider interests and the NHSO as a purchaser, aligned only with patient rights is considerable theoretical over-reach- when all it really signifies is the shift of budgeting and financing functions to a separate department under the same minister, and a much better, more efficient organization of financing.

But certainly, by all accounts, this separation has been effective. It brings in the right skill mix and the level of financing and governance innovation that public services have always needed – but have never managed under the usual department structure. Traditional budgetary allocation tends to be an increase (or decrease) of budget allocations on a large number unchanging budget lines historically acquired. The NHSO mechanisms enable budgetary allocations that are made matched to outputs, and able to flex allocations to where needs are more.

These are great achievements of the NHSO- but can it be termed “purchasing”? For in-patient care, which is paid for on the basis of reimbursement for services delivered, there is a case to call it “purchasing” and as demand side financing. The only problem is that a reader who does not know the context would interpret the term purchasing to understand that the NHSO purchases care from a market through a tendering process with

competitive bidding, or by some mechanisms of choice from many potential suppliers, much like an individual purchasing a commodity on the market, or a state procures/outsources services. But this not the NHSO is doing. NHSO is a form of flexible, responsive, needs based resource allocation to government providers that defines 95% of the budget. Only for a few high cost, high technology packages is some form of procurement happening.

However, there is another more serious reason why one would prefer the term "responsive resource allocation" in preference to "purchasing" (except of course for some high cost disease specific services it purchases from a few tertiary hospitals). As the system continues to reform what should be the focus – better rules and more local flexibility for resource allocation, or push towards the ideals of purchaser- provider split and its projected benefits.

The desirability of achieving a purchaser-provider split, now taken so much for granted, has always had its critics. Here is what Andrew Wall writing in 1993 in the context of pressures to 'reform" NHS, had to state: "the benefits of purchaser-provider split, now seemingly the gospel of the public services in the western world are by no means self-evident. Organizations need to have the capacity to learn if they are to be flexible and adapt to circumstances. At a very fundamental level of work anyone at any level of the hierarchy will have ideas about how their job could be done differently and better. The purchaser-provider split introduces something inherently unnatural because there is a forced division between those who do the job, and those who plan the job. People and organizations are motivated by the prospect of being able to have a significant say in their futures. Rob them of that, and they become lackluster, unimaginative, and in the end obstructive, if only to recover some sense of power." (5, pg 130)

In a more forthright criticism of this, Arnold Relman, former editor of New England Journal of Medicine, writing in a Review of the US Institute Medicine's Report on the Quality of Care in the USA, had this to say about the managed care health system in the US: "In all parts of the system, the providers of care see themselves as competing businesses struggling to survive in a hostile economic climate, and they act accordingly. The predictable result is a fragmented, inefficient and expensive system that neglects those that cannot pay, scrimps on the support of public health services and medical education, and has all the deficiencies in quality that are so well described and analysed.. It is a system that responds more to the financial interests of investors, managers and employers than to the medical needs of patients."(6)

Many may not agree with such a sweeping statement, and anyway the US context is very different, but clearly, the benefits of a provider-payer split are contested, and it need not be assumed to be an ideal to which all health care systems must aspire.

Thailand has mercifully been spared these extremes and the reason seems to lie in the resistance offered by the MOPH and the good sense in the NHSO itself, and though international papers may hope for movement towards the ideals of provider- payer split, the Thais remain an essentially pragmatic people- doing what needs to be done and calling it what it needs to be called.

3. UC Scheme uses *purchasing as a tool to improve performance. In many countries, fixed salaries for government employees are perceived as a major problem in improving public sector efficiency. A common statement made in this context is "There is no motivation for a government service provider to work more or less- since they would earn the same anyway." The challenge of health sector reform was seen as building a set of incentives that would reform behavior of both providers and patients. The ideal is pay for performance, or results based financing. Thailand is perceived as moving towards this ideal.*

Discussion: Thailand has always gone for an adequately staffed network of public health facilities, with fixed salaries and with considerable job security. There are considerable additional allowances for people working in significantly more difficult situations or having much higher caseloads, but this is seen as being fair to them. Some allowances, like non-practicing allowance are simply ways of providing additional remuneration to ensure their retention. Monetary incentives are *not* seen as driving performance. When care is purchased from private providers for specific high cost services on a fee for service mode, the private providers would have an increased income. However this does not apply to public providers where the additional allocations earned by seeing more in-patients or more complex cases, have no implications for take-home pay of providers. Even increased monetary awards for achieving quality of care accreditation do not lead to increase in personal incomes. Most commentaries are either silent on these HR policies- or portray them as weaknesses. But as Julian Tudor Hart spells out in his book "the political economy of health care", (5) there could be an alternative theory that sees this absence of monetary incentives as desirable , rather than as a problem. To quote:

" The National Health Services (NHS of United Kingdom) health care system operates in ways entirely different from commodity producing industries. Progress in health care depends on developing professionals as skeptical co-producers of health gain rather than as salesmen or process, and developing patients as skeptical co-producers rather than as consumers searching for bargains and shorter queues. Productivity in health care depends on complex decisions abut complex problems, involving innumerable unstable and unpredictable variables. These decisions require increasingly labor intensive production methods with ever deeper more trusting and continuing relationships between professionals and patients. Though machines may

be increasingly useful, they need to be subordinated to human decisions. These decisions need to be based on evidence freed so far as possible from bias, from rewards, penalties or personal vanities. They require an increasingly skilled thoughtful labor-intensive service. ….Progress and productivity in this field depends on new social relationships between public, patients and health professionals based on levels of trust unattainable within commercial transactions."(5)

Part V:

Does theory matter? Reflections on taking UHC forward.

Theory not only provides explanations of the facts, it also guides future action. The Thailand health care system is work in progress. There are many challenges it faces and many gaps in its performance. Depending on what programme theory we apply, the actions recommended as correctives and for moving forward could be different.

For example, one of the repeated comments with respect to the governance is the tension between the Ministry of Public Health and the NHSO. If one sees purchaser-provider splits as the ideal goal then it is a question of how NHSO must overcome the resistance of MOPH. But if the relationships and terms of production of health care services have meaning in themselves than the provider and consumer/purchaser are not opposing interests but need to be seen as different functions. Then the challenge is of how each would accommodate the other's concerns.

The movement of salaries through the MOPH may have its advantages in eliminating moral hazards, but MOPH institutional frameworks create major problems for flexible deployment of professional human resources, according to case loads. This could be in one framework of analysis sufficient reason to push ahead with taking HR control out of MOPH hands by making each district hospital autonomous. But in another framework of analysis it would need an understanding of the reasons- at the levels of formal and informal rules to help MOPH find a way out of this problem.

Similarly there is a problem that in this capitation based financing system there is a trend to reduce the range of services provided (in private sector it could lead to denial of care). Thus some observations made during the field visit indicate district hospitals withdrawing from C-sections and surgeries and more complex processes and PHCs withdrawing from normal deliveries etc. To correct this, more and more of such secondary care is being added into disease management initiatives, and paid on fee for service basis/purchase from tertiary care hospitals, of public or private. But an alternative approach would be

to look at family medicine courses and the creation of new specialist entities, who are skilled and confident of providing these services with the same safety levels, or at other innovations in the organization of service delivery.

Similarly the low level of engagement of private providers is portrayed in most narratives as a problem- or at best not commented upon. But what is the learning? Are services better where the CUP is a private hospital or an autonomous district hospital? Why have private hospitals exited? What is the mix of providers and the nature of care provided in the CSMBS where the per capita costs are four to five times higher- and wonder whether that is the best way to go. Whereas UHC discourse is based on a premise that it is immaterial whether providers are public or private, a purchaser treats them both equally, others would argue that the nature of production has bearing on its value- and call for health care to remain public even if it could be otherwise. Not only do different theories make for different answers, even the questions could be different!

Public systems are slow to innovate- as compared to private ones- and slow to modernize and upgrade themselves. The strategies of public financing that would promote innovation are itself a major area for innovation. But in another theoretical lens, it is the reason for moving away from dependence on public provisioning alone.

One could argue that such a debate on theory is only of academic interest as the Thais would use theory and experimental knowledge to solve these problems and pragmatism to choose between alternatives. However the concern for Thailand is that while there is so much work to develop explanations and actions along the lines of the mainstream UHC discourse, there is so little effort in recognizing that there is space for alternative theoretical frameworks of analysis that could provide equal if not more powerful explanations and possibilities for action. While Thailand has recognized the space for making alternatives in practice, it is still denying itself the space to make it own alternatives in theory.

For the other LMICs, and especially in India, the concern is that Thailand is often used in policy debates as an argument for shifting from fee for service insurance schemes to capitation fee based insurance plans. Also to advocate a shift from public finances going to largely support public provisioning of health care- to using public finances for purchasing health care from private contracting units which would manage provider networks where both public and private providers would compete to become a part of the network. That would be a sweeping misinterpretation of Thailand. Though few academic narratives of Thailand would assert as much, they do lend themselves to such a mis-reading of the lessons of the great success that Thailand's successful move towards UHC has been.

References:

1. Piya Hanvoravongchai, Health Financing Reform in Thailand: Toward Universal Coverage under Fiscal Constraints;UNICO Study Series 20; The World Bank, Washington DC, January 2013. A highly visible paper as part of the series. Presents a wealth of the information, as part of the UHC discourse.
2. Thailand's Universal Coverage Scheme: Achievements and Challenges; An Indpendent Assessment of the first ten years- 2001 to 2010, Synthesis, Report, Health Insurance System Research Office, Nonthaburi, Thailand pg 59). Published by a Thai secretariat team and guided by an international team of experts, this is a good example of expositions of viewing the Thai model as part of the UHC discourse. Used for training programmes on UHC internationally.
3. National Health Security Act,B.E. National Health Security Office
4. Viroj Tangcharoensathien1*, Siriwan Pitayarangsarit,Walaiporn Patcharanarumol1, Phusit Prakongsa, Hathaichanok Sumalee, Jiraboon Tosanguanand Anne Mills, Promoting universal financial protection: how the Thai universal coverage scheme was designed to ensure equity; Health Research Policy and Systems: 2013, 11:25. Recent paper- has a good focus on measured outcomes in terms of social protection and equity.
5. Julian Tudor Hart, The Political Economy of Health Care- Where the NHS came from and where it could lead: Policy Press, Bristol, UK, 2010.pg,82

6. Relman, Arnold. Book Reviews; The Insitute of Medicine: Report on the Quality of Health Care. Crossing the Quality Chasm: A new Health System for the 21st Century. N. Engl. J Med. 2001,345(9): 702 as cited in John Geyman, Falling Through the Safety Net: Americans Without Health Insurance; Common Courage Press, Monroe, 2005. pg.9

Further Readings:

7. Dr. Sanguan Nitayarumphong; Struggling Along the Path to Universal Health Care For All:2006, NHSO,Bangkok.(this book is a translation from Thailand to English. It explains the evolution and thinking about UHC. Its written with almost no reference to the UHC discourse- and shows an entirely different way of thinking about the issues. At times poetical- it refers to a process of having considered both ideologies- one viewing health care as a right and public good and another as just one other competitive business model- and how the 30 Bt programme was designed to accommodate both.)
8. Ed. Viroj Tangcharoeansathien & Pongpisut Jongudomsuk; From Policy to Implementation: Historical Events During 2001- 2004 of Universal Coverage in Thailand.. NHSO, Bangkok: First print 2004, third 2012: Covers the thinking about UHC and its evolution in the first few years. Many words like the purchasing –provider split are not there. There is a strong affirmation that the international aid agencies had minimal role at best. Though there is an effort to borrow ideas from international discourses, the 30 Bt scheme was its own design. Clearly international UHC discourse borrowed from UC scheme rather than the other way around.
9. Sirawan Pitayarangsarit (2004): Introduction of Universal Coverage of Health Care Policy in Thailand: Policy Responses. Doctoral Thesis submitted to University of London (2010):Explains the political and administrative and technical contexts in which such a change could be brought about and in so rapid a manner.

Table 1:

Thailand – A Statistical Profile

Population: 67 million Regions – 6 Provinces- 77 (including Bangkok) Districts- 828 (not including BKK) Sub-districts: 7255 Village: 74,963 *	Regional & General Hospitals : 96 District Hospitals: 787 Primary Health Centers (Including Urban PHC) : 10,973 Community Primary Care Center >80,000 **

*Ministry of Interior, 2013** Ministry of Public Health, 2013

Macro-Indicators- With India as a reference comparison

Indicator	Thailand	India
Economic indicators		
• GDP per capita (PPP)	$10,000	$3,900
• GDP composition (%) – Agriculture/Industry/Services		
• % population below $ 1.25 / day	13/43/44.1	17/18/65

	0.4	33
Social development indicators • % of urban population • Improved drinking water coverage (%) – Total/Urban/Rural • Improved sanitation coverage (%) – Total/Urban/Rural • Literacy: ➢ Adult (15+) literacy rate, by sex (M/F) • Employment:Adult unemployment (%) (M/F) • Gender inequity index • Global Hunger Index (2012) • Human Development Index (HDI) (2011)	 34 98/99/98 96/95/96 96/92 53/40/56 40.7/13.2/46.1 .682	 30.3 88/96/84 31/54/21 75/51 13/19/39 53/19/28 .554
Health Service Indicators • Births attended by skilled health personnel (%)		

• Physicians density (per 10 000 population) • Hospital beds (per 10 000 population)	99.4 3 22	52.7 6.5 9
Health financing indicators	*(2008/2009/2010)*	
• Total expenditure on health (TEH) as % of GDP. • General government expenditure on health (GGHE) as % of TEH. • Private expenditure on health (PvHE) as % of TEH • Private insurance as % of PvEH • Out of pocket expenditure as % of PvEH • Per capita total expenditure on health (PPP in int. $) (2011) • Per capita government expenditure on health (PPP int. $) (2011)	4/4.2/3.9 76.2/74.6/75 23.8/25.4/25 26.7/28.5/31.4 60.9/59.6/55.8 353.3 266.6	4/4.2/4.1 27.6/30.3/29.2 72.4/69.7/70.8 4.1/4.6/4.6 87/86.4/86.4 141.1 43.8

Health outcome indicators		
• Life expectancy at birth (yrs): (Total/Male/Female)	70/66/74	65/63/66
• Infant Mortality Rate	15.9	46.07
• Under Five Mortality Rate	13	63
• Maternal Mortality Ratio	48	200
• Adult mortality rate (probability of dying between 15 and 60 years of age per 1000 population (T/M/F)	205/270/139	87/86.4/86.4
• Prevalence of tuberculosis per 100 000 population	182	256

Table 2 : Resource Allocation At National Level for UC Scheme: in Percentage of Capitation allocation, (2003-2014)

Item	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
- General outpatient service	47.7	37.3	38.2	33.9	32.5	29.4	29.0	30.2	29.5	33.9	33.7	35.22
- General inpatient service	25.2	32.0	31.2	26.8	25.9	38.5	36.4	35.5	35.4	33.4	33.5	32.98
- Remote area & special area	-	0.8	0.5	0.4	1.5	1.4	3.1	2.9	2.4	2.1	2.1	8.71
- High cost , AE, disease management & Special drug	4.7	6.6	8.9	14.2	13.1	6.6	8.1	8.2	7.9	8.8	9.0	0.00

- Prevention & Promotion	14.6	15.7	15.0	13.1	12.5	11.5	11.4	10.9	11.6	10.8	10.8	0.00
- Rehabilitation service	-	0.3	0.3	0.2	0.2	0.2	0.2	0.3	0.4	0.4	0.4	12.32
- Emergency medical service	0.8	0.5	0.4	0.3	0.5	0.5	-	-	-	-	-	0.47
- Thai traditional medicine	-	-	-	-	-	0.0	0.0	0.1	0.2	0.2	0.2	0.00
- Capital replacement (depreciation)	6.9	6.5	5.5	7.5	7.2	6.6	6.5	6.0	5.5	4.9	4.4	0.26
- Pay for Quality performance	-	-	-	-	1.0	0.9	0.9	1.6	0.9	0.2	0.2	4.13
- No fault liability (Act 41)	-	0.4	0.0	0.0	0.0	-	0.0	-	0.1	0.0	0.2	0.00
- Compensation for health care personal's work injury	-	-	-	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.11
- Compensation for abolish 30Baht copayment	-	-	-	-	1.2	-	-	-	-	-	-	0.00
- Promote primary care	-	-	-	-	-	-	-	0.4	0.4	-	-	0.00
- Support special tertiary care	-	-	-	-	-	-	-	0.0	0.1	-	-	0.00
2.ARV drug	-	-	-	3.4	4.2	4.3	2.8	2.3	2.3	2.1	2.3	0.00
3.Renal replancement therapy	-	-	-	-	-	-	1.4	1.2	2.5	2.7	2.9	1.87
4.2nd prevention of DM/HT	-	-	-	-	-	-	-	0.3	0.5	0.3	0.3	3.40
5.Mental health (medicine)	-	-	-	-	-	-	-	-	0.2	0.1	-	0.53
Total Percentage	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100
Total (Baht/Capita)	**1,202.4**	**1,308.5**	**1,396.3**	**1,717.8**	**1,983.4**	**2,194.3**	**2,298.0**	**2,497.2**	**2,693.5**	**2,909.2**	**2,916.8**	**3,114.8**

Table 3: Age adjusted cost index of outpatient care 2014

	Year Age							
	<3	3-10	11-20	21-40	41-50	51-60	61-70	>70
Weight	0.529	0.419	0.290	0.415	0.790	1.373	1.951	2.232

: Calculate for OP & cost by age-year in 2010

Table 4 : **Revenue Receipts of a CUP:** ***Bangpa – In (District) for Fiscal year (2011 – 2014)***
(Fiscal Year =1 Oct - 30 Sep.)

No.	Budget Head	year 2011		year 2012		year 2013		Year 2014 (6 m)		clarifications sought
		Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	
1	User Fee collection/service charge (cash revenue)	10,471,706.00	15.83	11,465,893.00	11.94	9,179,212.00	7.87 (13.59)	4,628,336.00	10.63	Cash revenue from out of package payment from patients, who are not registered with Bangpa-In hospital, Non-Thai patients, private insurance payments etc
2	CSMBS reimbursement	3,898,175.00	5.89	-	-	-	-		0.00	
3	CSMBS - OP fee for Service reimbursement	-	-	3,849,430.00	4.01	4,213,626.00	3.61 (6.24)	2,317,219.00	5.32	Fee for service basis
4	CSMBS - IP fee for Service reimbursement	-	-	1,351,655.00	1.41	622,806.00	0.53 (0.92)	710,651.00	1.63	DRG plus special room & food service (600 Bt/day)
5,6, 7	Reimburse form Reimburse form Road Accident Victims Protection Act 6. Is OPD costs and 7 is IPD costs- but these are merged in the district hospitals	61,562.00	0.09	130,667.00	0.14	167,349.00	0.14 (0.25)	55,850.00	0.13	It's from the enforcement of the protection from the Road Accident Victim Protection Act, B.E.2535 (1992), it's mandatory for every car and motor cycle, managed by Ministry of commerce. Road accident will reimburse from this act first, it has ceiling, additional from the ceiling, reimburse from the each schemes
8	Bank interest	10,876.22	0.02	21,092.84	0.02	241,696.21	0.21 (0.36)	40,919.67	0.09	
9	CSMBS: State enterprise group reimbursement revenue	213,316.00	0.32	100,901.00	0.11	254,297.00	0.22 (0.38)	87,096.00	0.20	The Benefit Package is the same as CSMBS, but some State enterprise have additional health benefit, higher special room rate etc
10	Other income	941,213.15	1.42	683,238.03	0.71	495,002.94	0.42 (0.73)	123,726.71	0.28	

No.	Budget Head	year 2011		year 2012		year 2013		Year 2014 (6 m)		clarifications sought
		Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	
11	Annual Health check up at external agency	1,356,790.00	2.05	1,197,110.00	1.25	997,910.00	0.86 (1.48)	183,060.00	0.42	This revenue received form annual Health check up from both government and private employee. For the government employee, they can get reimbursement from CSMBS.
12	UCs copayment (30 Bt co-payments)	-	-	48,540.00	0.05	576,990.00	0.49 (0.85)	311,460.00	0.72	This 30 Bt per visit was a compulsory payment in 2002- with exemption for the poor. This was stopped in 2006. But it returned in Sept 2013 – now positioned as voluntary co-payment.
13	SSS : Workmen Compensation fund (WCF)	82,018.50	0.12	43,934.00	0.05	66,458.00	0.06 (0.10)	38,933.00	0.09	Reimbursement of costs for pts covered by SSS scheme which is under Workmen Compensation Act 1994, WCF benefits : Medical Service, rehabilitation service, cash benefit (temporary, partially totally disability and death), funeral grant.
14	SSS reimbursement from main contractor.	3,253,461.00	4.92	4,421,438.75	4.60	3,886,587.60	3.33 (5.75)	2,181,834.00	5.01	SSS, beneficial register at main-contract under SSS which is hospital >100 beds. Bangpa-In Hospital is network of main-contractor; it's a flat rate.
15	Service fee Reimbursement of SSS (Accident/Emergency within first 72 hours)	171,764.00	0.26	464,782.00	0.48	156,394.00	0.13 (0.23)	108,782.00	0.25	SSS: Accident /Emergency within first 72 hours reimburse from SSS central fund after that from SSS main contractor.
16	Budget form Local government (Health project)	900,130.00	1.36	730,800.00	0.76	342,580.00	0.29 (0.51)			Additional support from Local government for health projects (dengue control, food sanitation campaign, hospital solid waste management etc.)
17	CSMBS: Local government group reimbursement revenue	-	-	-	-	-	-	130,854.00	0.30	The benefit Package is the same as CSMBS, 2014, NHSO manage as a clearing house for all local government, before manage by each local government, which sometime not enough budget.

No.	Budget Head	year 2011		year 2012		year 2013		Year 2014 (6 m)		clarifications sought
		Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	
18	The treatment of migrant workers.(foreigner)	862,741.00	1.30	2,172,300.00	2.26	805,500.00	0.69(1.19)	844,430.00	1.94	
19	Rent from ATM	36,000.00	0.05	36,000.00	0.04	33,000.00	0.03 (0.05)	18,000.00	0.04	The rent paid by the bank for being allowed to use hospital space for its ATM machine
20	UC Scheme (OPD), Capitation basis	16,826,483.26	25.43	18,257,410.24	19.01	23,007,636.79	19.72 (34.06)	16,193,961.54	37.19	**This is the main income of the CUP**
21	UC Scheme from NHSO (IPD) IP reimbursement :DRG with global budget basis	10,417,096.44	15.74	10,679,497.35	11.12	9,615,389.69	8.24 (14.23)	6,273,310.08	14.41	**This is the second most important income of the CUP**
22	UC budget from NHSO (OP& PP individual record)	912,386.92	1.38	525,955.29	0.55	444,235.90	0.38 (0.66)			It' paid per individual key in of OP&PP data record, incentive them to send data, In yr 2014 it was merged into new items 40&41
23	UC Scheme (On top)	793,200.00	1.20	291,521.88	0.30	1,841,445.27	1.58 (2.73)			Pay for quality/performance, measure performance and the quality use report/indicator, some by third party, example pap smear slide, by Clinical Review Institute.
24	UC Scheme (emergency medical fund)	2,088,134.83	3.16	1,739,725.24	1.81	1,956,329.95	1.68 (2.90)	801,372.60	1.84	
25	UC Scheme (specific diseases)	357,567.00	0.54	519,800.00	0.54	501,533.00	0.43 (0.74)			
26	UC Scheme (P&P express demand)	5,274,424.80	7.97	5,993,097.65	6.24	5,218,773.51	4.47 (7.72)	2,450,571.41	5.63	
27	UC Scheme (P&P for operation level)	-	-	-	-	882,430.00	0.76 (1.31)			
28	UC Scheme (P&P for national level)	-	-	106,720.00	0.11	52,180.00	0.04 (0.08)			
29	UC Scheme (Primary care)	469,516.58	0.71	-	-	-	-			An fund to establish new PHCs where PHCs have catchment popn of more than 5000 peoples. This head was provided only in 2010-2011
30	UC Scheme (mental care)	30,000.00	0.05	142,290.00	0.15					
31	UC Scheme (dental care)	996,333.70	1.51	1,343,769.84	1.40	1,006,893.00	0.86 (1.49)	357,808.00	0.82	

No.	Budget Head	year 2011		year 2012		year 2013		Year 2014 (6 m)		clarifications sought
		Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	
32	UC Scheme (depreciation)	3,662,600.58	5.54	27,648,375.37	28.79	49,140,127.48	42.11 (0.00)			
33	UC Scheme(rehabilitation)	32,400.00	0.05	52,230.00	0.05	280,800.00	0.24 (0.42)			
34	UC Scheme (HIV&AIDS)	46,140.00	0.07	54,123.00	0.06	37,621.00	0.03 (0.06)			
35	UC Scheme (Service quality standards)	887,142.00	1.34	1,017,162.00	1.06	119,000.00	0.10 (0.18)			
36	UC Scheme (Thai traditional medical service)	22,243.50	0.03	-	-	128,925.00	0.11 (0.19)			
37	UC Scheme (DM-HT)	735,709.00	1.11	427,984.61	0.45	426,482.21	0.37 (0.63)	1,039,223.38	2.39	Since 2013, integrated into OP capitation and P&P
38	UC Scheme(Asthma)	353,500.00	0.53	519,800.00	0.54				0.00	Since 2013, integrated into OP capitation
39	Remuneration of public health staff	-	-	-	-	-	-	3,167,156.00	7.27	New payment under UC scheme item since 2014, an allowance for Health Personnel, professional allowance + duration of work in rural, remote area.
40	UC budget from NHSO (OP-Quality and Outcome Framework)	-	-	-	-	-	-	908,107.00	2.09	New payment UC scheme item in 2014, pay for performance for OP by point system with global budget manage by NHSO regional office, it will have indicator, criteria to measure the quality and outcome.
41	UC budget from NHSO (PP-Quality and Outcome Framework)	-	-	-	-	-	-	567,567.00	1.30	New payment UC scheme item in 2014, pay for performance for PP by point system with global budget manage by NHSO regional office
Total		**66,164,631.48**	**100.00**	**96,037,244.09**	**100.00**	**116,699,211.55**	**100.00**	**43,540,228.39**	**100.00**	

Table 5 Expenditure in Bangpa – In CUP(District Hospital) for Fiscal year (2011 – 2013)
(Fiscal Year =1 Oct - 30 Sep.)

Table 5A: Summary Table of Expenditures (as derived from table 3 B- the original data sheet)

No.	Budget Head							Budget items from Main table 3 b.
1A	Human Resources- Contractual Staff employed locally	7161980.54	13.20	8634886.58	13.96	8870458.93	14.42	Rows- 1 to 3
11B	Human Resources- Additional Allowances for regular staff.	10498676	19.32	14476499	23.56	12215287	19.85	Rows 4 to 14
1c	Human Resources- Training and scholarships	1803041.87	3.32	1041062.11	1.69	1483589	2.42	Rows 16-17 & Rows 57 to 61
1	**Human Resources Sub-total.**		**35.84**		**39.21**		**36.69**	
2	**Medical Supplies Sub-total**	**10416428.48**	**19.18**	**16406298**	**26.53**	**14622842**	**23.77**	Row 36-38
3A	Laboratory - outsourced	2565784	4.73	2940941	4.76	3465047	5.63	Row 29
3B	Laboratory- supplies	1382988	2.55	3047012	4.93	2692439	4.38	Row 39
3	**Diagnostics – sub-total**		**7.28**		**9.69**		**10.01**	
4A	Repairs & Maintenance	1103270	2.01	5269377	8.52	2575480	4.18	18-28,30
4B	Running costs- water, electricity, sanitation, BMW etc	2494928	4.6	2412334	3.9	2879370	4.69	31-35
4C	Non Medical Supplies	2892604	5.32	2926967	4.73	2651603	4.31	40-46,,48-51
4	**Hospital Maintenance Sub-Total**		**11.93**		**17.15**		**13.18**	
5	**Food**	**1486554**	**2.74**	**1591082**	**2.57**	**1331041**	**2.16**	Row 47
6	**Outsourced Services/Miscellani**	**10397190**	**19.16**	**471435.5**	**0.76**	**1442124**	**2.34**	
7.	**Resource Allocation to PHCs**	**2086820**	**3.85**	**2610280**	**4.22**	**7291140**	**11.85**	62-65
	Grand Total	**54290267**	**99.98**	**61828173**	**100.13**	**61520420**	**100**	

Table 5. B .The detailed original table on expenditures as obtained from Bangpa-In CUP

No.	Budget Head	year 2011		year 2012		year 2013		clarifications sought
		Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	
1	Wages for service provider	5,442,700.17	10.03	6,565,339.69	10.62	6,538,928.93	10.63	These are wages paid from Hospital revenue, for locally hired additional doctors, nurses. (not government officers)
2	Wages for support staff	1,433,704.37	2.64	1,806,874.89	2.92	1,992,986.00	3.24	This wages pay from Hospital revenue, for locally hired additional support staff. (not government officers)
3	Employer payment for social security scheme contribution.	285,576.00	0.53	262,672.00	0.42	338,544.00	0.55	Payment by hospital towards employers' contribution for SSS coverage for its hospital employees.
4	Non private practicing allowance for doctor	200,000.00	0.37	450,000.00	0.73	630,000.00	1.02	

No.	Budget Head	year 2011		year 2012		year 2013		clarifications sought
		Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	
5	No clinic compensation for dentist	-	-	50,000.00	0.08	-	-	
6	No clinic compensation for pharmacist	-	-	80,000.00	0.13	70,000.00	0.11	
7	Monetary Allowance for district hospital/health center (version 4) employees	1,256,200.00	2.31	3,700,000.00	5.98	1,524,000.00	2.48	The criteria for allowance payment for health personnel is based on 1) *type of health facility:* regional& general hospital, district hospital, health center, and number of year work in health sector, 2) *location:* urban area, rural area, remote area, special remote area, 3) *Professional category*: Doctor, Dentist, Pharmacist, Nurse, Health worker, other Health Professional, physiotherapist, Radiographer etc, 4) *Years in service*: 1-3 yrs, 3-10 yrs, > 10 yrs by MoPH. Version 4 valid in year 2011-12, version 6 in year 2013, and version 8 in year2014, (different in area, year of work, additional professional group etc.)
8, 9	Allowance for district hospital/health center (version 6), (version 8)	-	-	-	-	990,900.00	1.61	
10	Other allowances	598,899.00	1.10	695,100.00	1.12	37,000.00	0.06	
11	Allowance for nurse in evening and late night on duty shift	729,720.00	1.34	1,173,196.00	1.90	984,180.00	1.60	
12	Allowance for over time on duty, health service section	5,675,554.00	10.45	8,028,203.00	12.98	6,715,838.00	10.92	This provides the major extra income over and above salaries and is broadly distributed across facilities based on case-loads managed.
13,15	Allowance for over time on duty, support section	-	-	90,000.00-	0.15	996,646.00	1.62	Some support section difficult to pay by working shift hospital pay lump sum per month
14	Allowance for Special professional (use from Hospital revenue)	2,038,303.00	3.75	300,000.00	0.49	266,723.00	0.43	Allowance for Doctors, Dentist, Pharmacist, Nurse and other health Use criteria: professional., Doctor: GP, Specialist, etc plus working year
16	Scholarship study in country	-	-	90,000.00	0.15	-	-	
17	Training course fee for staffs	1,413,043.00	2.60	470,604.00	0.76	114,042.00	0.19	
18	Repairing/maintenance: building	7,980.00	0.01	-	-	-	-	
19	Repairing/maintenance: official equipment	9,000.00	0.02	2,600.00	0.00	-	-	
20	Repairing/maintenance: vehicle	159,089.48	0.29	180,840.95	0.29	153,753.34	0.25	

No.	Budget Head	year 2011		year 2012		year 2013		clarifications sought
		Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	
21	Repairing/maintenance: technical equipment	1,500.00	0.00	46,000.00	0.07	-	-	
22	Repairing/maintenance: medical equipment	-	-	-	-	32,309.00	0.05	
23	Repairing/maintenance: electronic equipment	-	-	-	-	1,200.00	0.00	
24	Repairing/maintenance: other equipment	6,775.00	0.01	11,288.50	0.02	-	-	
25	Repairing/maintenance: air conditioner	122,106.00	0.22	166,383.50	0.27	2,632.20	0.00	
26	Repairing/maintenance: Staff accommodation in the hospital	-	-	5,200.00	0.01	46,000.00	0.07	
27	Outsource Cleaning	2,000.00	0.00	-	-	24,000.00	0.04	
28	Infectious Waste Management	45,193.00	0.08	61,492.80	0.10	34,208.60	0.06	
29	Laboratory outsource	2,565,784.41	4.73	2,940,940.80	4.76	3,465,047.15	5.63	
30	Other out source management	749,626.81	1.38	4,795,570.99	7.76	2,281,376.72	3.71	
31	Electricity	2,314,645.58	4.26	2,279,683.52	3.69	2,699,101.20	4.39	
32	Water supply	20,003.92	0.04	9,360.47	0.02	37,142.56	0.06	
33	Telephone	128,059.11	0.24	100,431.20	0.16	121,870.59	0.20	
34	Internet	7,593.79	0.01	8,089.30	0.01	3,353.10	0.01	
35	Post and logistic	24,625.81	0.05	14,769.03	0.02	17,903.00	0.03	
36	Medicine	8,351,047.78	15.38	10,744,599.49	17.38	10,989,197.97	17.86	
37	Pharmaceutical products and equipment	1,081,572.45	1.99	4,051,382.97	6.55	2,707,255.98	4.40	
38	Medical material	983,808.25	1.81	1,610,315.04	2.60	926,388.09	1.51	
39	Laboratory material	1,382,988.39	2.55	3,047,012.01	4.93	2,692,438.50	4.38	
40	Office material supply	861,716.58	1.59	891,228.69	1.44	680,202.30	1.11	
41	Vehicle equipment	7,384.00	0.01	8,089.30	0.01	26,080.00	0.04	
42	Fuel	500,936.00	0.92	612,045.33	0.99	643,762.20	1.05	
43	Electronic material/equipment	2,568.00	0.00	35,194.36	0.06	20,535.00	0.03	
44	Public relation and Advertisement material/equipment	-	-	5,819.00	0.01	-	-	
45	Computer	405,570.82	0.75	204,895.00	0.33	303,021.93	0.49	
46	Home material/equipment	663,481.03	1.22	800,645.63	1.29	775,090.00	1.26	
47	Food material	1,486,554.00	2.74	1,591,082.00	2.57	1,331,040.50	2.16	
48	building material/equipment	328,570.87	0.61	156,624.98	0.25	160,481.28	0.26	
49	other material	62,277.00	0.11	79,795.45	0.13	20,480.00	0.03	
50	dental care material	-	-	90,306.50	0.15	-	-	

No.	Budget Head	year 2011		year 2012		year 2013		clarifications sought
		Amount (Bt)	%	Amount (Bt)	%	Amount (Bt)	%	
51	other equipment (non Medical)	60,100.00	0.11	42,323.06	0.07	21,950.00	0.04	
52	land renting	42,323.06	0.08	103,300.00	0.17	42,323.06	0.07	
53	pay for P&P project	130,500.00	0.24	214,946.00	0.35	450,400.00	0.73	
54	pay for project	1,005,000.00	1.85	33,189.50	0.05	913,110.00	1.48	
55	Pay for medical service who register at Pangpa-In CUP	9,216,623.25	16.98	-	-	36,291.00	0.06	
56	Pay for medical service cost Migrant Lobour who register at Pangpa-In CUP	2,744.00	0.01	120,000.00	0.19	-	-	Migrant labour buy Insurance card manage by MoPH, the price the same as capitation, benefit package is the same UC scheme, except not cover ESRD.
57	Support Scholarship tor the Collaborative Project to Increase Production of Rural Doctor project (CPIRD)	-	-	-	-	120,000.00	0.20	Scholarship for the Collaborative Project to Increase Production of Rural Doctor project (CPIRD) when fellows finish from Medical school will come back work in this CUP
58	Refunding of medical fee	-	-	11,430.00	0.02	3,500.00	0.01	Refunding of medical fee to patient or other health facilities. (notice or complain from patient or health facilities)
59	paying for buy/rent land.	98,000.00	0.18	339,028.11	0.55	894,672.00	1.45	
60	other payments	291,998.87	0.54	130,000.00	0.21	351,375.00	0.57	
61	study without clinical service	-	-	-	-	-	-	
62	Transfer to PHCS for Specific Group	-	-	-	-	2,122,219.00	3.45	Transfer budget to PHCS for Specific Group, DM-HT, etc
63	Depreciation cost	1,132,470.00	2.09	-	-	1,152,427.00	1.87	
64	Top up to PHCs	-	-	-	-	1,406,214.00	2.29	Provided to PHCs for additional case loads and performance scores
65	Allocation for UC to PHCs (period 1-2)	954,350.00	1.76	2,610,280.00	4.22	2,610,280.00	4.24	Main transfer to PHCs
Total		**54,290,266.80**	**100.00**	**61,828,173.06**	**100.00**	**61,520,420.20**	**100.00**	

Tables: 6: Budget Allocation for PHCs of Bangpa-In District & CUP for year 2556 (2013)

PHC. Sl No. 18 is Talad Kreab- the PHC presented in the case study- shown in bold

PHC Sl. No.	Cleaning	Electricity & Water	Overtime	Office expenses	Medical Equipment	Dental Equipment	Others	Medicines	Total	In Cash to PHC	First Installment 50%	Second Installment 50%
1	36,000	40,000	116800	15,000	25,000	40,000	10,000	519,840	802,640	202,800	101,400	101,400
2	30,000	40,000	--	15,000	8,000		10,000	56,230	159,230	80,000	40,000	40,000
3	30,000	40,000	66,560	15,000	8,000		10,000	67,220	236,780	146,560	73,280	73,280
4	30,000	40,000	116800	15,000	16,000		10,000	268,600	496,400	196,800	98,400	98,400
5	30,000	40,000	116800	15,000	10.000		10,000	140,100	361,900	196,800	98,400	98,400
6	30,000	40,000	--	15,000	5000		10,000	37,966	137,966	80,000	40,000	40,000
7	30,000	40,000	116800	15,000	10,000		10,000	86,182	307,982	196,800	98,400	98,400
8	30,000	40,000	66560	15,000	8,000		10,000	67,916	237,476	146,560	73,280	73,280
9	30,000	40,000	--	15,000	5,000		10,000	37,148	137,148	80,000	40,000	40,000
10	30,000	40,000	--	15,000	8,000		10,000	73,694	176,694	80,000	40,000	40,000
11	30,000	40,000	--	15,000	7,000		10,000	41,406	143,406	80,000	40,000	40,000
12	12,000	5,000	--	15,000	5,000		10,000	2,112	49,112	27,000	13,500	13,500
13	30,000	40,000	--	15,000	5,000		10,000	43,684	143,684	80,000	40,000	40,000
14	30,000	40,000	--	15,000	7,000		10,000	49,892	151,892	80,000	40,000	40,000
15	30,000	40,000	66560	15,000	8,000		10,000	73,676	243,236	146,560	73,280	73,280
16	30,000	40,000	-	15,000	5,000		10,000	29,338	129,338	80,000	40,000	40,000
17	30,000	40,000	116800	15,000	23,000	30,000	10,000	420,420	685,220	196,800	98,400	98,400
18	**30,000**	**40,000**	**116800**	**15,000**	**20,000**	**30,000**	**50,000**	**295,438**	**597,238**	**236,800**	**118,400**	**118,400**
19	30,000	40,000	-	15,000	7,000		10,000	46,366	148,366	80,000	40,000	40,000
20	30,000	40,000	116800	15,000	10,000		10,000	111,434	333,234	196,800	98,400	98,400
	588,000	765,000	1,017,280	300,000	200,000	100,000	240,000	2,468,662	5,678,942	2,610,280	1,305,140	1,305,140

In addition Talad Kreab got 120,000 for quality top ups, 300,000 for CHW salary and " x " amount for staff salaries.