Executive Summary

Research Project: Developing Recommendation of Payment Mechanisms for Health Promotion and Disease Prevention in Thailand

Under the Thai universal health coverage system, health promotion and disease prevention (P&P) is one of the key measures used to tackle public health problems. In 2002, Parliament passed the National Health Security Act, B.E. 2545 (2002), which aims to ensure appropriate financial and resource allocation for P&P activities as well as to assure that essential health services are available for the population. As mandated by the Act, the Thai population has been granted a comprehensive benefit package, comprising various lists of health promotion and disease prevention items that have been continuously updated and amended since its inception. The Health Promotion and Disease Prevention Fund was subsequently established under the National Health Security Office (NHSO) with the primary intention of appropriately managing the P&P budget.

Since 2002, the P&P budget management system has continuously been developed over time. In 2017, the budget management system remains based on the concept of decentralized allocation. Currently, the P&P budget has been divided into four categories according to each fund's specific purposes, namely: 1) the National Priority Program (NPP) and Central Procurement; 2) P&P Area-based Services (PPA); 3) P&P Community-based Services (PPC); and 4) P&P Basic-based Services (PPB). Despite these developments, problems related to managing and regulating the P&P budget at the area level remain unsolved, which then affects P&P service performance at the national level.

This study aims to conduct a literature review regarding the payment mechanism for individual providers and facilities as remuneration for P&P delivery services, as well as to develop recommendations for P&P services payment mechanisms in Thailand. This study is based on a qualitative approach using systematic, narrative, and institutional reviews. Ultimately, 12 articles were included in this study. Moreover, grey literature regarding payment methods in the United Kingdom, the Netherlands, and Thailand were also obtained by hand searching.

Data analysis have been divided into two groups. Data obtained from the narrative literature review was independently analyzed with the aim of understanding the relationship between payment remuneration and provider incentives. Meanwhile, data gathered by the systematic literature review was analyzed with the intention of investigating the outcomes and impacts created by each payment system. The plausible effects including volume and quality of provided P&P services, providers' behaviour and motivation, risk selection, supplier-induced demand, and administrative burden. Each individual payment method and its potential effects was compared side by side, and presented as follows:

1) **Potential benefits and pitfalls of a fee-for-service (FFS) system, and recommendations on appropriate services**

   Implementing FFS payment schemes may result in the volume of provided P&P services being inappropriate. Providers under an FFS system were likely to provide a large quantity of services which were more than necessary. However, the FFS payment system had no clear effect on service use (volume provided). Unsurprisingly, the FFS remuneration scheme had

positive effects on the quality of provided services, providers' motivation, and risk selection. In addition, the FFS payment system resulted in a high rate of supplier-induced demand. However, it might have led to substantial administrative burden, particularly in settings where health information systems were yet to be fully developed. This study proposed that a FFS payment scheme with a fee-schedule should be applied only for P&P services with explicit predefined unit cost as this will help to simplify the reimbursement process for both providers and purchasers.

2) **Potential benefits and pitfalls of a capitation (CAP) system, and recommendations on appropriate services**

The CAP payment scheme indicated either positive or negative associations with the volume of services provided, quality of services, and risk selection. Registered population were likely to receive a small quantity of services, and sometimes less than the medically-necessary requirements (under-servicing). This was because providers attempted to prevent revenue loss. The CAP system did not lead to supplier-induced demand since providers tried to reduce all possible expenses and control costs by decreasing the number of services provided. Moreover, the CAP payment system was incapable of creating intrinsic motivations for health providers as it did not link the remuneration amount to work performance. Therefore, this study recommended that the CAP payment system would be suitable for services without predefined unit cost such as health education and promotion, and behaviour-change strategy. It should also be applicable for project-based activities such as projects for promoting public access to health screening and vaccinations.

3) **Potential benefits and pitfalls of a pay-for-performance (P4P) system, and recommendations on appropriate services**

P4P payment systems led to an increase in health screening rates, and behaviour changes. On the other hand, in some cases, providers under a P4P payment scheme may have ignored services that were not additionally compensated. Furthermore, several studies have illustrated that a P4P payment system had a positive effect on quality of services provided. Nonetheless, the improvement in quality of services might not have been influenced by the P4P payment system alone as other factors may have also played a role. Moreover, a P4P payment system, particularly in the form of a Quality Outcome Framework (QOF), encouraged providers' motivation. A P4P payment scheme, however, might result in irrational services provision to certain population groups. A positive association between a P4P payment system and administrative burden was also reported. This study suggested that a P4P remuneration system should be applied for underutilized health services, and health policies which governments designate as high-priority at that certain point of time. In order to set priority for health policies, the government needs to take several factors into account including burden of disease, number of people affected by specific diseases/illnesses, severity of the health problem, variations of treatments received by high and low socioeconomic status groups, and the contexts of areas that need to implement such policies.

4) **Potential benefits and pitfalls of a global gudget (GB) system, and recommendations on appropriate service**

The results gathered from the literature review was unable to draw a conclusion about whether a GB payment system has either positive or negative impacts on the quality and volume of services provided, and risk selection or not. This is due to the limited number of studies examining the relationship between a GB payment scheme and the aforementioned consequences. Despite this problem, other studies have indicated that a GB payment system results in irrational decisions to provide services to certain groups of the population. Moreover, it does not encourage providers' motivation. However, a GB payment system allows for cost containment, budget predictability, and efficient use of the budget. Thus, a GB payment scheme should be used to allocate the annual budget at the national, regional, and provincial levels.

5) **Potential benefits and pitfalls of a blended payment method, and recommendations on appropriate services**

In principle, a blended payment system was formed in order to avoid providers' adverse incentives and behaviour created by a single-based payment approach. Adverse incentives and behaviour often led to health inequity, for instance, problems concerning access to health services, variations of quality of care across areas, and an increase in expenditure for health services delivery. This hybrid payment method means to combine the potential benefits of each individual traditional payment system into one. However, a common shortcoming of the blended payment method is that it is hard to incorporate all possible payment approaches in the right proportion to maximize benefits and minimize weaknesses. Furthermore, it is difficult to develop an effective, reliable, and precise information/output reporting system as the health information system used in blended payment models tend to be more complicated than other models. This study suggested that a blended payment system is applicable and appropriate for all P&P services, depending on what type of providers' incentives need to be improved.

Policy Recommendations

The NHSO – as the P&P budget management body – should allocate the budget at two levels as follows:

1) **National level:** The NHSO should allocate budget in the form of a capitation payment for central procurement including vaccination purchasing and delivery. Moreover, a proportion of capitations and P4P should be allocated to the National Priority Program (NPP) to implement prioritized health policies, which are set by taking into consideration the burden of disease and number of population affected by the particular health problem.
2) **Regional level:** The NHSO should allocate budget in the form of per capita to the Regional Health Board (RHB), a regional-based committee committed to preserving and strengthening health care for people in the region as well as distributing budget at the provincial level. The budget dispensed by the RHB should be allocated to the Provincial Health Board (PHB) in the form of a global budget with capitation, adjusted by age and performance in the previous year. We recommended that there should be a Monitoring and Evaluation Health Board (M&E HB) at the provincial level. It would be responsible for monitoring all areas of the public health sector's activity, and evaluating it to determine the impact, quality, and effectiveness of its work. The PHB should then allocate the P&P budget in the form of a global budget with

capitation, adjusted by age and work performance in the previous year at the district level. The M&E HB should also be established at this level to monitor and evaluate whether public health sector is achieving its aims and objectives, showing progress towards its mission and purpose, complying with laws and regulations, and working within its policy framework. Subsequently, the District Health Board (DHB) should allocate the P&P budget to health facilities at the district and sub-district levels. The payment system used in P&P budget allocation at this level should comply with the recommendations earlier for appropriate services. Furthermore, the NHSO shall allocate the P&P budget directly to the local authority as capitation together with matching funds by local authorities.

3) Both health facilities and local authorities are required to report performance/outputs including context-specific health determinants within which the health system operates (socio-economic, environmental behavioral, genetic factors), availability, accessibility, and quality of services as well as health outcomes (mortality, morbidity, disease outbreaks, health status) to the RHB through the PHB and DHB to use as fundamental information for calculating the P&P budget the following year.

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