

VISIT BY DELEGATION FROM
MINISTRY OF HEALTH,
CHHATTISGARH STATE, INDIA
TO LEARN ABOUT UHC
IMPLEMENTATION AND
CHALLENGES IN THAILAND
29-30 JANUARY, 2019

HITAP International Unit (HIU)

Abbreviations

BMGF	Bill and Melinda Gates Foundation
CUP	Contracting Unit of Primary Care
DRG	Diagnosis Related Group
HITAP	Health Intervention and Technology Assessment Program
HTA	Health Technology Assessment
iDSI	International Decision Support Initiative
IHPP	International Health Policy Program
NHSO	National Health Security Office
NLEM	National List of Essential Medicines
OOPE	Out-of-pocket expenditure
UCS	Universal Coverage Scheme
UHC	Universal Health Coverage
WHO	World Health Organization

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Executive Summary

In January 2019, the Minister of Health from Chhattisgarh state, India, reached out to International Health Policy Program (IHPP), a semi-autonomous research program in Thailand, to learn about the Thai experience of implementing Universal Health Coverage (UHC). The minister requested to meet with senior Thai experts to discuss and understand the healthcare system in Thailand. This request was shared by IHPP with the National Health Security Office (NHSO) and the Health Intervention and Technology Assessment Program (HITAP) to facilitate and support the visit.

Chhattisgarh state had a change of government in late 2018. The Minister and his team were therefore keen to learn from the Thai experience in this early phase of a new political term, to inform planning for Chhattisgarh healthcare over the coming five years.

On Tuesday 29th January, a dinner was held where the Chhattisgarh Minister of Health, Dr. T. S. Singh Deo met with Thai technocrats and officials working to support UHC in Thailand. The dinner was attended by senior Thai experts, Dr. Suwit Wibulpolprasert and Dr. Somsak Chunharus and representatives from HITAP, including Founding Leader Dr. Yot Teerawattananon and Senior Researcher Dr. Wanrudee Isaranuwachai. The dinner provided a forum for lively discussion on the priorities of Chhattisgarh state, how Thailand addressed UHC challenges and how an institutional system was built in Thailand to support UHC.

On morning of 30th January the delegation were hosted at NHSO. Dr. Prachaksvich Lebnak, Deputy Secretary-general of NHSO, provided an introduction. Dr. Porntep Chotchaisuwattana, Director or Bureau of Planning and Budget Administration, NHSO then provided further detail about UHC in Thailand and management of the Universal Coverage Scheme (UCS) by NHSO. The delegation visited the NHSO's call centre and learned how the

acts as a key grievance redressal mechanism for the UCS, and learned from Waranya Rattanavipapong, Researcher at HITAP, about the role of Health Technology Assessment (HTA) in setting priorities in Thailand. A team from HITAP and a representative from the Bill and Melinda Gates Foundation (BMGF), India office, accompanied this visit.

The afternoon of 30th January the team visited the HITAP office, Ministry of Public Health, Thailand. Here they learned in detail from Dr. Netnapis Suchonwanich about further UHC implementation issues, including the information requirements and systems needed to identify and enroll patients, manage and reimburse claims and run a UHC scheme effectively. The day was concluded with a discussion of HITAP International Unit's work in the region and potential avenues for further learning or engagement with the Chhattisgarh delegation.

Background

Thailand implemented the Universal Coverage Scheme (UCS), or gold-card scheme, in 2001. This tax-financed scheme covers approximately 75% of the population and provides access to health-care free at the point of service. The successful implementation of the scheme required a large number of parallel efforts to identify the eligible population, set-up effective claims and reimbursement systems, define a sustainable benefits package, ensure quality of care, and ensure trained cadres of health-workers located across the country, etc. Over fifteen years, the UCS has refined its systems to become increasingly efficient and effective at delivering care for the Thai population.

Chhattisgarh is one of the 29 states of India, located in the centre-east of the country. It is the ninth largest state in India with a population of 25.5 million (as of 2011). Since its statehood in 2000, Chhattisgarh has come a long way in terms health and healthcare services. The various schemes employed by the state are gradually helping Chhattisgarh reach out to its population to provide better medical services and access to care. Apart from operating

governmental structures, healthcare needs of some parts of the state are also catered through non-governmental organisations which have made significant contributions to healthcare in Chhattisgarh.

A new state government was appointed in Chhattisgarh in late 2018. This new state government looks to establish comprehensive primary health care and UHC, and to ensure accessible, quality healthcare facilities that can provide effective care to patients. As the government is in its initial phases of planning for the coming 5 year term, the team wished to learn about Thailand's history and ongoing journey towards achieving UHC.

Specific areas of interest

Chhattisgarh Ministry of Health may plan to start up health and wellness centres (one for a population of 3000 to 5000) to provide comprehensive primary health care as an element of its UHC program and thus the Minister and his team were keen to understand more about the situation in Thailand regarding:

- The working of Contracting Units of Primary Care, their infrastructure, the financing- allocation of UC funds and their spending.
- Staffing of district hospitals and the services provided.
- Functioning of community health workers
- Information systems

The team also requested to learn about the health insurance model, continuum of care, different levels of service provision and their linkage, health financing including fund allocations mechanisms, and the grievance redressal and compensation systems. It was hoped that learning about the Thai experience could provide some context and possible lessons which might be helpful to inform Chhattisgarh's own health reforms.

Dinner for discussion with Thai experts

On Tuesday 29th January 2019, a dinner was held for the Chhattisgarh Minister of Health, Dr. T. S. Singh Deo and his team to meet with Thai technocrats and officials working to support UHC in Thailand.

The dinner provided a forum for lively discussion of the priorities and challenges of Chhattisgarh state and how Thailand addressed some similar challenges and built an institutional system to support UHC.

Discussions included the payer/ provider relationship in Thailand and how the UHC manager, NHSO, in Thailand is also the payer who manages claims and releases funds to health facilities. This contrasts to India where claims go through external insurance companies. Some of the issues discussed were how reimbursements from insurance providers in Chhattisgarh can take a long time to process, that treatment may not always be reimbursed, and significant premiums may be charged by companies. In Chhattisgarh, a significant aim is to ensure that effective care is genuinely accessible to the poor with no out-of-pocket payments.

It was described how Thailand has established significant data storing and tracking mechanisms which spot patterns in data that alert to any misuse of funds. The NHSO also established a grievance redressal system which allows patients to find out their coverage scheme, what they are entitled to, and send complaints if they are being requested to pay for services that should be provided for free. This manifests in a 24 hour grievance redressal call-centre at the NHSO.

Outpatient services are often not covered in Chhattisgarh, which means that access to healthcare can depend on the illness in question, and services often do not reach the poor.

When treatment is given there are significant instances of out-of-pocket payments being made, even by the poorest.

Thailand's experience of including Renal Replacement therapy in its UHC scheme was discussed in detail. This provides an example of how a strong and transparent system for designing UHC benefit packages can be used to include even high-cost treatments that provide value-for-money or are priorities for other social and ethical reasons.

Dr. Suwit Wibulpolprasert described how Thailand can only provide context for Chhattisgarh to consider, but that the challenges of Chhattisgarh health and thus the form of its health-care system will be unique. However, it was hoped that the discussions over dinner and learning the following day would be helpful and informative for the Chhattisgarh team's consideration.

Visit to NHSO

On the morning of 30th January 2019, the delegation was hosted at NHSO (Agenda included in Appendix 1). The delegation was accompanied by a team from HITAP and a representative from the Bill and Melinda Gates Foundation, India office.

Dr. Prachaksvich Lebnak, Deputy Secretary-general of NHSO, provided a welcome address and an introduction. In his address, he described how there are three insurance schemes in Thailand, with the UCS, introduced in 2001, covering over 70% of the Thai population and providing healthcare free at the point of service. The main principle of this scheme was that patients should not be subject to out-of-pocket expenditure for necessary healthcare. The key challenge was to do this with limited resources in a way that ensured sustainability. Dr. Prachaksvich Lebnak echoed Dr. Suwit's sentiments regarding the importance of respecting

the different contexts between countries and using the Thai experience to inform thinking rather than as a mold to fit in.

The presentations began with a video providing background to the establishment of an effective UHC system. This highlighted the importance of a scheme that promotes ‘ownership’, among other things. This spurred discussion on the meaning of ownership; ownership involved both rigorous stakeholder engagement, such as doctors providing input to deciding protocols, so that stakeholders understand and can buy into decisions. Ownership also referred to the flexibility that the UCS gave service providers. The UHC scheme enhanced flexibility for health care providers to manage financial resources and design services in the most effective manner for their own contexts. Prior to UHC, finance was delivered according to line items with specific amounts earmarked for salaries, drugs etc. All capital investments were required to be planned at least one budget cycle in advance and there were significant time lags between the needs emerging and funds being disbursed. The UCS differs as it allocates an amount to a hospital for a category of care, for instance outpatient, but does not specify the line items. This allowed hospital directors greater flexibility to review their own facility demands and requirements and allocate resources in the most effective manner. Documents must however be submitted so that expenditure remains monitored and accountable. The Diagnosis Related Group (DRG) system of payments for inpatient care also allowed hospital and networks of other facilities to collaborate positively on referrals and providing care. This was the meaning of designing a health-system that supported ownership by all stakeholders.

The discussion turned to another aspect of Thai UHC, heightened by the video; Primary care centres acting as ‘gatekeepers’ of health services. The UCS in Thailand worked to send a strong message about primary care as patients are required to visit their registered Contracting Units of Primary Care (CUPs) first before being referred for any further or more specialized treatments. This ensured integrated, streamlined service delivery and avoided

situations where more expensive treatment is given and reimbursed, before more preliminary steps of care have been considered. This system strengthened primary care facilities in Thailand and enhanced the sustainability of UHC.

It was discussed how the benefit package for the UCS or UCBP does not cover any and all types of medical treatment, and items undergo rigorous assessment to decide whether they will be reimbursed under the benefit package. The package does however, include all basic and essential medicines and care. Thai doctors are also encouraged to prescribe generic versions of drugs covered by the scheme.

Dr. Porntep Chotchaisuwattana, Director of Bureau of Planning and Budget Administration, NHSO then provided a presentation on UHC in Thailand and management of the UCS by NHSO (Presentation included in Appendix 4). There are three dimensions of health-care coverage for UHC, the population to be covered which must start with the poor, the level of financial protection which must be free at the point of service for the poor and have minimum out of pocket expenditure (OOPE), and the degree of service coverage which must be described by a rigorously defined benefit package.

Dr. Porntep Chotchaisuwattana described the functions of NHSO in UCS including strategic planning of the annual budget and M&E, registration of health service providers and beneficiary enrollment, fund management including administration of the budget and claim management, health service quality control and mechanisms for consumer protection including complaint management. The budget allocation, financial management, and provider payment methods were then described in detail along with the mechanisms of strategic and central purchasing. HTAs are required to be conducted for high cost treatment options. Outpatient care is paid mainly through differential capitation and performance pay, inpatient care is paid by DRG with a global budget and performance, and central reimbursement is provided through fee schedule.

UHC led to significant reductions in household impoverishment from healthcare expenditure and the establishment of UHC as a perceived human right.

Future challenges for UHC in Thailand include questions of its dependence of tax income and sustainability, problems of demographic transition, conflicting role of the Ministry of Public Health as both regulator and provider, different packages and payments across the different insurance schemes, brain drain of qualified health workers and strengthening primary health care as an effective gatekeeper, among others.

Discussion then followed on to the total cost to the Thai Ministry of Health when UHC was first introduced as there is some trepidation in India that total costs may be larger than expected upon introduction. It was described how many of the richest in Thailand turned toward higher utilization of the private sector after UHC introduction. Total cost of the scheme will also depend on what is included in the benefit package and can be controlled by carefully defining what is to be reimbursed. There is also an upper limit placed on payments for in-patient and out-patient care, and about 20 high cost items are paid according to fee-schedule.

The delegation asked questions about the price negotiation and purchasing system in Thailand. It was explained that price negotiation is done at the central level, which allows the NHSO to wield significant negotiating power. Hospitals then purchase at the local level, but at the recommended price that is communicated by NHSO after negotiations with industry. NHSO will only reimburse their recommended price. Hospitals must pay the difference if they choose to purchase items above their recommended price (e.g. for banded versions, or from a more expensive provider etc.). This allows NHSO another means to control its financial outgoings.

The mechanisms to ensure service provision in rural areas were then discussed. In Thailand, financial incentives were given to trained health professionals to work in rural areas. However this has posed challenges later in time, as it is difficult to reduce or discontinue incentives which can place a long-run financial burden on healthcare. Thailand also used financial incentive mechanisms to tackle the problem of dual-practice by healthcare professionals.

The delegation then visited the NHSO's call centre and learned how it acts as a key grievance redressal mechanism for the UCS. The contact number is widely advertised to the general public and provides a 24 hour service. The public contact the number to ask queries regarding their scheme coverage and eligibility, ask what facility they are registered to, and to report instances of malpractice such as hospitals charging patients for items that are covered under UHC.

Lastly at NHSO Ms. Waranya RattanaVIPapong, Researcher at HITAP, presented about the role of HTA in setting priorities in Thailand (Presentation included in Appendix 4). It was explained how Health Technologies Assessments are performed for all high cost drugs or medical interventions to assess whether they should be included in the benefit package. Factors considered in a typical HTA include effectiveness, safety, cost-effectiveness, budget impact and social, ethical and institutional priorities. HTAs are also a useful tool as they uncover the price at which an intervention ceases to be 'cost-effective' to reimburse, and can provide strong bargaining tool to enter price negotiations with industry.

Methods and guidelines have been established for the conduct of HTAs. These ensure standardization in the quality of studies, and that studies undertake rigorous stakeholder engagement. Stakeholder engagement ensures that the most important topics are identified for review and all relevant aspects of the question are captured within the assessment.

Visit to HITAP

In the afternoon, the team travelled to HITAP located in the Ministry of Public Health, Thailand. Here they heard from Mrs. Netnapis Suchonwanich about price negotiation, primary care structures and implementation challenges regarding the HMIS systems required to successfully enroll patients, track care, and manage and reimburse claims (Presentation included in Appendix 4).

Mrs. Netnapis spoke further about how central price negotiation and central procurement of many medicines utilizes bargaining power and economies of scale. For material reimbursements there is an online tracking system to monitor where requests have got to.

Registered primary care providers was discussed further and it was shared how patients can go directly to the primary care facility or main contractor in rural areas where travelling distances can be long. Quality of care is ensured through a strong accreditation system in Thailand as standards are required for provider registration.

The fund management system was then discussed emphasizing the importance of data and monitoring and evaluation. NHSO collects routine services data, hospital profile data, beneficiary registration data, medical records, and financial accounting data. Data required for annual budget planning includes demographic data, economic data, geographic and epidemiologic data, health service utilization rates, health provider registration data and beneficiary registration data. From this data, capitation per person per year and fund allocations can be made. Data is used to define DRG groupings, for data validation and to assign relative weightings. However it was stressed that there must be a continuous monitoring and evaluation process so that the payments and weightings can be constantly revised and improved for accuracy. The e-claims process is also done digitally with electronic invoices and payments done online.

These systems required huge investments in software and hardware but allowed the time for reimbursement of claims to reduce from over a month to just three days. e-Financial tracking follows claim processing, accounting and payments. There was also recognition that systems must carefully protect the data that is handled.

The delegates were keen to know how the NHSO established the HMIS systems at the start of UHC. It was shared how experts were brought from different ministries and universities to advise the small NHSO team. The team identified what information was needed and made a proposal for the IT system requirements. The success of the system depended on the political commitment to provide the investment. For initial patient identification, the government allowed significant information interchange in the Ministry of Public Health and with the Ministry of Interior. All health data is now stored on a smart card that uses pin-code, not biometric data. Birth and death data, as well as health insurance data is shared between the NHSO and Ministry of Interior on a daily basis to keep enrollment lists accurate and up-to-date.

NHSO has a unique position of purchaser which can cause groups to claim existence of corruption however, to date, these groups have never been successful as NHSO can provide strong and transparent data on all its transactions and processes.

The day was concluded with a brief discussion of the HITAP International Unit's work in the region. This includes provision of support to HTA capacity building and also broader health systems strengthening initiatives.

Next steps

Time constraints meant that it was not possible to cover all aspects of UHC implementation and the associated challenges in detail. The delegation from Chhattisgarh was requested to reflect on their specific priorities for learning and communicate areas of interest or suggestions for further engagements to HITAP. HITAP can then organize such knowledge exchange to occur, liaising with other partners within the Ministry of Health where appropriate.

Appendix

1. Agenda 30th January, 2019

AGENDA



Chhattisgarh, India, State Delegation Visit to Thailand:

Understanding Thailand's Strategy for Achieving Universal Health Coverage

Wednesday, 30 January 2019

Time	Session	Speaker(s) / Facilitator(s)
Venue: Meeting Room 202, National Health Security Office (NHSO) Office		
9:00 – 9:15	Welcome address and introduction	MD. Prachaksvich Lebnak, NHSO
9:15 – 10:45	Universal Health Coverage (UHC) in Thailand and management of UC scheme by NHSO ("Thailand UHC & UCS for Informal Sector")	MD. Porntep Chotchaisuwattana, NHSO
10:45 – 11:15	Tour of NHSO's call centre	Ms. Pensom Pengsombat, NHSO
11:15 – 12:00	Role of HTA in setting priorities in Thailand	Ms. Waranya Rattanavipapong, HITAP
12:00 – 14:00	Lunch*	Indian Delegation, NHSO, HITAP, and others
Venue: Meeting Room 2, Health Intervention and Technology Assessment Program (HITAP) Office, Ministry of Public Health		
14:00 – 14:30	Reflections and moving forward: Priorities in Chhattisgarh	Indian Delegation
14:30 – 15:30	Implementation of UCS: key issues	Mrs. Netnapis Suchonwanich, HITAP
15:40 – 17:00	Use of evidence informed decision making for healthcare in Asia	Ms. Juliet Eames, HITAP

* Lunch: Location: **Tewa Restaurant** (131/3 M.4 Soi Chaengwattana 13 Chaengwattana Road Thungsonghong Laksi Bangkok 10210 Thailand, Tel: 0-2982-8151-3)

Link: <https://1drv.ms/b/s!AgWIO9PqiPQogpwrKji-TR1yT6flnA>

2. Participants

Dinner meeting

Delegation from Chhattisgarh, India

1. Dr. T S Singh Deo, Minister for Health, Chhattisgarh state, India
2. Mrs. Niharika Barik Singh, Secretary Health, Chhattisgarh state, India
3. Mr. R Prasanna, Commissioner Health, Chhattisgarh state, India
4. Dr. Yogesh Jain, Health Specialist, Chhattisgarh state, India
5. Mr. Vijendra Katare, Addl CEO State Insurance Agency
6. Mr. Neelabh Dubey, Advisor to the Minister, Chhattisgarh state, India
7. Mr. Aadityeshwar Singh Deo, Advisor to the Minister, Chhattisgarh state, India

Delegation from Thailand

1. Dr. Suwit Wibulpolprasert, Former Deputy Permanent Secretary and Senior Advisor, Thailand Ministry of Public Health
2. Dr. Somsak Chunharus, President of National Health Foundation (NHF) and Former Deputy Minister of Health for Thailand
3. Dr. Yot Teerawattananon, founding leader of the Health Intervention and Technology Assessment Program (HITAP)
4. Dr. Wanrudee Isaranuwachai, Senior researcher at the Health Intervention and Technology Assessment Program (HITAP) and Assistant Professor at the Institute of Health Policy, Management and Evaluation (IHPE) | University of Toronto
5. Ms. Saudamini Dabak, Manager, HITAP International Unit (HIU)
6. Mr. TaeYoung Kim, International Cooperation Officer, Health Intervention and Technology Assessment Program (HITAP)
7. Ms. Juliet Eames, Project Associate/ODI Fellow at HITAP International Unit (HIU)
8. Ms. Pornpimon Sawatdang, HITAP International Unit (HIU) Coordinator
9. Dr. Yashika Chugh, Intern at Health Intervention and Technology Assessment Program (HITAP) and MPH Student at PGIMER, Chandigarh, India

Visit to NHSO and HITAP
Delegation from Chhattisgarh, India

Mr. T S Singh Deo (Minister of Health)
Mrs. Niharika Barik Singh (Secretary Health)
Mr. R Prasanna (Commissioner Health)
Dr. Yogesh Jain (Health Specialist)
Mr. Vijendra Katare (Addl CEO State Insurance Agency)
Mr. Neelabh Dubey (Advisor to the Minister)
Mr. Aadityeshwar Singh Deo (Advisor to the Minister)

National Health Security Office (NHSO)

D. Prachaksvich Lebnak (DepMuty Secretary-general)
MD. Kanitsorn Sumriddetchkajorn (Director, Bureau of International Affairs on UHC)
MD. Porntep Chotchaisuwattana (Director, Bureau of Planning and Budget Administration)
Mrs. Wilailuk Wisasa (Manager, Bureau of International Affairs on UHC)
Dr. Nantawan Kesthom (Manager, Bureau of Planning and Budget Administration)
Ms. Pensom Pongsombat (Section Head, Bureau of Policy and Strategy Development)

Health Intervention and Technology Assessment Program (HITAP)

Dr. Yot Teerawattananon (Secretary General and Senior Researcher)
Ms. Netnapis Suchonwanich (Advisor)
Dr. Wanrudee Isaranuwatthai (Senior Researcher)
Ms. Saudamini Dabak (Manager)
Ms. Waranya Rattanavipapong (Researcher)
Ms. Juliet Eames (Project Associate/ODI Fellow)
Mr. TaeYoung Kim (International Cooperation Officer)
Dr. Yashika Chugh (Intern)

3. Biographies of senior Thai attendees and Speakers

Dr. Suwit Wibulpolprasert is a general practitioner, a public health specialist, an administrator and a policy advocator. He began his career as a director and a practitioner in four rural district hospitals in Thailand from 1977 to 1985. He then held senior positions within the Thai civil service throughout Thailand's health reforms including Director of Technical Division of the FDA, Director of Bureau of Health Policy and Planning, Deputy Permanent Secretary and Senior Advisor at the Thai Ministry of Public Health, before retiring in 2013.

Dr. Somsak Chunharas served as Deputy Minister of Public Health from 2014–2015 and is currently the President of the National Health Foundation of Thailand, a key institute spearheading research on Thai health priorities. Dr. Somsak Chunharas has also been a member of numerous national and international health committees and advisory boards.

Dr. Yot Teerawattananon is a medical doctor and health economist and is a founding leader of the Health Intervention and Technology Assessment Program (HITAP), a semi-autonomous health technology assessment agency. In addition, he provides technical advice on global health to many national and international agencies.

Dr. Wanrudee Isaranuwatthai is a Senior Researcher at the Health Intervention and Technology Assessment Program, Ministry of Public Health, Thailand. She is also a Research Scientist and Director of the Centre for Excellence in Economic Analysis Research at St. Michael's Hospital in Toronto, and Assistant Professor at the Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health, University of Toronto.

Dr. Prachaksvich Lebnak is a medical doctor and the Deputy Secretary General of the National Health Security Office (NHSO). He previously held roles as the Deputy Secretary

General at the National Health Commission Office and at the National Institute of Emergency Medicine.

Dr. Porntep Chotchaisuwattana is the Director or Bureau of Planning and Budget Administration at the National Health Security Office (NHSO).

Waranya RattanaVIPapong joined the Health Intervention and Technology Assessment Program (HITAP) as a Researcher working on Economic Evaluations in February 2010. Waranya has been involved in numerous research projects to support national and international policy making.

Mrs. Netnapis Suchonwanich is a Senior Advisor at the Health Intervention and Technology Assessment Program (HITAP) and sits on the National Essential Drugs subcommittee. Mrs. Netnapis previously held roles of Director of Bureau of Information and Technology Management and Deputy Secretary-General of the National Health Security Office (NHSO).

4. Presentation slides

Link:

<https://onedrive.live.com/?authkey=%21AOoMG7jV834lmFE&id=28F488EAD33B8905%2136047&cid=28F488EAD33B8905>