

# Hospital sector responses to external and internal environments in the 2000s: Thailand case study

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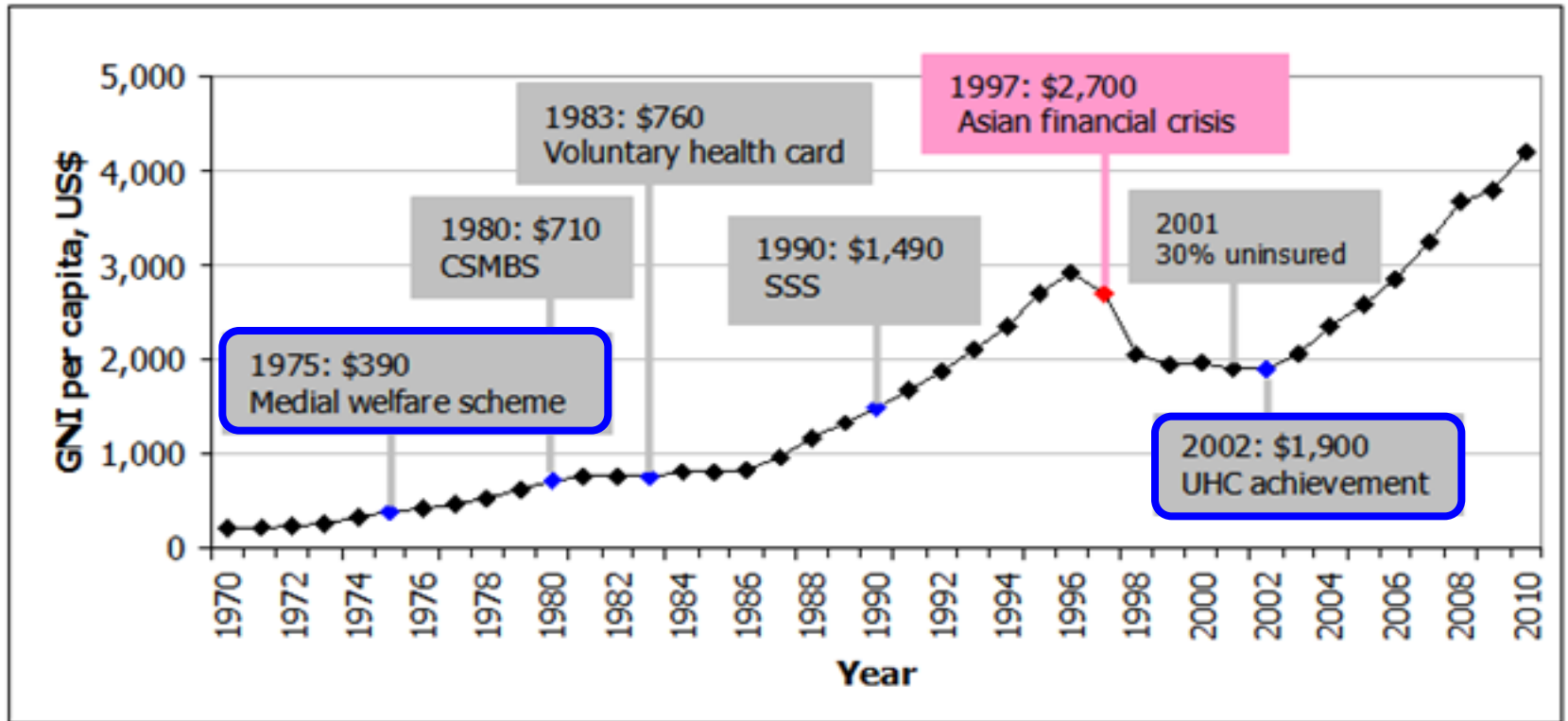
December 11, 2013  
Regency Hotel, Singapore

# Country profiles: Thailand



- Population - 67 million
- GNI 2011 US\$4,440 per capita, Gini 40
- Fiscal space: tax to GDP 17.6 (2011)
- Total Health Expenditure (2010NHA)
  - US\$194 per capita, 3.9% GDP,
  - Sources of finance: Public 65%, SHI 8%, Private 25%, OOP 14% of THE,
    - GGHE 13.1% GGE
- Health status
  - Total fertility rate 1.6 (2010)
  - Life expectancy at birth 74.1 years
  - U5MR 14/1000
  - MMR 48/100,000
- Physicians per capita 4/10,000
- ANC & hospital delivery 99-100% (2009)

# Trajectory toward UHC: 1970-2010



**1975**  
**Medical welfare scheme**  
**For the poor**



**2002, UHC**

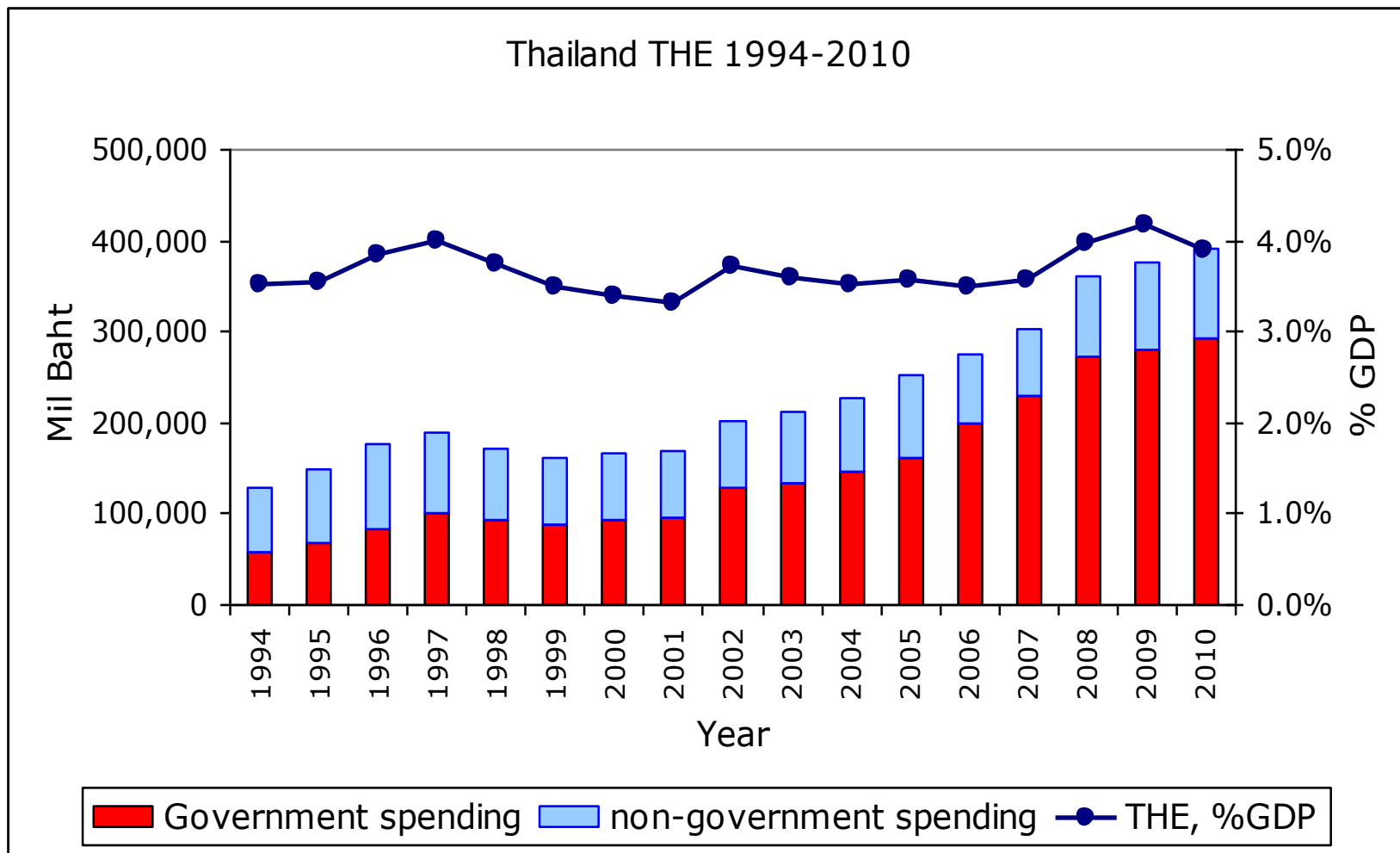
- UC scheme 75% of pop
- Social Security 15%
- Civil Servant 9%

Note: CSMBS: civil servant medical benefit scheme, SSS: social security scheme

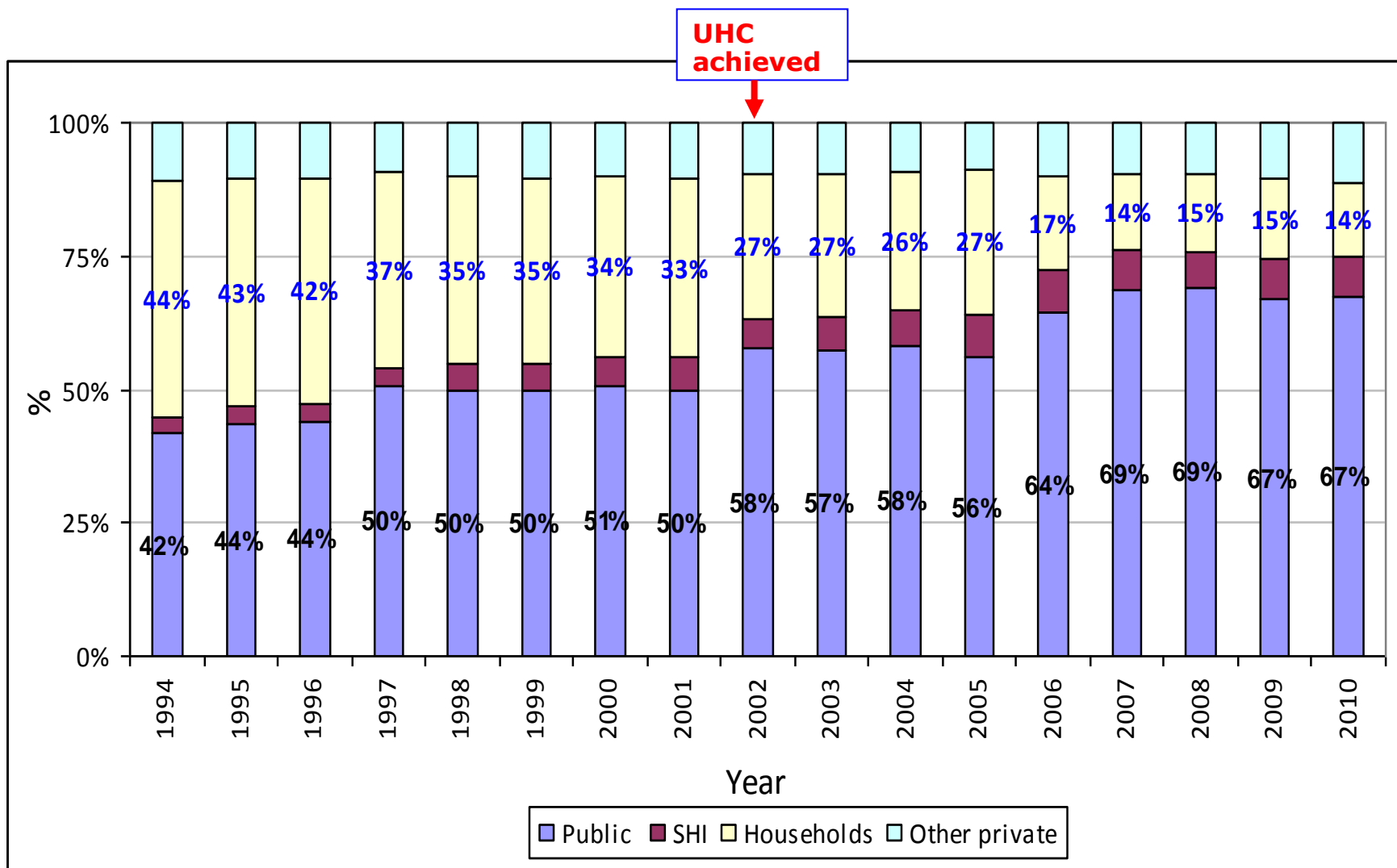
# Three schemes cover entire population

	<b>UC Scheme</b>	<b>Social Security Scheme</b>	<b>Civil Servant Scheme</b>
1. Established	2002	1990	1980
2. Managed by	National Health Security Office	Social Security Office	Ministry of Finance
3. Population coverage	Who are not covered by the other two schemes (75% of pop)	Private sector employees (15% of pop)	Government employees plus dependants (9% of pop)
4. Source of finance	General tax	Tripartite contribution (1.5% of salary)	General tax
5. Provider payment	OP: Capitation IP: DRG + global budget	OP+IP: capitation	OP: FFS IP: DRG
6. Expenditure per year, 2011	2,900 Baht/person or <b>97 USD/person</b>	~2,134 Baht/person or <b>71 USD/person</b>	~11,000 Baht/person or <b>366 UDS/person</b>

# Total health expenditure, % GDP 1994-2010

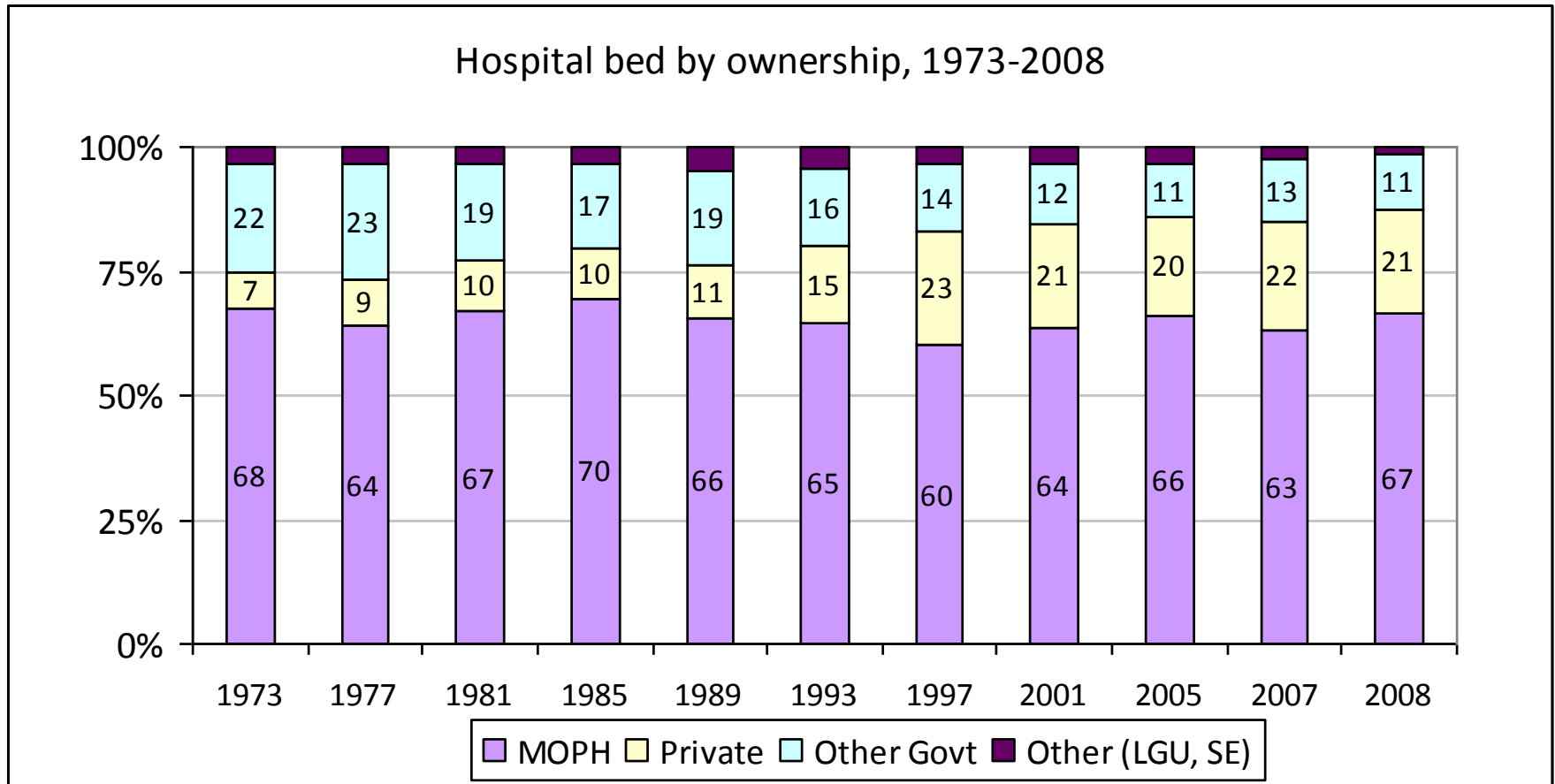


# Source of finance 1994-2010



# I. Hospital sector profiles

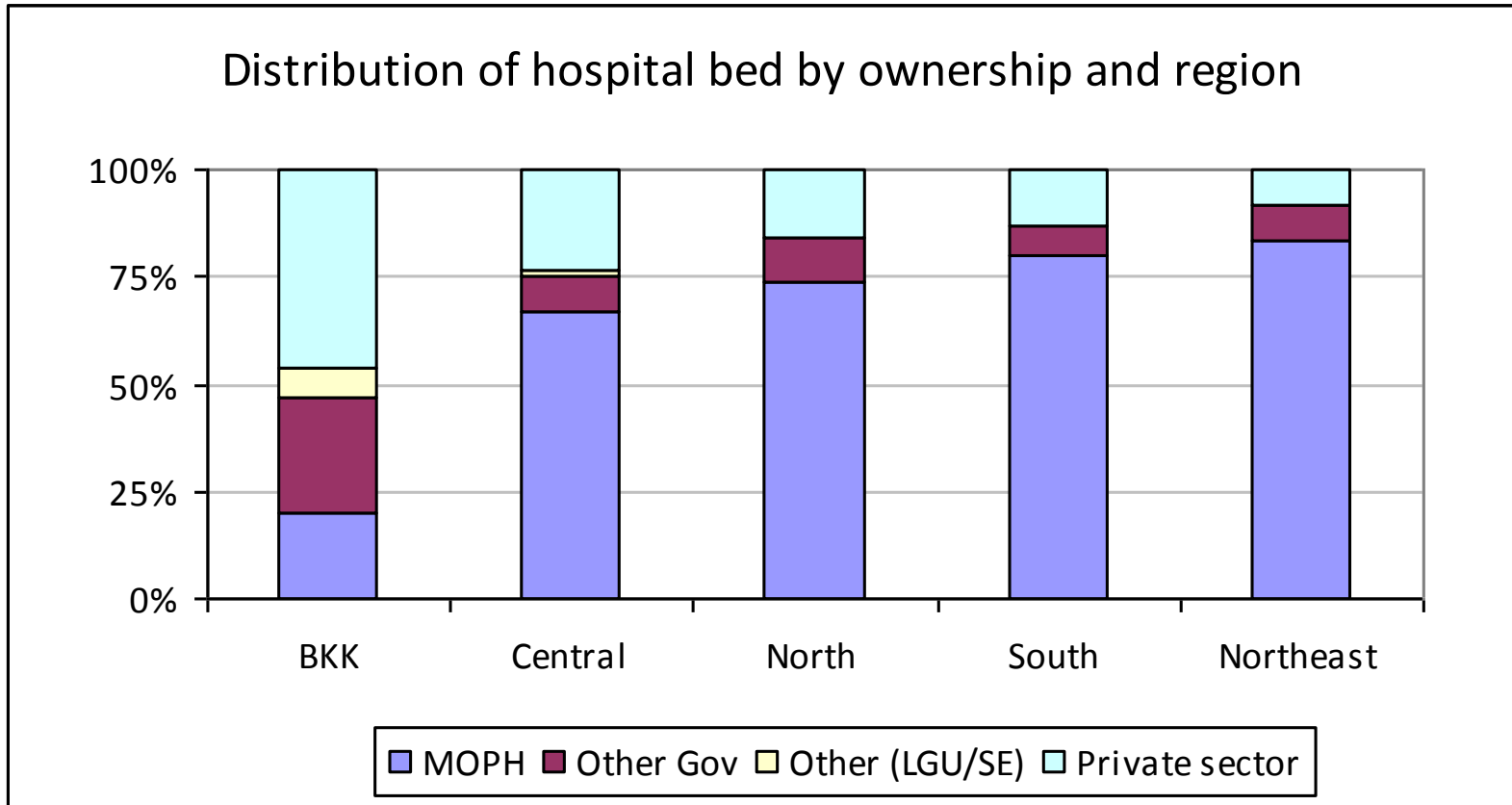
# Public and private hospital bed shares 1973-2008



**Key message:** Public hospital dominant role: 75% of total 1310 hosp (2009), bed share 79% of total. Private shares 25% and 21% of hospitals and beds, no significant changes in proportion for the last decade

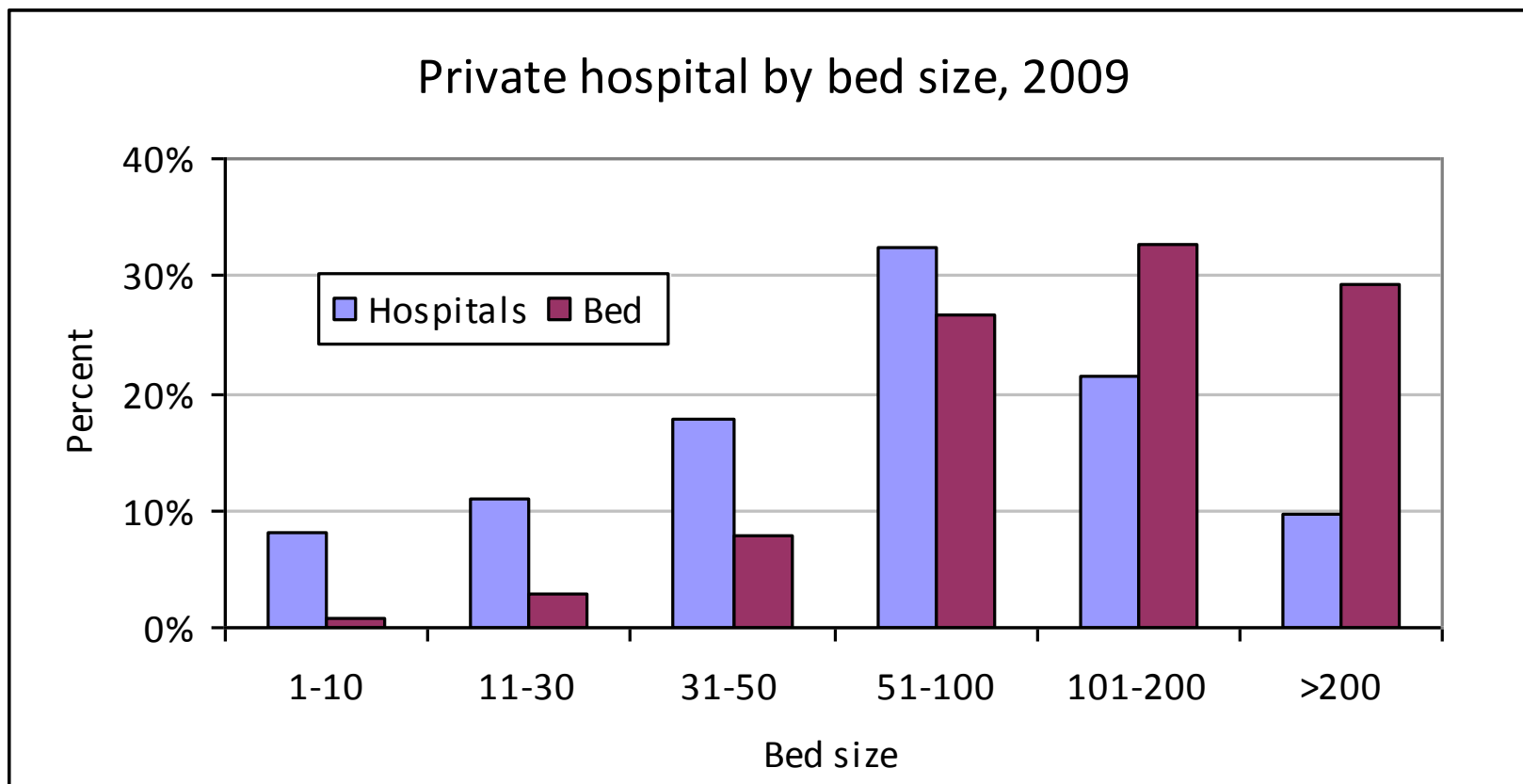


# Hospital bed share by ownership and geographical region, 2009



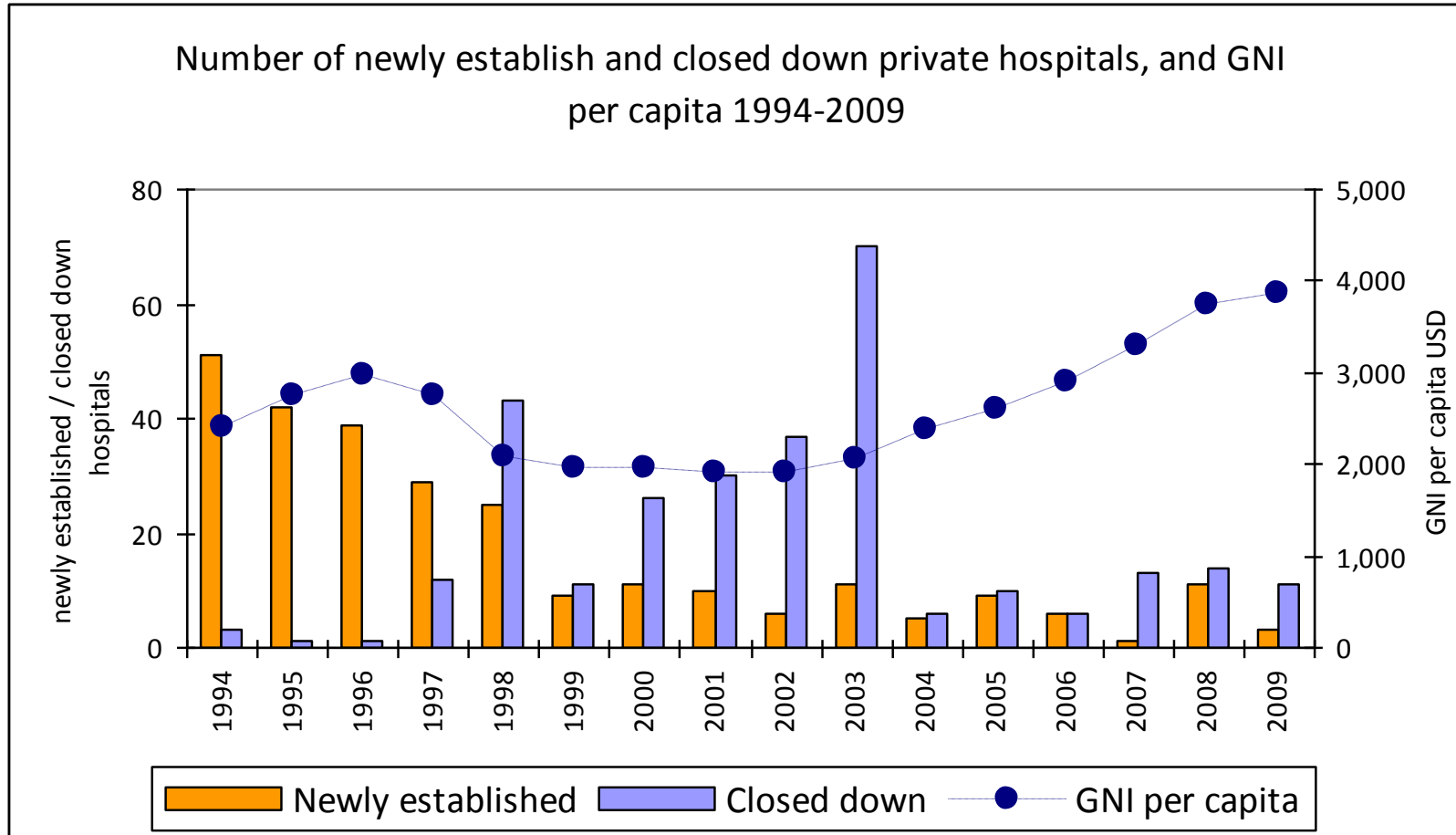
**Key message:** MOPH major share outside Bangkok, especially the poorest and poor NE, S and N region. Private concentrates in Bangkok and urban cities

# Private hospital sector by bed size, 2009



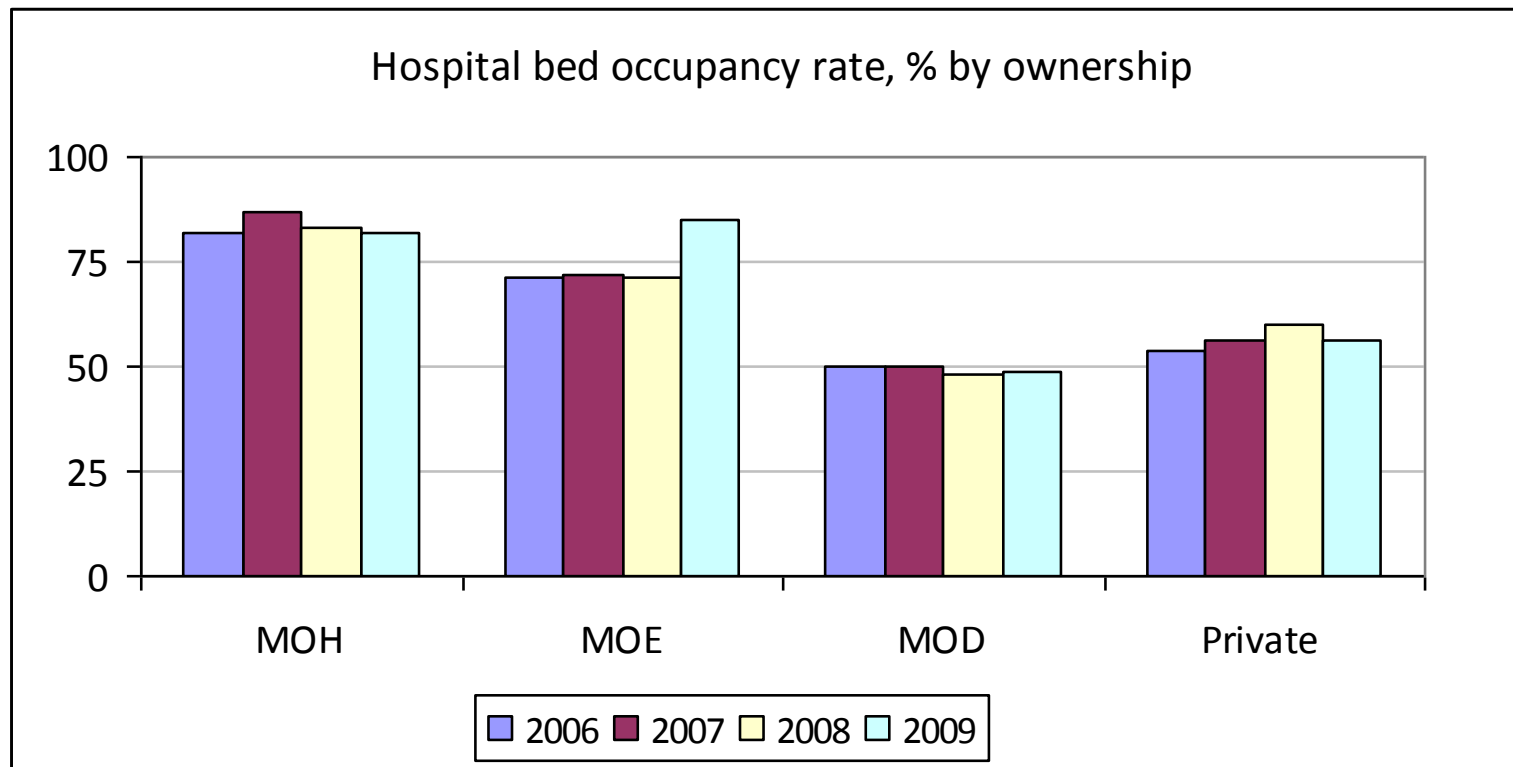
**Key message:** Private hospitals are small size, 69% < 100 beds, large hospitals form into chain, registered in Stock Market offering services to international patients (medical hub), private not for profit charity run hospital has negligible role.

# Private hospitals: newly established and closure 1994-2009



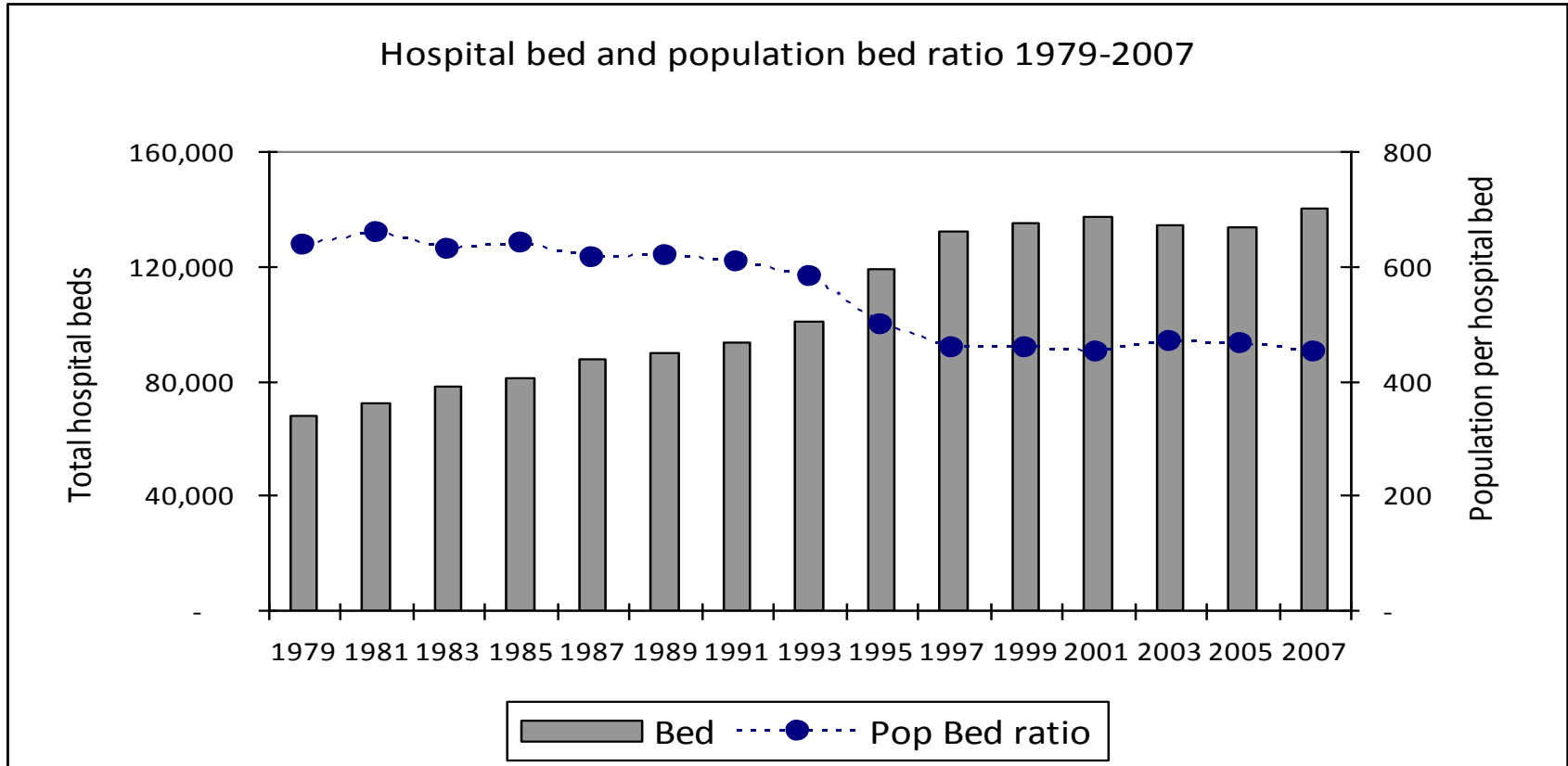
**Key message:** cyclical boom and bust, 40 newly established per annum (1994-97), only 9 new but 23 closure per year between 1998 and 2009 were noted.

# Bed occupancy rate by ownership, 2006-2009



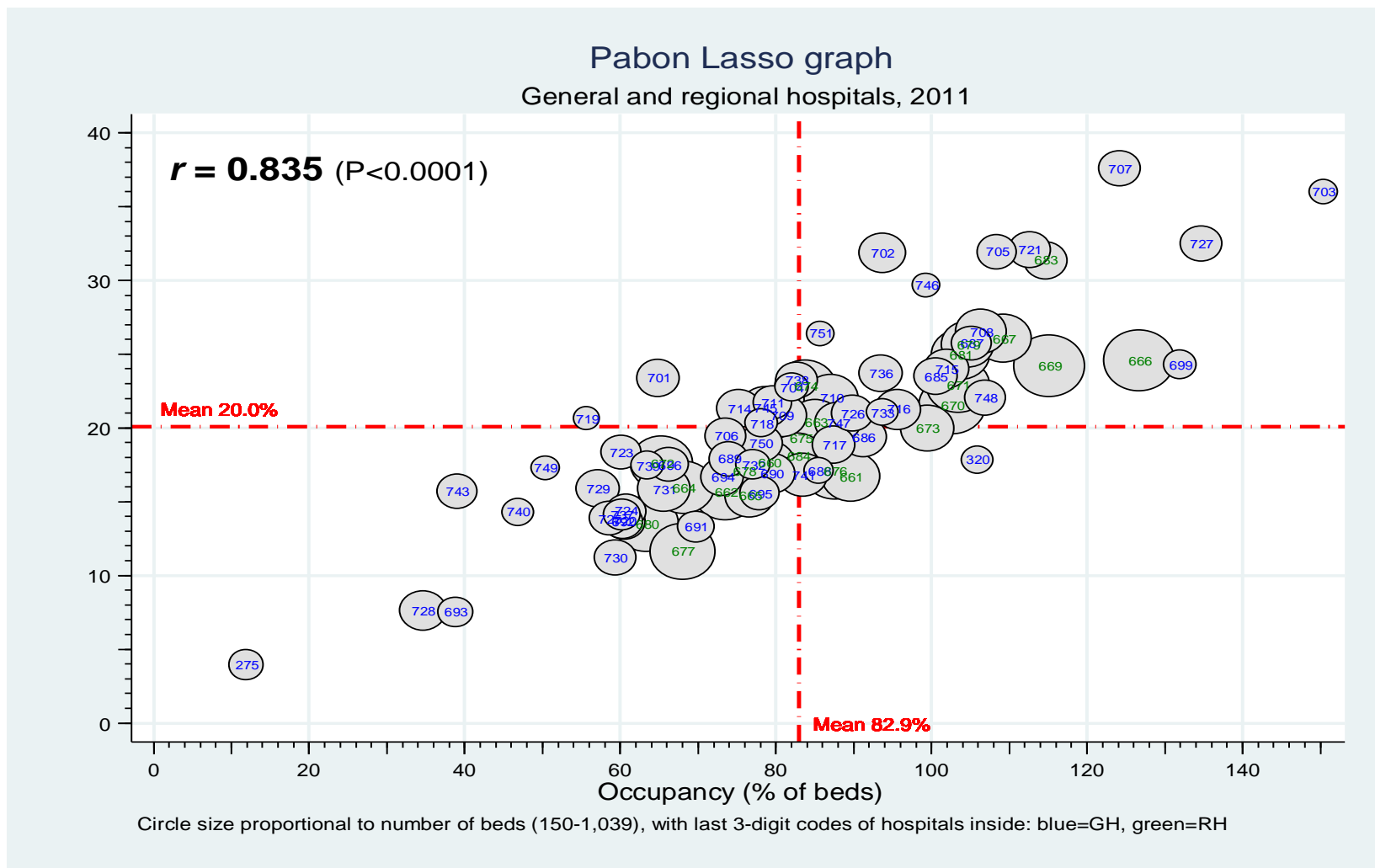
**Key message:** MOPH hospitals had higher bed occupancy rate (80%) than others (Ministry of Education and Defence); private had occupancy rate slightly higher than 50%

# Total hospital beds and population per bed ratio: 1979-2002



**Key message:** MOPH district hospital beds expansion, (esp. 1993-2000), insignificant bed expansion of other public and private hospitals (after 1998); the population bed ratio improved to around 450 people per bed in 2002, and saturated.

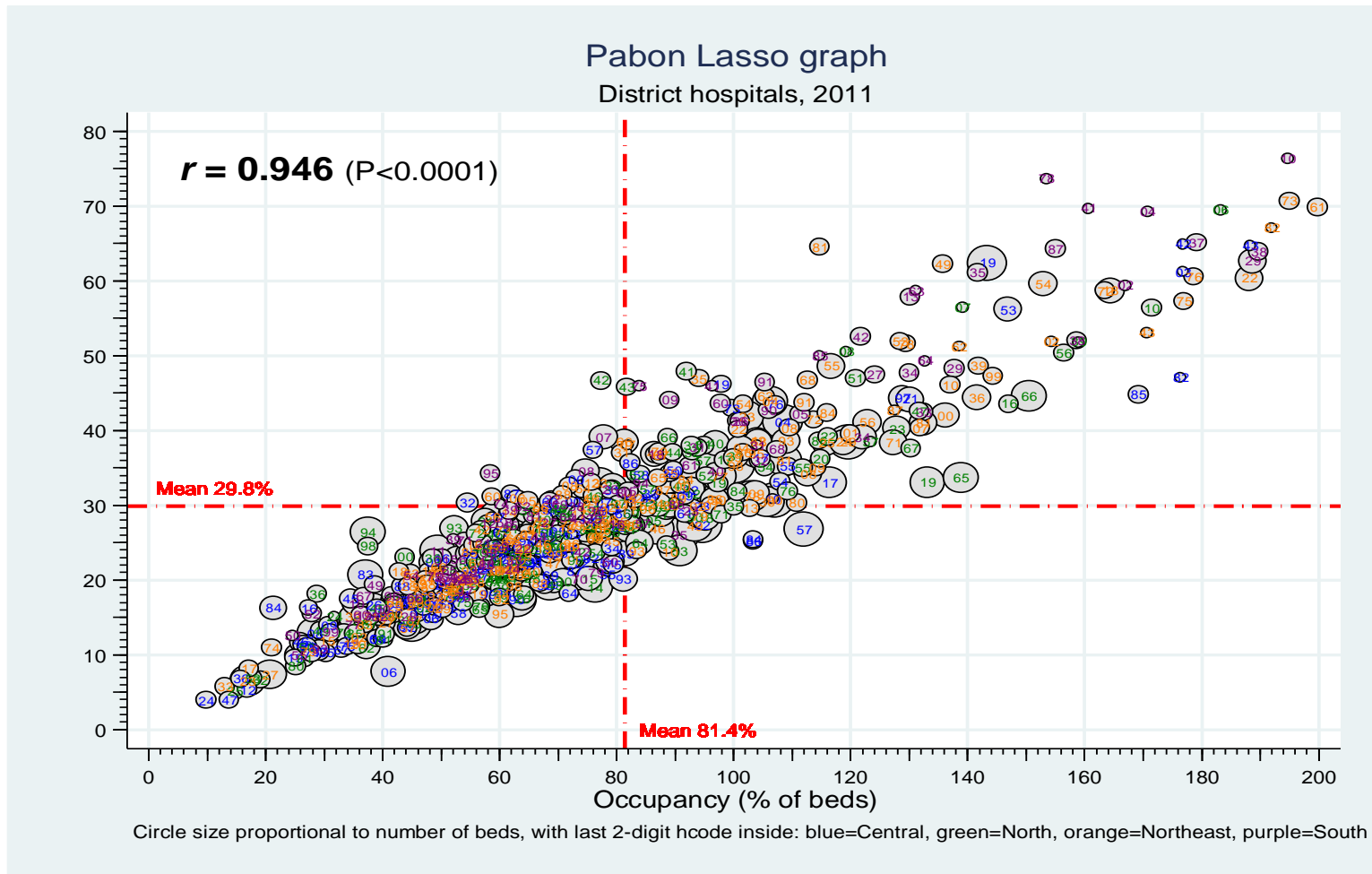
# Bed occupancy VS turn over rate: general and regional hospitals, 2011



**Note:** Average LOS, General Hospital 4.1, Regional Hosp 4.6 days

# Bed occupancy VS turn over rate: district hosp. 2011

## LOS 2.7 days



**Key message:** more concentrated in less efficient left lower quadrants, policy to ensure equitable access to care by all citizens no matter where they live, island, mountainous and hard to reach areas with sparse population. A district hosp is there. 15

## II. Key reforms in 2000s affecting public hospitals and their responses



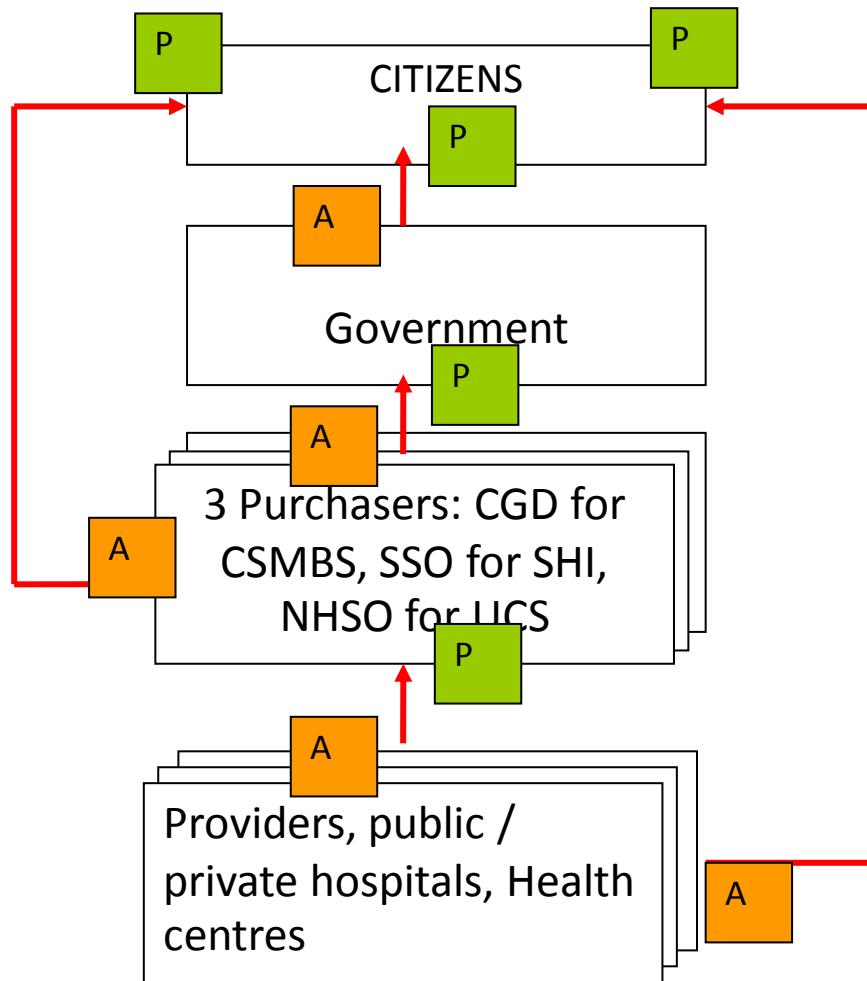
# I. Universal coverage scheme 2002

- Purchaser-provider split contract model by all 3 insurance schemes
  - NHSO, SSO and CGD purchase services from public and private contractor providers
  - Supply side financing to public hospitals terminated, all earn revenue from services offered to insurance scheme
    - Furnish an accountability framework: Government VS purchaser VS providers VS patients/population
    - Small proportion of OOP, 14% THE pushes hospitals more accountable to purchasers and patients.

# I. Universal coverage scheme 2002

- Closed end payment
  - Age adjusted capitation for OP services to the registered catchment population
    - Improved efficiency, use of generic medicines, rational prescription
    - Increased focus on prevention and health promotion, better control of chronic NCD, home visit for chronic
    - Increased responsiveness and improved accountability to population served.
  - Provincial collective bargaining, bidding for lowest price given assured quality of certain common items result in cost saving

# Principal Agent relations



A: Agent

P: principal

## I. Universal coverage scheme 2002

- District health system (DH + HCs) main contractor provider for OP, prevention and promotion
  - Better coordination and service integration between DH and HC especially NCD care
    - Supply of medicines and others at HC was managed by DH,
    - Once a week visit by MD to health centres
    - Same medicines used at HC/DH builds trust and confidence to patients on quality service
- DHS as primary care fund holder
  - Bypassing are liable for full payment by patients
  - Improved efficiency, rational use of service by level of care
  - Foster effective referral

# I. Universal coverage scheme 2002

- DRG and global budget for IP payment
  - Increased completeness/accuracy hospital discharge summaries, ICD10,
  - On site audit by NHSO auditors: money back from over-coded, additional money to under-coded hospitals are mutual accountability between purchaser and providers
- NHSO unbundling certain intervention with long waiting list, outsource to competent private hospitals
  - Stimulate healthy competition, improve hospital efficiency, performance to address long waiting time.

## II Quality assurance and accreditation

- Hosp Accreditation Program
  - 1997: locally initiated as R&D Project hosted by HSRI
    - Concept: accreditation as educational and learning processes, not inspection, based on self-assessment + external peer reviews with positive attitude and approach.
  - 1997-2008: a decade of learning and form a critical mass
  - 2009: Healthcare Accreditation Institute Public Organization (HAI)
    - Established under the Public Organization Act BE 2542 (1999).
    - HAI: national agency for healthcare accreditation.
    - HAI has been accredited by the International Society for Quality in Healthcare according to its healthcare standards in 2013; reflecting HAI international recognition

## II Quality assurance and accreditation

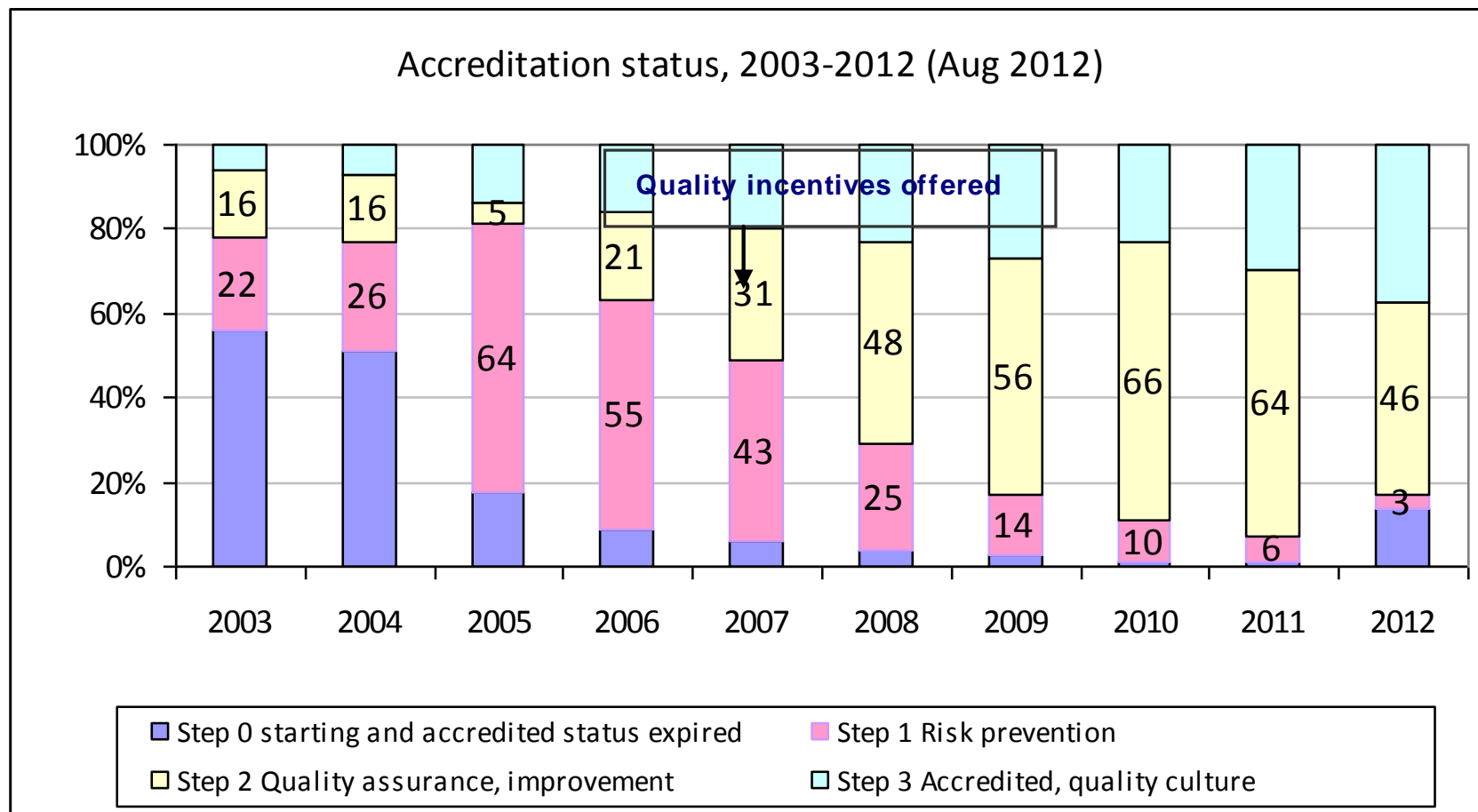
- Public private hospital responded in a positive way
  - Incentive to enhance quality of care, minimize adverse event, risk management, trust and confidence by patients
- Quality status: not a pre-requisite for NHSO and SSO enter into contractual agreements,
  - Certain geographical monopoly DHS,
    - Impossible for NHSO not to contract the only provider in the district.
  - Positive approach, financial incentive found effective
    - 2002: NHSO recognized a stepwise recognition program.
    - 2007: NHSO offered financial incentives to different level of quality status (Step 1, 2 and 3).
    - 2008: SSO offered financial incentive in favour step 2 and 3.

## II Quality assurance and accreditation

- HAI in international accreditation context
  - International standards systems (ISO) influence quality improvement in specific component:
    - Quality Management System (ISO 9001), Environmental (ISO 14001), Laboratory (ISO 17025), Quality of Medical Laboratory (ISO 15189), Information Security (ISO 27001), Business Continuity (ISO 22301), and Occupational Health and Safety (BS OHSAS 18001).
  - Also 18 private hospitals accredited by Joint Commission International (2013).



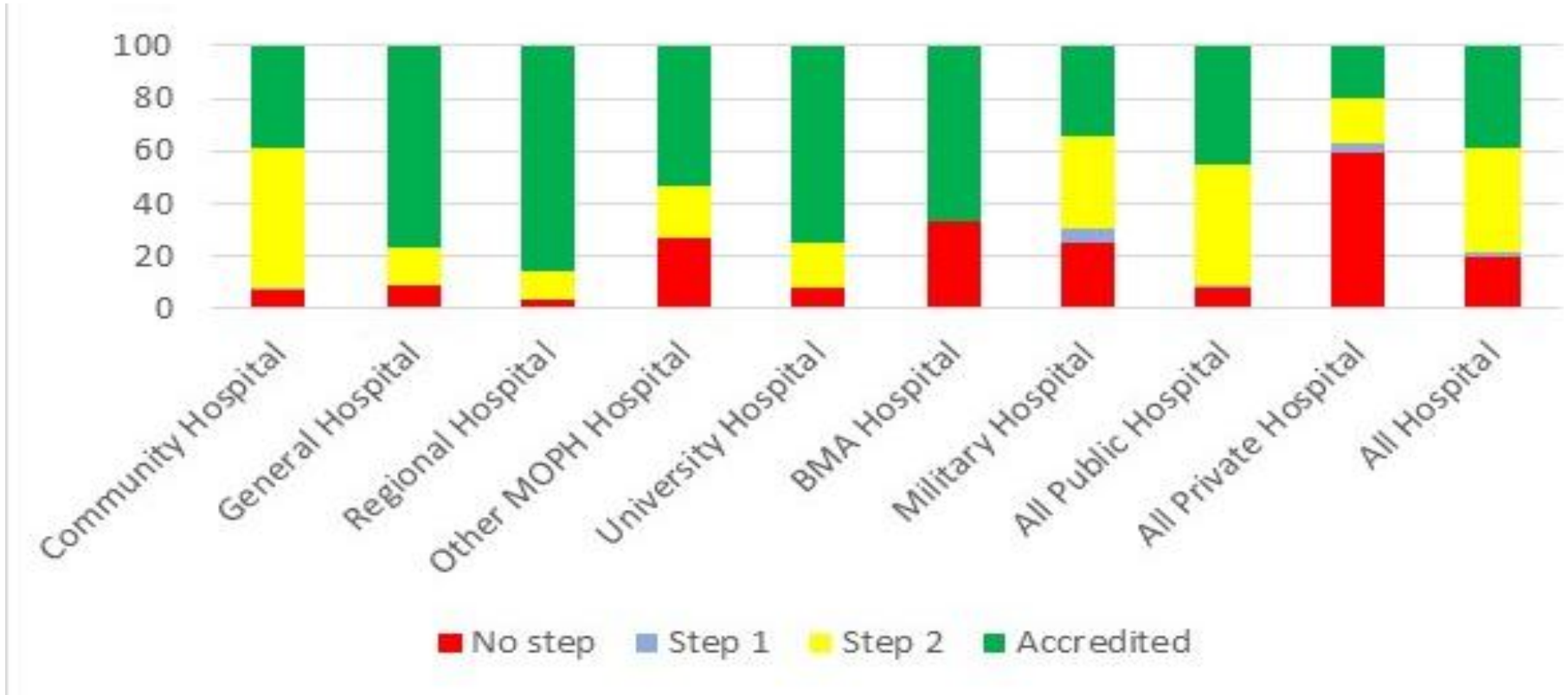
## II Quality assurance and accreditation



**Note:** Rapid transition from step 1 to 2 after 2007 quality incentives offered by NHSO. Note an increase in step 0 from 1% in 2011 to 14% in 2012 was the effect of hospitals with accreditation status expired after 3 years and not yet re-accredited.

# II Quality assurance and accreditation

## Hospital status by level of recognition: 2013



**Note:** Step one: systems for risk preventions were installed; step two: quality assurance and quality improvement were in place; and step three: an accreditation or re-accreditation every three years. **In 2013, full accredited hospitals has increased to 40.6% of total hospitals nationwide**

### III. Hospital Governance Structure and Function

- Study conducted in 4 MOPH hospitals
  - One regional, two general and one district hospital, purposively selected for in-depth interviews of key informants on site,
  - KI are senior management team, rep from ancillary and clinical services, hospital management committee.
  - total of 32, 21, 18 and 18 key informants were interviewed through group discussion
  - Several common patterns emerged on hospital governance features

# Hospital Governance Structure and Function

- MOPH policies were centralized
  - At hospital, decisions are made at the operational level,
    - Improve service efficiency, quality and sustain trust and supports from communities they served.
    - Financial resources generated from providing services to 3 schemes, and OOP were kept as hospital revenue
      - Use is governed by MOPH rules and regulation; Subject to external audit by the Auditor General [monthly financial audit, on-site sample audits].
      - Procurement of medicines and supplies was governed by related rules, regulation and procedures.
- Contract signing:
  - Annual contract was legally signed between NHSO and MOPH,
    - Contractor provider / hospitals did not have corporate status.
    - But, NHSO transfers OP capitation directly to contractor network and disburses IP claims based on DRG system; not via MOPH

# Hospital Governance Structure and Function

- Accountability framework, very clearly developed and emerged in all sample hospitals
  - Hospitals are financially accountable to three purchasers, subject to audits by purchasers.
  - Hospitals accountable to the MOPH for priority national policies and public health function, subject to programmatic supervision by MOPH Inspector General.
  - Hospitals accountable to the population they served, through the influence of purchaser organizations and professional adherence to the Declaration of Patients Rights

# Hospital Governance Structure and Function

- All hospitals appoint a management board,
  - Represented by key departments, though lay people from community is not common.
  - Provincial hospital director, appointed by MOPH from a roster of executives, trained in certified courses, serves 4-5 year and rotation across hospitals are common,
  - Other staffs in hosp board stayed longer and more knowledgeable about organization culture.
    - Contribute more to the function of hospitals if mobilized well be director.

# Hospital Governance Structure and Function

- All hospitals have a standard procedure of personnel management:
  - Quantitative scoring of the assessment of staff performance and achievement for annual salary scale adjustment;
    - Based on merit, participatory and transparency.
- All hospitals have adequate management capacities:
  - Well advance IT and information systems,
    - Some are fully computerized facilitate prompt services, laboratory, pharmacy and appointment.

# Hospital Governance Structure and Function

- All hospitals in different steps of accreditation,
  - Some got full accreditation and re-accredited.
  - Not all hospitals have effective systems of conflict resolution between patients and professionals.
  - Hospitals are not working in isolation, they affiliated with health centres in their network and offer full support, as mandated by NHSO UCS.



# Hospital Governance Structure and Function

- All hospitals have adequate technical capacities,
  - Full board of specialists in regional, general hosp,
  - District hospital has only general doctors,
  - Equipment and facilities are adequate according to requirement by level.
  - Clear professional ethics and service minds, responsiveness and prompt attention are much improved.

# Conclusions

- External policies in the 2000s affected public (and private) hospitals in responses to improve internal governance functions and mechanism to respond to these external influences and also improved responsiveness to the communities and patients they served.
- Technical and clinical capacities are key foundation for these positive responses.

Thank you for your attention  
Welcome comments and suggestions