



# Examples on how quality of care contributes to the success of UHC in Thailand

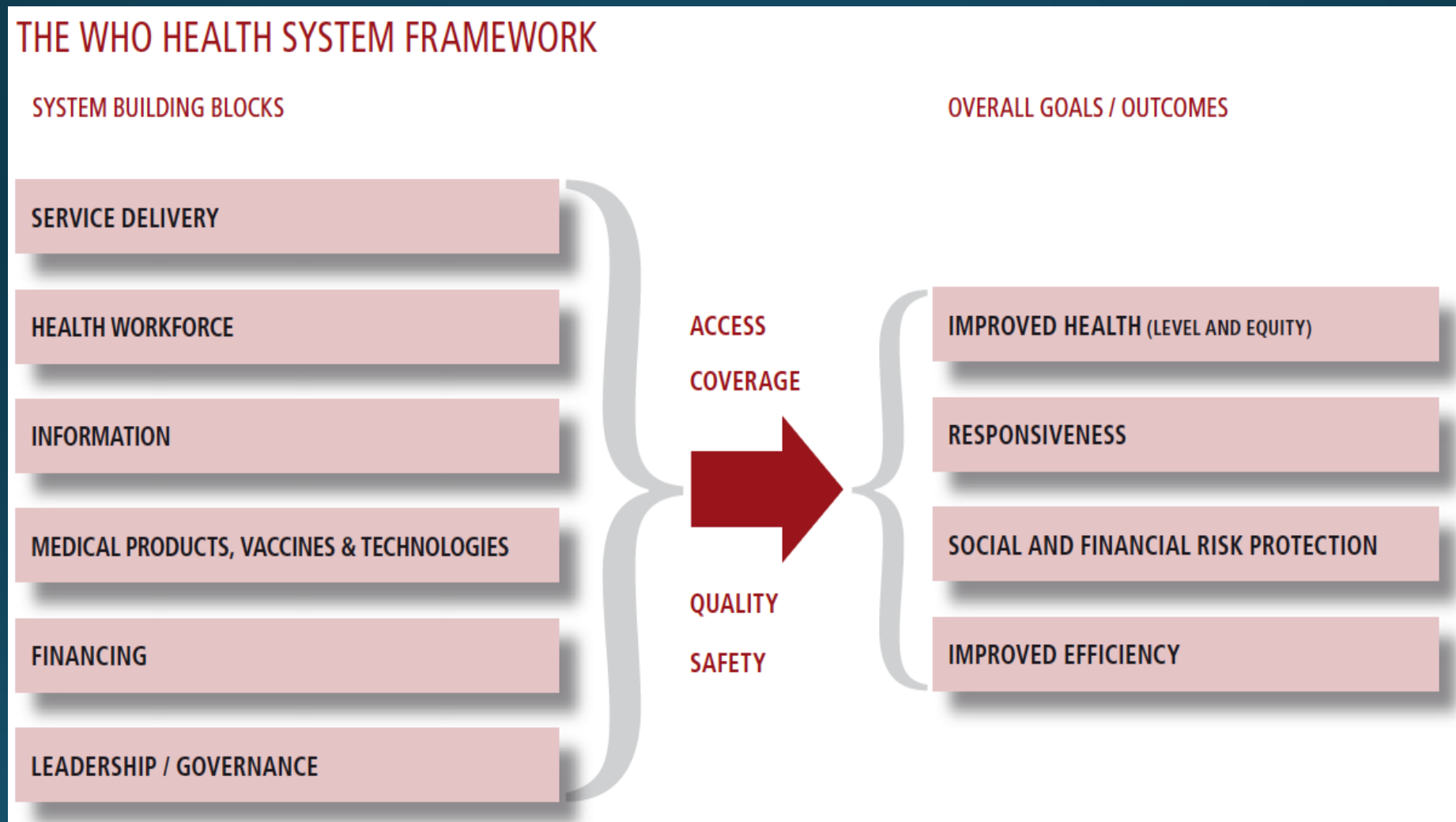
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# Financing (e.g. UHC) alone is not enough for achieving the goals of our health system





**Effective coverage**

To what extent are services satisfactory from a safety and quality perspective?

**Contact coverage**

To what extent are services being used?

**Acceptability coverage**

To what extent are services affordable and culturally appropriate?

**Accessibility coverage**

To what extent are services within reasonable reach?

**Availability coverage**

What services are currently being provided and where, by whom (including both private and public sectors)?

TARGET POPULATION WHO DO NOT USE SERVICES

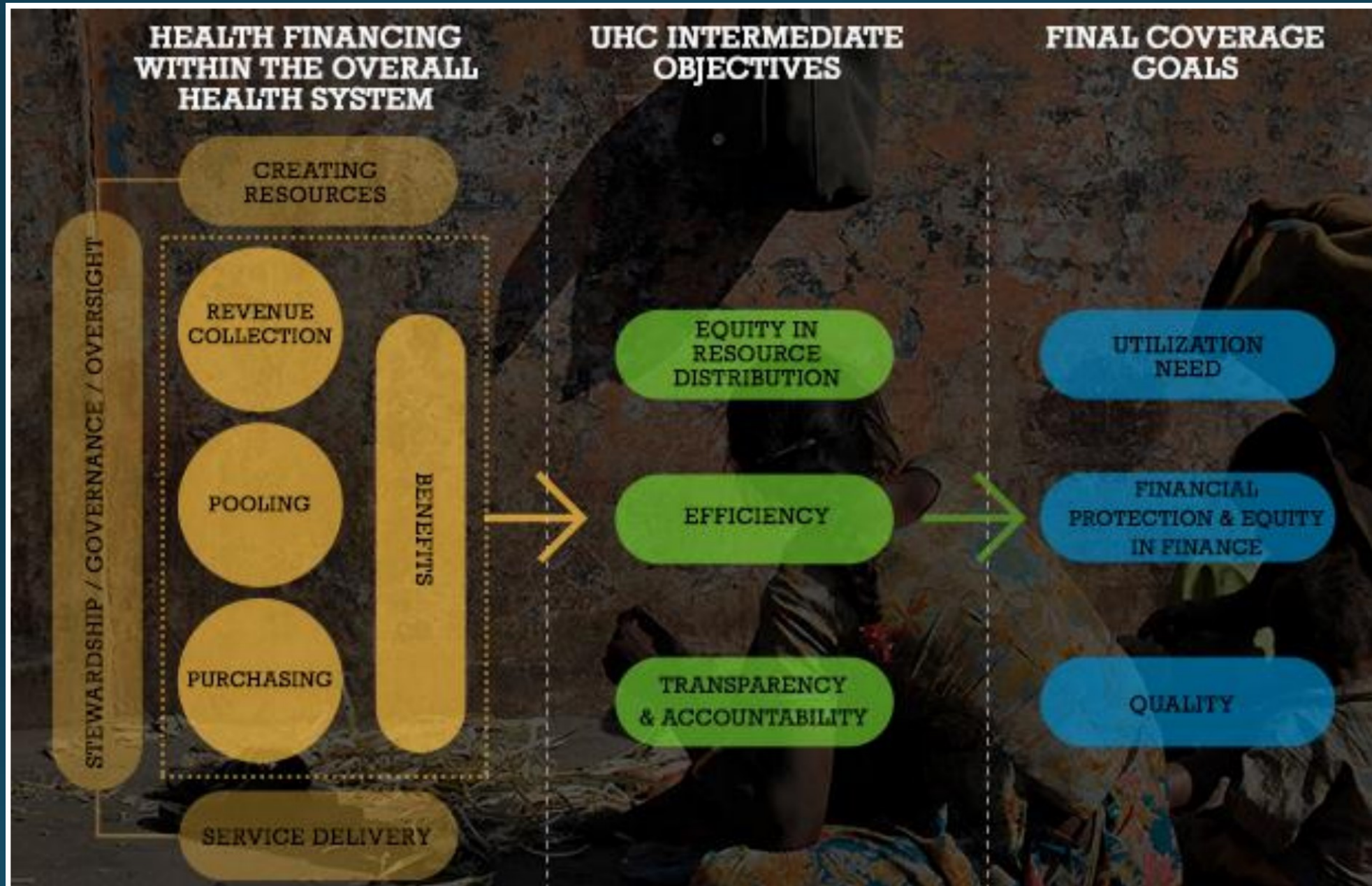
Process of service provision

TARGET POPULATION

# Tanahashi Model of Evaluating Health Service Coverage

Source:

Tanahashi, T. 1978. Health Service Coverage and Its Evaluation. Bulletin of the World Health Organization. 56: 295–303.



Source: [http://www.who.int/health\\_financing/policy-framework/en/](http://www.who.int/health_financing/policy-framework/en/). Accessed on October 23rd, 2016.

# UHC in Thailand

- Three major schemes:

UCS (75%), SSS (15%), CSMBS (10%)

- Increasing use of close-ended provider payment mechanisms:

- Capitation (OP)

- DRG case-based payment, and DRG-based global budget payment (IP)

- Fee schedule for specific care

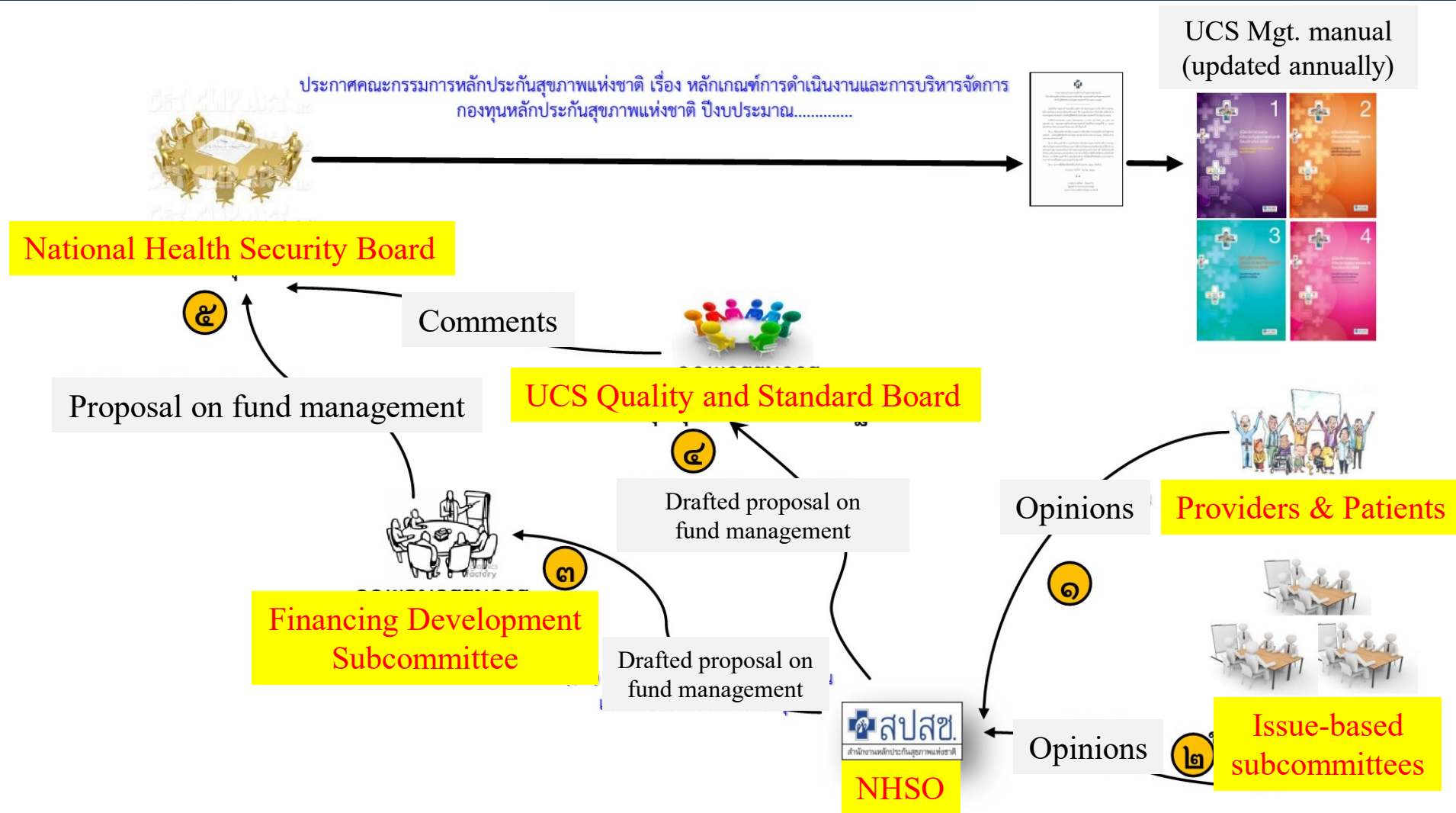
- Other key challenges:

Aging population and cost increasing, inadequate funding and service infrastructure, distribution of human resources

# Design of UCS in Thailand and Quality of care

- Payment: Capitation (OP) / DRG with global budget (IP)
  - **Positive incentive:** Efficiency, Care coordination, Primary care, +/- Disease prevention and Health promotion (PP)
  - **Negative incentive:** Cost cutting by denying or delaying treatment, Delay “higher-standard” care, Shortages of services
- Comprehensive benefits including PP
- Emphasis on primary care and referral system to higher levels of care

# Ensuring quality of care in UCS



# Selective contracting: Disease management in UCS

## ■ Purposes:

- Increase access to care by using different payment schemes
- Promote quality of care by application of evidence-based practice guidelines, selective contracting, and close monitoring of key performance and outcomes

## ■ Examples

- Medicine for acute care, e.g. STEMI, Stroke
- Chemotherapy and radiotherapy for cancer treatment
- Chronic disease management, e.g. Thalassemia, Tuberculosis



# Pay for Performance in UCS

- ❑ System-wide requirements + Area-based requirements
- ❑ 3 Focal areas of system-wide requirements in 2016
  - ❑ **Quality and results of health promotion and disease Prevention:**  
e.g. % Pregnancy with 1<sup>st</sup> ANC within the first 12 weeks of gestation.
  - ❑ **Quality and results of primary care provision:**  
e.g. Rate of admission with DM short-term complications
  - ❑ **Quality and Results of Organizational and Referral System Management and Development:**  
e.g. % primary care providers passing the requirements

# UHC factors affecting public hospitals

- ❑ Close-ended provider payment mechanisms
- ❑ Policy to strengthen primary care
- ❑ Capital financing and initiatives on “Excellent centers”
- ❑ Selective contracting and quality-based purchasing initiatives, increasing demands for :
  - Data and information
  - Healthcare provision and coordination

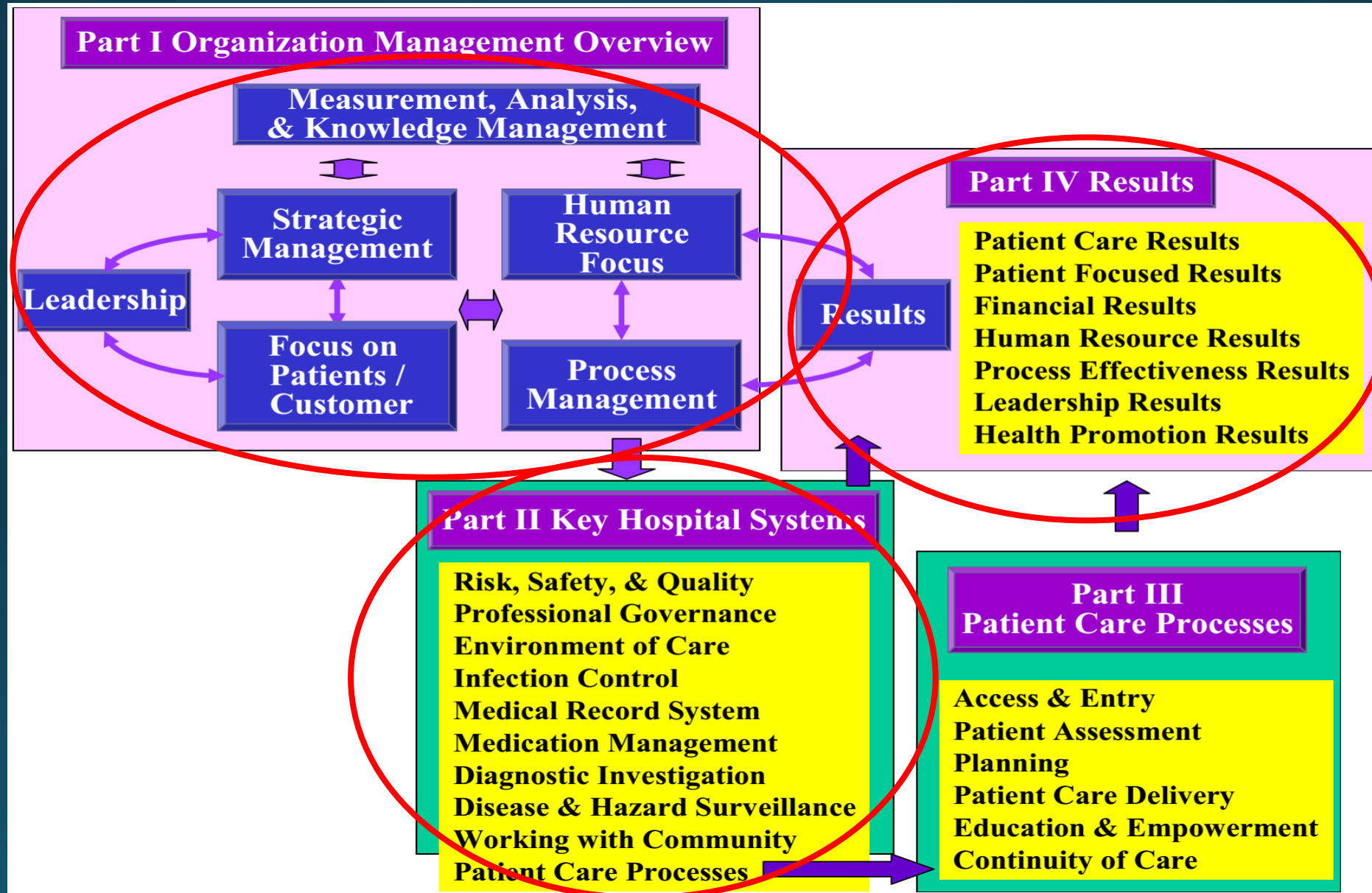
# Hospital adaptability

- New organizational policies and internal regulations
  - e.g., Hospital drug formularies, Service outsourcing
- Health insurance management unit
  - e.g., Claim management, Utilization review, Complaint mgt.
- Rearrangement of Internal financial incentive
- Information system enhancements
- Public-Private-Partnership initiatives

# Hospital adaptability (Cont.)

- ❑ Service expansion (both volume and scope of services)
- ❑ Strengthening of primary care and integration with community healthcare networks
- ❑ Use of generic drugs
- ❑ Patient referral processes
- ❑ Engaging quality improvement and support networks, “Not to be left behind”

# Hospital Accreditation in supporting UCS



# Accreditation emphasizes CQI, thus the process takes time.

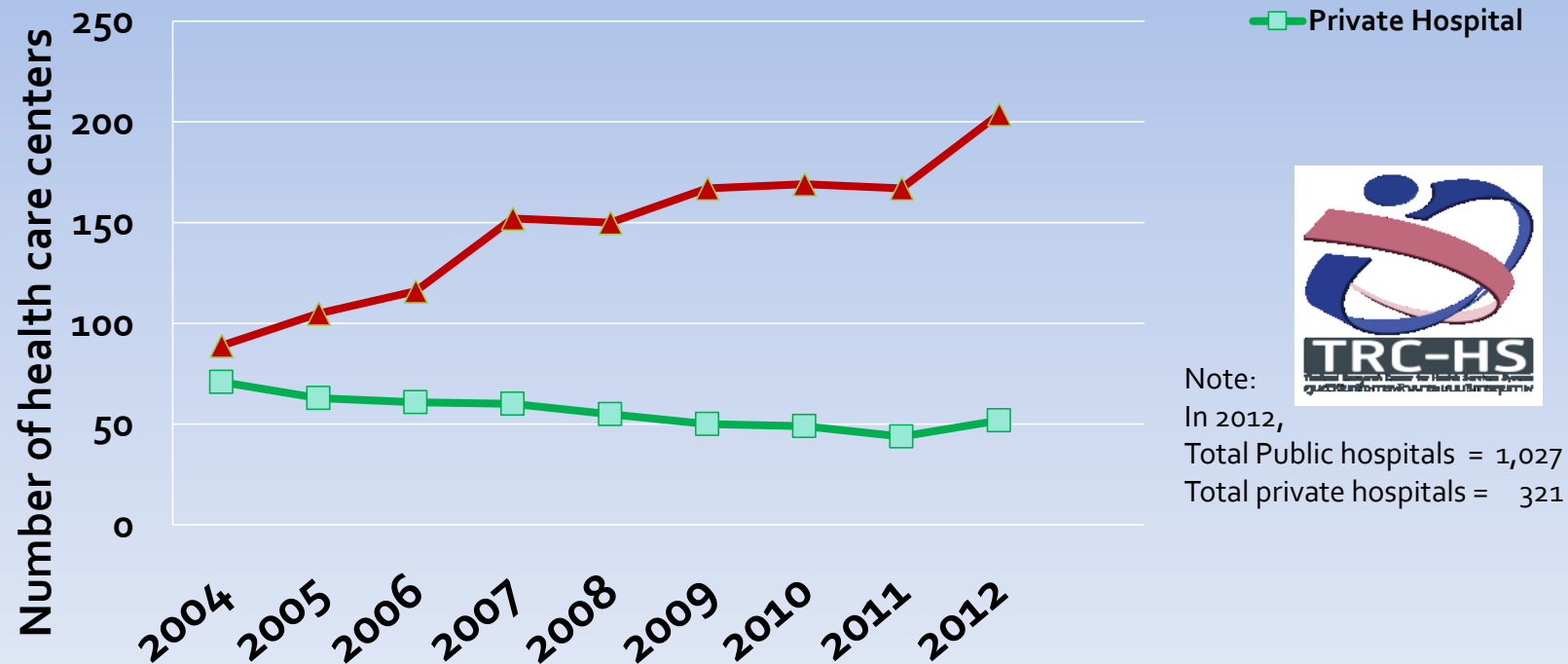
Accreditation status	Sept. 2009	Sept. 2010	Sept. 2011	Sept. 2012	Sept. 2013	Sept. 2014
<u>Step -1 certified</u>	56	111	52	30	17	14
<u>Step -2 certified</u>	512	635	612	531	476	411
<u>Accredited hospitals</u>	163	182	288	443	534	674
<u>All certified and accredited hosp.</u>	731	928	952	1,004	1,027	1,099

Note: Total number of hospitals (2015) = 1320 [public= 1012; private= 308]

Source: Thailand Research Center for Health Services System (TRC-HS)

# HA complementing PPP in UCS

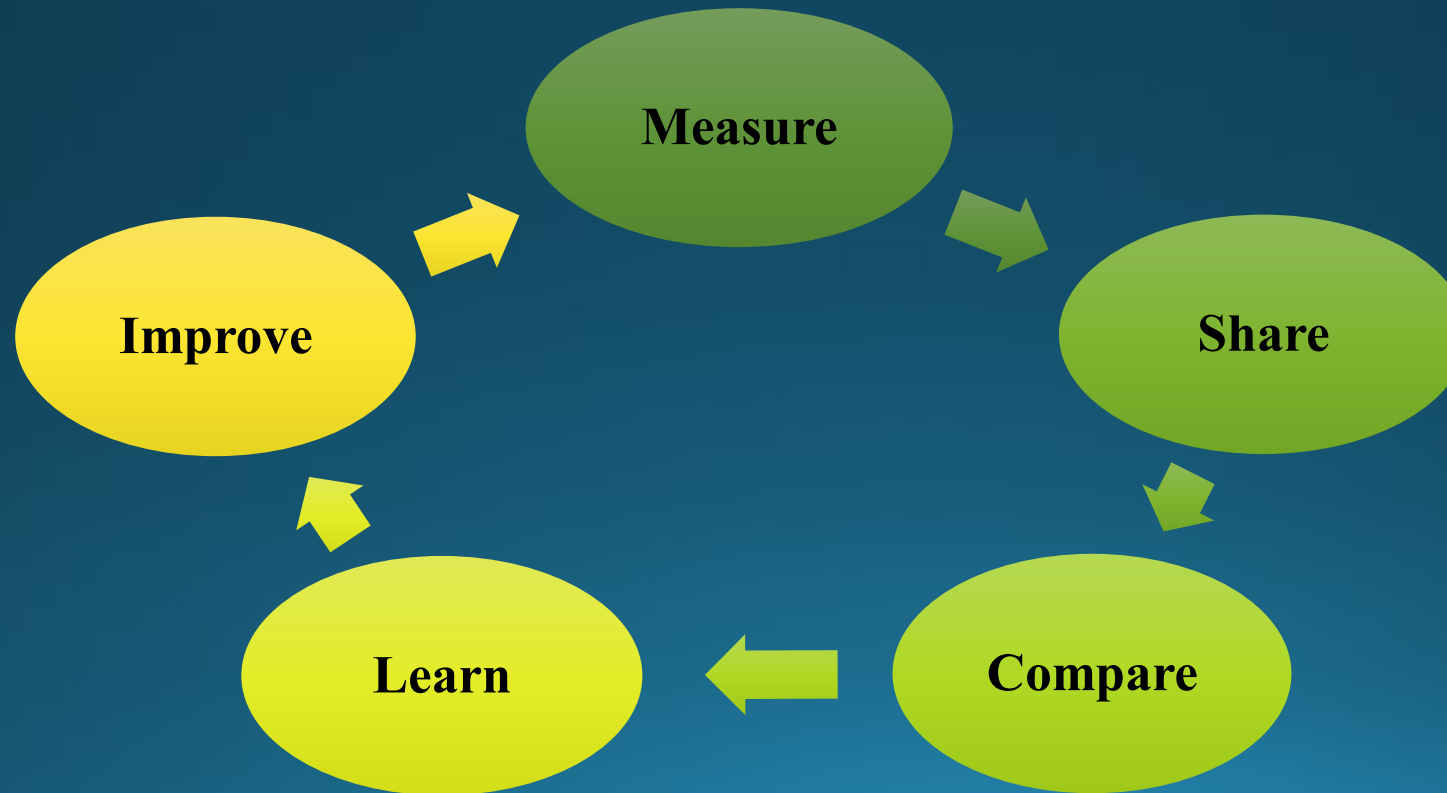
Number of private providers participating in the UC scheme in Thailand (Fiscal year 2004 – 2012)



Source: Thailand Research Center for Health Services System (TRC-HS)

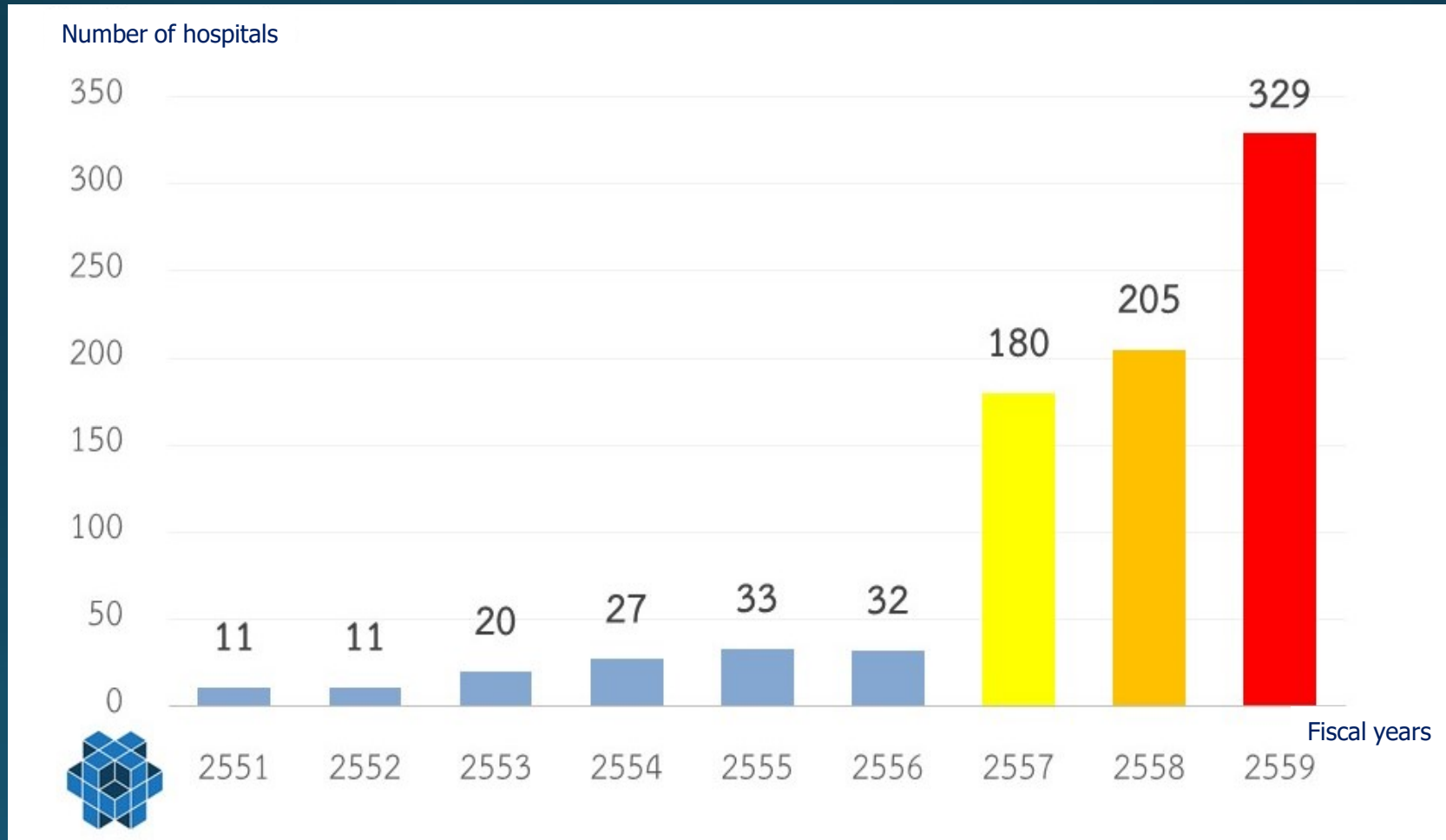
# Thailand Hospital Indicator Program (THIP)

- ❑ Voluntary participation: 329 hospital members
- ❑ 176 KPIs in THIP available for benchmarking in four areas:  
(1) Disease-specific results, (2) Care processes, (3) Key hospital systems and  
(4) Health promotion

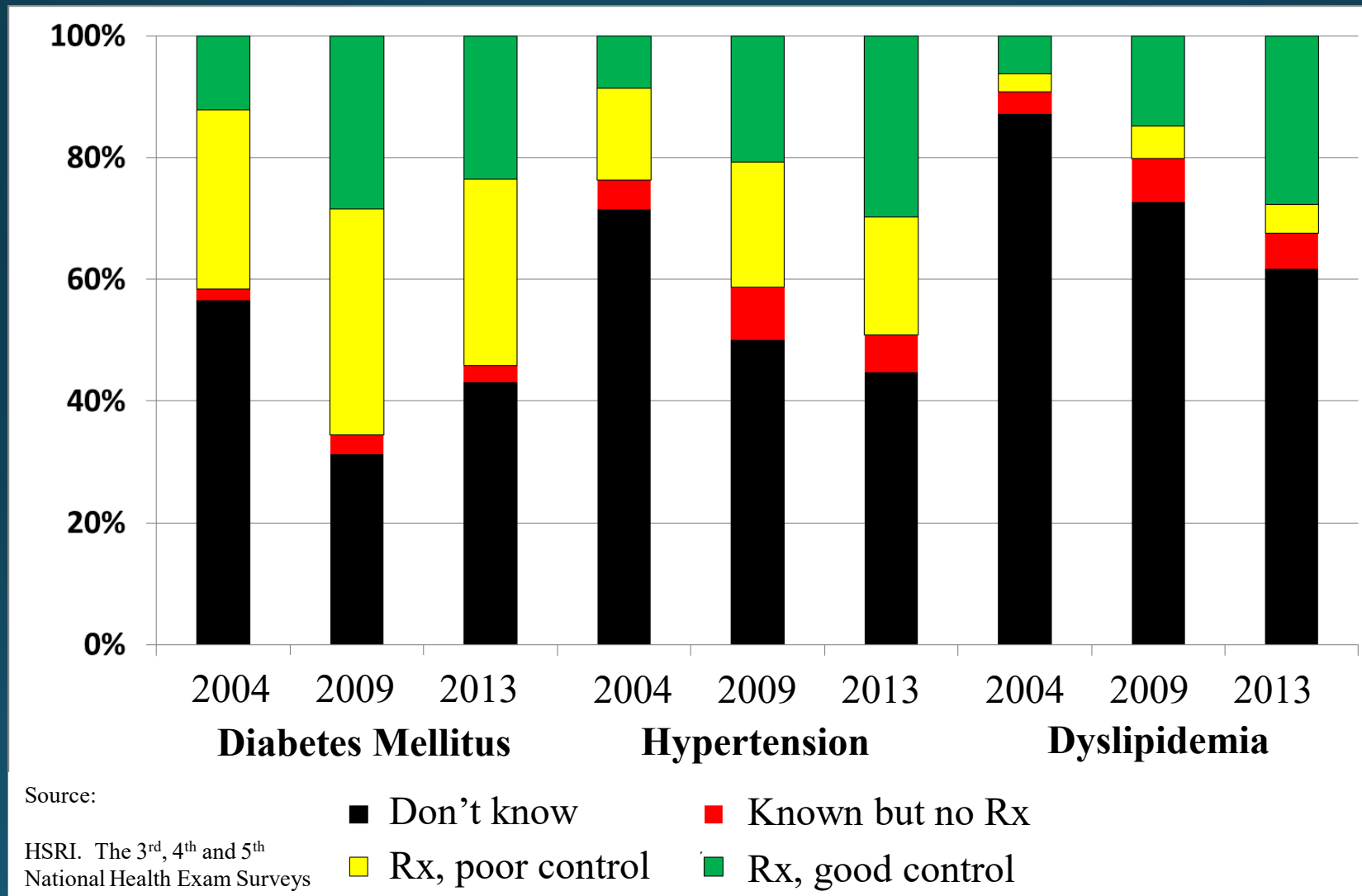




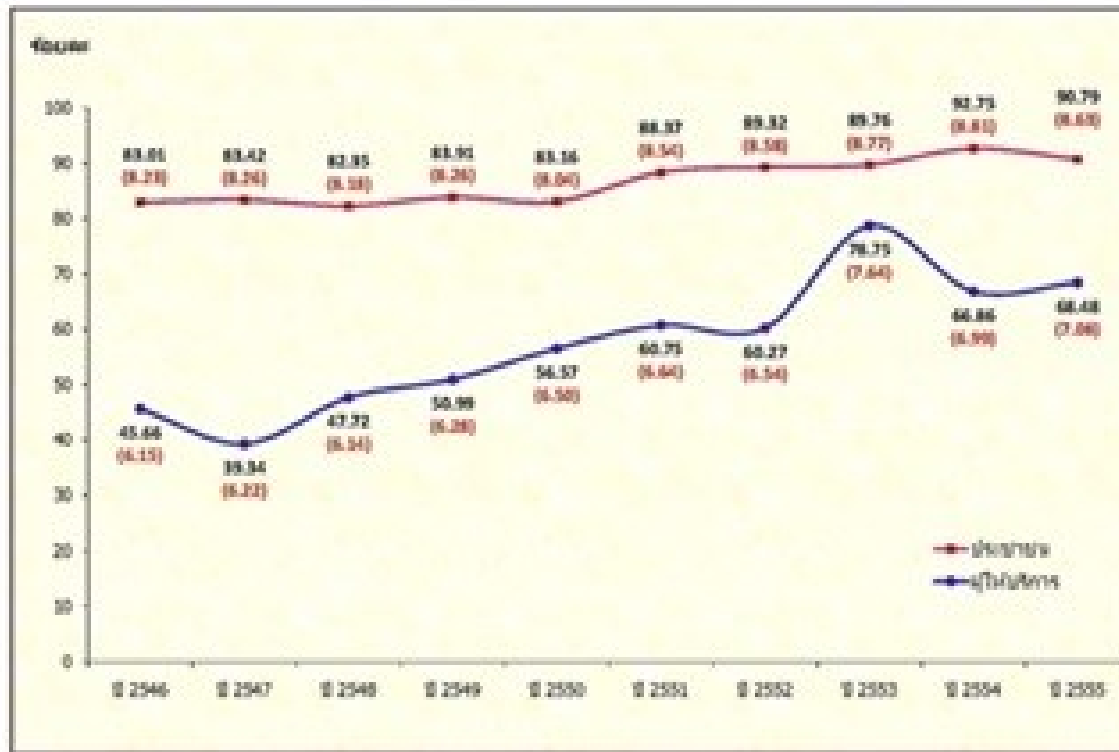
# Increasing number of hospital participants



# Examples of reported health outcomes



# Public reporting of key performance: Nation-wide satisfaction survey

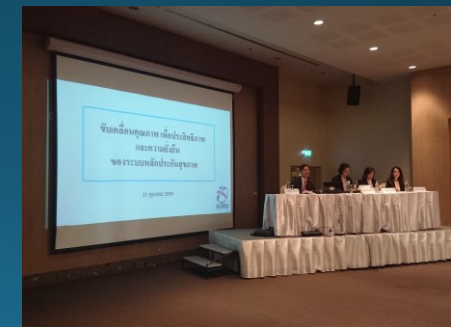
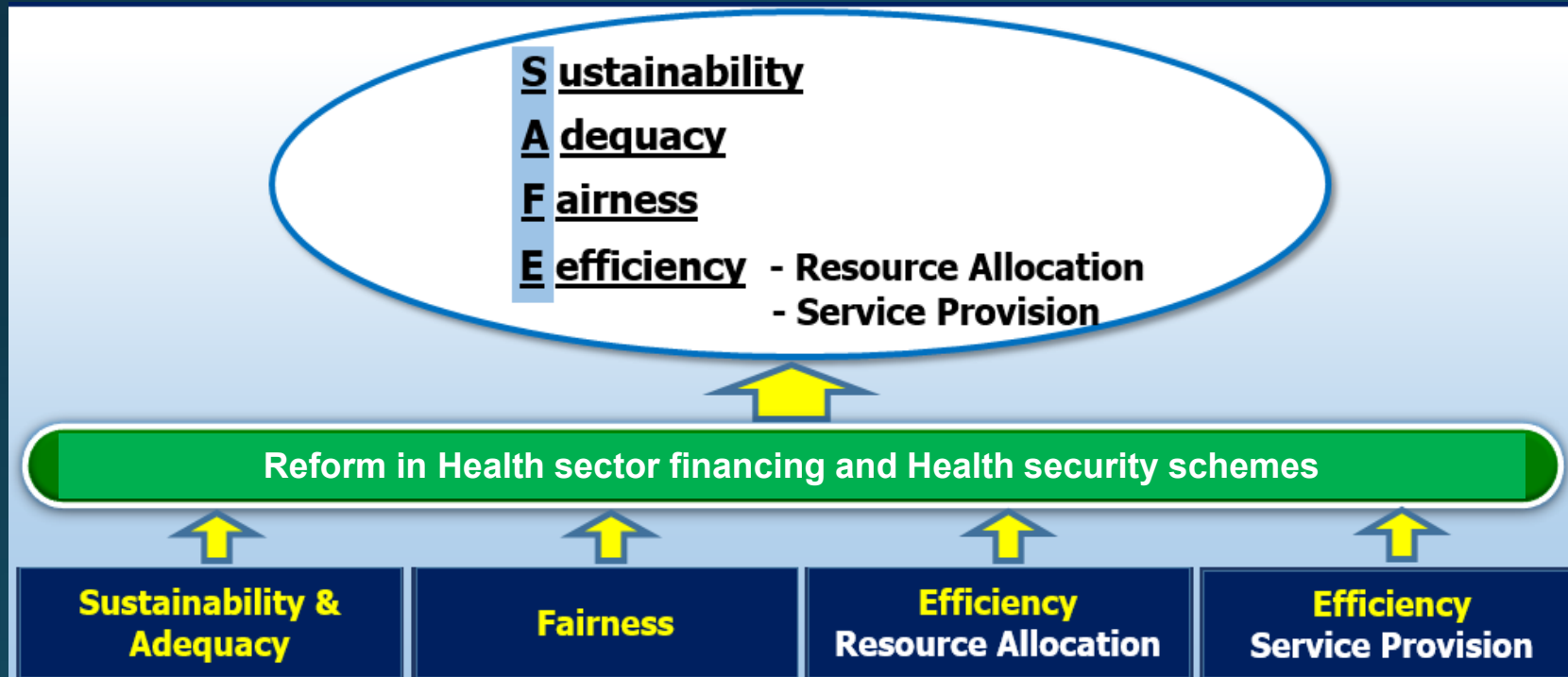


People

Provider

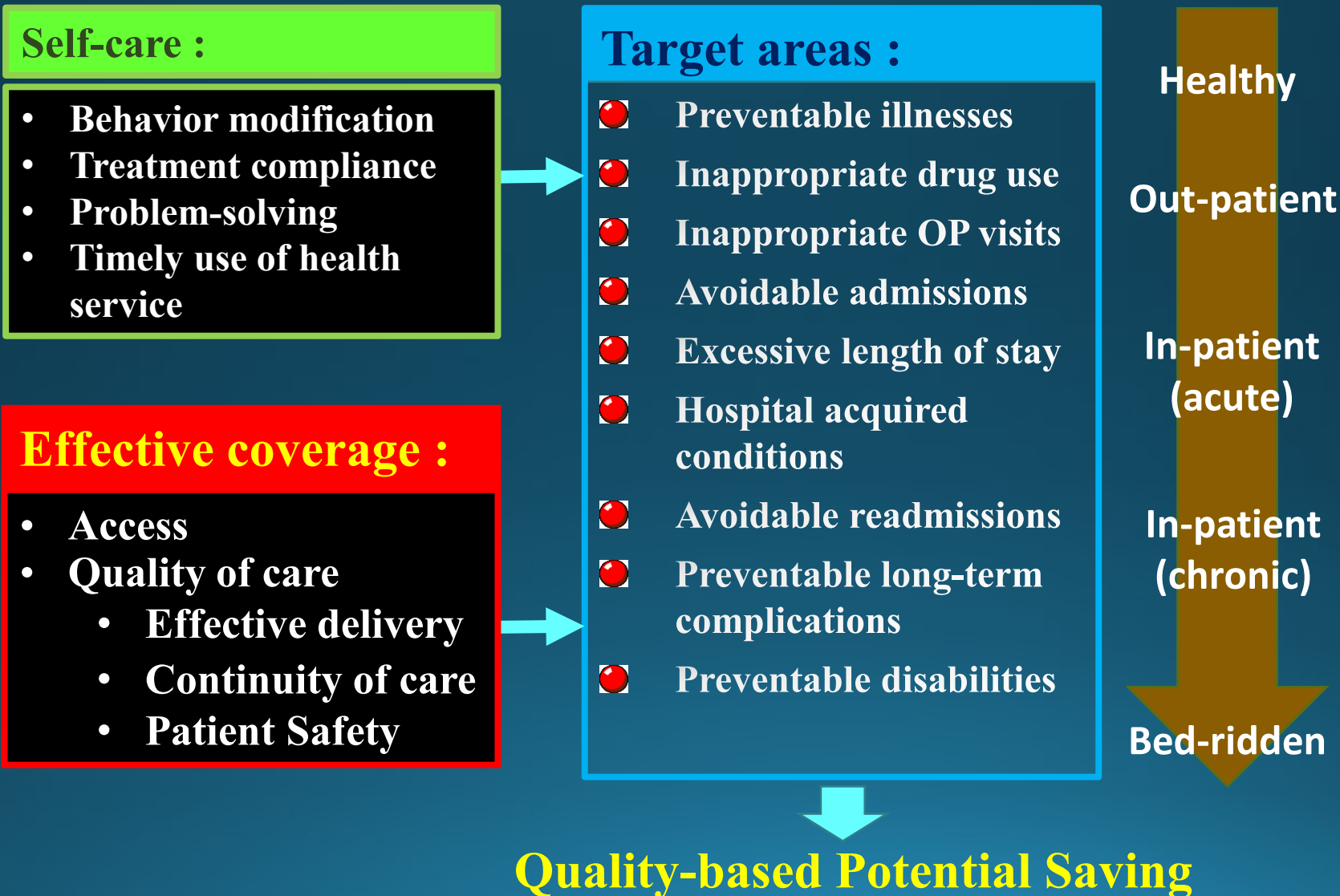
# The present challenge for Thailand's UHC :

## *Sustainability*

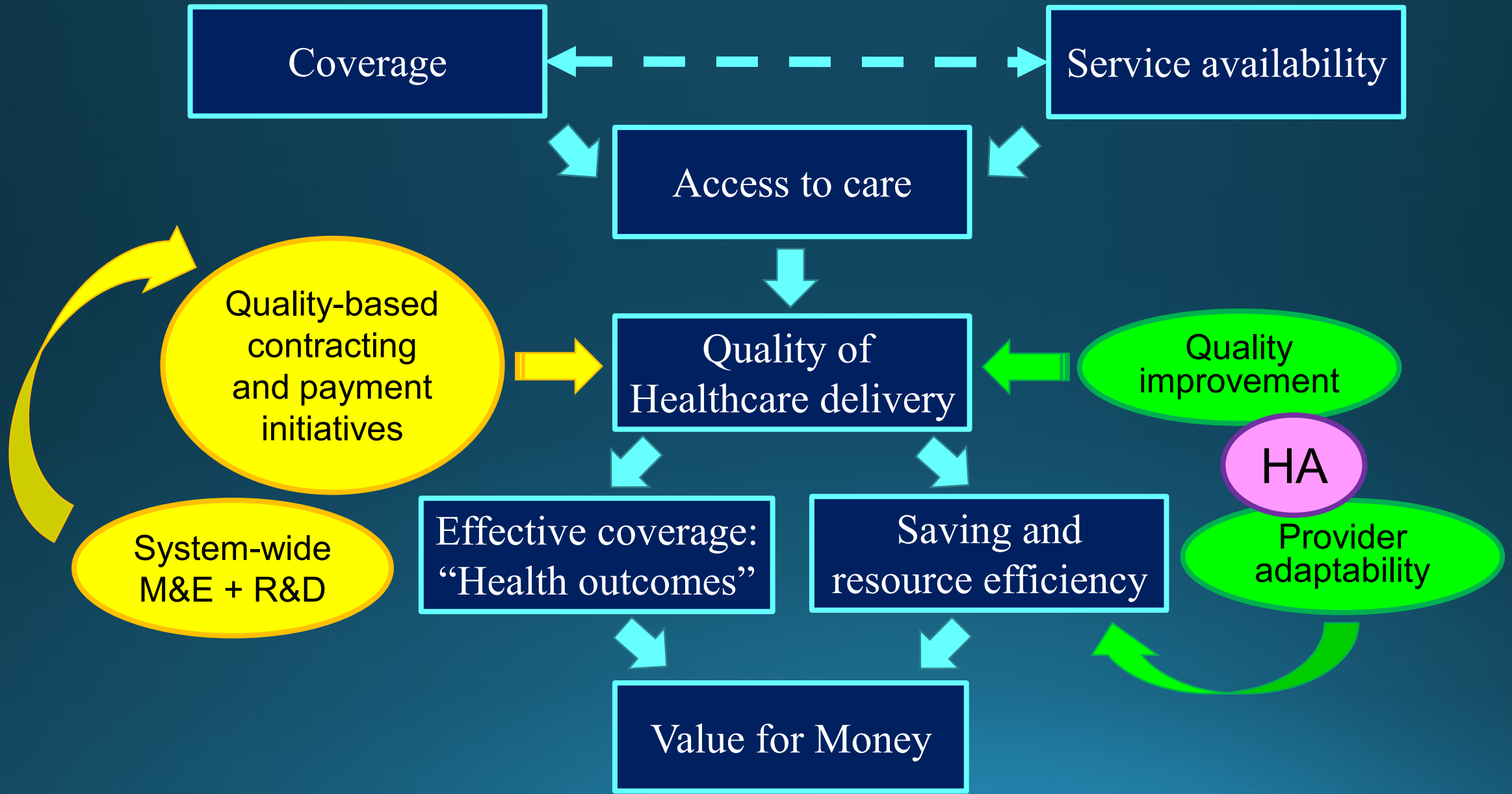


# “Cheaper” but “Better”

## Quality of care can lead to substantial saving in UCS



# Roles of QoC in UHC: Thailand Experience



# Questions and Answers