

CHAPTER I

INTRODUCTION

Rationale

Thai health sector has witnessed the biggest changes in recent years after the Thai government's launch of "Universal Health Coverage" ("UC") policy under the 30- Baht Scheme in 2001. Among the changes, a hospital financial system is the most chaotic because financing method is used as a main tool in the reform under the implementation of the UC policy. Previously, public hospitals were subsidized by historically-based budget from the Thai government. They also received other revenues from out-of-pocket payment by patients who are not covered by any health insurance scheme. However, the situation has been dramatically altered after the UC policy implementation in 2001 changed the budget subsidization into a population-based basis or capitation.

Capitation payment method is not new in Thailand. Capitation has been used to budget the hospitals under the Social Security Scheme ("SSS") since 1990, which, according to data from the SSS, has proved to be successful payment method under the payer's perspective (Mill, et al., 2000). Apparently, SSS' capitation experience seemed to enjoy good feedback; however, before public hospitals were left with a question why, after the finance reform in 2001, capitation method has become chaos for them. One of possible reasons is because the proportion of people holding insurance under the SSS scheme is relatively small, i.e. as low as 9% of the total Thai population and, therefore, causes less capitation's effects on hospital's financial system.

Another reason is that, before 2001, public hospitals could generate more revenues from other sources, such as out-of-pocket payment from patients who did not have any health insurance, which was accounted to 80 % of the total Thai population. Nevertheless, after 2001, budgets of public hospitals have been mostly paid by payers under capitation method, resulting in the gradual decrease of hospitals' cash-flow. Most

public hospitals are confronted with a new challenge, which is to balance the hospitals' revenues and expenditures. Some hospitals can manage the situation, whereas many others cannot. Therefore, some hospitals have suffered from chronic financial problems in recent years, and are inevitably on the verge of bankruptcy (Naranong, et al., (2004). Today, the problems and chaos still continue unabated, but none of them have been disclosed by directors of the hospitals due mainly to political concerns. Faced with multiple modes of payments and their incentives, public hospitals are having a big problem involving financial sustainability.

At present, Thailand has three main public health insurance schemes each employs a combination of payment mechanisms. The 30-Baht Project or the 30-Baht Scheme is the biggest scheme that pays hospitals mainly on the basis of capitation for out-patient services and diagnosis with Diagnosis Related Groups ("DRGs") for in-patient care. In additionally, it also pays for specific diseases, especially those that demand high cost of care, by per visit with ceiling (Mill, et al., 2000). Although the 30 baht co-payment was canceled in 2006 and it become a free, the name of scheme and payment methods were still the same. Similarly, the Social Security Scheme for employees also uses capitation as its main payment method to hospitals, and additional payment with utilization-related payment, per patient per year with ceiling and per visit with ceiling (Chayasriwong, 1999). The third scheme is Civil Servant Medical Benefit Scheme ("CSMBS") covering government officials and their families. CSMBS is the only scheme that pays to hospitals on a fee-for-service method (Naranong, et al., (2004).

To summarize, a public hospital is confronting three main public health insurance schemes, under which two methods of payment – capitation and fee-for-service – are offered. The two payment options generate different incentives to hospital's behaviors. While capitation stimulates the hospital's management to set rules to contain the costs, fee-for-service method urges the hospital to provide more utilization. Such concept is generally known among the hospital's management and, in some hospitals; has become norms in the hospital's practice.

Most of the hospital's management opts to set rules to contain the costs for capitation patients but excuse most rules that restrict utilization for fee-for-service insured patients. Examples of rules commonly applied to capitation patients are "Do not dispense

COX-II inhibitors for capitation patients”, “Dispense only one month supply of drugs for capitation insurance”, and “Substitute generic drugs for capitation patients”. Thus cost-containment policies mentioned above are generally exempt from fee-for-service patients. For example, patients under CSMBS are regularly prescribed and dispensed newer drugs as well as branded drugs. In addition, drugs not included in the Thai National Essential Drug Lists (“ED”) are also regularly prescribed and reimbursed despite restrictions on their use issued by the CSMBS. In practice, the hospital committee usually allows almost every case to be prescribed drugs not stipulated in the ED lists.

These are facts generally known in public hospitals. Unfortunately, only few researchers have attempted to reveal them (Bryart and Prohmno, 2005, and Mill, et al., 2000). One of the studies (Mill, et al., 2000) found that generic substitution policy has been adopted and fully implemented for Social Security Scheme patients and also found that generic substitution is used only for capitation insurers. However, the evidence in both is conducted in terms of broad views. The researchers were unable to conduct in-depth studies since their findings may adversely affect the reputation of the hospitals and, thus, remain unknown to the public.

These dispensing guidelines based on the category of insurance payments affect both hospital’s cost and hospital’s revenue, and most importantly may also affect the quality of care. To illustrate, some hospitals set rule that new drugs would be dispensed only to fee-for-service insured patients. It is commonly known that new drugs are highly expensive. Therefore, if new drugs are dispensed to fee-for-service patients, the hospital will subsequently gain more revenue from mark ups.

In contrast, if a hospital dispenses new drugs to capitation patients, the hospital’s cost of providing services will be increasingly high. But as a provider, the hospitals need to control the treatment cost. However, this cost-containment measure may negatively affect patient care if the patients need breakthrough drugs in order to be cured or to enhance the quality of life. It means that capitation patients cannot access new technology and may receive low quality of care. Consequently, it is possible that the clinical outcomes of capitation patients may be lower than that of fee-for-service patients. If this is the case, the claim that capitation payment method would yield higher efficiency might not be true under this situation.

On the other hand, if efficacy of new drugs and traditional drugs are equal, the clinical outcome of patients receiving different drugs may also be equal. In addition, if the incidence rate of adverse drug reactions of the new drugs and traditional drugs are equal, the percentage of patients who suffer from adverse drug reactions should be equal also. Under this circumstance capitation payment method can increase efficiency on providing health care with low cost. Consider these two possible consequences mentioned above, the effect of capitation mode can either increase or decrease efficiency, which leads to an issue of inequity in providing health services in public hospitals.

At present, there has been no study in the country addressing the effects of payment modes on economic efficiency, whereas only few of them have studied in comparative the effects of payment modes on the equity of treatment. The studies of the effects of payment modes on access, quality, economic efficiency and equity requires is highly beneficial to policy makers and other researchers in order to understand the hospital's practice and reaction to different payment mechanism. Thus, this study aims to assess and understand hospital behaviors in responding to different payment mechanisms.

Purpose of study:**General purposes:**

1. To assess the effects of insurance payment methods on access to care, equity care, and quality dimension of practice patterns.
2. To assess the impacts of insurance payment methods on efficiency of health care services.

Specific purposes:

1. To assess the effects of insurance payment methods on access to drugs and high technology equipment.
2. To assess the effects of insurance payment methods on equity care.
3. To assess the effects of insurance payment methods on quality dimension of practice patterns.
4. To assess the impact of insurance payment methods on efficiency of health care services.

Research Questions:

How do different insurance payment mechanisms affect access, equity, quality and efficiency of health care services?

Contributions of the study:**Policy makers**

1. This study is expected to concrete evidence on the provider response that allow policy makers to understand what happen at the hospital's responses to multiple payment mechanisms.
2. This study provides evidence for policy makers to realize impacts of payment mechanisms on quality, efficiency, and equity in real situations.
3. This study is expected to enable payers to acknowledge facts concerning the impacts of payment mechanisms adopted under their insurance schemes.

Providers

This study is expected to support hospital's management to assess effects of their hospital's policies on the efficiency and quality of treatment.