CHAPTER 5
POLICY IMPLICATIONS AND RECOMMENDATION

5.1 Policy Implications

This study could be used as a basic guideline for hospital directors, health administrators and policy makers to make a policy planning on UC scheme. From the result of this study, some policies may need to be reconsidered.

5.1.1 Combination of Utilization rate and Utilization rate

Table 5.1 shows combination of utilization rate and utilization rate of two CHs. From the Table 5.1, combination of utilization of Krasung CH is equal to 0.93 in OP and 0.07 in IP, and Lampraimach CH 0.70 in OP and 0.30 in IP. For percent utilization, Krasung CH has total utilization rate of 38.82% of total population and Lampraimach CH has total utilization rate of 36.54%.

Unit cost of Lampraimach CH is higher than that of Krasung CH due to not only the sizes of CHs but also the different combination of utilization rate. Because Lampraimach CH has higher proportion of IP patients, then the TC of Lampraimach will be higher.

Table 5.1: Utilization rate of two CH in FS 2001.

	Number of patient	Number of Population in district	% Utilization	Proportion
Krasung CH		104,457.00		
OP (visit)	108,203.00			
OP (capita)	37,622.74		36.02	0.93
IP (capita)	2,925.00		2.80	0.07
Total			38.82	1.00
Lampraimach CH		132,148.00		
OP (visit)	97,772.00			
OP (capita)	33,995.83		25.73	0.70
IP (capita)	14,291.00		10.81	0.30
Total			36.54	1.00

Note: The number of OP capita come from OP (visit) *2.876 (Utilization rate of health facilities (OP)). See more detail of Utilization rate of health facilities in Appendix I, Table I.2.

If the combination of utilization rate or utilization rate changes, the TC will change, too. For instance, if combination of IP becomes higher than the current data in Table 5.1, the TC will increase (because unit cost per case of IP is higher than unit cost per case of OP). Then, the cost-recovery ratio will decrease. Therefore, hospital directors should be aware in these factors and should prepare themselves for these transitional factors especially for Lampraimach CH (because the ratio of cost-recovery of Lampraimach CH is lower than that of Krasung CH).

5.1.2 Reimbursement rate of CHs of different sizes

Because the sizes of the hospitals in Thailand correlate with the complexity of their services, larger hospitals will have higher per unit cost. Health administrators and policy maker should strongly consider in this factor. The hospitals that provide more complex services have more chance to confront with financial bankruptcy of under the same reimbursement rate

condition. The health administrators should have other sources of fund to compensate this problem. Policy makers should set clear criteria for using this fund.

5.1.3 Number of people registered with UC scheme in each hospital

Because the major proportion of revenue of contracting unit under UC scheme comes from number of people registered in the catchments area, the number of people registered will be extremely important for financial survival. Policy makers should reconsider about ARR or other factors (such as the number of people registered) in case of CHs similar to Krasung CH and Lampraimach CH, which have numbers of people registered under UC less than 29,428 person for Krasung CH and 81,630 person for Lampraimach CH.

Also, for those similar CHs with Krasung CH and Lampraimach CH that have higher numbers of people registered under UC Policy makers should rethink about ARR and (+) DV from TR and TC. If (+) DV is too high, policy makers should have mechanism to manage this money. For example, if a hospital has more than twenty percent profits, the health administrator can collect the surplus and return it to MOPH. The heath administrator may also put this surplus into the compensation fund (for bankruptcy problem).

5.1.4 Bankruptcy problem

In 1994, the health expenditure in Thailand comes from three sources: 52% from public facilities, 27% from private facilities and 16% from private pharmacies (Pannarunothai, S., et al.1999). If public facilities are bankrupt, Thailand will face a serious problem of scarcity in health facilities. Many other problems will follow such as equity in health services.

Actually, many factors can cause the bankruptcy problem. Policy makers should clarify that chance and should prevent this problem.

Before the problem of bankruptcy occurs, the first thing that policy makers should think is the problem of bankruptcy panic. This problem leads to other problems. For example, a hospital director may change the management policies of the hospital such as decreasing the number of transitional workers, or providing different treatment packages for patients under different schemes. To prevent this problem, policy makers should have clear policy and methods for the remedy of the bankruptcy problem.

5.2 Recommendations

In this study, there are some difficulties with the raw data. While the raw data are almost complete, the lack of a good data collection system makes it timely to clarify them. With a good data collection system, it will be easier and more time efficient to conduct a research study. However, some data are still missing. I have to omit some data, for example, in the case of capital costs, purchased dates or values of equipment or building are not recorded. Also for allocation criteria of laboratory, instead of recording the numbers of patients in term of OP visits or IP visits, the hospitals record the number of visits for each laboratory's diagnosis. I have to adjust these figures using the interview and the data that I have.

Since, this study is conducted during FS 2002, lack of the data to calculate utilization rate, I have to use retrospective data of FS 2001. Hence, I cannot calculate the absolute number of unit cost per case of OP (because this study analyzes the costs in the first quarter of FS 2002). If UC scheme in Thailand had been implemented in the whole country for one year, I would have been able to calculate the utilization rate of patients under UC scheme compared with that of the total population registered under UC. The results of utilization rate will be more accurate.

ANP in this study is calculated by direct method. In reality, TC depends on many factors. For example, TC will change if utilization rate changes. Thus, if further studies include other factors that affect the value of ANP, the value of ANP will be more convincing.

Public hospitals are non-profit organizations. Therefore, this study calculates ARR and ANP based on profit equal to zero. In practice, public hospitals should have some profit to cover some expenditure. The policy makers should have more awareness in this condition.

Unfortunately, because of time limitation, this study has to use data for the period of only three months of the first quarter of FS 2002. And due to the UC scheme has been implemented in the whole country for only six months, the costs data of two CHs (in this study) do not cover some items of TC that may occur under UC scheme such as the cost of prevention and control disease program in core package of UC scheme (see more detail in Chapter 2, 2.2.2 Why did Thailand's Government implement the UC?) For better results, further studies should analyze data of at least one year after the implementation of UC scheme in all of the hospitals, which that are the contracting units of UC scheme.

However, this study does not indicate the pattern of referral system. Under UC system, if the hospitals, which are the contracting units of UC scheme, refer patients under UC (who are register in their catchments area), they must pay that treatment cost by themselves. So the pattern of refer cases may be change. For instance, the hospitals may attempt to treat the patients by themselves. Therefore, this factor should be in consideration as well.

Lastly, Thailand UC system should be single system or multiple systems is another question. WHO lead away from a form of universalism that has government attempting to provide and finance everything for everybody (WHO

1999). This "classical" universalism, although seldom advanced in extreme form, shaped the formation of many European health systems. It achieved important successes. **But classical universalism fails to recognize both resource limits and the limits of government**. WHO advocates a "new universalism" that recognizes governments' limits but retains government responsibility for the leadership and finance of health systems. The new universalism welcome diversity and, subject to appropriate guidelines, competition in the provision of services.