โครงการ

จัดกระบวนสร้างองค์ความรู้และถอดบทเรียนพร้อมเผยแพร่งานระบบหลักประกันสุขภาพฯ ฉบับภาษาอังกฤษ/ภาษาไทย

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จัดทำโดย

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เสนอต่อ

สำนักงานหลักประกันสุขภาพแห่งชาติ – สปสช.

(14 พฤษภาคม 2563)

PRIVATE
HEALTHCARE PROVIDER PARTICIPATION
IN THE UNIVERSAL COVERAGE SCHEME (UCS)

NHSO
National Health Security Office

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National Health Security Office

GLOSSARY

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1

HEALTH SERVICES IN THAILAND AT A GLANCE

Thailand's health service system has evolved over a long time. The service centers range from primary, secondary, and tertiary care facilities, covering the entire country. There are services for health promotion, disease prevention, medical treatment, and rehabilitation, and both the public and private sectors participate in providing these services to people at all levels of society.

1.1

GOVERNMENT SERVICES

Primary care provision: There are 48,049 community primary health centers at the sub-district level, 9,777 sub-district (Tambon) health promotion hospitals (THPH), 3,108 community health centers, and 125 community health outposts in urban areas. These primary health care facilities cover all areas and be accessible to all people.

Secondary care provision: There are 780 community (district) hospitals providing both primary and secondary care, covering 89 percent of the total districts in the country.

Tertiary care: Nationally, there are 83 hospitals under the Ministry of Public Health and 93 hospitals under other ministries or government agencies.

In Bangkok, there are 68 Primary Health Care Centers of the Bangkok Metropolitan Administration (BMA) and 136 primary health care facilities if include all other organizations. There are 26 general hospitals at the secondary and tertiary levels in Bangkok, most of which are under the Ministry of Public Health (MOPH) or other government entities. There are five hospitals as part of medical schools and eight specialized government hospitals.

PUBLIC
HEALTHCARE
PROVIDER

1 PRIMARY

PRIMARY CARE

There are

48,049

Community Primary Health Centers at the sub-district level

2 SECONDARY

SECONDARY CARE

There are

780

Community (district) Hospitals providing both primary and secondary care

3 TERTIARY

TERTIARY CARE

There are

83 Hospitals under the Ministry of Public Health and 93 hospitals under other ministries or government agencies.

1.2

PRIVATE HEALTH SERVICES

There are approximately 24,800 private clinics nationwide that provide primary health care. As for the secondary and tertiary levels, there are 347 private hospitals, of which 90.8% are general secondary hospitals and 9.2% are specialized tertiary hospitals.[1] In Bangkok, 4,558 private clinics are providing primary health care, and 25 private hospitals providing secondary and tertiary care.[1]

There are 810 private health care service units registered in the UCS of the National Health Security Office (NHSO) system throughout the country, divided into 452 in Bangkok and 358 outside of Bangkok.[2] The registered private health facilities can be classified under the UCS system as "primary unit", "contracted unit of primary care (CUP)", and "referral unit" (Table 1). Bangkok "Ob-un" (i.e., community-friendly) community clinics serve as primary care unit. For secondary and tertiary care, hospitals are serving for referral unit for in- and out-patient care. There are also private hospitals that serve as both primary care units and referral unit. Besides, many specialized private hospitals provide tertiary care. For disease prevention and special services, some private hospitals and clinics are registered as participating units to provide preventive services. These are distributed mostly in Bangkok since there have been more pilot projects there (Table 1).

PRIVATE HEALTHCARE PROVIDER

Table 1

NUMBER OF PRIVATE CARE FACILITIES REGISTERED WITH THE NHSO BY TYPE OF SERVICE IN 2020

REGISTERED UNITS **IN BANGKOK (N=453)**

TYPE OF SERVICE	PRIMARY/ CONTRACTED	PRIMARY / CONTRACTED/ REFERRALS	REFERRALS	PARTICIPATING UNITS / PP UNITS
Out-patient care	190	14 2 (Non Cap)		166
In-patient care		14 2 (Non Cap)		
Specialized			81	
Health promotion and disease prevention				166

REGISTERED UNITS **OUTSIDE BANGKOK (N=357)**

TYPE OF SERVICE	PRIMARY	PRIMARY/ CONTRACTED	PRIMARY / CONTRACTED/ REFERRALS	REFERRALS	PARTICIPATING UNITS / PP UNITS
Out-patient care	20	94	16 2 (Non Cap)		34
In-patient care			16 2 (Non Cap		
Specialized				191	
Health promotion and disease prevention	20	94			34

*A health care service unit can be registered with the NHSO for more than one type of service; hence multiple counts

Cap (Capitation): This refers to compensation for a service unit based on a per capita rate set by the NHSO

Non-Cap (Non-capitation): This refers to a service unit that is not compensated for a service based on a per capita rate set by the NHSO

Source: Database of the NHSO, 2020, Office of the Registrar

2

PARTICIPATION OF PRIVATE HEALTH SECTORS IN THE NHSO SYSTEM

2.1

RATIONALE FOR INCLUDING PRIVATE HEALTH SECTORS IN THE UCS

REDUCE CROWDING IN PUBLIC FACILITIES AND INCREASE ACCESS TO SERVICES

Although public health service units are numerous and play the principal role in the health service system, there are still not enough to support patient caseloads in some areas. When analyzing the bed occupancy rate of government hospitals in some provinces, it is found that rates are close to 100%, such as Loei (98%), Phuket, Mukdahan, and Surat Thani (96%), and Udorn Thani and Pathum Thani (94%).[3] This means that the number of inpatients often exceeds the number of beds provided. The use of outpatient services still requires a long wait, especially in urban areas, causing congestion and queuing problems of many patients in the government hospital.[4] Therefore, including private health service units in the UCS service network is an alternative way of making the most of the available resources. Plus, the government does not need to invest in additional infrastructure by partnering with private facilities, and this increases access to services in urban areas, especially for effective primary care which will help reduce congestion in large hospitals.[5]

Bangkok has the largest population of any city/province in the country with a registered population as of December 2017 of 5.6 million people. However, there are at least as many persons who are not registered in the Civil Registration System for Bangkok who come to work in Bangkok, including foreigners who live in Bangkok, and tourists. When combined, at any time, Bangkok has a de facto population of over 10 million people. Further, health service providers in Bangkok are not evenly or fully distributed, and that is an important difference with the distribution of public health facilities in other provinces. Outside of Bangkok, the system requires that there is at least one health center for each Tambon (and some large Tambon have three health centers); at least one community hospital in each district, and at least one hospital with specialist care in each

WHEN ANALYZING THE BED OCCUPANCY RATE OF GOVERNMENT HOSPITALS IN SOME PROVINCES, IT IS FOUND THAT RATES ARE CLOSE TO

100%

THIS MEANS THAT THE NUMBER OF INPATIENTS OFTEN EXCEEDS THE NUMBER OF BEDS PROVIDED.

province. Large provincial hospitals can be designated as a regional hospital which has a similar capacity as hospitals under the medical school system.[5]

Congestion at government hospitals in Bangkok is also caused by the fact that tertiary hospital and medical school hospitals must accept referrals from all other provinces in the nation. This is even though many of the referrals are for common diseases/conditions that can be treated without the need for a specialist. This congestion situation denies some patients with severe disease or symptoms to timely care.

Plus, this situation means that the tertiary hospitals are unnecessarily burdened, and those who seek treatment there have unacceptable wait times.[5]

In 2006, Bangkok organized the "Ob-un" community clinic project as a CUP to reduce congestion in large hospitals. There are 26 of these clinics which have the goal of providing people with access to primary care services, effective, and standardized services conveniently, quickly, and more thoroughly. At the same time, assessments of the system show that private health service have helped citizens to gain access to primary care. Accordingly, the NHSO expanded its operations to include other hospitals to develop a more efficient operating model.[5] In sum, including private health service units in the UC scheme reduces hospital overcrowding, both for outpatient and inpatient service, as well as specialized care.

TO MAXIMIZE THE USE OF EXISTING RESOURCES; THE GOVERNMENT DOES NOT NEED TO INVEST IN NEW INFRASTRUCTURE

Due to the private hospitals distributed widely in the country especially in urban areas with capacity in technology, personnel, and management, it makes sense for the government to create partnerships with the private sector. That allows the government to benefit from the use of new technology and innovation from the private sector and increase the number of affiliated health personnel, resulting in saving of infrastructure costs without additional investment. This arrangement also enables the transfer of risk to the private sector because the private sector is more effective in risk management. Also, private service units can, therefore, benefit in terms of investment opportunities and distribution of resources and personnel, resulting in the public benefit from more efficient service at a reasonable price.

In the past, service provision in Bangkok faced limitations in increasing the number of public health facilities including medical personnel. In addition, (unlike the public medical education system for the provinces) the BMA did not have a scholarship system for medical graduates to hire them for positions working under BMA. Further, budget limitations constrained the ability to expand human resources positions. When the NHSO began operations for UCS, Bangkok had only 68 public health centers and 14 general hospitals to serve the large number of patients.

ACSC
AMBULATORY CARE SENSITIVITY CONDITION
PREVENT UNNECESSARY HOSPITALIZATION OF PATIENTS

For this reason, Zone 13 of the NHSO (i.e., Bangkok) produced the plan to enlist the private sector to join in the National Health Security System.[5]

A major strength of Bangkok is its concentration of many private hospitals. That provides an opportunity to mobilize various service units to join the public service network to maximize coverage and increase accessibility. This plan was the starting point for the introduction of collaborative concepts of private health service units, adapted to the context of Bangkok.

BENEFIT FROM THE USE OF NEW TECHNOLOGY AND INNOVATION FROM THE PRIVATE SECTOR AND INCREASE THE NUMBER OF AFFILIATED HEALTH PERSONNE

TO INCREASE THE EFFICIENCY OF HEALTH SERVICES

Increasing the efficiency of health services, especially outpatient services, helps prevent unnecessary hospitalization of patients. This approach is called an Ambulatory Care Sensitivity Condition (ACSC) system. The outcome of a hospital stay with a high ACSC condition will reflect the quality of service and access to primary care.[6] Disease that can be treat as an outpatient treatment such as epilepsy, chronic obstructive pulmonary disease, asthma, diabetes and high blood pressure etc.[7] Therefore, with the participation of the private primary, secondary, and tertiary care units, the service will be distributed more widely. This allows the patients to access outpatient services more conveniently, and this helps reduce medical-related expenses as well.[8] In addition, having a private hospital to support inpatients and cases who need specialized care helps spread bed occupancy more evenly and reduces the burden of emergency services in public hospitals.

2.2

THE ROLE OF PRIVATE SECTOR SERVICES IN THE NHSO UCS

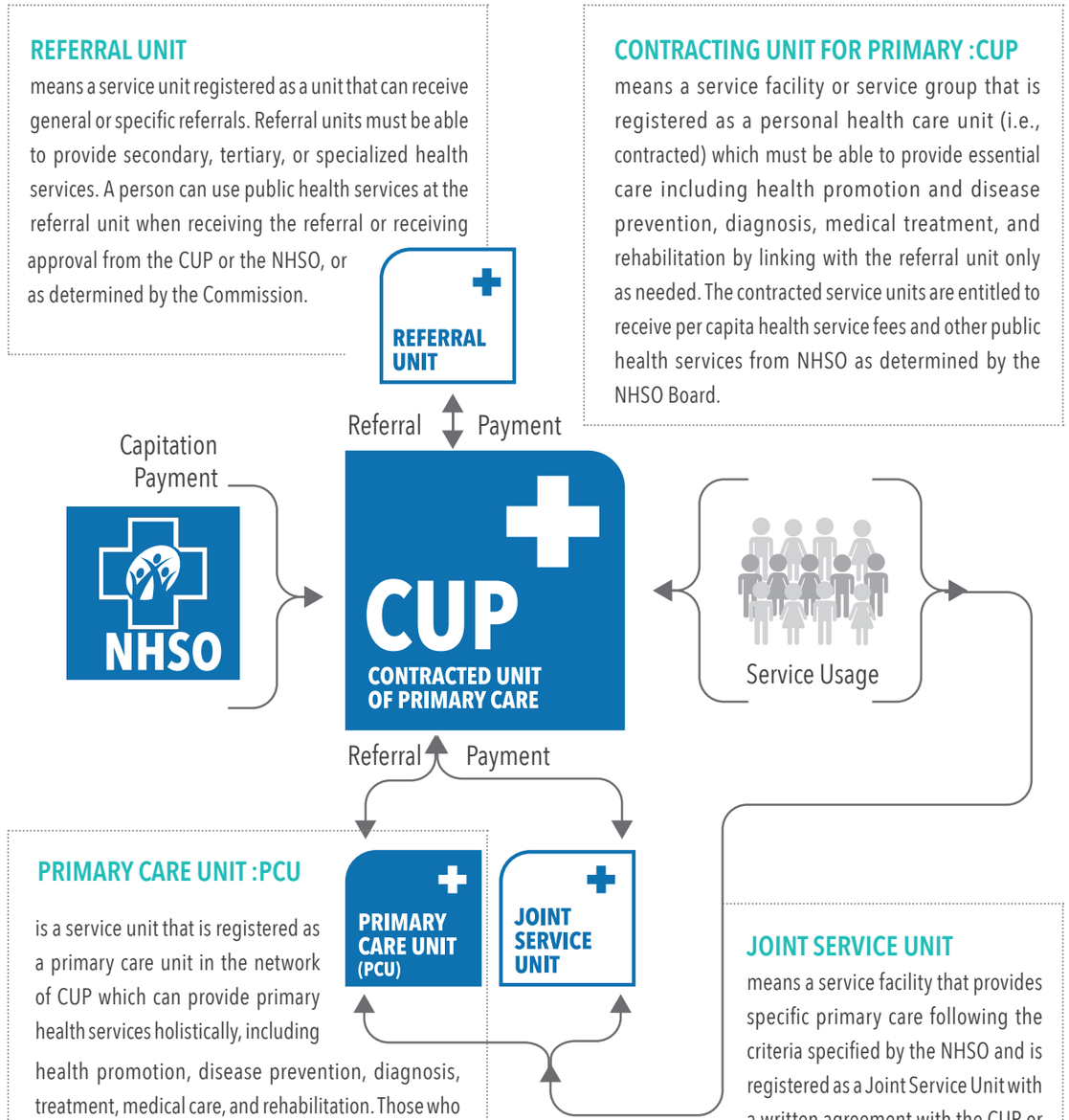
THE PRIVATE SECTOR AS A NETWORK OF HEALTH SERVICE UNITS

There are four types of service units registered with the NHSO to form a network as follows: Contracted Unit for Primary Care (CUP), Primary Care Unit (PCU), Referral Unit, and Joint Service Unit. These units are linked together as a service network by providing health services according to their potential (Figure 1). The private sector has a role as a network of service units in the UCS by acting as both a CUP, a primary care unit (PCU), a referral unit, and joint service unit.

NETWORK OF HEALTH SERVICE UNITS

Figure 1

Under the NHSO Regulations on Rules, Procedures and Conditions for Registration of Service Units and Networks (2015), there are four types of service units, which are 1) contracted units for primary care 2) primary care units 3) referral units and 4) joint service units



REFERRAL UNIT
means a service unit registered as a unit that can receive general or specific referrals. Referral units must be able to provide secondary, tertiary, or specialized health services. A person can use public health services at the referral unit when receiving the referral or receiving approval from the CUP or the NHSO, or as determined by the Commission.

CONTRACTING UNIT FOR PRIMARY :CUP
means a service facility or service group that is registered as a personal health care unit (i.e., contracted) which must be able to provide essential care including health promotion and disease prevention, diagnosis, medical treatment, and rehabilitation by linking with the referral unit only as needed. The contracted service units are entitled to receive per capita health service fees and other public health services from NHSO as determined by the NHSO Board.

PRIMARY CARE UNIT :PCU
is a service unit that is registered as a primary care unit in the network of CUP which can provide primary health services holistically, including health promotion, disease prevention, diagnosis, treatment, medical care, and rehabilitation. Those who have chosen CUP can use public health services at PCU in the network. However, PCU is entitled to receive reimbursement for expenses for public health services from CUP or the NHSO as determined by the Commission.

JOINT SERVICE UNIT
means a service facility that provides specific primary care following the criteria specified by the NHSO and is registered as a Joint Service Unit with a written agreement with the CUP or the NHSO to provide public health services to eligible patients. Joint service units to receive compensation for health services from CUP or the NHSO as determined by the Commission.

Source: NHSO Regulations on Rules, Procedures and Conditions for Service Unit and Network Registration 2015[9]

The service units involved in each level of the service system vary by area, both in and outside of Bangkok. Private sector participation in the health service network varies at different levels of the system based on the context. In large cities and Bangkok, there is more participation from the private sector than in the countryside due to the large concentration of private hospitals to support the densely-settled urban population. In addition, urban facilities have specialized services to address some of the unique health issues of city populations, such as corrective dental services, sophisticated pharmaceutical service, and treatment of rare diseases. By contrast, outside of urban areas, most of the hospitals are government-run.

To organize the service network, service units are registered as the contracted unit of primary care (CUP) for populations in a given catchment area and link with primary care units and referral units. Under the NHSO system, these service units can be classified into the following four types:

NETWORK OF SERVICE UNITS

1

TYPE

1

THE SERVICE UNIT ACTS AS ALL THREE TYPES OF SERVICE FACILITY

A single health facility may function as the primary care unit, the CUP, and the referral unit, all in one. In this part of the network, many patients have to go to a hospital for primary care, and that can cause unnecessary crowding, and reduces access to needed services. This aspect of the system also raises the cost of treatment compared to going to a private clinic nearer to the patient's home. By contrast, going to a clinic near the patient's home consumes less time in travel and waiting for service (Figure 2). These types of service units are mostly found in Bangkok.

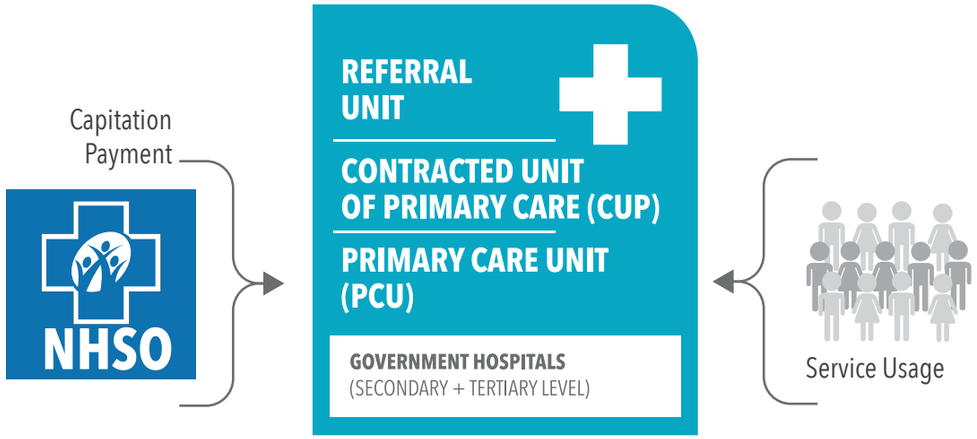


Figure 2

NETWORK OF TYPE 1 SERVICE UNITS UNDER THE NHSO SYSTEM

TYPE

2

THE CUP AND REFERRAL UNIT ARE THE SAME FACILITY; THE PRIMARY CARE UNIT IS SEPARATE

In this category, the CUP is the same facility as the referral unit. The primary care unit is a separate facility. In urban areas, the general (provincial) hospital, the regional hospital, and other hospitals outside the MOPH serve as the CUP and referral unit for patients in the catchment area. These hospitals have direct links with the primary care facility which a patient is assigned to (e.g., health center or community health outpost). Associated service units include private clinics and clinics in government hospitals which provide case-specific primary care (e.g., internal medicine clinic, physiotherapy clinic, Ob-un Community-friendly Drug Store, dental clinic, etc.). In rural areas, the community (i.e., district) hospital is the CUP and referral unit for patients in the catchment area. The Tambon Health Promotion Hospitals (THPH), health centers and community health outposts serve as the primary care facilities in the network (Figure 3).

The regional and general (provincial) hospitals usually have a high level of clinical capacity, and they have specialists to deal with uncommon conditions (i.e., tertiary care). Thus, patients who come to these hospitals as their CUP are mixed in with those patients who are referred from other areas, and this can cause a problem of overcrowding at these facilities.

This system of Type 1 and 2 service units in the network actually exacerbated crowding and hindered convenient access to the health service system. These units also had long wait-times for patients to be served. Even the largest hospitals had problems of unnecessary crowding due to this aspect of the system. Accordingly, the NHSO modified the network, particularly in the urban areas and Bangkok, to allow the qualified primary care unit as the CUP for patients in the locality. This modification created service unit Types 3 and 4 in the network.

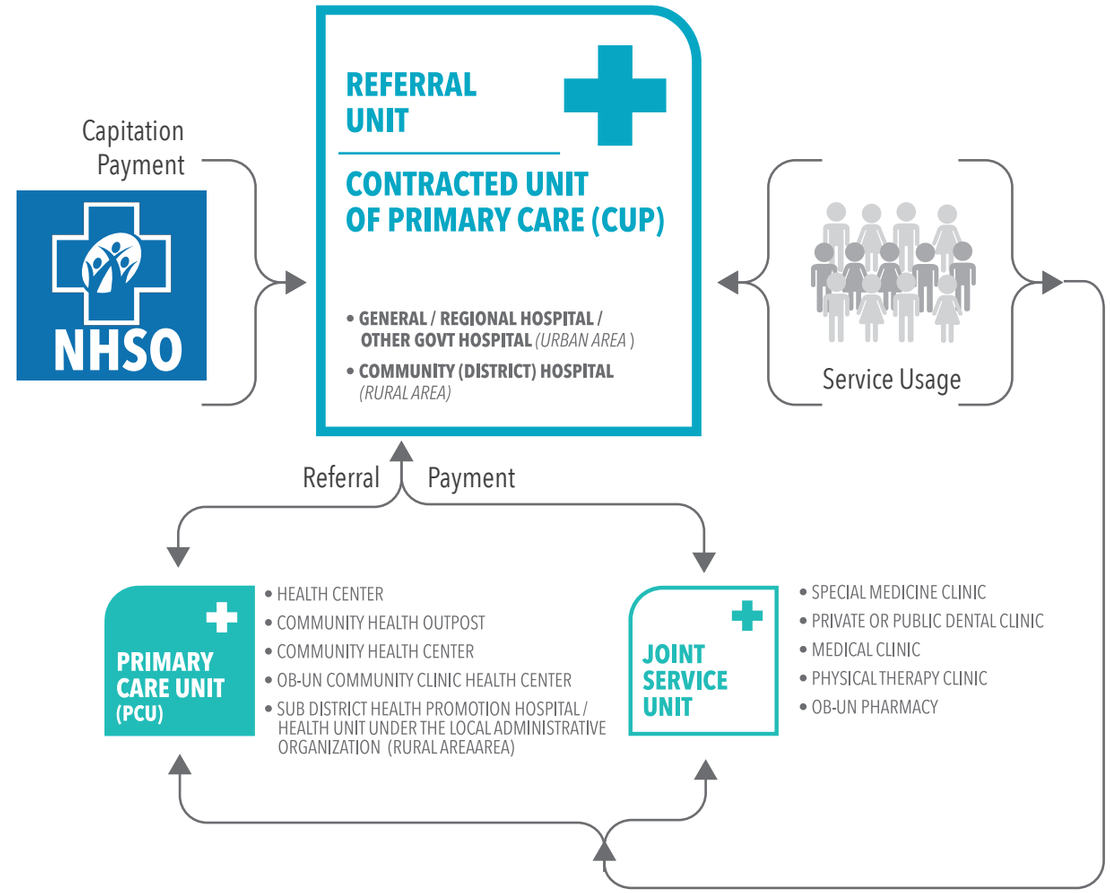


Figure 3

TYPE 2 FACILITIES IN THE NETWORK OF SERVICE UNITS IN THE NHSO SYSTEM

TYPE

3

THE PRIMARY CARE, CUP, AND REFERRAL UNITS ARE EACH CONTAINED IN A SEPARATE FACILITY

In this type of the system, the primary care, CUP, and referral units are each contained in a separate facility (Figure 4). A primary care unit can be registered as the CUP such as the Ob-un Clinic or local health center. Primary Care units (e.g., Ob-un Clinic, Public Health Center, Ob-un Community Drug Store, dental clinics, specialized medicine clinic, physiotherapy clinic, etc.) may be adjuncts to the CUP. Most of these auxiliary units are private. The referral units include secondary and tertiary care hospitals of the government, medical school, or private sector. Those patients registered with these CUPs will be able to seeking service for basic health needs near their home.

This modification is most relevant for the situation in large cities and Bangkok, which usually have an extensive network of Ob-un Community Clinics. The advantage for both patient and provider is that this modified system increases options for the patient with basic care needs, and reduces crowding in the larger hospitals.

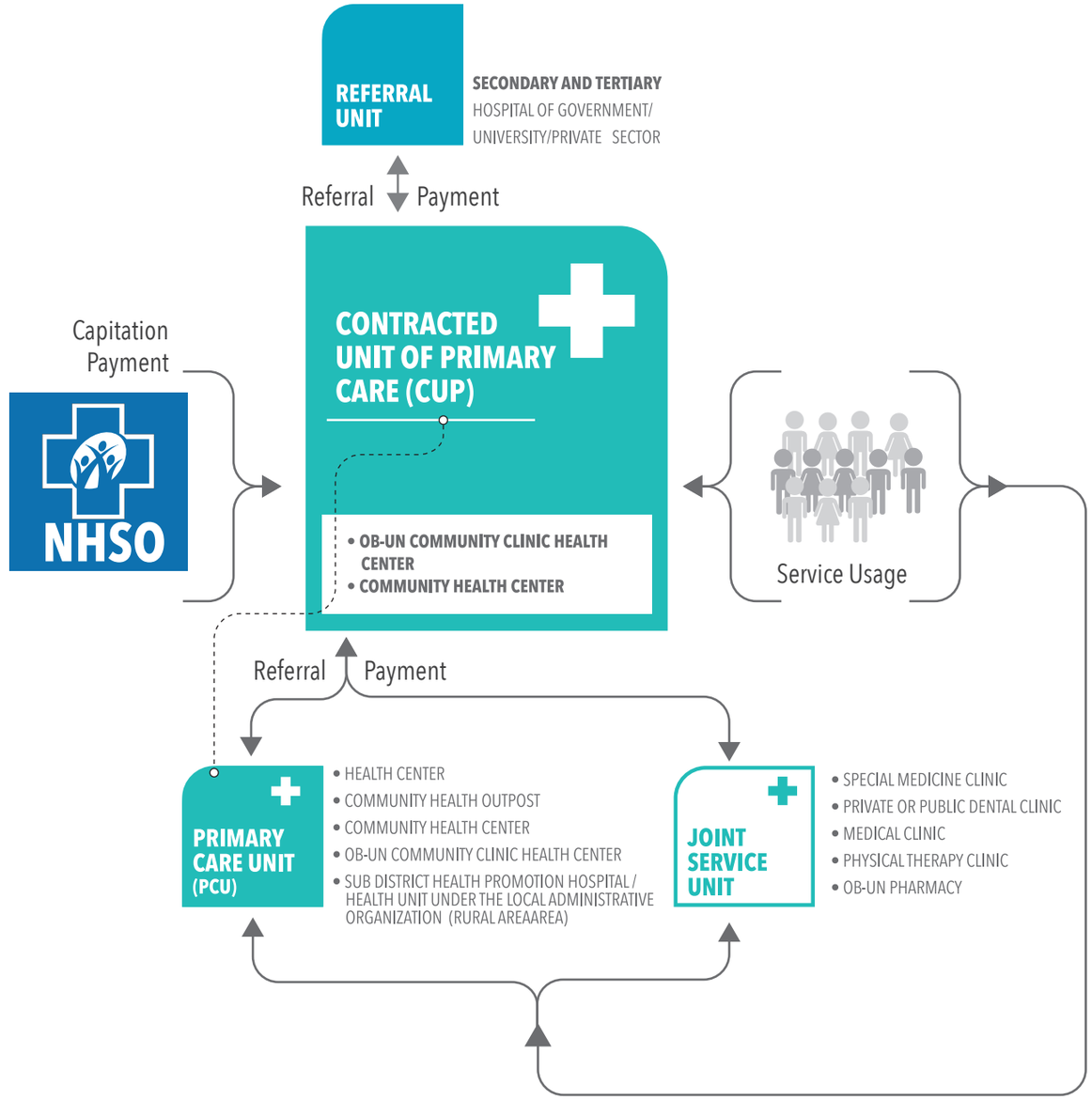


Figure 4

TYPE 3 SERVICE UNITS IN THE NHSO SERVICE NETWORK

TYPE

4

THE PRIMARY CARE AND CONTRACTED UNIT OF PRIMARY CARE (CUP) ARE ONE AND THE SAME, BUT THE REFERRAL UNIT IS A SEPARATE FACILITY

In this type, the primary care and CUP are one and the same, and may include the Ob-un Community Clinic or a private hospital, with links to primary care facilities such as the community health outpost, dental clinic, Ob-un Community Drug Store, etc. All of these facilities have an assigned referral unit which may be the general hospital, the regional hospital, or a specialized-care hospital in the public or private sector. In Bangkok, the referral units include the 28 hospitals under the BMA (Figure 5).

In rural areas, the THPH and service units under the local administrative organization serve as the CUP and primary care unit. The health center and community health outpost are adjunct primary care facilities, while the community hospital is the referral unit.

In this system, Types 3 and 4 have the advantage of allowing patients to seek primary care at a facility nearer their home. That improves convenience and reduces crowding and wait times at the large hospitals. That gives those hospitals more space and personnel to attend to emergency and critical-care patients. It also allows those hospitals to receive more of the most vulnerable patients.

That said, a limitation of the Types 3 and 4 components is that on ensuring the participating units to provide quality care for the catchment population.

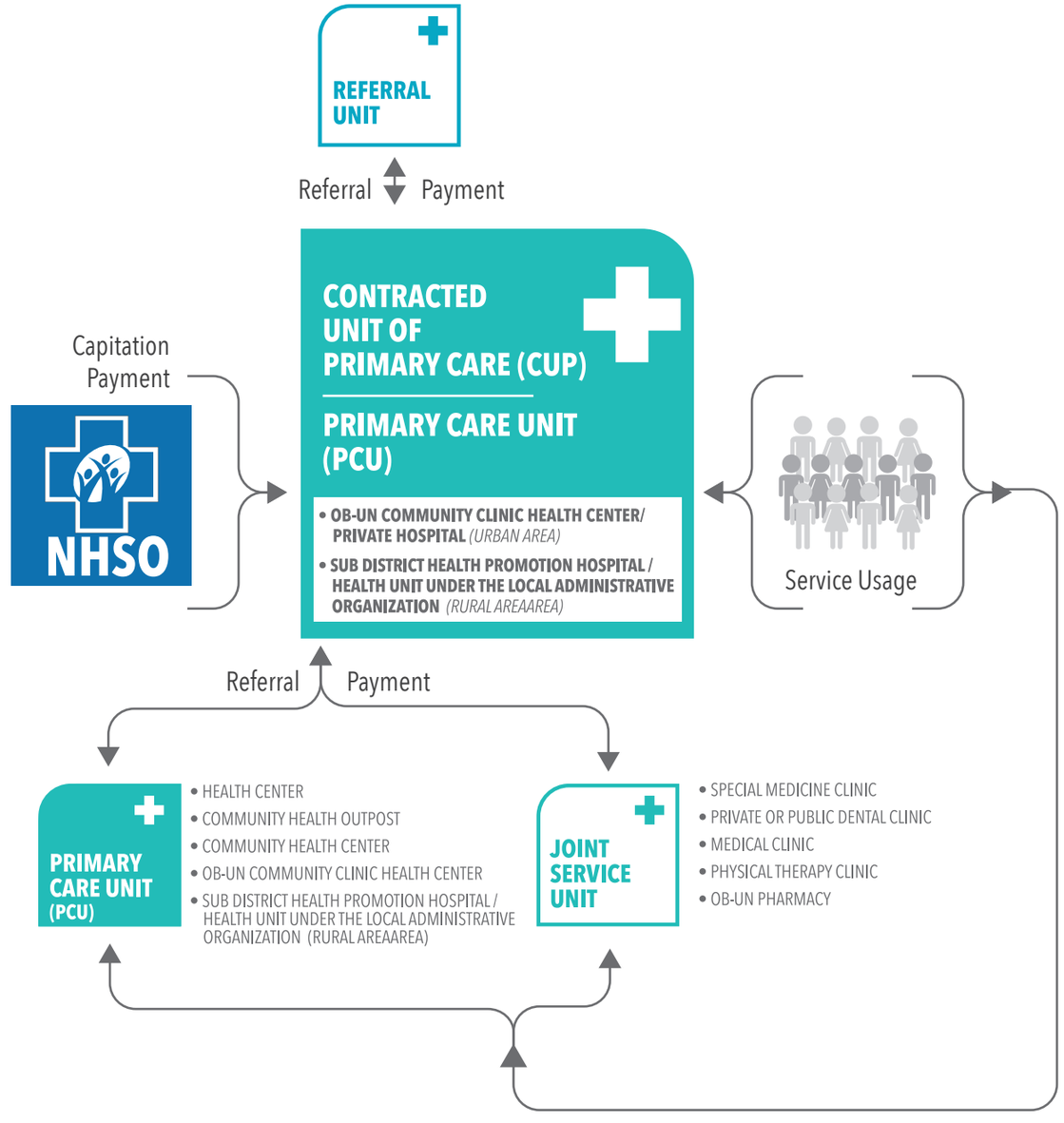


Figure 5

TYPE 4 SERVICE UNITS IN THE NHSO NETWORK

2 ACCIDENT & EMERGENCY SERVICES

Accident/emergency services consist of three types: Critical condition in the event of an accident or illness, non-critical condition emergency/ accident cases, and indicated cases. There is no difference in these types for Bangkok or the other provinces. Private services play a significant role in the event of an accident or emergency.

Previously, some private hospitals require proof of ability to pay in advance or a down payment for care. In other cases, the private hospital may not have enough beds or does not accept inpatients. Cases usually have to pay out-of-pocket, and this may result in denied or delayed service for emergency illnesses/conditions, which can result in death. The NHSO has a policy to allow patients with emergency illnesses to receive medical care at the nearest hospital according to the crisis illness emergency policy, i.e., Universal Coverage for Emergency Patients (UCEP) with reimbursement from NHSO as follows:

TYPE 1

CRISIS EMERGENCY

Cases can get services at a hospital nearest the site.[11] If admitted to a private hospital, the hospital will assess the symptoms by emergency level according to the criteria of the Institute of Emergency Medicine. If the criteria indicate the case is a crisis emergency, patients are entitled to treatment from the private hospital without having to pay service fees.

Within 72 hours, the hospital sends patient information to NHSO to find an available bed in their registered hospital. Emergency patients will be transferred to their registered hospital after they are out of critical condition or within 72 hours. If the case cannot be referred within 72 hours because the crisis has not yet passed, or due to lack of an available bed, the participating hospital can charge service fees to the NHSO at the agreed rate or per actual costs incurred. If in case bed is available but a patient refuses referral, they are responsible for their cost of care.[12]

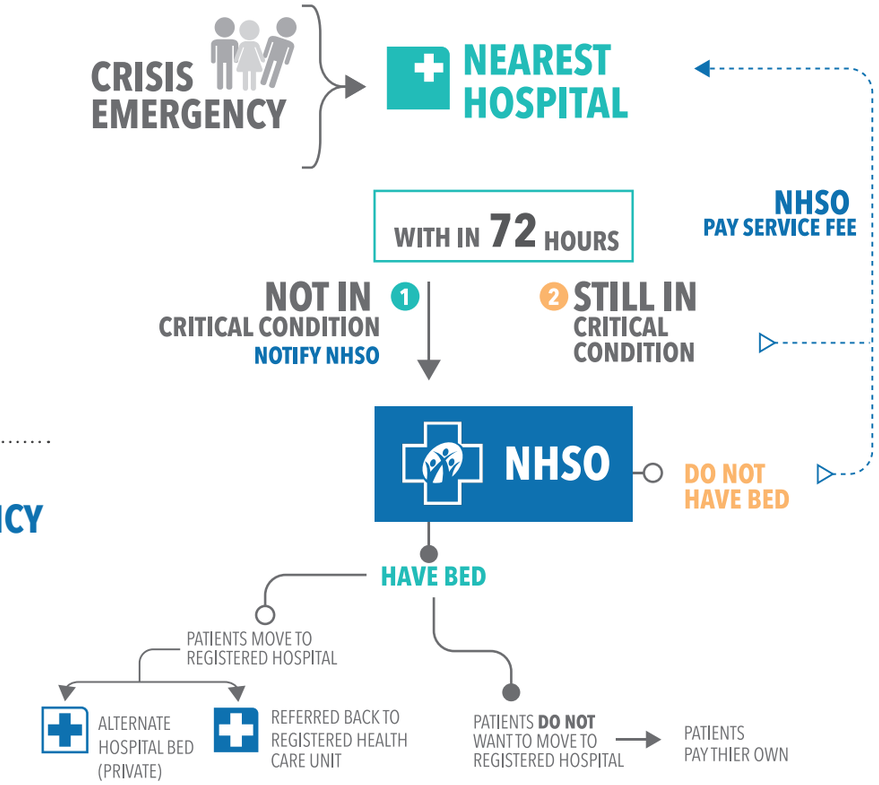


Figure 6
CRISIS EMERGENCY

TYPE

2

IN CASE OF NON-EMERGENCY CRITICAL ILLNESS OR TRAVELING TO OTHER PROVINCES

If there is a need to be hospitalized, such as for high blood pressure, extreme headache, severe diarrhea which is not life-threatening and which is under NHSO regulations governing the exercise of public health service rights, or in the event of accident/emergency illness (No. 2) 2015 and the Regulations 2017, which states that patients have the right to UCS, and there is a reasonable cause, then that case can receive treatment at another facility (e.g., private/government hospital outside the NHSO network). When a case is admitted to a private hospital outside the network, the hospital will notify the NHSO within 24 hours. The NHSO will process the cost of treatment and pay the hospital at the rate specified by the NHSO. If the notification is later than 24 hours, or in the case that after 24 hours the patient cannot yet move back to their registered hospital (i.e., since they are still critically ill, or there is a lack of a bed), the hospital will receive compensation for the service fee as agreed with the NHSO. However, if the case is no longer critical, and the patient refuses to be referred, then they are responsible for their own care.[12] (Figure 7)

TYPE

3

INDICATED CASES

If there is a referral of an emergency patient from a CUP unit to a private hospital outside the UCS system because the treatment is beyond the capacity of the CUP, in this case, only NHSO will refer the patient to the private hospital outside UCS system and NHSO will pay the service fees at the rates of the referral hospital or according to the agreement.[12]

In cases of accident/emergencies, all participating private service units must accept cases admitted until the case is stabilized. They must not collect medical fees from patients during that time. They are to coordinate with the NHSO for referral to registered hospitals.

In the case that the registered hospital bed is not available, then the patient can be referred to a reserved-bed private hospital. In sum, private service has a role both to care for primary care patients including cases of accidents/emergencies and refer the patient per the flow chart .

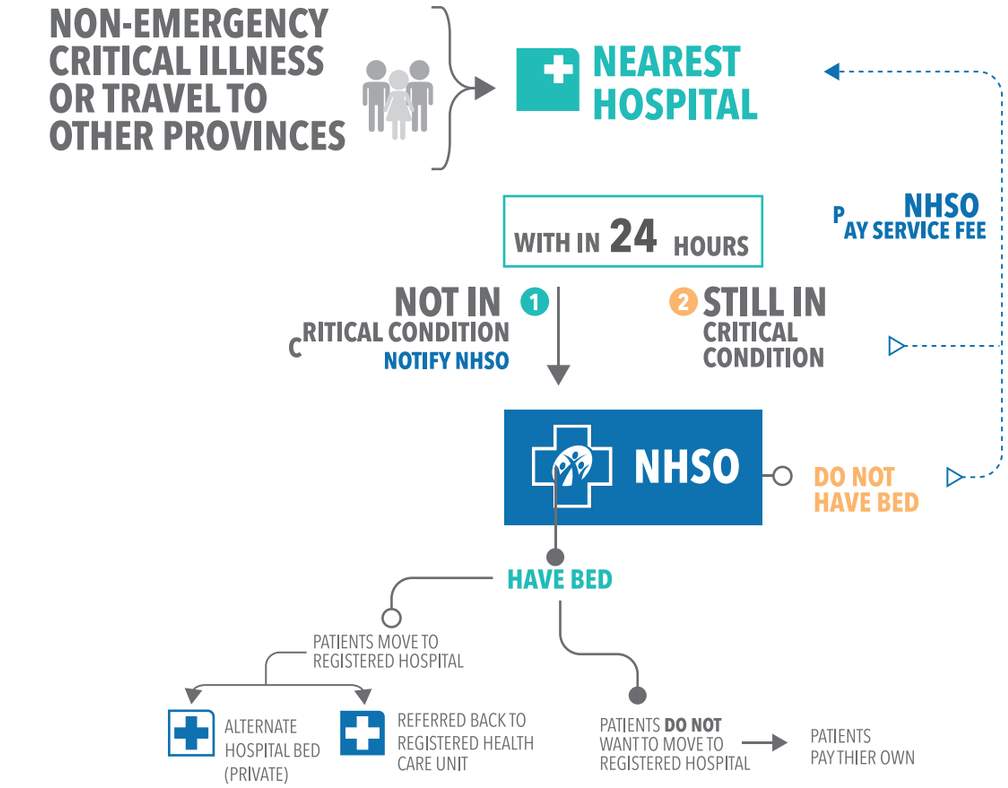


Figure 7

NON-EMERGENCY CRITICAL ILLNESS OR TRAVELING TO OTHER PROVINCES

3

SPECIALIZED
SERVICE PROVIDER

ROLE OF THE PRIVATE SECTOR IN SPECIALIZED SERVICE

Specific services are organized to solve problems of the hospital in the areas that do not have sufficient capacity, or the public hospital is full or unable to support patients or having to wait in a long queue. The NHSO has enlisted private hospitals that can treat specific diseases to join the UCS. The public facility may lack technology or specialized doctors for treatment in those cases, but can refer to hospitals outside the network, with the NHSO paying service fees. But in the case of a referral to a private hospital outside the network, payment is made by "reimbursement of reserved-bed " by the NHSO based on a negotiated service fee with private hospitals.

In 2012, the NHSO and the BMA signed an agreement with four private hospitals to provide cancer screening and treatment services.

Those facilities had a high capacity for cancer care, and could help reduce waiting times, increase early diagnosis and treatment, and improve patient quality of life. The private hospitals are compensated according to the rate specified by the NHSO. Non-cancer patients but need radiation treatment such as certain types of brain tumors, auditory nerve tumors, and abnormal aneurysms, have access to equal treatment.[15] Bhumibol Adulyadej Hospital is one of the hospitals that made an agreement with the NHSO for referral services for outpatients and those with cancer or other complex diseases that require radiotherapy as specified in the referral letter, and can be sent to three hospitals that have agreed to care for these cases. The cost of treatment is still under the conditions of the NHSO, Social Security Office, or the Comptroller General's Department.[16] Currently, the disease-specific services are:1) Cataract Surgery 2) Osteoarthritis Surgery 3) Cardiovascular Disease Services 4) Stroke Patients 5) HIV Infection Services and AIDS patients, and 6) Chronic renal services.[10]

The private sector participates in health promotion and disease prevention services as follows: 1) Screening for health risks and health-promoting factors; 2) Changing behavior, such as providing advice or knowledge and demonstrations for health promotion and disease prevention; and 3) Immunization, drug use and procedures for health promotion and disease prevention. In Bangkok with its large catchment population, service units are still limited in coverage and capacity, and that hinders access to screening services.

Thus, the NHSO introduced a pilot project called "Ob-un" pharmacies (community-friendly drug stores) as an alternative for people to access disease screening services. The pilot began in Bangkok in 11 districts in 2019 with 26 pharmacies participating in preliminary screening tests using risk screening, weight measurement, height measurement, physical examination, obesity assessment, blood tests for diabetes risk, etc. The screening results are recorded in a health log which is distributed to all patients. Patients receive advice and health education. If abnormalities are found, they will be referred for treatment as according to their rights. In 2020, these facilities were authorized to provide resupply of prescribed medication in patients with chronic diseases including activities to promote health and prevent other diseases.[17, 18]

PROVIDER OF HEALTH PROMOTION & DISEASE PREVENTION P&P 4

There is also a joint service unit project for preventive dental services. The NHSO, together with the health center network of the BMA and 82 participating private dental clinics in the Bangkok area, covers services including oral examination and advice to all age groups, coating with fluoride gel or fluoride varnish in children at risk, coated fluoride gel or varnish fluoride with a high concentration of local fluoride for persons age 6-20 years, sealant in children, and apply fluoride varnish for the elderly, removal of plaque, and cleaning of the whole mouth/teeth in pregnant women.[18]

For local participation in Bangkok, in FY 2018, the NHSO provided 45 baht per capita (360,087,750 baht) to create a "Bangkok Health Insurance Fund", to which the BMA contributed not less than 50% * , which is following the National Health Security Act 2002 Section 47 [19] that

"to create a national health insurance for people in the locality by promoting participation processes according to readiness, suitability and needs of local people. The committee shall support and coordinate with the local government organization. Establish rules for the said organization to be the operator and manage the health insurance system at the local or area level to receive expenses from the fund to promote health, prevent disease, rehabilitation and proactive primary care necessary for health and living, including caring for the elderly who are dependent on the community."

In addition, the NHSO and BMA created cooperation with the private sector in health promotion and disease prevention for all age groups including the vulnerable and various risk groups, such as the elderly, public bus drivers, etc. They solicited private service agencies to join, such as the Ob-un community clinics, Ob-un pharmacies, dental clinics, physical therapy clinics, part-time medical clinics, joint service units, etc. These private service units play an important role in health screening, health awareness, home visits and patient care at home, and coordinating physical therapy for the disabled, etc., with a medical professional, nurse, or physical therapist as part of the team.

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* Article 8: Local administrative organizations (LAO) agree to contribute to the Health Security Fund at the percentage of money allocated from the National Health Security Fund under Article 7 (1) as follows:
(1) Contribution of not less than 30% in the case of revenue of the LAO excluding subsidies of less than 6 million baht;
(2) Contribution of not less than 40 percent in the case of the income of the LAO excluding subsidies from 6 to 20 million baht;
(3) Contribution of not less than 50 percent in the case of revenue of the LAO not including subsidies above 20 million baht

5

PRIVATE SECTOR PARTICIPATES IN GOVERNANCE STRUCTURE OF NHSO

The private sector is involved in the governance structure of the UCS by participating in two levels of governance: policy and operation levels (Figure 8).

At the policy level under the National Health Security Act 2002, Article 13 (5) stipulates that five representatives of public health professions, namely representatives from the Medical Council, Nursing Council, the Pharmaceutical Council, the Dental Council, and the Private Hospital Association serve on the NHSO Board. In addition, Article 48 (3), stipulates that one private hospital representative who is a private hospital association member serves on the Quality Control Board of Public Health Service.[19]

At the operational level, the National Health Security Act 2002, Article (9) stipulates that local government organizations, community organizations, private organizations, and the non-profit private sector are to participate in the management of health insurance systems at the local level or area.[19] The private sector, therefore, participates in the National Health Insurance Subcommittee at the local level with an organization as a representative of one private hospital (if any).

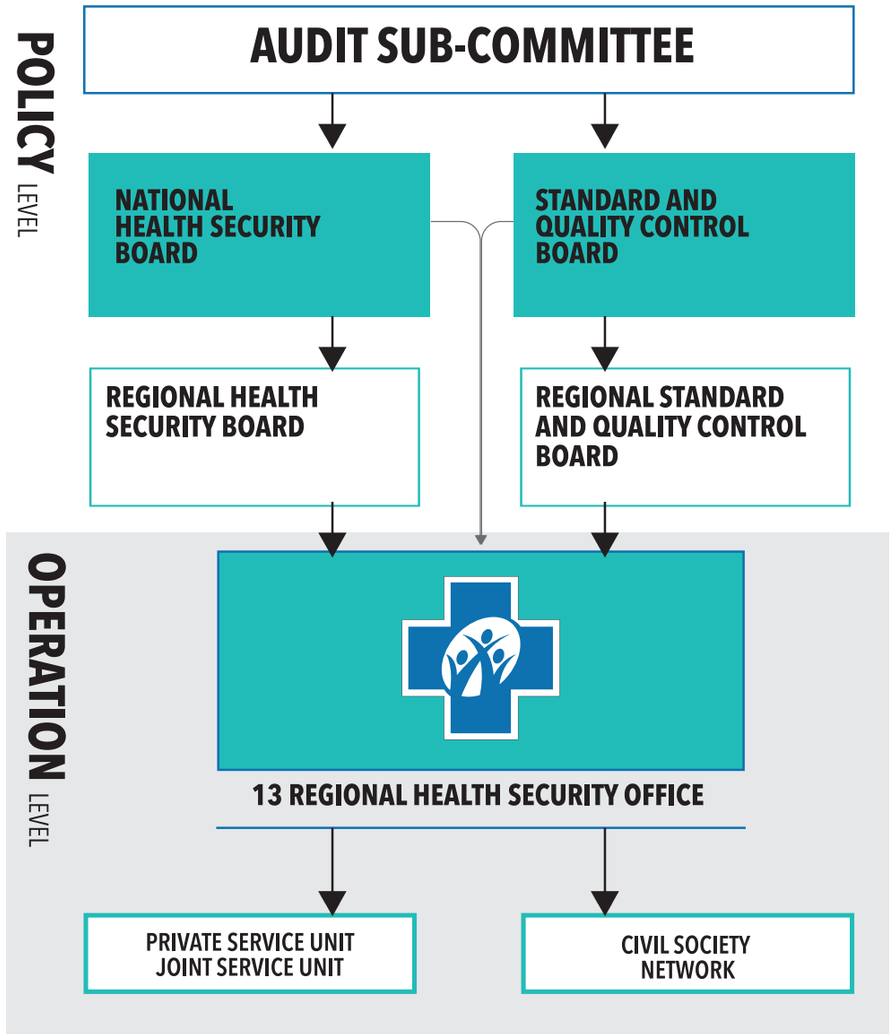
THE ROLE OF PRIVATE SECTOR PARTICIPATES IN GOVERNANCE STRUCTURE OF NHSO

POLICY LEVEL

There is the National Health Security Board and the Standard and Quality Control Board which work in parallel with the Audit sub-committee which is responsible for internal auditing. All three groups work together to form a national health insurance oversight system through various sub-committees.

Figure 8

PARTICIPATION OF THE PRIVATE SECTOR IN THE NHSO



OPERATION LEVEL

At the local level, representatives of private service units participate via the Regional Health Security Subcommittee and Regional Quality Control and Service Standards Subcommittee, which has a similar role to the National Health Security Board and the Quality Control and Standards of Public Health Services Board at the national level. The only difference is that the scope of responsibility is at the local level (i.e., district branch of the NHSO). Both sub-committees are mechanisms that work with the regional NHSO and the concerned parties, especially the people's network and private service units in the area. This is according to the role set out in the National Health Security Act 2002, such as the Quality Control and Service Standards Subcommittee, which has one representative from the private service unit sector as a committee member. That enables the private sector to have a role in quality control and standardization of service units and service networks, including supervising the service reports of inspections and control of service units, including setting criteria, methods, and conditions for complaints of violators, etc. The Regional Health Security Subcommittee plays a role in establishing the framework for managing the health insurance system in the area to establish fund management guidelines, guidelines for registering service networks, referral systems, allocating the number of registrants of each service unit, and appointing a working group for the work of NHSO at the district level, etc.

The participation of private service units in the governance mechanism allows the private sector to reflect on the problems and suggestions that are relevant. This makes it possible to solve problems and develop service systems that are more in line with the needs of the people, and in line with the operating conditions of the private sector. Because private service units are directly related to the service system, they receive the budget and manage budget per capita for service provision and referral. In addition, participation from all parties leads to good governance in fund management.

SUMMARY OF THE ROLE OF THE PRIVATE SECTOR IN THE NHSO UC SCHEME

1

PART OF THE SERVICE NETWORK

The private sector has a role both as the CUP, the PCU, the referral unit, and joint service units in the following numbers:

- 20 PCU units
- 284 CUP/PCU units
- 34 CUP, PCU and referral units
- 200 joint service units
- 4 capitation referral units, 4 non-capitation units and 272 specialized referral units

One service unit can be registered in multiple types

2

ACCIDENT & EMERGENCY SERVICES

Private hospitals play an important role in accidents and emergencies as follows:

- Accepting accident/emergency patients in the event of a crisis and treating the crisis
- Coordinating to refer patients via the NHSO or the CUP of the patient in order to provide a hospital for the patients to recover.

3

SPECIALIZED SERVICE PROVIDER

Private hospitals with high capacity play a role in the treatment of specialized diseases that require modern technology, such as cardiovascular disease, cancer, knee surgery, cerebrovascular disease, HIV/AIDS, kidney failure, cataract surgery, etc.

4

PROVIDER OF HEALTH PROMOTION & DISEASE PREVENTION (P&P)

- Screening to find health risks
- Enhancing risk behavior modification, giving advice and providing knowledge about health promotion, drug use, and conducting for health promotion and disease prevention in all age groups
- Conducting home visits

5

PRIVATE SECTOR PARTICIPATES IN GOVERNANCE STRUCTURE OF NHSO

3

REGISTRATION OF PRIVATE AND GOVERNMENT SERVICE FACILITIES

There are a total of 12,151 health service units that registered in the UCS system dividing into 11,587 units registered as primary care unit, 1,331 units as CUP and 1,355 units as a referral unit. The government sector plays an important role especially in primary care services accounting for 94 percent of primary care units while the private sector accounts for only 2.3 percent. The private sector plays more role in CUP and referral services where the percentage of units registered as CUP and referral unit accounts for 19 and 21 percent respectively (Table 2).

Table 2
NUMBER OF GOVERNMENT AND PRIVATE SERVICE UNITS REGISTERED IN UCS IN 2018

TOTAL OF GOVERNMENT AND PRIVATE SERVICE UNITS REGISTERED IN UCS IN 2018

12,151 UNIITS

PRIMARY CARE UNIT 11,587 **UNITS**	
MINISTRY OF PUBLIC HEALTH	94.31%
OTHER GOVERNMENT SECTORS	1.54%
PRIVATE SECTOR	2.35 %
LOCAL GOVERNMENT ORGANIZATION	1.80%
PRIMARY CONTRACTED UNIT 1,331 **UNITS**	
MINISTRY OF PUBLIC HEALTH	68.59%
OTHER GOVERNMENT SECTORS	11.50%
PRIVATE SECTOR	19.01%
LOCAL GOVERNMENT ORGANIZATION	0.90%
REFERRAL UNIT 1,335 **UNITS**	
MINISTRY OF PUBLIC HEALTH	70.48%
OTHER GOVERNMENT SECTORS	7.98%
PRIVATE SECTOR	21.03%
LOCAL GOVERNMENT ORGANIZATION	0.51%

The registration of various service units follows the same steps between the public and private sectors. That is to say, a unit must indicate the intention to join the system and fill out the application for registration. Government service agencies are registered automatically, while the private sector joins voluntarily. Health facilities that are registered as units of each type must pass the assessment criteria. The criteria include the ability to provide services for easy access to the public. The service system shall be organized according to the type and scope of the public health service, personnel, management, location, equipment, and tools. The oversight of the Ob-un community clinics is the responsibility of the Provincial Quality and Service Control Sub-Committee. The NHSO has determined that, after opening the service for the public, in the case of a private health service center outside the MOPH, there must be a random assessment at least once per year or every time there is a complaint from a patient regarding quality and service standards. In the case of public health service centers under the MOPH, they are to report the results according to the system via the MOPH.[21] The registration procedures for each type of private service unit are as follows:

The process of registering a service unit consists of: 1) The NHSO, publicizes the system to private unit to join as a service unit; 2) The interested private unit must submit a request and fill out an application; 3) The private unit audit team consists of representatives from public health centers, hospitals, and community representatives in the area to assess the qualifications and readiness in accordance with the criteria set by the NHSO Board; 4) When the private unit passes the assessment criteria, the NHSO will announce registration as a service unit and enter into a legal contract.

Private service units will be evaluated according to the criteria on an annual basis. If they pass the criteria, then they can renew the contract. There are ad hoc special audits and visits to the Ob-un community clinics that have complaints or problems with the service system.

PROCESS OF REGISTERING A SERVICE UNIT

1. The NHSO, publicizes the system to private unit to join as a service unit
2. The interested private unit must submit a request and fill out an application
3. The private unit audit team assess the qualifications and readiness in accordance with the criteria set by the NHSO Board
4. The private unit passes the assessment criteria, the NHSO will announce registration as a service unit

The number of private service units, especially the Ob-un community clinics, registered in the national health insurance system between 2004-2019, increased, especially in the city areas and Bangkok. By contrast, the number of private hospitals tended to decrease. In Bangkok, the number of private hospitals that participate in the UCS is relatively small, while the number of participating Ob-un community clinics has been on the rise since 2003 but slowed since 2013 (Figures 9 and 10).

Figure 9

NUMBER OF PRIVATE UNITS (PRIVATE HOSPITALS AND OB-UN COMMUNITY CLINICS) THROUGHOUT THE COUNTRY WHICH HAVE REGISTERED WITH THE NHSO, 2004-2019

Source: NHSO website and NHSO Zone 13, Bangkok[22]

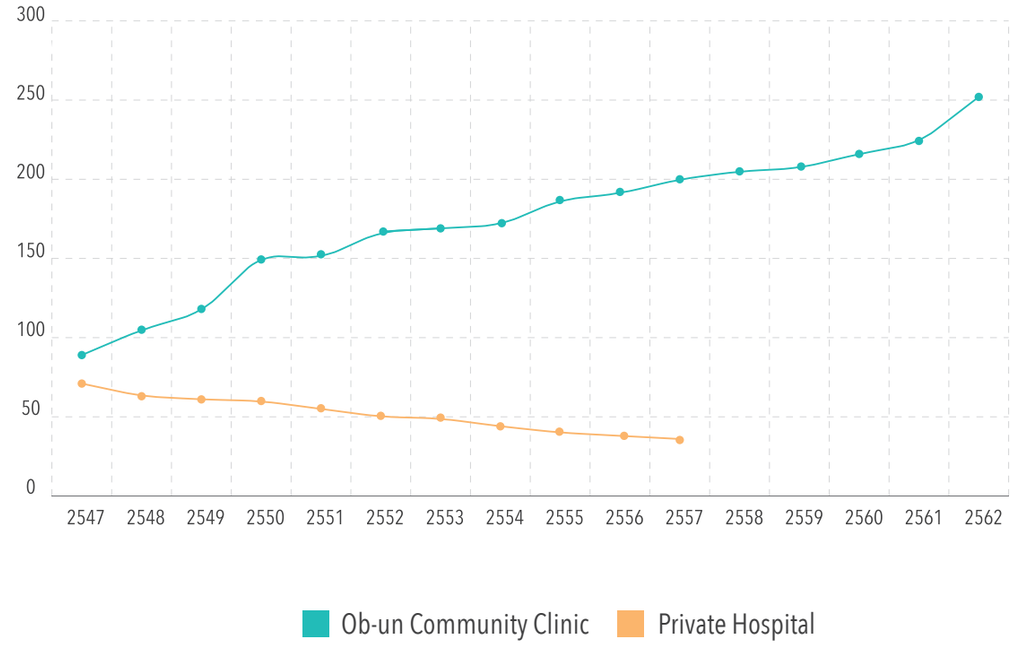
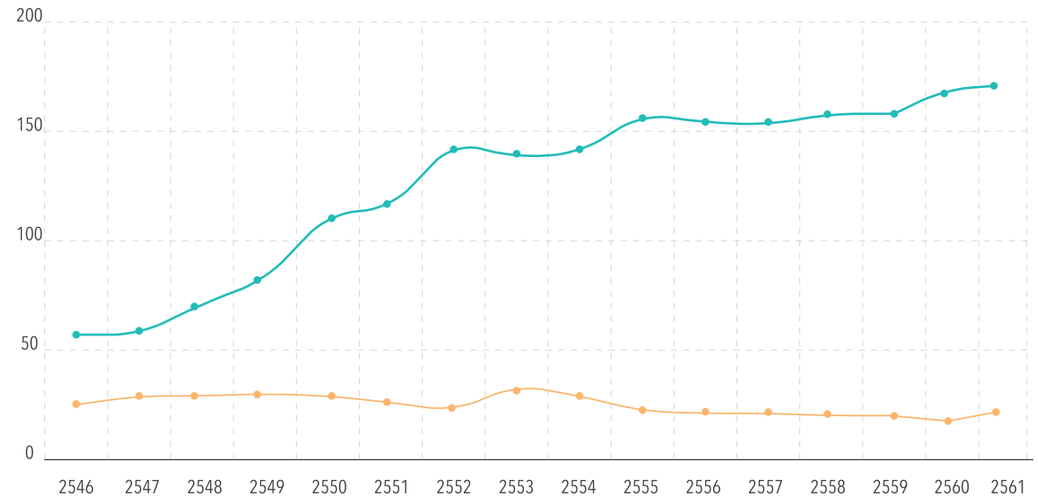


Figure 10

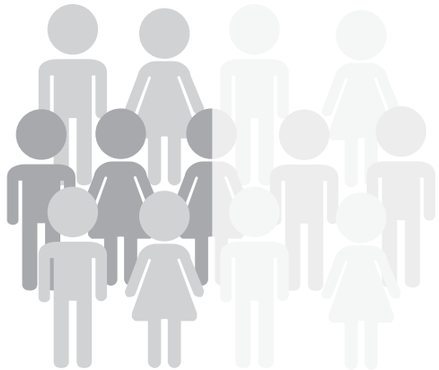
NUMBER OF PRIVATE UNITS IN BANGKOK METROPOLITAN AREA (PRIVATE HOSPITALS AND OB-UN COMMUNITY CLINICS) REGISTERED WITH THE NHSO DURING 2003 TO 2018

Source: NHSO website



4

REGISTRATION OF BENEFICIARIES



3.9

MILLION
POPULATION IN BANGKOK OR ABOUT HALF OF THE TOTAL ARE UCS MEMBERS

ACCORDING TO THE NATIONAL HEALTH SECURITY ACT B.E. 2545 (2002)[19], SECTION 6[20]

STATES THAT PERSONS WISHING TO EXERCISE THEIR RIGHT TO UCS MUST FILE AN APPLICATION FOR REGISTRATION WITH THE LOCAL OFFICE OR THE DESIGNATED DEPARTMENT TO SELECT THE CUP

According to the National Health Security Act B.E. 2545 (2002)[19], Section 6[20] states that persons wishing to exercise their right to UCS must file an application for registration with the local office or the designated department to select the CUP. In Bangkok, people can choose the CUP near home (Ob-un community clinics/private hospitals) as well as the CUP near the point of rented residence near the workplace or school. Currently, the total population of Bangkok is 8,055,122, with 3,926,964 UCS members, or about half of the total population in Bangkok. The total is divided into 78% with a house registration in Bangkok and 22% in a province with a provincial registration. Most beneficiaries with house registration in Bangkok are 0-24 years old, while the majority of those who have house registration in other provinces but register in UCS in Bangkok are laborers age 20-59 years. Most Ob-un community clinics cover around 10,000 people per unit.[10]

5

QUALITY ASSURANCE AND STANDARDIZE SERVICE UNITS

The Committee for Quality Control and Public Health Service Standards has the power to supervise the service of the unit to ensure quality by setting standards for quality control and promotion of service unit standards. Results are reported to the NHSO Board, including notifying service units and sub-committees on quality control and standard of public health services at the district level to further improve the quality and service standards.[10] The mechanism of quality control of service unit standards is a participatory operation through two sub-committees, namely:

REGIONAL HEALTH SECURITY SUBCOMMITTEE

Regional Health Security Subcommittee consisting of members from many sectors, including government, Civil Society, private and local organization (including Bangkok). There are various working groups which nclude assessment and inspection. These working groups are responsible for managing the national health security system in the area with good governance.

REGIONAL QUALITY CONTROL AND STANDARDIZATION SUBCOMMITTEE

This body has members from all sectors, including government, private sector, various professions, and public sector representatives. There is continuous monitoring to ensure that the quality of the service units can be controlled in accordance with the expectations of the people who use the service and meet the uniform standards.

Box #1

ADJUSTMENT OF THE RELATIONSHIPS OF THE MEMBERS OF THE SERVICE NETWORK AND USE OF IT

The NHSO zone area for Bangkok has introduced the concept of building trust in primary care for people and the PCU and the referral unit in the form of a host-network relationship. This is called the Primary Care Trust (PCT) to adjust the working model of the cooperative service network to develop an efficient referral/receive system in the network to improve the quality of service units and enable patients to receive standardized, complete, and continuous services. The first phase was to create a pilot project in Bhumibol Adulyadej Hospital, then expand it to a government hospital in the area. This was then expanded to with more places during 2014-16, and then to six other private hospitals in 2017.[22]

The method is to format the relationship network of the PCU with the referral unit as the "host and network", with the host (secondary and tertiary hospital) playing a role in the care and development of the network (the PCU).

They co-created a Clinical Practice Guideline to train personnel in service and referral. Later, the e-Referral system was used to improve the efficiency of the referral system in which the host and network can track patient history and see the treatment history. This system replaced paper delivery slips into electronic systems, thereby helping to increase the convenience for the public to not have to travel back and forth to request for a case file and reduce duplication of service. This system can also summarize the list of medical expenses and diagnosis.

The information can be used to plan research and treatment as well. This type of cooperation improves the relationship of service units resulting in increased confidence and reducing complaints. For example, in Bhumibol Hospital, it was found that the use of IT reduced the time to see a doctor, resulting in improved service quality and referral. This helps to reduce congestion and can reduce the waiting time by queueing.[21] Doctors have more time to check up on patients, and the hospital has more time to manage patient services more efficiently.

In 2014, the guideline for quality assurance of the Ob-un community clinic system was developed by the NHSO, Bangkok Branch in collaboration with the Faculty of Public Health, Mahidol University, and a working group that has a hospital quality certification institute. They developed a manual on Private Primary Care Accreditation (PPCA) with 20 pilot clinics. After that, the clinics received mentoring and advice to improve the quality of services, as well as being evaluated according to the PPCA guidelines. Subsequently, 20 additional Ob-un community clinics were recruited.[10] These centers are given in-service training, and they are evaluated every year. With this system, it can improve the quality of clinics of which 9 Ob-un community clinics can be accredited as "Good quality clinics."

Accreditation is divided into three levels: good, excellent, and outstanding. At the "good" level, the service unit must receive at least two visits and have a score indicating the improvement or maintenance of the level. In addition, the latest survey results must exceed the previous results. If the level is "very good," the service unit must have continuous performance in accordance with the quality criteria and the same or higher evaluation score for not less than three consecutive times. "Outstanding level" service units must have continuous performance in accordance with quality criteria and have the same or higher scores for least four consecutive times.[10]

6

BENEFITS ARISING FROM THE PARTICIPATION OF PRIVATE HEALTH SERVICE UNITS IN THE NATIONAL HEALTH SECURITY SYSTEM

6.1

REDUCED CROWDING IN THE HOSPITAL

From the performance of Bhumibol Hospital in partnership with the PCU network, including both Ob-un community clinics and public health centers, it was found that the number of outpatients in the hospital was reduced to about 30 people per day from over 500 patients, and the waiting time for doctors was reduced to only 30 minutes from the previous one and a half hours. This proved that the participation of private service units helped to share the care of outpatients and distribute caseloads out of the hospital setting. Currently, there is a project to expand the participating service units to further reduce congestion in the hospital and reduce waiting times for outpatients waiting to receive medicines, such as the "drug resupply project from a drugstore near home." The pilot project was conducted in 55 hospitals with over 500 pharmacies nationwide in 38 provinces in four groups of patients, namely, those with diabetes, high blood pressure, asthma, psychiatry, and other chronic diseases. There is also a provision that allows service outside office hours in the event of a reasonable situation, which will reduce congestion in the emergency room in the hospital.[23]

6.2

INCREASING ACCESS TO SERVICES

The presence of private hospitals that are specialized in disease improves public access to more expensive health services such as stroke services, cardiovascular disease, chronic renal disease, cataracts, HIV/AIDS, etc. According to previous data, the number of patients accessing antiretroviral drugs has increased steadily from 178,264 people in 2014 to 261,936 people in 2018. The use of renal replacement therapy in chronic kidney disease patients has increased from 25,876 in 2014 to 57,288 in 2018, while access to services for acute myocardial infarction has improved since 2009, with 73% more cases receiving anti-coagulants or wireless PCI in Bangkok in 2018.[20]

The rate of PCI performed in ischemic heart disease patients has improved dramatically. The UC rights have been increasing steadily since 2005-2016, and open-heart surgery rates were in the range of 4.5-4.7 percent in 2005-2014 and, in 2015-2016, slightly decreased.[6]

Traditionally, cataract surgery had long wait times, sometimes causing the patient to go blind before undergoing surgery. The NHSO has adjusted the payment method which is separated from the inpatient disbursement according to the DRG system by paying a fixed fee schedule which charges per capita paid to the hospital at the same rate. NHSO has also negotiated with suppliers which resulted is greatly reduced the price of replacement lens. After adjusting the payment system, there was a significant increase in the participation of the private sector, doubling the use of the service during the four years after the program began in 2008 (Figure 11-12).

In 2017, it was found that people had more access to health promotion and disease prevention. The population in the 35-74 year age group who received screening for diabetes, high blood pressure, cervical cancer in women aged 30-60 years, and ANC in the first 12 weeks of pregnancy had increased.[10] The results of the service found that 35-74 year-olds who were screened and diagnosed with diabetes or high blood pressure declined over time (i.e., there was a reduced prevalence of disease).

Figure 11

RATE OF ACCESS TO INTERVENTIONS FOR HEART DISEASE: 2005-16

Source: Universal Health Coverage Report for 2014 and 2016

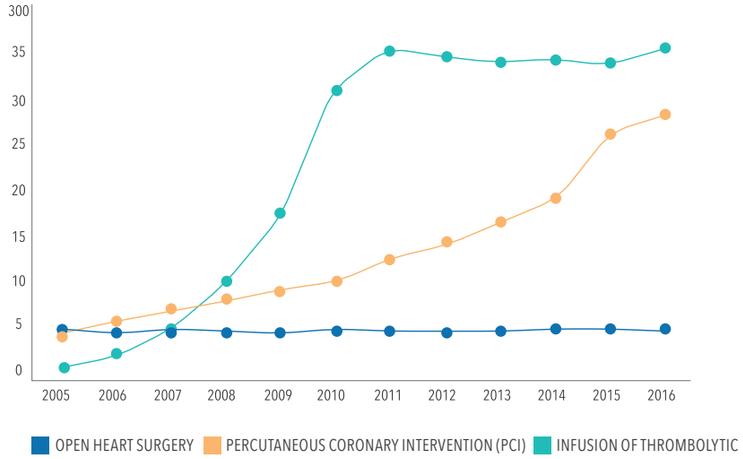
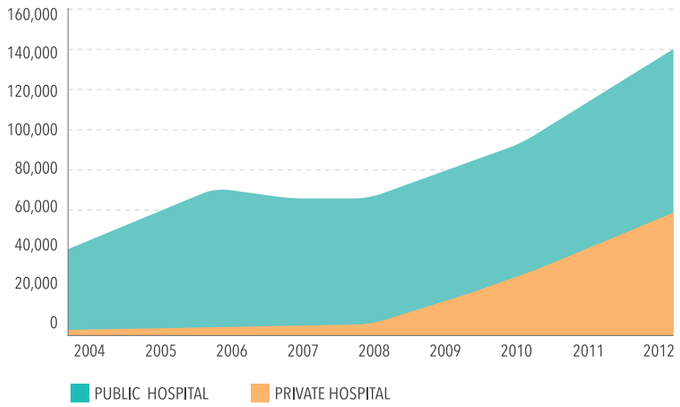


Figure 12

NUMBER OF CATARACT SURVEY BEFORE AND AFTER UNBUNDLING FROM DRG AND REPLACED BY SPECIAL FIXED FEE SCHEDULE

Source: NHSO, 2012



7

CHALLENGES & LESSONS LEARNED

7.1

REFERRAL PROBLEMS

Service provision with the participation of private service units has challenges in referring patients and budget management. In the past, the referral system from the CUP, Ob-un community clinics created a burden for the Ob-un community clinics since they had to cover costs incurred at the referral site. With more patients requiring referral to secondary and tertiary hospitals, healthcare costs mounted. Moreover, referral service units may treat patients that need drugs outside the national drug list with higher prices. These resulting in Ob-un community clinics receiving deductions from the per capita budget from the already limited amount.[24] This system also discouraged Ob-un community clinics from referring patients.

7.2

HEALTH PROMOTION AND DISEASE PREVENTION IN BANGKOK STILL LACKS COVERAGE COMPARED TO THE PROVINCES

The context of Bangkok's area and population is complex, and that poses an obstacle to proactively cooperate between the public and private sector, especially the work in health promotion and disease prevention (P&P). Effective P&P requires outreach and home visits in vulnerable communities. But because of the haphazard expansion of the city, the communities have changed in ways that are hard to track and reached. Plus, many migrant workers in Bangkok do not live in a formal residence or registered domicile. There are a variety of housing conditions, such as condominiums, rental rooms, slum communities, group housing, etc., making it difficult to access communities in Bangkok with P&P.

7.3

UNEVEN DISTRIBUTION OF SERVICE UNITS

Many urban service units are not yet widely distributed, such as in the northeast and southern regions. There are no hospitals and private hospitals for specific diseases in some areas. Health Region [7] (eastern region) and the Region (northeastern region) also have a shortage of participating private service units.[24] In Bangkok, most service units are still concentrated in the inner city. For suburban areas, such as Nong Chok and Min Buri Districts, the distribution of hospitals is quite sparse. Therefore, it is a challenge to encourage the private sector to have more investment in those areas[26] (Figure 13).

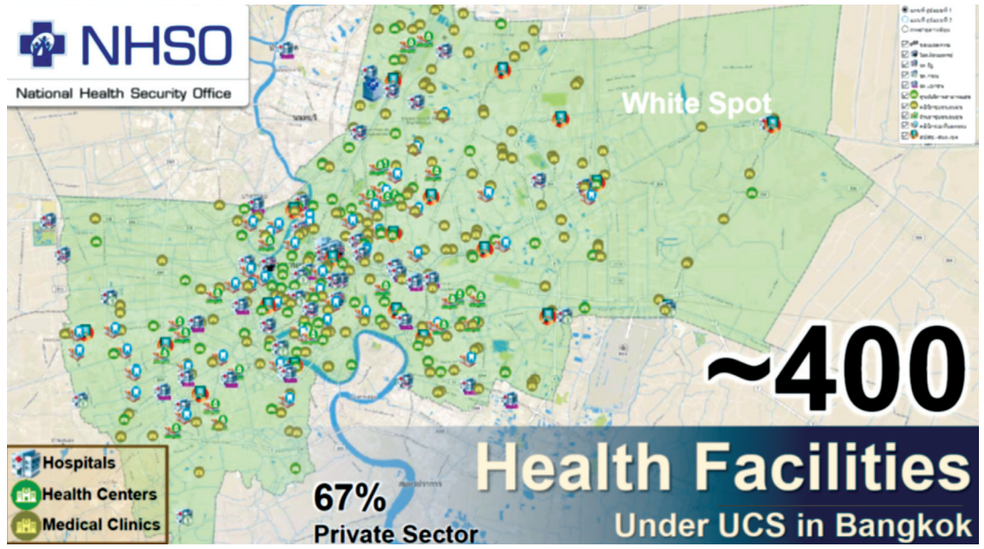


Figure 13
DISTRIBUTION OF HEALTH SERVICE UNITS IN BANGKOK

Source: NHSO Zone 13 Bangkok (PowerPoint presentation)

7.4

CREATING INCENTIVES FOR PRIVATE HOSPITALS

Creating incentives for private hospitals to participate in the NHSO system is still a challenge because health services are public goods, i.e., are not for profit. Private hospitals and private clinics are business that needs to make a profit. As a result, some private hospitals have withdrawn from the UCS because they face losses. For example, in FY 2017, a number of service units in Bangkok withdrew from the UCS, including one private hospital withdrew from the CUP and referral service unit, and five other facilities withdrew from being referral service units for Ob-un community clinics (but did not withdraw from CUP). The withdrawal of these private units had a potential impact on 270,000 people. The main reason for withdrawal was the inpatient service caseload increased by 24 percent, and abnormal births increased by 17 percent, resulting in increased cost of inpatient care. However, the NHSO in Bangkok (Zone 13) is still receiving cooperation from other CUPs and referral service units both public and private sectors to accept those 270,000 beneficiaries. As a consequence, it will affect the congestion of those service units.

One incentive for participation of private service units is more creative use of the budget of the BMA for P&P. That is, private service units could be paid according to the price per unit (Itemize), causing the private service unit to recover the full cost of activity. That would differ from the payment system in the provinces which is a capitation system.

8 SUMMARY

Thailand has government services providing primary, secondary, and tertiary care, with the PCU being the most distributed type of unit outside of Bangkok and large cities. Health services in urban areas are overcrowded due to the large number of outpatients visiting the hospital, and occupancy of the inpatient beds is pushing hospitals to capacity. Thus, there needs to be a system with comprehensive distribution of facilities and improving management problems of hospitals. Without improvements, access to public services is impeding access, wait times are too long, and congestion reduces efficiency of service and quality care. To address this problem, the NHSO invited a large number of private-sector health care units to participate in the UCS. Currently, there are 810 private health service network members around the country, with 452 in Bangkok, and 358 in provinces outside Bangkok. Most are PCU or CUPs, and regularly provide outpatient services and preventive care. Participating referral service units in the private sector are still too few, and there is a tendency of private hospitals to withdraw from the UCS due to the inability to recover costs.

Therefore, current health services have the characteristic of participation between the public and the private sector, but the government still plays the main role in the allocation of the budget and laying out the service format and monitoring the quality and service standards through a committee mechanism with multiple partners. The private sector is responsible for providing health services, including outpatient services, inpatient services, preventive services, and specialized services. In addition, private hospital representatives are also involved in the NHSO Board which is involved in policy formulation and management. Therefore, it is considered that the private sector in Thailand plays an important role in the national health insurance system, by helping to make it more comprehensive and more efficient.

The result of private sector participation helps to improve access to services, especially outpatient services because users can choose to register in the CUP near home and go to use the service without having to go to the public hospital. This can reduce wait times and congestion of the hospital. This also reduces unnecessary service costs. In the case of Bhumibol Hospital, when the private sector joined the network, the PCU could distribute outpatients to treatment in the Ob-un community clinics, helping to reduce the number of hospital patients to around 30 per day, from over 500. Waiting times for doctor visits declined from 77 to 33 minutes per person, allowing the hospital to provide full service.

Private hospitals that want to participate in the NHSO system must be registered as a service unit so that UCS members can choose a service unit near their home. The private hospital must request and fill out an application. After that, qualifications will be evaluated according to the criteria to ensure the quality of services that people will receive.

However, optimal private-sector participation in the UCS still faces many challenges. These include problems of referral, health promotion, and disease prevention services, service unit quality, and the distribution of private service units for the population in need. Especially in Bangkok, referral issues are caused by Ob-un community clinics not referring patients because of the loss of deductions from the medical services of secondary/tertiary hospitals. In addition, in 2017, many hospitals gradually withdrew as the referral unit. The number of inpatients increased by 24 percent, and abnormal births increased by 17 percent, resulting in an insufficient in-patient budget of the BMA and causing the recovery of inpatient service fees to decline; private hospitals, therefore, faced losses. Another challenge of health service coverage in Bangkok and the participation of the private section is the complex settlement pattern and housing conditions in the megacity like Bangkok, especially among the lower-income population. Residential areas are complex and difficult to access. That impedes P&P services which rely on home visits to follow-up patients and provide proactive service. Private sector and staff are reluctant to do this kind of work. In addition, the capacity or motivation of private sector personnel may not be sufficient for such "soft" areas as health education and outreach to reduce risk behavior.

THAT SAID, THE INCREASED PARTICIPATION OF THE PRIVATE SECTOR IN THE THAI HEALTH SERVICE SYSTEM IS A RATHER PROMISING TREND. THE NUMBER OF CUP/PCU, AND ESPECIALLY THE OB-UN COMMUNITY CLINICS ARE ON THE RISE

That said, the increased participation of the private sector in the Thai health service system is a rather promising trend. The number of CUP/PCU, and especially the Ob-un community clinics are on the rise.

The number of CUP/PCU, and especially the Ob-un community clinics are on the rise. Despite operational problems, the NHSO has a monitoring mechanism that helps Ob-un community clinics to improve quality. Therefore, there have been no Ob-un clinics that have withdrawn from the UCS. However, private hospitals that provide inpatient services for the system have decreased in number due to the losses and burden mentioned above. Thus, one consideration that will help the private sector continue to cooperate with the government is to create appropriate incentives, so that all parties can benefit equally from cooperation.

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