NHSO
National Health Security Office

UNIVERSAL COVERAGE FOR EMERGENCY PATIENTS

UCEP

IN THAILAND

GLOSSARY

EMERGENCY MEDICINE

In accordance with the Emergency Medical Act of 2008, "emergency medicine" refers to emergency operations, education, training, evaluation research and assessment, management, and treatment of emergency patients and prevention of emergency illnesses

EMERGENCY PATIENT

According to the 2008 Emergency Medical Act, "emergency patient" means a person who is injured or has a sudden illness that is a threat to the life or function of vital organs and requires immediate evaluation, management, and treatment to prevent death or aggravation of that injury or illness.

CRITICAL EMERGENCY PATIENT (CODE RED)

"Critical emergency patient" means an emergency patient who has been diagnosed and screened for injuries or a sudden illness and is in critical condition in accordance with the criteria of the Emergency Pre-authorization program of the National Institute of Emergency Medicine (NIEM) and in accordance with Article 4 of the Ministry of Public Health's Notification on the Rules, Procedures, and Conditions for Emergency Patient Assistance and Remediation, Resource Mobilization, and Referral of Patients to other Hospitals. Critical emergency patient (Code Red) denotes an injured person or person who has a sudden illness which is life-threatening if not treated immediately. The illness or injury can be one that affects the respiratory, circulatory, or nervous system. These patients have a high chance of death or risk of severe and sudden complications. Thus, the "Code Red" indication is to alert practitioners that this case is a critical emergency patient in accordance with the Universal Coverage for Emergency Patients (UCEP) policy.

EMERGENCY SCREENING AND SORTING SYSTEM TO APPROVE RIGHTS (EMERGENCY PRE-AUTHORIZATION)

The Emergency Pre-authorization program was developed by NIEM to efficiently screen and sort emergency patients to ensure they are afforded their full rights, and as a tool for hospitals and clinics to efficiently evaluate a patient's condition in a standard and uniform way across the country.

EMERGENCY MEDICINE BOARD (EMB)

The Emergency Medicine Board (EMB) was established as part of the Emergency Medical Act of 2008. The EMB members include representatives from government agencies, professional councils, public and private medical institutions, local government organizations, non-profit organizations, and qualified specialists. The Minister of Public Health is the chairperson of the EMB. The EMB is responsible for defining standards and criteria for the emergency medical system, formulating management policies, and approving action and financial plans of the emergency medical institutions to facilitate cooperation between relevant agencies in accessing information for the benefit of emergency medical operations.

COMMITTEE ON MEDICAL FACILITIES

A Committee on Medical Facilities was established as part of the Medical Facilities Act (No. 4) 2016, whose members consist of the Permanent Secretary of the Ministry of Public Health (Chairperson), the heads of agencies under the Ministry of Public Health, representative of the Ministry of Defense, representative of the Ministry of Interior, representative of the Office of the Council of State, representative of the Office of the Consumer Protection Board, and representative from the Healthcare Accreditation Institute (Public Organization). In addition, the Minister appoints qualified members who are specialists from the various professional councils in the art of healing, other professional practitioners, representatives of the Private Hospital Association and non-profit private organizations that carry out consumer protection activities. The Committee has the duty to give advice, opinions, and recommendations to the Minister or the authority that issues Ministerial Regulations or Directives for the execution of the Medical Facilities Act. The Committee oversees permission to operate a hospital business, hospital operations, hospital closures, or revocation of a license, including the designation of emergency patients according to the Emergency Medical Act, when patients are in need of emergency medical treatment from a medical facility.

NATIONAL HEALTH SECURITY BOARD

This Board was established as part of the National Health Security Act of 2002. Members consist of representatives from various sectors: Government agencies, professional councils, local administrative organizations, private hospitals, non-profit private organizations, and qualified specialists. The Minister of Public Health is the chairperson. According to Article 18 of the Act, the Board is responsible for administering and managing the National Health Security Fund, determining the scope and standards of public health services, and directing the operations of the National Health Security Office (NHSO).

FEE SCHEDULE

The fee schedule lists the cost of medical expenses according to specific items on a standard list. The list includes compensation rates and subsidies for each type of service to be reimbursed. This method of payment is widely used in social security systems and compensation funds. In some cases, payment will be a direct disbursement from the hospital, such as a crisis care subsidy payment. Some cases are reimbursed as compensation from the insured, which may be operated by a medical facility. This method of payment has been able to control the medical costs of the service system quite well. However, there are still some problems with the quality of medical care under the system.

DIAGNOSIS-RELATED GROUPS (DRGs)

The Diagnosis-Related Groups (DRGs) is a pre-agreed medical payment system for costly diseases. This method of payment creates fairness in the health care system and helps to control expenses. This is because the system does not use an itemized payment that each service unit charges. The DRGs system is tailored and aligned with the context of each country in order to be consistent with the disease and the technology used to treat a patient, what resources are used, and pricing. The NHSO currently uses this system for in-patient payments, while the Social Security Office (SSO) uses this system to pay only for critical care. Cost control must be done in conjunction with setting a cap on total system costs.

FEE-FOR-SERVICE

The fee-for-service payments system is for the payment of medical expenses in an open-ended manner and in accordance with the amount of work that is billed after the service is provided. This system sets a price to pay but does not control the amount of service. Paying in this way may result in an insufficient budget for reimbursement to the service unit, and could potentially have a significant impact on the health and financial system. In some cases, payments are made directly from hospitals, for example, in the case of inpatients who are covered by the Civil Servants Medical Benefits Scheme (CSMBS) or private health insurance. In some cases, costs will be claimed as compensation from the patient, directly from the agency or the insurance company (e.g., in the case of drugs and medical supplies for outpatients who are entitled to medical benefits for civil servants and state enterprise employees). In many cases, there will be a limit on the maximum amount that can be covered, for example, in the case of insurance under the Motor Vehicle Accidents Protection Act and private health insurance.

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INTRODUCTION

In 2002, Thailand launched its universal health coverage (UHC) system, which meant that all Thai citizens can access to health services under one of the three main government health insurance schemes: (1) the Civil Servants Medical Benefits Scheme (CSMBS), (2) the Social Security System (SSS), and (3) the Universal Coverage Scheme (UCS). Even though these three schemes should cover all Thais in need, the three funds have differences in details or conditions for exercising rights, such as the benefits package, terms of service, and compensation rates. These different conditions may affect patient access to services, especially in the case of emergency illness, which has a high risk of death, loss of vital organs, and serious complications.

The emergency service system is needed to bridge the gap between the scene of the accident/acute illness and qualified hospital

Timely and effective medicine reduces the risk of disability or death

The Thai emergency medical service system was established to provide efficient and effective medical care for emergency patients by mobilizing resources in the area where the emergency service system is needed to bridge the gap between the scene of the accident/acute illness and qualified hospital.[1] Timely and effective medicine reduces the risk of disability or death because qualified emergency medical teams (EMTs) can provide first aid properly and transport a victim to the nearest hospital as soon as they are stabilized. These EMTs coordinate with hospitals to prepare to receive the patient. Generally, emergency patients cannot choose to receive services from hospitals they are registered with under their health insurance, especially if the scene of the accident is remote from the participating hospital. In Thailand, the emergency medical system is based on the principle that emergency patients can receive services at the nearest medical facility without conditions or restrictions on benefits or hospitals. The emergency medical service system in Thailand originated from the operations of civil society organizations (CSOs). Originally, it was a basic service that simply transported the injured to the hospital, staffed by non-clinical volunteers from various foundations such as the Poh Teck Tung and Ruamkatanyu Foundations.[2] But the implementation in the first phase was not very clear or coordinated due to lack of human resources and budget support. Around 1995, the Medical Services Department of the Ministry of Public Health (MOPH) established the 'Narenthorn EMS Center' at Rajavithi Hospital as a model for on-site medical treatment that uses the principles of emergency medicine, that is, to provide services to both the critically ill and injured.[3] Then, in 2002, the MOPH announced the development of the formal emergency medical service system throughout the country as one of the main policies of the MOPH, and established the Office of Emergency Medical Service System (Narenthorn EMS Center, MOPH) as the agency responsible for the development and expansion of emergency medical services.

Since the inception of the National Health Security Fund or the Universal Coverage Scheme (UCS) in 2002, the cost for emergency services was calculated at the same rate as the Social Security System (SSS)[a], or ten baht per eligible beneficiary. This amount was the basis for preparing a budget for emergency services. However, the development of the emergency medical service system was not initially implemented in a systematic and unified manner until the Emergency Medical Act was enacted in 2008.[5] As part of the Act, the National Institute for Emergency Medicine (NIEM) was established to support the development of emergency medicine and advocate for the standardized implementation of the service nationwide. That helped to unify the components of the system, including the human resources as registered according to the criteria of the Emergency Medicine Board (EMB), the standard service equipment, the rate for service subsidies, and the development of support systems allocated by NIEM.

[a] Capitation of health service payments for emergency accidents was already implemented in the Social Security Scheme; the insured can receive services from any medical facility. The Social Security Office (SSO) will be responsible for expenses during the first three days (within 72 hours) from admission according to the types and rates that are set on a capitation basis. In 2000, the capitation rate for emergency accidents in the SSS was 25 baht per insured person per year.

The initial implementation of the policy was not smooth as there were problems both in terms of policy and practice.

For example, there was no law requiring private hospitals outside the network of an insured patient to participate.

Prior to 2012, access to emergency medicine in Thailand was still very limited. That is because the government health insurance schemes did not always stipulate medical treatment rights for emergency care patients who are admitted to private hospitals outside the contractual providers under the funds. That posed a problem of recovering the cost of care. Later in 2012, the government announced the policy called 'Emergency Claim Online' (EMCO) to cover every critical emergency patient, including the right to receive services in private hospitals outside the contracted provider of whatever scheme the patient was enrolled in. That way, at admission at the Emergency Room (ER), patients would not have to present their entitled insurance as a requirement for treatment. However, the initial implementation of the policy was not smooth as there were problems both in terms of policy and practice. For example, there was no law requiring private hospitals outside the network of an insured patient to participate. Thus, many emergency care patients who received services at a private hospital near the site of an accident were billed for the care, and could not reimburse that through their health insurance scheme. There were also problems in assessing and classifying the severity of a given emergency care case.

In other words, the development of the emergency medical service system is another health policy process that required decision-making based on data and empirical knowledge, and sometimes it was necessary to proceed by 'trial and error' to find patterns and develop appropriate methods. It was not until 2017 that the current policy entitled 'Universal Coverage for Emergency Patients' (UCEP) was formalized.

1.1

WHAT IS THE UCEP POLICY?

UCEP, or the Universal Coverage for Emergency Patients, is the right to medical treatment according to the government policy to ensure that all critical emergency patients are able to receive treatment in the nearest hospital anywhere without cost until the crisis is over, but not to exceed 72 hours, and the patient can be moved safely to their registered hospital if on-going inpatient treatment is needed.

1.2

WHAT WAS THE PROBLEM OF EMERGENCY SERVICES BEFORE UCEP?

The current UCEP policy (effective as of April 1, 2017) is a continuation of the original 'Emergency Claim Online' (EMCO) policy as implemented between April 2012 - March 2017. The EMCO policy was a part of the national advocacy effort to standardize the three major public health insurance funds, starting from April 1, 2012.

The EMCO policy aimed to provide all emergency patients with a package of minimum essential rights to care

The EMCO policy (2012-17) aimed to provide all emergency patients with a package of minimum essential rights to care. The goal was to ensure that no critically ill/injured patient would be denied life support out of lack of advance, out-of-pocket payment, or proof of coverage. At that time, the NHSO was designated as the 'National Clearing House' (i.e., the central authority) for disbursement transactions to cover emergency medical expenses and related information systems. According to Thai government policy, the NHSO advanced funds to cover the cost of hospital services first and then collected reimbursement from the health insurance fund of the eligible beneficiary. In the initial policy (2012-17), private hospitals received compensation for emergency care services according to the diagnosis-related groups (DRGs) system. However, over the first five years of implementation of EMCO, an evaluation of the program[6] identified the following major obstacles and gaps:

1. **Access to services and health outcomes** from the services were different depending on which health insurance scheme the patient was covered. Beneficiaries under the CSMBS could access emergency services from private hospitals (59.8%), followed by those under the UCS (34.1%), and for those under the SSS (6.1%).[6] In addition, emergency patients under the UCS and SSS had worse health outcomes overall, in that the condition did not improve or resulted in death upon discharge from the hospital, compared to patients under the CSMBS.[7]

2. **Co-payment** – It was reported that, on average, emergency patients had to co-pay 70% of the total cost of care.[7] That situation was directly contrary to the objectives of the policy, and caused unfair access to emergency services, specifically at private hospitals. This problem arose because many private hospitals did not consider the NHSO reimbursement rates to be adequate to meet the actual cost of care. Generally, the cost of medical services at private hospitals is several times higher than the same services in public hospitals.

3. **Lack of legal framework** – The practical definition of the word 'emergency' was unclear. There were no laws, rules, or regulations to require private hospitals to comply with the EMCO policy. So, naturally there was confusion and alternative interpretations between the private service providers and the government.

4. **Public understanding** – People's understanding of the scope of benefits under the policy was limited. Public relations communication regarding emergency care coverage according to the policy was not comprehensive or effective.

5. **Weak policy regulatory mechanisms** – There was a lack of appropriate information systems in place to regulate the actions of private hospitals, both in terms of recording data for reimbursement of medical expenses and preventing them from collecting medical expenses directly from patients and/or relatives of the patient.

In sum, the implementation of the 'Emergency Claim Online' (EMCO) policy was only a partial step toward the current policy. Several obstacles and challenges, as mentioned above, prevented the policy from achieving the intended goal. There was a lack of comprehensive preparation before the policy implementation. Still, to its credit, the Thai government never abandoned the vision, and has attempted to find ways to resolve the various obstacles. Accordingly, in 2017, the government launched the UCEP policy as an improved version of EMCO.

1.3

HOW DOES UCEP BENEFIT THE POPULATION?

To bridge the gaps and barriers of implementing the EMCO policy mentioned above, the related agencies, including the MOPH, NIEM, NHSO, SSO, Comptroller General Department, and the Private Hospitals Association brainstormed to develop a solution to the problems of the UCEP policy by establishing new guidelines for protecting the rights of critically ill patients so that they would not have to pay out-of-pocket for care at a private facility. The goal was to create a standard system of payments and reimbursements that would be accepted by private facilities, and manageable through reimbursement from one of the public health insurance funds. That way, a critically-injured or acutely ill patient could expect to receive affordable emergency care at the nearest facility, whether public or private.

2

UCEP
POLICY DEVELOPMENT

2.1

AMENDMENT OF THE MEDICAL FACILITIES ACT 1998 (NO. 4) 2016

Given the lack of a clear legal framework for implementation of the EMCO policy, the reformulation of the UCEP policy began with the amendment of the relevant laws (both primary and secondary) in order for the government to have the power to require private hospitals not to charge emergency service fees from patients. Accordingly, the government amended the Medical Facilities Act 1998 (No. 4) 2016, which became effective December 20, 2016.[8]

The amendments to the law have several intentions and themes that are reflected in the subsequent UCEP policy-based emergency guidelines, including:

1. Improving the composition of the Committee on Medical Facilities to reflect the principles of quality assurance and consumer protection, which was unclear in the past (Article 7)

2. Determining the roles and duties of private hospitals to provide treatment for emergency patients to stabilize them according to professional standards and according to the type of hospital for the public benefit (Article 36)

3. Controlling to ensure that a medical facility must disclose the cost of medical treatment, medicines, medical supplies, related clinical fees, and other service charges, and the patient's right to act accordingly (Article 32)

4. Protection of the right to access emergency medical services by giving the Minister of Public Health the authority to define 'emergency patient' under the Emergency Medicine Act," for which the patient is required to receive emergency medical treatment from a medical facility (Article 33/1)

5. A medical facility has the duty to mobilize resources and provide assistance or take action as appropriate and necessary. Actions under Paragraph 1 and Paragraph 2 are to be in accordance with the Rules, Procedures, and Conditions announced by the Minister of Public Health (Section 36)

2.2

PROCLAMATION OF RELEVANT LEGISLATION

In addition to the amendments to the Medical Facilities Act, the Cabinet passed a resolution on March 28, 2017, agreeing on the following five main issues which are important for the initiation of the UCEP policy:[9]

1. Approve the Rules, Procedures, and Conditions for Determination of Expenses for Emergency Patient Operations. In the event that a critical emergency patient is entitled to protection under the Motor Vehicle Victims Protection Act or the Life Insurance Act, the patient is to exercise said rights first, as proposed by the MOPH, and let the MOPH receive the opinion of the Ministry of Defense, the Budget Bureau, Office of the National Economic and Social Development Council, and the Ministry of Finance on the issue of creating understanding for the people to consider proceeding further.

2. Approve that all public hospitals comply with the rules, and allow public hospitals to transfer critical emergency patients after 72 hours as proposed by the MOPH.

3. The Ministry of Finance, NHSO, SSO, other government agencies, and various funds with objectives related to the provision of medical services or public health operations are to act in accordance with the rules, and cover expenses at the rate according to the fee schedule attached to the Rules. The MOPH is to be the main agency in collaboration with the Ministry of Finance, Ministry of Labor, Ministry of Interior and relevant agencies to consider taking action in order to amend the regulations of various agencies or funds, especially state enterprises and local administrative organizations, in order to reimburse hospitals in accordance with the Rules in a timely fashion, according to the opinion of the NHSO.

4. If there is a revision of the fee schedule rate, the MOPH shall submit the matter to the Cabinet for further consideration according to the opinion of the Office of the Council of State.

5. As part of the request for approval for NIEM to act in accordance with the aforementioned criteria for emergency case management, and promote cooperation throughout the whole emergency system for smooth implementation of emergency medical services in collaboration with the public and private sector facilities, the Minister of Public Health is to accept and proceed in accordance with associated powers and duties.

The Minister of Public Health signed the following two MOPH Notifications: (1) The MOPH Notification on the Designation of Emergency Patients; and (2) The MOPH Notification on the Rules, Procedures, and Conditions of Assistance to Emergency Patients, Remediation, and Referral as per the Medical Facilities Act 1998 (No. 4) 2016, effective on April 1, 2017. This Notification was also sent directly to all private hospitals across the country to encourage them to comply with the law. In addition, there was a series of meetings to clarify the UCEP policy and implementation for all private hospitals in order to guarantee that emergency patients would receive needed medical care from the nearest hospital up to 72 hours, without billing the patient, as each hospital will be reimbursed from one of the public health insurance schemes.

In addition, in order to resolve issues (e.g., definition of emergency patient, service rates, payments, and 72-hour post-crisis care) and to be consistent, fair, and applicable to all sectors, the MOPH issued the Notification on the Rules, Procedures, and Conditions for Determination of Expenses for Emergency Patient Operations according to the Medical Facilities Act 1998 (No. 4) 2016, and instructions for referral if the patient's condition exceeds the capacity of the attending medical facility to attend to, including the reimbursable expenses for emergency patients that will be compensated by various funds at the rate proposed by the Committee on Medical Facilities, and approved by the Cabinet on March 28, 2017.

2.3

THE ESSENCE OF THE UCEP POLICY

2.3.1

DEFINITION OF 'CRITICAL EMERGENCY PATIENT' ACCORDING TO UCEP POLICY

According to the MOPH Notification on the Rules, Procedures, and Conditions of Assistance to Emergency Patients, Remediation, and Referral dated March 31, 2017, there are three types of emergency patients according to the patient's severity of the condition, as follows:

Critical emergency patient (Code Red): This is a person who is critically injured or has suddenly taken seriously ill and whose condition is life-threatening if not tended to immediately. The condition can be one that affects the respiratory, circulatory, or nervous system, and the patient has a high probability of dying or sustaining permanent damage from complications if not stabilized and treated in a timely fashion.

Urgent emergency patients (Code Yellow): These are persons who have sustained an injury or illness which is very acute or severe, and requires urgent medical attention in order to prevent permanent complications or exacerbation of the acute condition.

Non-serious emergency patients (Code Green): These are persons who have been injured or have an acute medical condition which is not life-threatening, and the patient can wait for medical attention for a period of time or can travel to a clinical facility by themselves. However, if the patient's condition is left unattended, it could exacerbate the injury or illness to become a more urgent and severe condition.

The entry into force of all three MOPH notifications dating from April 1, 2017 marks the termination of the 'Emergency Claim Online' (EMCO) policy and the official start of UCEP. The UCEP policy covers the cost of treating critically ill/injured patients (Code Red) without the need to bill the patient for up to 72 hours of care. The eligible beneficiaries under this policy are any person who is enrolled in one of the three public health insurance schemes, including persons with rights problems and foreigners who are entitled to the SSS, and who meet the NIEM assessment criteria.

6 symptoms of critically injured/ill person (Code Red)

1. Unconscious with faint or no breath
2. Tachycardia, extreme fatigue, and loud, labored breathing
3. Fainting with excessive perspiration, skin cool to the tough, or in shock
4. Acute and severe chest pains
5. Hemispherical limb weakness slurred speech with acute or continual convulsions
6. Symptoms of a malfunctioning respiratory and/or circulatory system, and the condition of the brain is life-threatening

2.3.2

COMPENSATION FOR HOSPITALS USING A FEE SCHEDULE

The EMCO policy (2012-17) specified a method for compensating hospitals using the diagnosis-related groups (DRGs) system.[b] From the point of view of private hospitals, compensation for service fees by the DRGs methods was inadequate to cover their actual costs. As a result, some private hospitals charged the patients or relatives to make up the difference, or required advance appointments for emergency care, which is clearly not possible in an acute and life-threatening situation.

Thus, the current UCEP policy (2017-present) solved that problem through negotiations with representatives of the three major health insurance funds and the Private Hospitals Association by adjusting the rates of compensation through the use of a fee schedule.[c] The proposed fees were more in line with the average actual cost of private hospitals in providing emergency medical care. The fee schedule covers 4,292 items, divided into the following 13 sections:[d]

Section 1:	Room and meals
Section 2:	Cost of prosthetic organs and therapeutic equipment
Sections 3-4:	Medication and nutrition for intravenous/homeopathic medicines
Section 5:	Non-drug medical supplies
Section 6:	Blood and blood components
Section 7:	Medical technical diagnosis
Section 8:	Diagnosis and treatment in radiology
Section 9:	Other special Diagnostic methods
Section 10:	Procedures
Section 11:	Anesthesia
Section 12:	Professional services
Section 13:	Other services that are not directly related to medical treatment

[b] The National Health Security Board resolved on April 4, 2016 that the NHSO could adjust the mechanism and payment rates under the EMCO policy, from using the diagnosis-related groups (DRGs) to the fee schedule system as proposed by the NIEM.

[c] The Rules, Procedures, and Conditions for Determination of Expenses for Emergency Patient Operations (effective August 28, 2018).

[d] Emergency medical service rates were prepared for reference in the payment of medical services using a fee-for-service by improving from the data for calculating service rates in the 16 categories that the Thai Health Security Research Office (HSRO) provided to the Comptroller-General Department in 2013. Since the inception of the UCEP policy, there are 2,976 items in the fee schedule. However, some private hospitals provide medicines outside the reimbursable list. Therefore, the UCEP requested 1,316 additional items be added to the schedule. The Sub-committee on the Protection of the Rights of Critical Patients resolved to approve said transactions, and submitted the request to the Department of Health Service Support. The Cabinet approved the request, effective October 31, 2018.

2.3.3

EMERGENCY SCREENING AND SORTING SYSTEM TO APPROVE RIGHTS

NIEM developed the Emergency Pre-authorization program to screen and classify emergency cases as a tool for hospitals to assess patient symptoms in a consistent and standardized way throughout the country. The program assigns a username for each private hospital and participating health insurance fund.

Medical facilities use the Emergency Pre-authorization program to determine which emergency patients are eligible for UCEP subsidies and reimbursement. Therefore, the program is one of the key mechanisms that helped win acceptance from all sectors and avoid conflict between private hospitals and patients or their relatives. This action removed one of the shortcomings that plagued the implementation of the EMCO policy during 2012-17.

3

IMPLEMENTATION OF THE POLICY

3.1

GOVERNANCE: ROLES AND DUTIES OF VARIOUS AGENCIES

Medical facilities

- Classify emergency patients according to NIEM criteria
- Provide emergency medical care to stabilize the patient without conditions for collecting reimbursement from the patient's insurance

Ministry of Public Health (MOPH)

- Create understanding among the public
- Coordinate with related agencies to make improvements to the rules and regulations
- Review and improve the fee schedule rates, and propose them to the Cabinet

National Institute for Emergency Medicine (NIEM)

- Manage the entire emergency medical system
- Manage the Emergency Pre-Authorization program

National Health Security Office (NHSO)

- Verify the accuracy of the disbursement information and produce a summary of expenses
- Notify the fund of the beneficiary within 30 days from the time the completed documents are received

Funds

- Amend the regulations to support payment of compensation and pay expenses at the rate of expenses attached to the rules
- Pay the hospital within 15 days

Figure 1: Role and Responsibilities of Agencies under UCEP
Source: Office of the Service Allocation and Compensation Administration, NHSO[10]

3.1.1

MEDICAL FACILITIES AND THE PRIVATE HOSPITALS ASSOCIATION

The UCEP policy is primarily intended to increase access to emergency medical services by focusing on the cooperation of private hospitals and not billing the patient. The 'medical facility,' according to the criteria of the UCEP, includes all private hospitals that are not a party to one of the public health insurance schemes, and all public hospitals. The UCEP policy stipulates that the medical facility is responsible for screening emergency patients according to the criteria set forth in the guidelines, and provide emergency medical care for critically ill patients until they are stabilized and out of immediate danger. The guidelines also allow the medical facility to be reimbursed for costs incurred up to 72 hours after admission. This is in accordance with the guidelines of the NHSO. In the event that expenses are incurred after 72 hours, the medical facility is required to bill the eligible person's health insurance fund, or bill the patient directly.

The UCEP policy stipulates that the medical facility is responsible for screening emergency patients according to the criteria set forth in the guidelines, and provide emergency medical care for critically ill patients until they are stabilized and out of immediate danger

In 2020, 370 private hospitals (out of a total of 382 nationwide) were participating in the Emergency Pre-authorization program, accounting for 96.9% of the total.[11]

3.1.2

MINISTRY OF PUBLIC HEALTH (MOPH)

According to the Cabinet Resolution on March 28, 2017, the MOPH was assigned by the Cabinet to be the main unit to coordinate with various agencies related to amendments to the rules and regulations of various agencies or insurance funds in order to support the reimbursement of the medical facility according to the Rules.

The Cabinet Resolution also required the MOPH to hear the opinions of relevant agencies in creating an understanding of the UCEP policy and the public at large. The MOPH organized meetings to clarify the various health insurance schemes, in addition to the three main funds, and to identify any problems that the critically ill patients encounter or which services hospitals are not being reimbursed for.

The MOPH Notification on the Rules, Procedures, and Conditions for Determination of Expenses for Emergency Patient Operations, Clause 12, stipulates that the MOPH is responsible for reviewing and improving the fee schedule so that the rates are appropriate and take into account the benefits that emergency patients will receive. This review is to be conducted every three years or as the Committee on Medical Facilities deems appropriate as a basis for proposals to the Cabinet.

3.1.3

NATIONAL INSTITUTE OF EMERGENCY MEDICINE (NIEM)

The MOPH Notification on the Rules, Procedures, and Conditions for Determination of Expenses for Emergency Patient Operations requires NIEM to establish the 'Coordination Center for the Protection of the Rights of Critical Emergency Patients' to be the authority in making the discretion[e] in cases where there is a dispute about the assessment of the severity level of an emergency patient through the Emergency Pre-authorization program.

The Coordination Center under NIEM also manages the system for critical emergency patients to receive safe treatment according to their rights by providing the following:

1. The attending physician serves as a consultant on the designation of the severity level of an emergency patient;
2. The registered nurse or emergency medical practitioner supervises emergency operations; and
3. The medical emergency staff perform support duties in emergency operations in order to protect the rights of the patient and register any complaints through the Coordination Center under NIEM. The staff also provides consultations to the relevant parties and the public, and coordinates with various agencies by phone. The Coordination Center can be contacted around the clock at 02 872 1669.

If a critical emergency patient is eligible for UCEP rights, the Coordination Center under NIEM will notify the NHSO of the assessment results to process medical expense reimbursement. The Center will also monitor the patient until the crisis is over or the patient can be safely transferred to a participating hospital under the patient's health insurance scheme. The Center will help coordinate the transport of critically ill patients to an appropriate hospital. The Emergency Medicine Board (EMB) has set up a Sub-committee on Emergency Patient Rights Protection in accordance with the UCEP policy to supervise and administer projects as assigned by the Minister. Meetings are held every month. At the same time, the Sub-committee on Emergency Patient Rights Protection has a working group to organize the bed reservation system for critical emergency patients and a working group to consider improving the fee schedule rates that are reimbursable.

[e] At the time of this report (from the presentation of the NHSO),[10] the NIEM assigns the on-site physician at the attending medical facility assesses the patient's condition through the Pre-authorization program.

3.1.4

NATIONAL HEALTH SECURITY OFFICE (NHSO)

Since the inception of the EMCO policy in 2012, the NHSO was designated as the National Clearing House for 'reimbursements'. The NHSO was responsible for making advance payments to private hospitals according to the DRGs system, and then collecting money from the patient's health insurance fund to cover the cost of care provided.

However, after the UCEP policy was introduced in 2017, Article 8 of the Rules Procedures and Conditions for Determination of Expenses for Emergency Patient Operations requires the NHSO to verify the accuracy of the claims by a medical facility, and to prepare a cost summary to notify the relevant health insurance fund of the patient within 30 days from the time the completed documents are received.

Therefore, under the UCEP, the NHSO has adapted its role to be the National Clearing House for 'data management'. It is responsible for sending information to each participating health insurance fund to cover the cost of treatment by hospitals that receive and treat emergency patients. The patient's information will then be sent to the NHSO. After that, the NHSO will determine what the patient's rights are, calculate the reimbursable cost of treatment, and forward that information to the health insurance fund to manage payment needed to compensate the hospital. The NHSO will generate the report based on the data on the 1st and 16th of each month.

Under the UCEP, the NHSO has adapted its role to be the National Clearing House for 'data management' responsible for sending information to each participating health insurance fund to cover the cost of treatment by hospitals that receive and treat emergency patients

3.1.5

FUNDS OF THOSE ENTITLED TO RECEIVE MEDICAL TREATMENT

In addition to the NHSO's role as National Clearing House for data management related to the UCEP, the NHSO also administers the National Health Security Fund, while the Comptroller General Department and the SSO are responsible for the CSMBS and SSO beneficiaries, respectively.

According to the Cabinet resolution on March 28, 2017, various agencies or funds consider taking action in order to amend the rules and regulations to support the payment of reimbursement to the medical facility in accordance with the rules in order to comply with said Cabinet resolution. The main agencies that manage various funds abide by a uniform set of regulations related to the UCEP, are as follows:

1. **National Health Security Fund (for the UCS or 'Gold Card' system)** - The 2017 Regulations of the National Health Security Board on the Exercising of the Right to receive Justifiable Health Services in the Case of Accident or the Case of a Medical Emergency (August 28, 2017)

2. **Civil Servants Medical Benefits Scheme (CSMBS)** - Notification of the Ministry of Finance on the Rules and Rates for Medical Expenses for Outpatients or Private Medical Facility in Case of Emergency (2017) and Guidelines for Reimbursement of Medical Expenses in Case of Emergency (August 17, 2017)

3. **Social Security Fund** - Notification of the Medical Committee under the Social Security Act on the Criteria and Amount of Medical Fee Compensation in Case of Life-threatening or Emergency (September 22, 2017)

4. **Medical Welfare for Local Employees** - Regulations of the Ministry of Interior on Welfare for Medical Treatment of Local Employees (No. 2) (October 22, 2018)

According to Article 9 of the Rules, a fund is established for those who are eligible for medical treatment under the National Health Security Act, or the Social Security Act, or the law on compensation from government agencies or local administrative organizations or state enterprises or other government agencies. The fund is used to pay the expenses for emergency treatment according to the fee schedule rates attached to the Rules to the medical facility within 15 days from the date the NHSO notifies the fund of those eligible for medical treatment.

3.2

SERVICE COMPENSATION INNOVATION

3.2.1

COMPENSATION SYSTEM OVERVIEW

The UCEP policy supports a timely emergency medical service that only applies to critical emergency patients (Code Red), in which the medical facility is not to impose conditions on the patient for collection of medical expenses from initial treatment until the end of the crisis, or until the patient's condition has stabilized enough to allow the referral to the patient's insurance provider. Medical facilities are eligible for reimbursement for care up to 72 hours after admission. At admission, the attending physician assesses the symptoms to determine the level of severity of emergency according to the criteria and methods established by NIEM, and this is recorded through the Emergency Pre-authorization program.

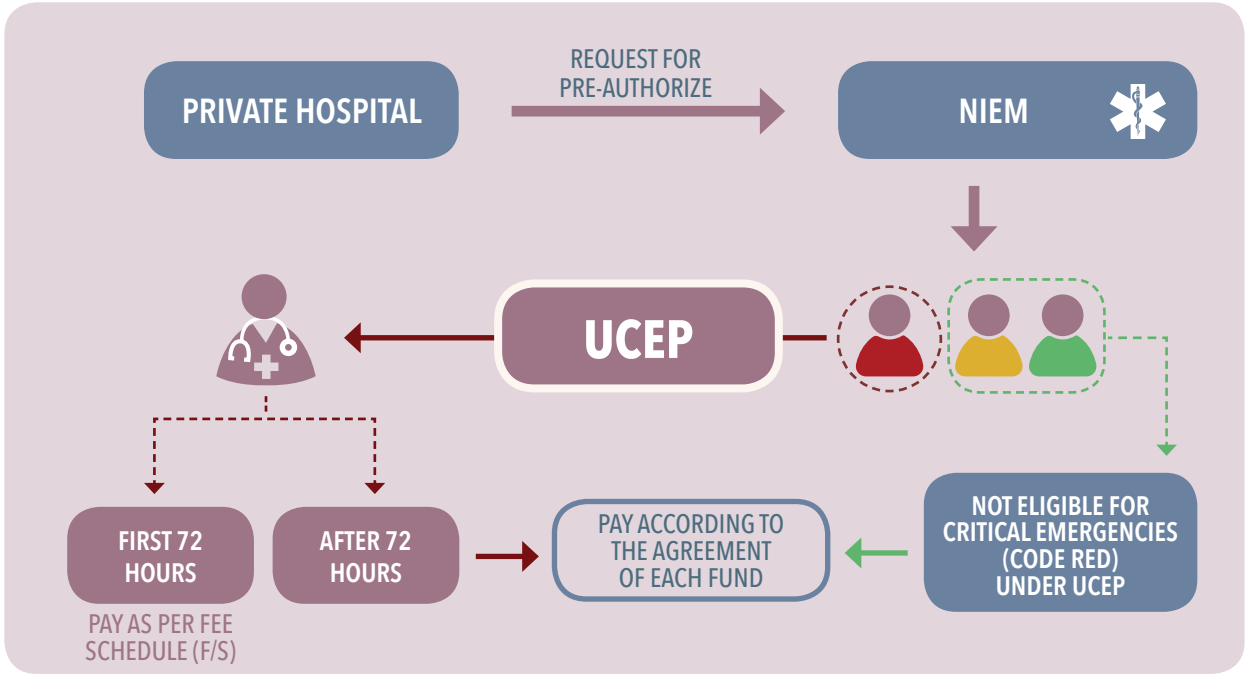

Figure 2: Flow of Payments for Reimbursements under UCEP

Source: Office of the Service Allocation and Compensation Administration, NHSO[10]

If the assessment does not meet the criteria for immediate intervention, the patient can be transferred to a hospital under the patient's health insurance, or other action prescribed by the plan. Patients who require immediate care are covered under the UCEP system as backed by the government. However, there are differences in terms and conditions of reimbursement as per the following two cases:

IN THE FIRST 72 HOURS AFTER ADMISSION OF A PATIENT

1. The medical facility is eligible for reimbursement of the costs incurred during the period of care according to fee schedule payment;
2. The reimbursement should first be processed through any coverage or plan which the patient is a beneficiary of, namely the Motor Vehicle Accident Victims Act, or the Life Insurance Act; and
3. The medical facility is not to bill the patient directly unless the crisis is over and there is a referral bed available, but the patient chooses not to be transferred.

AFTER 72 HOURS

Any medical care expenses that are incurred after 72 hours shall be billed in accordance with the facility's medical expense rate or the agreement between the medical facility and the eligible person's insurance fund.

If there is a dispute about whether the emergency condition is critical (Code Red) or not:

In the event of a diagnostic dispute in classifying a patient by the level of severity, the medical facility is to consult with the 'Coordination Center for the Protection of the Rights of Critical Emergency Patients.' At present, NIEM has assigned medical facilities to have the on-site physician assess admissions through the automated program system.[f] Nevertheless, both patient and relatives can appeal the diagnostic decision at the Center by calling the 24-hour Hotline (02 872 1669), which will be forwarded to the Department of Health Service Support for further consideration.

[f] In the first phase of UCEP policy implementation, the NIEM determined that the Coordination Center for the Protection of the Rights of Critical Emergency Patients would be responsible for the assessment of symptoms of an emergency case, and center staff would then notify the attending medical facility of that assessment, which was considered to be final.

3.2.2

COORDINATION OF REFERRAL TO A MEDICAL FACILITY UNDER THE PATIENT'S HEALTH INSURANCE

When a critically ill patient receives treatment at the nearest medical facility, that patient can be transferred to their participating hospital within 72 hours once the crisis has passed or the attending physician determines that the patient is stable enough to be transferred. The Coordinating Center for the Protection of the Rights of Critical Emergency Patients will then facilitate the referral to the participating hospital. The management of the bed reservation system for receiving patients after 72 hours of crisis care from a private hospital is under the responsibility of the Working Group for Organizing Bed Reservations for Critical Emergency Patients under the Sub-committee on Emergency Patient Rights Protection. In Bangkok and the vicinity, the MOPH coordinates with all public hospitals to receive referrals. Likewise, there will be hospitals under the MOPH that are ready to support referrals in other provinces. The system is functioning quite well as of this study.

3.2.3

RECEIVING COMPLAINTS

NIEM set up a working group to receive and investigate complaints. This is to protect critical emergency patients who have been processed in the Emergency Pre-authorization program. Since the implementation of the UCEP (April 1, 2017-September 30, 2020), there have been a total of 327 complaints filed with NIEM, and 106 were successfully resolved. Cases include hospitals that directly billed patients who were eligible for free services under UCEP (40.7%), patients who disagreed with the diagnosis (39.5%), hospitals which did not record data through the Emergency Pre-authorization program but collected reimbursement (16.5%), and other matters (3.3%).[11]

At present, the resolution of disputes or related issues has been transferred to the Department of Health Service Support (Tel. 02 193 7057). That is because that department is the agency that is responsible for administering the Medical Facilities Act, while the Coordination Center for the Protection of the Rights of Critical Emergency Patient only receives complaints.

4

IMPLEMENTATION PERFORMANCE

4.1

ACCESS TO EMERGENCY MEDICAL SERVICES UNDER UCEP

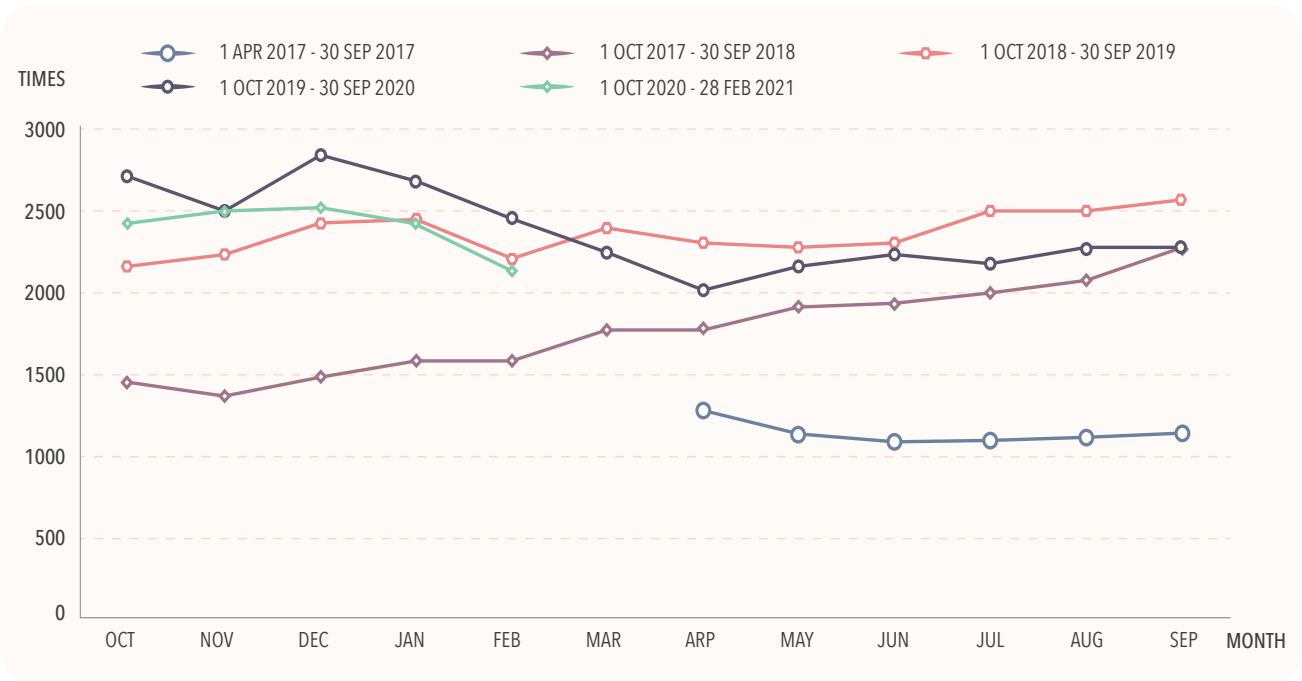

Figure 3: Results of Reports to the Pre-authorization program under UCEP, April 2017-February 2021
Source: Data from the Emergency Pre-authorization program, NIEM;UCEP program, NHSO, as of March 4, 2021[10]

4.1.1

NUMBER OF PATIENTS EXERCISING THEIR RIGHTS UNDER UCEP

From the performance of UCEP implementation (April 1, 2017-February 28, 2021), it was found that emergency patient information was sent through the Pre-authorization program and met the criteria for UCEP 97,125 times, or a monthly average of 2,066 times (Table 2).

4.1.2

PERCENTAGE OF ELIGIBLE EMERGENCY PATIENTS WITH RECORDS FOR DISBURSEMENT

Of the 97,125 submissions of patient information in the program, it was found that private hospitals recorded 92,226 for disbursement, accounting for 95.0% of the total submissions.

4.1.3

PERCENTAGE OF EMERGENCY PATIENTS WHO WERE APPROVED FOR COMPENSATION

Of the total of 97,125 submissions, there were 87,027 critical emergency patients who were approved for UCEP disbursement, accounting for 89.6% of the total submissions.

4.1.4

PERCENTAGE OF EMERGENCY PATIENTS WHO WERE APPROVED FOR COMPENSATION CLASSIFIED BY INSURANCE FUND

Performance under the UCEP policy (2017-present) can be compared to emergency medical services under the EMCO policy (2012-17). Compensation under UCEP totaled 87,027 cases. Of this total, patients covered by the UCS were able to access emergency medical services from private hospitals in the largest number (55,966 cases) compared to other funds. However, it was found that patients covered by the CSMBS received the highest proportion of disbursement approvals (91.9% of the total submissions), compared to other funds (Table 2).

By contrast, during the implementation of the EMCO policy, only 27,152 beneficiaries eligible for the UCS were covered for emergency care, which is less than that of the UCEP implementation period (2017-2021). Nevertheless, people who received emergency medical services under the EMCO policy were limited to those eligible for the CSMBS.[7]

Table 1: Results of Implementation under the EMCO Policy (April 2012-January 2017)

HEALTH INSURANCE SCHEME	NUMBER (TIMES)	AMOUNT OF CLAIMS (MILLION BAHT)	AMOUNT PAID (MILLION BAHT)	PERCENTAGE PAID OF CLAIMS
UCS	27,152	2,569.3	723.7	28.2
CSMBS	23,737	2,479.1	620.6	25.0
SSS	3,843	407.5	107.7	26.4
BMA officers	1,030	114.7	34.1	29.7
Local government officers	675	53.6	18.4	34.3
Other rights	745	94.1	25.6	27.2
TOTAL	**57,182**	**5,718.4**	**1,530.0**	**26.8**

Source: NHSO[12]

Table 2: Patients Approved for Compensation under UCEP by Health Insurance Scheme (April 2017-February 2021)

HEALTH INSURANCE SCHEME	CASES SUBMITTED FOR PRE-AUTHORIZATION	CLAIMS SUBMITTED TO UCEP	APPROVED CLAIMS	APPROVED CLAIMS AS A PERCENTAGE OF PRE-AUTHORIZATION SUBMISSIONS	APPROVED CLAIMS AS A PERCENTAGE OF CLAIMS SUBMITTED TO UCEP
UCS	62,430	59,405	55,966	89.6	94.2
CSMBS	15,363	14,805	14,118	91.9	95.4
SSS	15,295	14,211	13,347	87.3	93.9
BMA officers	954	905	858	89.9	94.8
Local government officers	1,220	1,163	1,116	91.5	96.0
Other rights	1,863	1,737	1,622	87.1	93.4
TOTAL	**97,125**	**92,226**	**87,027**	**89.6**	**94.4**

Source: Emergency Pre-authorization program, NIEM;UCEP program, NHSO (as of March 4, 2021)[10]

In conclusion, the UCEP (2017-present) gives the rights to all critical emergency patients in Thailand, and has significantly improved access to emergency medical services compared to the EMCO policy during 2012-17. Cases served by the UCEP policy increased from approximately 986 cases/month (under EMCO) to 2,066 cases/month. UCS beneficiaries receiving critical emergency medical services increased from 27,152 times under the EMCO to 62,430 times under the UCEP policy. This is evidence of reduction in the disparity between the health care right to better access to health services in life-threatening situations.

4.2

REIMBURSEMENT OF MEDICAL EXPENSES FOR CRITICAL/EMERGENCY PATIENTS UNDER UCEP POLICY

Based on information on disbursement of medical compensation for critical/emergency patients according to UCEP policy, classified by fund, it was found that 97,125 critical emergency patients were processed through the Pre-authorization program. Of these, 87,027 cases were approved for disbursement. The total medical expenses billed (all health insurance funds) was 5.059 billion baht, with disbursement amounting to 2.188 billion baht, accounting for 43.2% of the claimed amount.

Table 3: Reimbursements under UCEP (April 2017-February 2021)

HEALTH INSURANCE SCHEME	PERCENTAGE OF CLAIMS APPROVED (OF CLAIMS SUBMITTED)	AMOUNT OF CLAIMS (MILLION BAHT)	AMOUNT ADVANCED FOR CARE IN THE FIRST 72 HOURS NOT COUNTING INSURANCE CLAIMS (MILLION BAHT)	PERCENTAGE OF AMOUNT IN THE FIRST 72 HOURS	AMOUNT PAID FOR CARE AFTER 72 HOURS (MILLION BAHT)	NET COMPENSATION BEFORE PRIVATE INSURANCE ACTS (MILLION BAHT)	NET COMPENSATION (MILLION BAHT)
UCS (Gold Card)	94.2	3,119	1,303	41.8	93	1,396	1,394
CSMBS	95.4	831	371	44.6	0	371	371
Social Security	93.9	877	327	37.3	0	327	327
BMA Government officers	94.8	71	31	43.7	0	31	31
Local government officers	96.0	50	23	46.0	0	23	23
Other Coverage	93.4	111	42	37.8	0	42	42
TOTAL	**94.4**	**5,059**	**2,097**	**41.5**	**93**	**2,190**	**2,188**

Source: UCEP program, NHSO[10]

The funds compensate for emergency services in the first 72 hours at the agreed price according to the fee schedule. This amounted to 2.097 billion baht. Compensation after 72 hours (only for those eligible in the UCS system) according to the fee-for-service system amounted to 93 million baht, with each fund having details of disbursement of compensation as follows:

1. Universal Coverage Scheme (UCS) had medical expenses of 3.119 billion baht, with a disbursement of 1.394 billion baht, or 44.7% of the billed price. The fund paid compensation for the first 72 hours to the hospital at the agreed price according to the fee schedule, amounting to 1.303 billion baht, and compensation paid after 72 hours according to the fee-for-service system in the amount of 93 million baht. The NHSO processed full payment to the private medical facility within 15 days.

2. Civil Servant Medical Benefit Scheme (CSMBS) had medical expenses of 831 million baht, with a disbursement of 371 million baht, or 44.6% of the billed price. After receiving audited cost information from the NHSO, the Comptroller-General Department was able to pay the private medical facilities within 15 days.

3. Social Security Scheme (SSS) had medical expenses of 877 million baht, with a disbursement of 327 million baht, or 37.3% of the billed price. After receiving audited cost information from the NHSO, the SSO was able to pay the private medical facilities within 15 days.

4 Scheme for Bangkok Metropolitan Administration (BMA) officers incurred medical expenses of 71 million baht, with a disbursement of 31 million baht, or 43.7% of the billed price, and full payment was made within 15 days.

5 Scheme for local government officers incurred medical expenses of 50 million baht, with a disbursement of 23 million baht, or 46.0% of the billed price, and full payment was made within 15 days.

6 State enterprise employees and those covered under other health insurance funds incurred medical expenses of 111 million baht, with a disbursement amounting to 42 million baht, or 37.8% of the billed price. Currently, only some agencies are able to pay compensation to a private medical facility such as Thai Airways International, the Port Authority of Thailand, the Private Welfare Fund of Krung Thai Bank, and the Bank of Thailand.

From the implementation of the UCEP policy (2017-21), the amount of medical expenses billed (all funds), amounted to 5.059 billion baht, with the disbursement of 2.188 billion baht, or 43.2% of the billed price. This is higher when compared to the EMCO policy where patients incurred medical expenses (all funds) in the amount of 5.718 billion baht, with the disbursement of 1.530 billion baht,[9] or only 26.8% of the amount claimed.

[9] During the policy implementation, the UCEP system requires reimbursement to the NHSO from the patient's insurer or other fund within 30 days in order to have sufficient revolving funds and financial flexibility to be able to make advance payments to medical facilities in a timely manner.

5

FACTORS BEHIND THE SUCCESS OF UCEP AND REMAINING CHALLENGES

5.1

SUCCESS FACTORS

5.1.1

THE POLICY IS BACKED BY LAW AND THERE ARE CLEAR PROCEDURES AND REGULATIONS

Having a legal framework, comprised of the amendment to the Medical Facilities Act (No. 4) 2016 and the issuance of the three MOPH notifications stipulating the rules, procedures, and conditions for screening critical emergency patients, providing emergency patient assistance and referral, enabled the UCEP to have a clear policy-driven mechanism. These measures were enough to convince nearly all private hospitals to participate in the UCEP, and largely comply with the rules of the policy.

In addition, the UCEP policy is designed to have effective coordination and regulatory mechanisms. These include the Coordinating Center for the Protection of the Rights of Critical Emergency Patients and information systems through the Emergency Pre-authorization program. Any question or concern about emergency case management can be relayed to the 24-hour NIEM Hotline.

5.1.2

COOPERATION FROM RELEVANT AGENCIES

The policy implementers ensured they would get good cooperation from the relevant agencies in both the public and private sectors. These key players include the Office of the Permanent Secretary of the MOPH and the Department of Health Service Support of the MOPH, the NHSO, the SSO, the Comptroller General Department, the State Enterprise Policy Office, the Department of Labor Protection and Welfare, the College of Emergency Physicians of Thailand, the Private Hospitals Association, and private hospitals themselves. The overall picture of policy implementation is thus favorable and effective. Moreover, the role of most private hospitals is non-discriminatory, and they do not refuse treatment to anyone. As a result, the performance of UCEP policies can increase people's access to emergency medical services for the intended objectives.

5.1.3

WIDESPREAD AND ACCESSIBLE PUBLIC RELATIONS MAKE PEOPLE AWARE OF UCEP AND AWARE OF THEIR RIGHTS

One of the problems with the EMCO policy was the widespread lack of public understanding of the scope of the policy's benefits. At that time, public relations communication regarding emergency medical conditions was limited and lacking in clarity. As a result, the MOPH and NIEM developed various press releases and disseminated these in the form of printed documents, brochures, annual diary books, desk calendars, and standee banners to be delivered to every hospital so that staff and clients were fully informed. There was information dissemination through public relations spots on TV and radio, and online media (such as Facebook, YouTube, and various websites) to make people aware of the guidelines, procedures, and implementation of the UCEP policy. These public relations efforts are ongoing at the time of this report.

If a patient meets the criteria for a COVID-19 emergency, there is no need to process the case through the Emergency Pre-authorization program. The medical facility will receive reimbursement for the expenses incurred based on the COVID-19 inventory fee schedule.

In addition, during the pandemic of COVID-19, the NHSO, MOPH, and related agencies have held a series of meetings to clarify understanding with service units across the country on the management of patients with COVID-19 so that all medical facilities operate in accordance with the UCEP-specific criteria (UCEP-COVID-19). Emergency patients with COVID-19 need to be managed somewhat differently than general UCEP cases. For example, if a patient meets the criteria for a COVID-19 emergency, there is no need to process the case through the Emergency Pre-authorization program. The medical facility will receive reimbursement for the expenses incurred based on the COVID-19 inventory fee schedule. Hospitals are not to bill the patient until discharge. Hospitals are kept up-to-date on adjustments to the guidelines through online meetings (in view of COVID-19). This aspect of the UCEP has also been a factor behind its popularity and success.

5.2

REMAINING CHALLENGES

5.2.1

SOME MEDICAL FACILITIES STILL TRY TO BILL PATIENTS FOR TREATMENT OUTSIDE THE UCEP GUIDELINES

Based on grievances submitted to NIEM, it was found that the most common complaint is from patients who believed they were eligible for free emergency care, but were still charged by the private hospital. This is consistent with the findings in an independent evaluation which found that 20-30% of emergency patients at private hospitals are being asked to place a pre-service deposit.[13] Some hospitals charge the patient first and then reimburse the patient once the hospital receives its funds from UCEP or the insurance provider. These illegitimate demands for a deposit or co-payment are a key challenge in implementing UCEP policy that should be seriously addressed. However, the MOPH, the agencies responsible for health funds, and the Private Hospitals Association are jointly trying to address this issue through revising the fee schedule rates. These rates are reviewed and revised at least every three years, and this should help private hospitals have confidence in the UCEP policy and not burden the patient.

5.2.2

NON-INCENTIVE COMPENSATION RATE FOR SERVICES OF PRIVATE HOSPITALS

At present, the disbursement rate under the UCEP (2017-present) was 43.2% of the billed price. This is higher compared to the EMCO disbursement rate of 26.8% (Tables 1 and 3). The primary reason for clinical patient billing is that some private facilities provide treatment or services outside the UCEP fee schedule. In addition, some private hospitals may still feel that the UCEP rates are below the actual cost incurred by the hospital for emergency care. However, no empirical studies have determined what the actual average cost of treatment at the private medical facility should be.

Therefore, to ensure sustainability in the implementation of UCEP, cost data for emergency medical services at each level of the private medical facility should be empirically studied. Alternative compensation systems, such as DRGs, or a combination of DRGs-based payments and fee-schedule-based payments may be more appropriate for certain service categories, such as the use of expensive (but essential) drugs or materials.

5.2.3

DEVELOPMENT OF THE EMERGENCY MEDICAL SYSTEM IN A PUBLIC CLINICAL FACILITY

Thailand has been striving to develop its emergency medical system over a period of at least three decades, and this incremental development is moving the country toward the ultimate optimal solution. However, the emergency medical system in public medical facilities still needs improvement. In particular, public hospitals need to provide emergency care more quickly to reduce unnecessary loss from disability or death, and to build confidence in the service of the public. In addition, there should be a financial mechanism to support ongoing improvement in the emergency medical system in the government's medical facilities so that they are uniform and standard across the country.

5.2.4

DELAY IN IMPROVING STATE ENTERPRISE FUND REGULATIONS

Some of the relevant health insurance funds face obstacles in paying private medical facilities for emergency care of their beneficiaries. At the time of this study, there were 165 health insurance funds in operation in Thailand. However, only 13 of these funds have revised their regulations to conform to UCEP criteria, while the other 152 funds need to amend their regulations so that care and financing are uniform. The top priority for alignment is the large state enterprises that have large numbers of beneficiaries. This is one of the key challenges affecting access to emergency medical services. At the time of this study, discussions were ongoing to resolve this gap, including such agencies as the Department of Welfare and Labor Relations, the Office of the Public Sector Development Commission, and the State Enterprise Policy Committee.

6

SUMMARY: THE EMERGENCY MEDICAL SYSTEM AS AN INTEGRATION OF THE THREE MAJOR PUBLIC HEALTH INSURANCE SCHEMES TO REDUCE INEQUALITY

Implementation of the UCEP policy from April 2017 to the present is gradually closing the gaps in emergency care around the country. Compared to the Emergency Claim Online (EMCO) policy (2012-17), UCEP has significantly increased access to emergency medical services, focusing on cooperation from private hospitals, and has reduced the disparity among the three main public health insurance schemes. The UCEP policy ensures that patients will receive timely emergency medical services in the first 72 hours after an accident or acute illness, and not be billed. The implementation of the UCEP over the past four years has proven to be of great benefit to the people. In particular, UCS beneficiaries, under the responsibility of the NHSO, have greater access to emergency medical services compared to the previous policy. Although the implementation of the UCEP policy still has some obstacles and challenges, all the relevant agencies in both the public and private sector, including the general public, are working together to further develop the emergency medicine system so that the UCEP policy serves as a *'good-practice model'* for integrating and reducing the disparity of health care in Thailand.

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UNIVERSAL COVERAGE FOR EMERGENCY PATIENTS (UCEP) IN THAILAND

Project on Knowledge Management, Lesson Learnt Reflection and Dissemination of National Health Security Office [NHSO]

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