Issue#18 September 2020

Good Governance for Universal Health Coverage

Dr. Somsak Chunharas and Ms. Juliet Eames

Achieving universal health coverage (UHC) requires policy initiatives supported by long-term system reform and an accountable governance structure that can sustainably deliver all three dimensions of UHC, population coverage, breadth of benefits package, and degree of financial coverage. A good governance structure must match policies with available financial and infrastructural capacity, and incentivise all actors to work towards UHC goals. It must also ensure effective implementation and feedback use to consistently improve delivery on UHC dimensions.

There is no single structure of UHC governance and functions can be assigned to one or more administrative bodies. Available literature identifies some central attributes, outlined below:

- clearly defined goals, well understood by all actors,
- support to act synergistically, but with a degree of autonomy and financial capability,
- staff (or partners) with technical skills to design evidence-based policies,
- mechanisms to influence actors to implement pre-decided policies, and
- information capacity to monitor the scheme.

Transparency and accountability can ensure good governance, with stakeholders personally invested in monitoring their interests and influencing necessary changes in a participatory manner; a delicate balance must be struck between promoting transparency and accountability, while ensuring speedy action. Building strong systems takes time and countries may initially aim for governance that is 'good enough' to meet priorities and mitigate the greatest risks to the scheme's success, while enhancing capacity for improved governance over time.

This policy brief draws on theories of governance for UHC and describes practical aspects of Thailand's UHC governance, to enable other countries to learn from these successes and mistakes.

policy brief

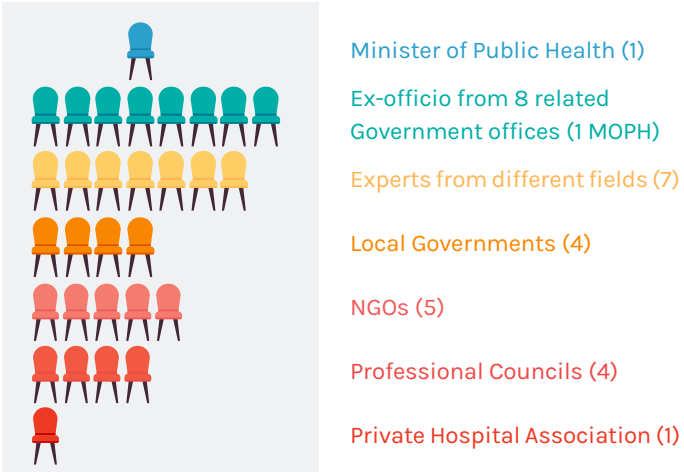
Governance for UHC in Thailand

Before 2002, Thailand's health insurance system comprised two major schemes: Social Health Insurance Scheme (SHI) and Civil Servant Medical Benefit Scheme (CSMBS) which covered only 30% of the population, who were either civil servants or formal sector employees. The country then implemented the Universal Coverage Scheme (UCS), expanding coverage to the remaining 70% that was previously uninsured. The UCS governance structures are limited to this scheme alone and do not cover SHI and CSMBS. However, since UCS covers most of the population, its design and operation reflect an attempt to build governance for UHC in Thailand. UCS governance was influenced by important contextual factors associated with the Ministry of Public Health's interest in improving their patient services, addressing rising out-of-pocket payments even at public facilities, increased demand for services and insufficient funds. In addition, previous health insurance schemes (SHI and CSMBS) had left a majority uninsured and vulnerable to catastrophic expenditures.

Systems for good policy making

The National Health Security Act (NHSA) was promulgated to outline the UHC governance system. The Act established the National Health Security Office (NHSO) and a Board (the National Health Security Board) to govern UCS, with a mandate over all aspects, including defining the benefits package, purchasing care and monitoring outcomes. As an 'autonomous public organisation', NHSO has the freedom to design evidence-informed policies. The multi-stakeholder governing Board, which includes government officials, civil society, technical experts, professional councils, and private health providers, is chaired by the Minister of Public Health, ensuring strong accountability to stakeholders, further enhanced by having a Board comprising multiple stakeholders that appoints the Secretary General who is responsible for implementing Board decisions . This balance between freedom and accountability indicates that policymaking is based on stakeholder interests and meets the political mandate. Thirteen similar "regional boards" operate at the local level to ensure that policy is tailored to context.

Participatory structure in Thai UHC board



Source: National Health Security Act 2002

The UCS system has been designed based on Thailand's past experiences, such as unaffordability of care by the poor due to user fees, unreliability and high resource-requirement for means testing of potential recipients. This led UCS to evolve into a tax-financed scheme, providing a uniform benefit package to all citizens uninsured by either pre-existing scheme. Provider payment systems were also built based on SHI which had been effective in controlling costs, improving access, and providing fairer reimbursements for patients with severe conditions. Availability of improved evidence on impacts of payment mechanisms has led to updates in these mechanisms and made them more complex.

Defining an affordable benefit package at inception was crucial due to limited funding and the need to avoid patient co-pay. Initially, the package excluded high-cost items but as the capacity for Health Technology Assessment (HTA) developed, it could be expanded in a sustainable, consistent and fair manner (see policy brief "Designing the Health Benefit Package: the essential component of a successful UHC program").

The NHSO Board estimates resource requirements from data submitted by providers during the scheme's reimbursement and performance assessment processes. Since UCS is fully tax-funded, NHSO uses this evidence to negotiate with the Bureau of the Budget, Ministry of Finance and senior political leaders to secure funds required to meet its commitments. Robust evidence has allowed the Board to negotiate a sustained increase in funding over 15 years and gradually expand the benefits package. If UCS funding sources are diversified in future, NHSO will need to ensure that commitments and resources continue to align.

Ensuring effective policy execution

Primary care is central to UHC and UCS implemented a system of 'Contracted Units for Primary Care' (CUP) to ensure entitlements extend beyond curative services. Under this system, patients must first visit primary providers and facilities which deliver disease prevention and health promotion activities for non-emergency cases (see policy brief "Primary health care: the building block of Universal Health Coverage"). The financing design, capacity, and coordination of CUPs continues to evolve and the changes will test UCS governance. NHSO uses its position as a purchaser to manage incentives, refine procurement arrangements, effectively balance supply and demand, and leverage its purchasing power to negotiate prices with manufacturers; this has saved USD 188 million in recent years.

NHSO must not abuse this power, ensuring payments are evidence-based and financially feasible and acceptable, as unfair prices undermine providers' ability to deliver quality care and support the scheme. When possible, NHSO selects a contractor through a competitive process incentivising efficiency and quality. However, since a choice is not always available, NHSO also requires that UCS empaneled facilities receive formal quality accreditation and supports facilities in meeting quality standards.

The importance of information systems for UCS implementation cannot be emphasised enough. Computerised systems for providers to submit data for reimbursements eased claims processing, increased transparency (which earlier systems lacked) and supported development of fair and

effective payment mechanisms. Linking UCS to the registration system enabled accurate allocation of populations to CUP networks and improved communication about entitlements and service networks from NHSO to citizens (before individuals had registered themselves). Continuous efforts are being made to make population and patient data interoperable, enhancing integrated and continuous care processes.

Tracking outcomes

NHSO aims to track outcomes through a 24-hour patient complaint hotline, financial and clinical audits of service providers, analysis of routine data, annual public surveys, and National Health Accounts. Performance is scrutinised at an annual public hearing where providers and beneficiaries provide feedback to the Board, which is then used to identify and redress scheme limitations. To date, indicators have shown high rates of satisfaction with UCS and significant financial protection, especially for the lowest income groups. However, increasing demand and utilisation of UCS will challenge the governing body to design policies that can maintain scheme outcomes, requiring concerted efforts from various stakeholder groups.

Building trust among stakeholders

Stakeholders must support UHC for effective implementation; they must trust that systems are fair, transparent, evidence-led, based on patient interests, and aligned to policy makers' targets with aims for equity, financial protection, and affordability for all. Though far from comprehensive, UCS has been designed to be responsive, transparent, and accountable through documentation of audits and audit appeals, public access to performance reports, annual public hearing, and through the multi-stakeholder Board. Despite these information dissemination channels and engendered trust, NHSO still faces criticism for not being transparent enough in terms of checks on claims processing and subsequent reimbursement as well as limited knowledge of inputs and resulting actions from the annual public hearing. NHSO must redress these shortcomings to maintain stakeholder support.

Building capacity and continuous learning

NSHO has worked to consistently review and strengthen its systems over the past 15 years, with investments made to improve information systems capacity, participation and communication channels, audit processes, assess benefit package inclusions and conduct regular reviews of payment systems and reported outcomes to inform the scheme.

NHSO's data requirements may need further improvements to reduce the time taken for data submissions, provide data in a form that is more useful for providers (see policy brief on "Health management information systems for universal health coverage"), and to expand data use for purposes beyond management, such as better population health planning, patient care coordination, and purchasing modifications.

Governance beyond UCS

NHSO's governance mandate does not extend beyond UCS and there is no harmonisation between the three public health insurance schemes. Different payment mechanisms for hospitals result in varied outcomes in terms of efficiency and quality of care; patients have different freedoms of choice regarding providers across schemes, and schemes cover different benefits, exacerbating inefficiencies and inequalities in healthcare provision. NHSA mentions scheme harmonisation without specific details on supporting such governance structures. Overarching governance by NHSO, or a national committee for UHC, with participation from all three schemes has been discussed as a potential option. However, different scheme structures, governance, and vested interests have meant that harmonisation has not gained traction. The mandate for defining this system is beyond NHSO and requires a body such as the Ministry of Public Health to take it forward. Having achieved the priority of UHC through UCS, Thailand must now turn toward addressing these challenges.

Key lessons for other countries ("do's and don'ts")

NHSO's experience of managing UCS can provide some lessons on good governance for UHC.

Do's

- Design a governing structure with clearly defined roles and functions for all relevant stakeholders with scope to evolve, based on short-term goals and long-term requirements of feasibility and sustainability.
- Ensure the governing mechanism is autonomous enough to mobilise competent and dynamic leadership at the executive level, workforce, and partners at an operational level, and have built-in capacity for improvements.
- Develop a model where policy is grounded in evidence and the governing body can utilise external evidence to maximise quality and quantity of healthcare.
- Monitor outcomes and executive performance through strong information systems and have an ability to respond to findings.
- Build trust through transparency and accountability against policy goals and principles of good UHC governance, with platforms to address feedback from various stakeholders.

Don'ts

- Make the governing structure overly bureaucratic. If possible, limit the ties between recruitment and compensation to public civil services rules, as it may limit ability to recruit and mobilise talented workforce at all levels.
- Limit roles and functions only to financing and expect others to do the rest at their best. Achieving desirable outcomes of UHC is complex and requires active partnership.
- Allow governance to be over-populist or introduce a benefit package that is not evidence-based or financially viable which results in ad-hoc rationing and detrimental health outcomes.
- Neglect to set up effective communication channels to regularly inform stakeholder groups on all aspects of scheme policy, deliberations, and developments etc.

References

- Barbazza, E. and Tello, J.E., 2014. A review of health governance: definitions, dimensions and tools to govern. Health policy, 116(1), pp.1-11.
- Fattore, G. and Tediosi, F., 2013. The importance of values in shaping how health systems governance and management can support universal health coverage. Value in Health, 16(1), pp.S19-S23.
- Fukuyama, F., 2013. What is governance?. Governance, 26(3), pp.347-368.
- Glassman, A., Giedion, U. and Smith, P.C. eds., 2017. What's in, what's out: designing benefits for universal health coverage. Brookings Institution Press.
- Greer, S.L. and Méndez, C.A., 2015. Universal health coverage: a political struggle and governance challenge. American journal of public health, 105(S5), pp.S637-S639.
- National Health Security Office internal presentation resources
- Greer, S., Greer, S.L., Wismar, M. and Figueras, J. eds., 2016. Strengthening health system governance: better policies, stronger performance. McGraw Hill Education/ Open University Press.
- National Health Security Office, Thailand. Annual reports year 2003 through 2017. Available at https://www.nhso.go.th/eng/FrontEnd/page-contentdetail.aspx?CatID=MTAyMw==
- Pannarunothai, S., 2018. Health Management Information Systems for Universal Health Coverage., Available at: http://www.hitap.net/en/documents/173308
- Pannarunothai, S., 2018. Primary Health Care: the building block of Universal Health Coverage., Available at: http://www.hitap.net/wp-content/uploads/2018/11/PB-India-Primary-Healthcare-Building-Block-for-web.pdf
- Sakunphanit, T., 2006. Thailand: Universal health care coverage through pluralistic approaches. Social Security Extension Initiatives in East Asia. ILO sub-regional office for East Asia. Bangkok: International Labour Organization.
- Supachutikul, A., 2018. Promoting Healthcare Quality for Effective UHC: Thailand's Trajectory., Available at: http://www.hitap.net/en/documents/173315
- Tangcharoensathien, V., Limwattananon, S., Patcharanarumol, W. and Thammatacharee, J., 2014. Monitoring and evaluating progress towards universal health coverage in Thailand. PLoS medicine, 11(9), p.e1001726.
- Tangcharoensathien, V., Limwattananon, S., Patcharanarumol, W., Thammatacharee, J., Jongudomsuk, P. and Sirilak, S., 2014. Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. Health policy and planning, 30(9), pp. 1152-1161.
- World Health Organization, 2016. Strategizing national health in the 21st century: a handbook. World Health Organization.
- Yot, T., Eames, J., Dabak., S. 2018. Designing the Health Benefits Package: the essential component of a successful Universal Health Coverage program., Available at: http://www.hitap.net/en/documents/173301

Contact: hiu@hitap.net

This policy brief can be downloaded from www.globalhitap.net