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Reason for Selecting Types of Provider Payment of the 30 Baht Scheme in Thailand, 2002

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Abstract In 2002, Thailand implemented universal coverage of health insurance for the entire population through the 30 baht scheme, which merged welfare schemes protecting the lower income groups, and extended insurance cover to those previously unprotected. Within the 30 baht scheme, payment for health services has been changed from a historical global budget to per capita funding for the catchment population. Provinces were permitted to choose the provider payment method, either exclusive capitation or inclusive capitation. Provinces could also choose the level of the system at which salaries were deducted, either at contracting unit for primary care (CUP) level or at provincial level. The aims of this study were to understand the reasons behind the selection of provider payment type of each province and to illustrate the impact of such payment on the initial budget of hospitals. A telephone interview survey was used to explore the reasons for the choice of provider payment type and budget allocation. Cases studies are selected to explore the impact of alternative provider payments on the initial budget of hospitals. The results of the study indicated that each province had their own reasons to select their types of payment. The main reason for selecting exclusive capitation were helping each other and sharing risk together and concerns about the quality of care and referral reimbursement problem from inclusive capitation whereas the main reason for selecting inclusive capitation were improving hospital efficiency and reforming the health system and requesting CF. The main reason for selecting salary deduction at CUP were having an appropriate worker distribution and requesting CF whereas the main reason for selecting salary deduction at provincial level were helping each other at all level of health services to survive as a whole province and advocating or looking after staff during the reform situation. Community hospitals are better off when they have salary deduction at CUP level. On the other hand, general hospitals and regional hospitals are better off when they have salary deduction at provincial level.

Key words: **provider payment, exclusive capitation, inclusive capitation, 30 baht Scheme**

Introduction

In 2002, Thailand achieved universal coverage of health insurance for the entire population through the 30 baht scheme, which merged the medical welfare schemes and the health card scheme and then extended to cover to those previously uninsured. Within the 30 baht scheme, provider payment for health services has been

changed from a historical global budget to capitation payment for the registered population. The staff's salary is also included in this capitation rate in order to reform the system. Furthermore, the main configuration of the 30 baht scheme comprises promoting the use of primary care as a gatekeeper, ensuring quality of care by using accreditation, providing standard package and decentralizing fund management to provincial authorities[1].

In the first year of implementation, provinces were permitted to choose the provider payment method, either exclusive capitation (a mixture of capitation for primary care and case-based payment for inpatient care) or inclusive capitation (a capitation for primary care and inpatient care). Provinces could also choose the level of the system at which salaries were deducted, either at contracted unit for primary care (CUP) level (where the whole capitation budget is allocated directly to CUP) or at provincial level (all provincial staff salaries are deducted first, and the balance is allocated to CUP).[2] As such, flexibility was allowed in order to introduce trial and error into the process as each method has its strengths and weaknesses. No empirical evidence indicates which one is better for the 30 baht Scheme. The government therefore allowed each province to select the provider payment method that they thought was appropriate for their province.

The aims of this study were: 1) to classify provinces by types of provider payment and to explore the variation of budget allocation within groups, 2) to understand the reasons behind the selection of payment type of each province and 3) to demonstrate hospital budgets under different payment regimes. The knowledge gain from this study would be useful to understand the details of the provider payment mechanisms currently applied to the 30 baht scheme and in evaluation the provider payments of the 30 baht scheme in the future.

Methods

Data were obtained by telephone inter viewing the head of the Public Provincial Health Office (PPHO), the deputy of the PPHO or a person involved in administration from every province (75 provinces) except Bangkok. Each province appointed one representative as an interviewee. The telephone interview was conducted during June - August 2002. The average time of each interview was about 30 minutes.

The questionnaire was a close ended and multiple-choice. It was adapted from the questionnaire of the Public Provincial Health Office Committee*, which was used to survey the administrations of all PPHOs during the first year of implementation of the 30 baht scheme. The response categories were also adapted from the PPHO Committee Questionnaire.[3]

It was then tested on 10 directors of community hospitals from different provinces and the response categories of each question were revised again. The directors of community hospital were asked to test instead of the heads of PPHO because of the unavailability of the heads of PPHO and the considerable roles of the directors of community hospitals through selecting process of provider payment.

The questionnaire was coded by the interviewer after reading out all the response categories to the interviewee. In some questions, particularly reasons for selecting types of provider payment, the interviewee could provide only the

*The Public Provincial Health Office Committee is the working group of the head of provincial health office in Thailand.

most important reason. The detail of the contingency fund (CF) was confirmed by rechecking the Ministry of Public Health (MoPH) data.

Furthermore, the case studies of Leuamnaj hospital and Amnat Charoen hospitals under Amnat Charoen PPHO were purposely selected as representative of community hospitals and general or regional hospitals to demonstrate the impact of payment regimes on the initial budget of hospitals. Their sizes and number of registered population seemed to represent the majority of community and general hospitals in Thailand.

Results

General information

a) Interviewees

Representing the 75 provinces, 20 heads of PPHOs (26.7%) and 42 deputy heads of PPHOs (56%) were interviewed, plus 13 related persons (17.4%) involved in decision-making, such as directors of community hospitals or the head of the planning and development division in the PPHOs.

b) Type of provider payment mechanisms

The results of the survey indicated that 43 provinces (57.3%) opted for inclusive capitation while 29 provinces (38.6%) used exclusive capitation. Three provinces (4%) used a combination of the two payment types.

c) Level of salary deduction

Forty provinces (53.3%) used salary deduction at CUP level, whereas 32 provinces (42.6%) used salary deduction at provincial level. Three provinces (4%) used both deduction levels simultaneously, with a fixed proportion of budget allocated at each level for such purpose. These provinces exercised salary deduction at CUP and provincial levels in different proportions. In one province, the ratio was 20:80; in the other two, it was 50:50.

Based on these survey results, provinces were categorized by type of provider payment mechanism and level of salary deduction into 7 groups as shown in Table 1.

Process and rationales for provider payment selection

a) Mechanisms of provider payment selection

It was found that there were 3 types of mechanism for selecting the type of payment and level of salary deduction.

Firstly, the decision was made by the provincial health insurance committee. Prior to its meeting, a sub-committee usually prepared an analysis of the strengths and weaknesses of alternatives and made recommendations. This mechanism was adopted by 39 provinces (52%).

Secondly, the decision was made by the

Table 1 Summary of categorization of provinces by types of provider payment

Salary deduction	Number of type of provider payment province (%)			
	Exclusive	Inclusive	Mixed	Total
CUP	11 (14.6)	27 (36.0)	2 (2.6)	40 (53.3)
Provincial	18 (24.0)	13 (17.3)	1 (1.3)	32 (42.6)
Proportion	0	3 (4.0)	0	3 (4.0)
Total	29 (38.6)	43 (57.3)	3 (4.0)	75 (100)

planning and evaluation committee, which includes only an administration team on the provider side, for example directors of community hospitals and heads of the district health offices. This mechanism was opted by 30 provinces (40%).

Thirdly, the decision was made by the head of the PPHO alone, which occurred in only 6 provinces (8%).

b) Reasons for selecting a particular payment type

Exclusive capitation: The most common rationale for selecting exclusive capitation was helping each other and sharing risk together. Based on such rationale, 17 provinces (58.6%) selected exclusive capitation. The second common reason was concerns about the quality of care and referral reimbursement problem from inclusive capitation which was reported by 6 provinces (20.6%). The third common rationale was the "PPHO can have room for management" which was reported by 3 provinces (10.3%). The rest of the exclusive capitation provinces gave other rationales. For example, Saraburi would like to have only 2 CUPs because the province had 1 general hospital and 1 regional hospital located in appropriate geographical areas, one in the north and one in the south. It is straightforward to manage as 2 CUPs, exclusive capitation seems, then, appropriate for 2 CUPs management.

Inclusive capitation: The most common rationale for selecting inclusive capitation involved improving hospital efficiency and reforming the health system. This rationale was reported by 16 provinces (37.2%). The second common rationale was "requesting contingency fund (CF)". The rationale was reported by 9 provinces (20.9%). The government allowed hospitals to request CF if they did not have sufficient budget. A hospital using inclusive capitation may gain additional funds from the CF compared with exclusive capitation because inclusive hospitals faced the financial risk on their own, while exclusive hospitals shared the risk with other community hospitals in the province. The third and fourth common rationales were hospitals would like to administer the budget by themselves and emphasizing prevention & promotion and a focus on holistic care. These rationales were reported by 5 (11.6%) and 4 provinces (9.3%), respectively.

c) Reason for selecting the level of salary deduction

Salary deduction at CUP level: The most common rationale was having an appropriate distribution of health personnel because health personnel always throng in urban area's hospitals. Eleven provinces (27.5%) reported this rationale. This was closely followed by the "requesting CF" cited by 10 provinces (25%). The third common referred to "reforming or improving capacity of the hospital" and "identifying the real financial situation of the hospital". These two agendas were reported by 8 provinces (20%).

Salary deduction at provincial level: The most common thrive for selecting salary deduction at provincial level was "helping each other at all levels of health services to survive as a whole province", as quoted by 15 provinces (46.8%). The second and third common reasons were "advocating or looking after staff during the reform situation" and "not ready to have salary deduction at CUP level". These were advocated by 10 (31.2%) and 5 provinces (15.6%), respectively. Two provinces (6.2%) reported "other" reasons for selecting salary deduction at provincial level; for example, Phuket prefers only one CUP management.

Three provinces adopted proportional levels of salary deduction at both CUP and provincial level. For example, Amnajareon province

initially would like to have had salary deduction at CUP level, but their system was not yet ready. They had an overstaffed general hospital. A solely capitation budget for its registered population might not be sufficient for the general hospital to operate. Thus, proportions of salary deduction at both levels, were used in order to share the financial risk of health service and while embarking on a new system. After the transitional period, the practice was replaced by salary deduction at CUP level.

The survey results indicate that the process of selecting type of provider payment for each province was mainly decision-making by the committee, which comprises representatives of consumers, purchasers, providers and academic persons of each province. The provider payment method has to be used for all types of hospital in a province. Each provider payment method however has strengths and weaknesses. Some types of payment may make general or regional hospitals better off whereas community hospitals may be made worse off. Moreover, some types of provider payment may have strengths such as improving efficiency of providers whereas they may have inevitable drawbacks in quality of care. Provider payment methods therefore affect the incentives and related behavior of different types of hospital in different ways.

Budget allocation

Although there were only two main types of provider payment and levels of salary deduction, the results of the survey indicate that there was a variation in the ways the budget was administered across the country. This suggests that comparison of the impact of alternative provider payment regimes may be affected by these variations. The details of budget allocation are summarized as follows.

a) Ambulatory care

All provinces were supposed to allocate the ambulatory care budget directly to CUPs and allow CUPs to be fully in charge. However, in 2 provinces, this budget was managed by the PPHOs which allocated it directly to health centers.

b) Preventive care budget

Sixty-seven provinces (89.3%) allocated the preventive care budget to CUPs, whereas in 4 provinces (5.3%) this budget was administered by the PPHO. Three of these four provinces reserved some preventive care budget to pay a bonus to health centers that achieved preventive care goals. Another province kept 10 percent of this budget and allocated it directly to health centers to guarantee the minimum requirements of the operating costs of health centers.

c) Reservation of part of the capitation budget at PPHO

Apart from its PPHO budget, 51 provinces (68%) set aside some part of the capitation budget at the PPHOs. The average amount of budget reserved in these provinces was 9 percent, ranging from 1 to 26 percent of the total capitation budget. The objectives of this were mainly to pay for reimbursement of out-of-province referral costs (45.1%) and to generate a risk-sharing fund in the province (15.7%). The risk-sharing fund was generated from pooling certain proportions of the budget of all hospitals in order to support hospitals with financial constraint within the province.

d) Provider payment method to other public hospitals

The change of budget allocation method from a historical global budget to a per capita for the catchment population also affected hospitals outside the MoPH. Public hospitals outside the

MoPH, such as military hospitals or university hospitals, received their operating budget, except for the salary budget, based on capitation budget for the registered population at the same rate paid to the MoPH hospitals. Only 31 provinces had public hospitals outside the MoPH participating in the 30 baht Scheme. Twenty-six provinces (83.3%) used inclusive capitation, and 5 provinces (16.1%) used exclusive capitation.

e) Provider payment method to private hospitals

The government allows private hospitals to participate in the 30 baht scheme, and freely allows consumers to register with them. These hospitals will receive a per capita budget from the government. The two methods of provider payment used by public hospitals also applied to private hospitals. The survey indicated that 70 private hospitals (18.2%) out of 385 private hospitals in the whole country participated in the scheme. These were located in 28 provinces. 26 provinces (92.8%) used inclusive capitation to pay private hospitals and only two provinces used exclusive capitation.

f) Provider payment method to health centers

Seventy-one provinces (93.3%) allowed CUPs to administer and to allocate their budget to health centers at the standard rate recommended by the MoPH. However, in 4 provinces (5.3%) the PPHOs directly allocated this budget to health centers. Furthermore, there were various methods of payment from CUPs to health centers throughout the country. The provider payment method to health centers also varied among districts within the same province. The methods included a flat rate for outpatient, a global budget for each health center and a mixed method of global budget for preventive care and reimbursement at a fixed rate for curative care.

g) Received CF

The government reserved 10 percent of the total budget of the 30 baht Scheme for the CF. If hospitals drained their resources, additional budget could be requested from the CF. Exclusive hospitals under salary deduction at CUP level (group 1) had a higher probability of receiving CF than other groups. However, inclusive hospitals under salary deduction at CUP level (group 2) had a higher total of amount of CF than other groups, and inclusive hospitals under salary deduction at provincial level (group 4) had a higher average amount of CF per hospital than other groups. (Table 2)

The result showed that hospitals under salary deduction at provincial level received CF less than hospitals under salary deduction at CUP level. This was because hospitals under salary deduction at the provincial level could help each other to bear staff salary within the province. Only

Table 2 Comparative CF received by community hospitals in each payment group

Variables	CUP salary deduction		Provincial salary deduction		Total
	Exclusive	Inclusive	Exclusive	Inclusive	
Number of hospitals receiving CF	30	51	15	6	102
Percent of hospitals receiving CF (%)	31.2	21.4	8.1	4.6	15.6
Average amount of CF per hospital (million baht)	5.4	5.3	6.2	8.4	6.3
Total amount of CF (million baht)	164.2	272.5	93.8	50.5	581

hospitals with severe budget constraints needed to receive CF from the government. In contrast, under salary deduction at CUP level, hospitals had to use only their budget from their registered population to pay their staff salary and operate their hospitals. Hospitals with lower registered population compared to their staff salary did not have other hospitals to share their staff salary. They had to request additional budget from the government. Hospitals under salary deduction at CUP level therefore had higher needs for CF than hospitals under salary deduction at provincial level.

Reimbursement rate

Based on the survey, although there were only two main types of provider payment and levels of salary deduction, there were variations in the reimbursement rate of OP and IP services from other health facilities across the country. The results are summarized as follows.

a) Reimbursement rate for OP services

The reimbursement rate for OP services was applied when an outpatient was referred to other health facilities. The NHSO recommends the standard rate to use at each level of health facilities. The standard rate was a fee-for-service with an upper limit. The standard rate for OP was applied to: 1) any treatment and drug but not more than 300 baht per visit, 2) any laboratory testing but not more than 200 baht per visit, and 3) any medical procedure but not more than 300 baht per procedure.

Although there were OP standard rates suggested by the NHSO, in practice the reimbursement method was decided among administrators in each province. From the survey, there were 3 types of reimbursement method. The first was the standard rate recommended by the NHSO, which was used when a public hospital under the MoPH referred a patient out of province or to other public hospitals outside the MoPH. The second was a fixed rate, set by individual provinces. For example, the OP rate was equal to 150 baht per visit when a community hospital referred a patient to a general hospital. The third method was a fee-for-service without upper limit. This always applied when referring a patient to university hospitals. The fee-for-service was set without an upper limit because cases that were referred to a university hospital or tertiary care were complicated cases. The fixed rate might not be appropriate.

Furthermore, the average reimbursement rates of provinces in each group were estimated in order to examine variations among the provinces. Since the distribution of reimbursement rates was highly skewed, its median was reported. The unit of measurement is for one visit.

The results indicated that when a patient visited other health center outside their registered area, the average reimbursement rate was 30 baht per visit. The reimbursement rates of exclusive hospitals under salary deduction at CUP level (group 1), inclusive hospitals under salary deduction at CUP level (group 2), exclusive hospitals under salary deduction at provincial level (group 3), and inclusive hospitals under salary deduction at provincial level (group 4) were 0, 45, 30 and 20 baht per visit, respectively.

At community hospital level, the average reimbursement rate was 150 baht per visit. The rates of groups 1, 2, 3 and 4 were 160, 170, 120 and 110 baht per visit, respectively. At general hospital level, the average reimbursement rate was 205 baht per visit. The rates of groups 1, 2, 3 and 4 were 250, 250, 160 and 150 baht per visit, respectively. At regional hospital level, the standard rate of the NSHO was applied in every group. All

Table 3 Median of reimbursement rates of OP and IP of hospitals in each group

Health Facilities	CUP salary deduction		Provincial salary deduction at		All
	Exclusive (gr-1)	Inclusive (gr-2)	Exclusive (gr-3)	Inclusive (gr-4)	
OP					
Health center	0	45	30	20	30
Community hospitals	160	170	120	110	150
General hospital	250	250	160	150	205
Regional hospital	ST	ST	ST	ST	ST
University hospital	FFS	FFS	FFS	FFS	FFS
IP					
Community hospital	AR	4,300	AR	5,000	-
General hospital	AR	8,000	AR	8,000	-
Regional hospital	10,000	10,000	10,000	10,000	10,000
University hospital	16,000	16,000	16,000	16,000	16,000

FFS = Fee-for-service
AR = Adjusted rate method
ST = Standard rate recommended by the NHSO

staff salary was 8,693,060 baht per year. Amnat Charoen is a 400-bed general hospital located in Amphoe Mueang. It had 23 physicians and 369 staffers and was responsible for a catchment population of 120,000. The staff salaries amounted to 56,954,395 baht per year.

The initial budget of Leuamnaj hospital within Amnat Charoen province under alternative payment regimes is summarized in Figure 1.

Initially, Amnat Charoen PPHO received a total capitation budget equal to 314,987,736 baht. For salary deduction at CUP level, this budget would remain the same before allocating to CUPs. For exclusive capitation under salary deduction at CUP level, Leuamnaj hospital would receive a capitation budget equal to ambulatory care (574 baht) and preventive care (175 baht) multiplied by the registered population (37,591 people), minus the total staff salaries of the CUP (8,693,060 baht). The hospital budget received would be equal to 19,462,599 baht plus inpatient care reimbursed from the provincial fund.

For inclusive capitation under salary deduction at CUP, Leuamnaj hospital would receive the total capitation budget (1,052 baht) multiplied by the registered population (37,591 people), minus the total staff salaries of Leuamnaj CUP (8,693,060 baht). However, inclusive hospitals had to pay for referral costs. The hospital budget received for inclusive capitation under salary deduction at CUP would be equal to 30,852,672 baht minus referral cost.

In contrast, for salary deduction at provincial level, the total staff salaries of Amnat Charoen province (135,871,841 baht) would be deducted from the total capitation budget. The amount of the budget would be reduced to 179,115,895 baht. After that, the remaining budget would be readjusted according to the type of services before allocating to CUPs. The ambulatory care, preven-

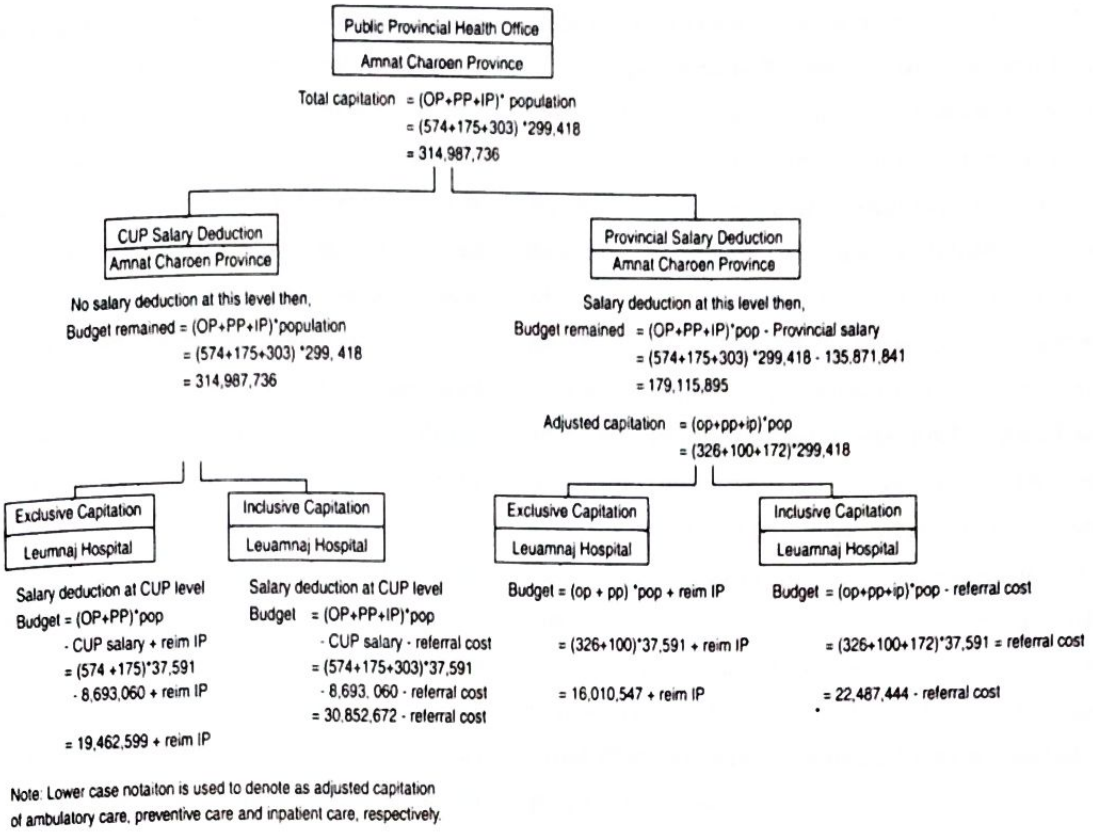

Figure 1 Budget of Leuamnaj hospital under different payment regimes

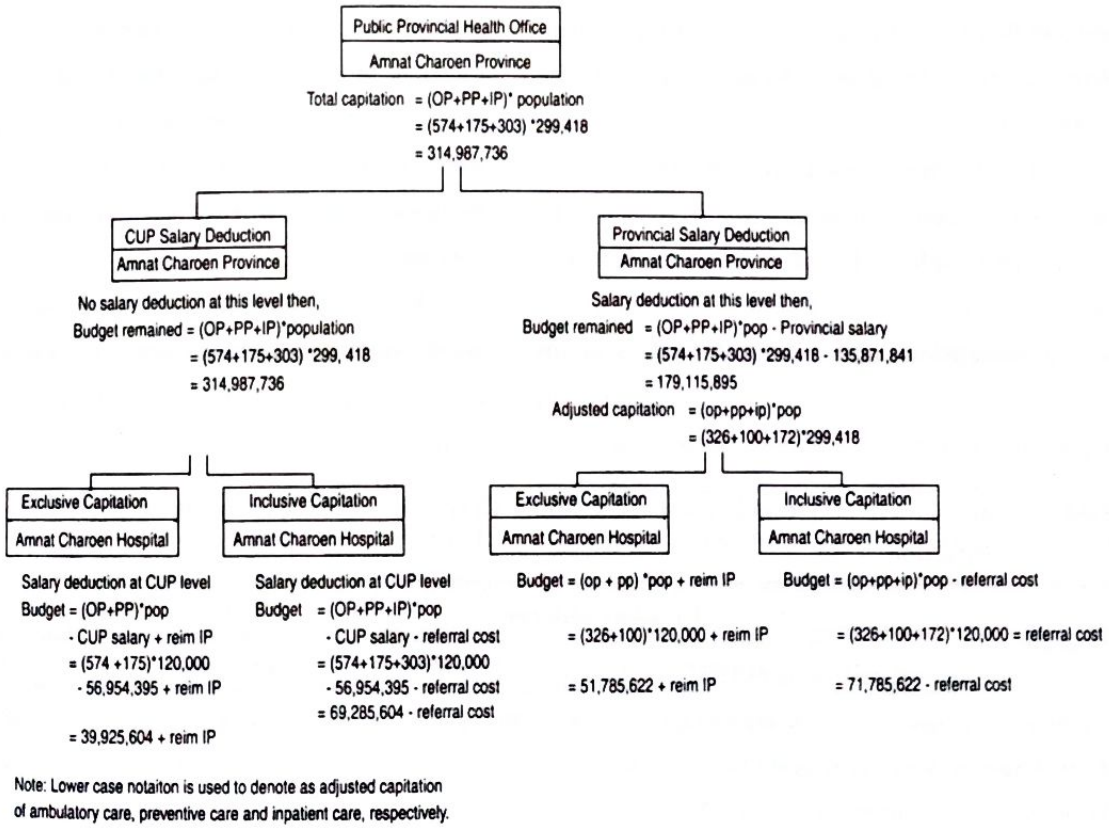

Figure 2 Budget of Amnat Charoen hospital under different payment regimes

tive care and inpatient care per capita budgets were equal to 326, 100 and 172 baht, respectively.

For exclusive capitation under salary deduction at provincial level, Leuamnaj hospital would receive a per capitation budget equal to the adjusted ambulatory care (326 baht) and adjusted preventive care (100 baht) budget multiplied by the registered population (37,591 people) plus reimbursement of inpatient care from the provincial fund. Then, the hospital budget would be equal to 16,010,547 baht plus reimbursement for inpatient care from the provincial fund.

For inclusive capitation under salary deduction at provincial level, Leuamnaj hospital would receive a per capita budget equal to adjusted ambulatory care (326 baht), adjusted preventive care (100 baht) and adjusted inpatient care (172 baht) multiplied by the registered population (37,591 people). However, inclusive hospitals had to pay referral costs. Therefore, referral costs are deducted from the budget. The hospital budget would be equal to 22,487,444 baht minus referral costs.

The method used to calculate Amnat Charoen hospital budget was the same as that for Leuamnaj hospital. The details are presented in Figure 2.

For exclusive capitation under salary deduction at CUP level, Amnajareon hospital would re ceive a budget equal to 32,925,604 baht plus re imbursement of inpatient care from the provin cial fund. For inclusive capitation under salar deduction at CUP, Amnajareon hospital would re ceive a budget equal to 69,285,604 baht minu referral costs.

For exclusive capitation under salary deduc tion at provincial level, Amnajareon hospita would receive a budget equal to 51,785,622 bah plus reimbursement for inpatient care. For in clusive capitation under salary deduction at pro vincial level, Amnajareon hospital would receiv a budget equal to 71,785,622 baht minus referra costs.

It can be seen that Leuamnaj hospital (com munity hospital) was better off when it had salar deduction at CUP level, whereas Amnat Charoe hospital (general hospital) was better off when had salary deduction at provincial level. This sug gests there is likely to be a conflict of interest be tween community hospitals and general or re gional hospitals in the choice of level of salar deduction. Decisions makers therefore need t be aware when implementing these payme mechanisms.

Furthermore, the hospital budget of the two hospitals between exclusive and inclusive cap

Table 4 Summarized budget of Leuamnaj and Amnat Charoen hospitals under alternative scenarios for sala deduction

Variables	CUP salary deduction		Provincial salary deduction	
	Exclusive	Inclusive	Exclusive	Inclusive
Leuamnaj hospitals (Community hospital)	19,462,599 + reimbursement of IP	30,852,672 - referral cost	16,010,547 + reimbursement of IP	22,487,44 referral co
Amnat Charoen hospitals (General hospital)	32,925,604 + reimbursement of IP	69,285,604 - referral cost	51,785,622 + reimbursement of IP	71,785,62 referral co

tation were compared. It is unlikely to indicate which one will eventually receive a higher budget because this depends on at least 2 factors: 1) the amount and value of the RW of referral patients that inclusive hospitals have to pay referral costs for, and 2) the amount and value of the RW of inpatients that exclusive hospitals receive reimbursement for from the provincial fund. The summarized budgets of these two hospitals are presented in Table 4.

Discussion

Telephone interviews were used to classify provinces by provider payment mechanisms, to identify the reasons and process for selecting types of payment regimes and to obtain details of budget administration in each province. There was a complete response from interviewees of every province.

The telephone interview seems to be an appropriate tool to classify the provinces by types of provider payment, to explore source of variation within groups and understand reasons behind the payments selection of each province because it was the fastest way to interview the PPHO in every province. In addition, it saves traveling cost.

This method is cheap and quick method for gathering information across the country. However, it may have limitations in terms of the amount of information gathered. If there is lots of information to be gathered and the questionnaire is complicated, this method may not be relevant. If comprehensive information is required, sending the questionnaire to interviewee before interview may help us to remedy the problem.

There are 2 major issues of the survey that have to be discussed. The first one is the validity of responses on classification. Comparing the results with the MoPH survey conducted in March 2002. The provider payment regimes of 11 provinces differed from the reported outcome. These results were therefore rechecked with the interviewees of the provinces in question. The results for 7 of the 11 provinces differed because they changed payment regimes (between March to June 2002) just before our survey. Four provinces had different results because of a miscommunication with the MoPH.

Two provinces had changed the type of payment from exclusive to inclusive capitation after March 2002 due to their applying for CF; one province had changed from exclusive to inclusive because of problems among hospitals after receiving CF; one province had changed from exclusive to inclusive capitation because of suggestions from a senior government officer to follow government policy.

The second point concerns the validity of responses on reasons. There is information bias from the choice of respondents in the survey. This information bias is such that provinces might withhold the real reason for decisions made for their own benefit. For example, some PPHOs could have authority over budget management if they selected exclusive capitation. Some PPHOs selected inclusive capitation and level of salary deduction at CUP level in order to be able to apply for the CF.

Two case studies of a community and a general hospital were scrutinized to look at hospitals budgets under different payment regimes. These 2 hospitals can be used as a representative of community hospitals and general or regional hospitals in Thailand because they have similar ratio of staff and registered population as the majority of community hospitals and general or regional hospitals in Thailand. The community hospital was better off when it had salary deduction at CUP

level, whereas the general hospitals was better off when they had salary deduction at provincial level. Thus, the alternative payment regimes affect different types of hospitals in different ways.

During the interview, it was found that there were various levels of knowledge of interviewees on the strengths or weaknesses of each payment regime. The provinces in the first implementation phase of the 30 baht Scheme had more knowledge than other provinces, for instance Yasothon, Khon Kaen, Nakhon Ratchasima, and Phayao. Most of them had participated in the Health Care Reform Project under collaboration with the Thai government and European Commission. This project had a field development program which had training courses for local staff and some action research carried out in the province[4]. This probably gave them more insights and made them more receptive to change than other provinces.

Conclusion

The results of the study indicate that each province had their own reasons to select their types of provider payment. There was variation in the ways the budget was administered throughout the country although there were only two types of payment and level of salary deduction. In addition, despite having a standard recommendation from the NHSO, another two types of method were used - fixed and adjusted rate - which were always applied in exclusive and inclusive capitation respectively.

The community hospital was better off when it had salary deduction at CUP level, whereas the general hospitals was better off when they had salary deduction at provincial level. Thus, the alternative payment regimes affect various types of hospitals in a different ways. Awareness on the matter is relevant prior to implementing provider payment mechanism in each province.

In all, there is the potential for endogeneity in the choice of payment method, variation of budget administration and reimbursement rate. These may affect the performances of hospitals in each payment group. The government should therefore be aware and find the mechanism to monitor the implications and minimize adverse consequences of each payment mechanism.

References

1. Jongudomsuk P. Achieving Universal Coverage of Health Care in Thailand through 30 baht Scheme. Nonthaburi: Health Care Reform Office, MoPH, Thailand; 2002.
2. Health Care Reform Office. Achieving Universal Coverage in the transitional period, a hand out (in Thai). Revised edition 1st ed. Bangkok: Ministry of Public Health; 2002.
3. Public Provincial Health Office Committee. The survey of 30 baht scheme's administration at the provincial level in Thailand. Nonthaburi: Public Provincial Health Office Committee; 2002.
4. Health Care Reform Office. Strategy of Health Care Reform Project and result of project implementation in 1997. Nonthaburi: Health Care Reform Office, Ministry of Public Health; 1997.

บทคัดย่อ **รูปแบบและเหตุผลในการเลือกวิธีจ่ายเงินให้กับหน่วยบริการในโครงการหลักประกันสุขภาพถ้วนหน้า, ๒๕๔๕**

พงศธร พอกเพิ่มดี

โรงพยาบาลพนมดงรัก จังหวัดสุรินทร์

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หลังจากที่รัฐบาลได้ขยายหลักประกันสุขภาพ ภายใต้โครงการหลักประกันสุขภาพถ้วนหน้าในปี ๒๕๔๓ กระทรวงสาธารณสุขได้เปลี่ยนวิธีการจ่ายเงินให้กับหน่วยบริการจากแบบเหมาจ่ายตามขนาดของโรงพยาบาลและงบประมาณที่เคยได้รับ (historical global budget) เป็นตามแบบรายหัวประชากร (capitation) อีกทั้งยังให้แต่ละจังหวัดเลือกวิธีการจ่ายเงินให้กับหน่วยบริการระหว่างการจ่ายเงินแบบเหมาจ่ายรวมเฉพาะรายการ (exclusive) หรือการจ่ายเงินแบบเหมาจ่ายรวมงบทุกรายการ (inclusive) และเลือกระดับการตัดเงินเดือนที่หน่วยบริการประจำ (CUP level) หรือที่ระดับจังหวัด (provincial level) ทำให้แต่ละจังหวัดมีวิธีการจ่ายเงินให้กับสถานพยาบาลที่แตกต่างกันออกไป การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อศึกษาถึงเหตุผลในการเลือกวิธีจ่ายเงินในแต่ละจังหวัดและผลของการเลือกวิธีการจ่ายเงินแบบต่างๆ เพื่อใช้เป็นข้อมูลในการประเมินผลวิธีการจ่ายเงินให้หน่วยบริการของโครงการหลักประกันสุขภาพถ้วนหน้า โดยใช้วิธีการสัมภาษณ์ทางโทรศัพท์ผู้บริหารสำนักงานสาธารณสุขจังหวัดทุกจังหวัดทั่วประเทศ ผลการศึกษาพบว่าแต่ละจังหวัดมีเหตุผลในการเลือกวิธีจ่ายเงินและมีการบริหารงบประมาณที่แตกต่างกัน เหตุผลที่สำคัญในการเลือกวิธีการจ่ายเงินแบบแบบเหมาจ่ายรวมเฉพาะรายการคือ ต้องการช่วยเหลือซึ่งกันและกันเพื่อให้อยู่ได้ทั้งจังหวัดและเกรงว่าจะมีปัญหาเรื่องคุณภาพและการตามจ่ายระหว่างโรงพยาบาล ส่วนเหตุผลสำคัญในการเลือกวิธีการจ่ายเงินแบบเหมาจ่ายรวมงบทุกรายการคือ เพื่อให้เกิดการพัฒนาศักยภาพและปฏิรูปการบริหารจัดการโรงพยาบาลและต้องการของบสำรองฉุกเฉิน เหตุผลที่สำคัญในการเลือกระดับการตัดเงินเดือนที่ CUP คือ ต้องการให้เกิดการกระจายกำลังคนที่เหมาะสมและต้องการของบสำรองฉุกเฉิน (contingency fund, CF) เพิ่มเติม ส่วนเหตุผลที่สำคัญในการเลือกระดับการตัดเงินเดือนที่จังหวัดคือ ช่วยเหลือซึ่งกันและกันระหว่างโรงพยาบาลเล็กและโรงพยาบาลใหญ่และเพื่อขวัญและกำลังใจของเจ้าหน้าที่ ส่วนการตัดเงินเดือนระดับจังหวัดจะเป็นผลดีต่อโรงพยาบาลขนาดใหญ่ เช่น โรงพยาบาลศูนย์หรือโรงพยาบาลทั่วไปที่ทำให้ได้รับงบประมาณเพิ่มขึ้น ในทางตรงข้ามการตัดเงินเดือนระดับ CUP จะมีผลดีต่อโรงพยาบาลชุมชนที่ทำให้ได้รับงบประมาณเพิ่มขึ้น ผลการศึกษาครั้งนี้จะเป็นประโยชน์ในการใช้ติดตามและประเมินผลรูปแบบการจ่ายเงินให้หน่วยบริการและการจัดสรรงบประมาณในโครงการหลักประกันสุขภาพถ้วนหน้าต่อไป

คำสำคัญ: **วิธีการจ่ายเงินให้หน่วยบริการ, วิธีการจ่ายเงินแบบเหมาจ่ายรวมเฉพาะรายการ, วิธีการจ่ายเงินแบบเหมาจ่ายรวมงบทุกรายการ, โครงการหลักประกันสุขภาพถ้วนหน้า**