How the contract model becomes the main mode of purchasing: a combination of evidence and luck in Thailand

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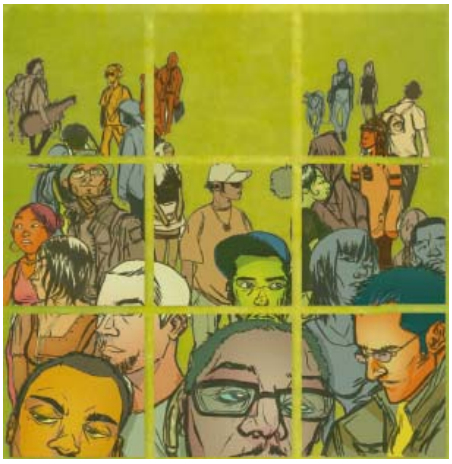

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1 Background

Thailand introduced Social Health Insurance (SHI) for formal sector private employees with the promulgation of the Social Security Act of 1990. The law was published in the Royal Gazette on 1 September 1990, after which there were 180 days for organizational preparation. The 1990 Act nullified the 1954 Social Security Act which was never implemented because of the lack of economic readiness. SHI is a tripartite payroll tax contributory scheme, equally paid for by the employer, employee and the government. The scheme covers four benefits: (1) non-work related sickness, (2) maternity, (3) invalidity and (4) funeral grants. It was initially enforced in all firms having more than 20 employees, but the scheme extended to companies with more than 10 employees after three years [1].

The actuarial estimate contribution rate specified by law was 1.5% of payroll by the three parties (4.5% of payroll in total) for the four benefits. This contribution estimate was based on the total resources required for these benefits. In the mid 1980s, when knowledge of strategic purchasing and provider payment was not widespread in some developing countries, International Labour Organization (ILO) consultants advised the Labour Department that with this contribution rate, the benefit package could only cover admission services; an estimate that was based on fee-for-service reimbursements using the ongoing Workmen Compensation Fund (for work related illnesses, injuries and deaths) experiences.

Because the capitation contract model contributed significantly to the success of SHI implementation, in particular with regard to cost containment and financial sustainability, the Universal Coverage (UC) scheme also adopted the contract model in 2001 and with a favourable outcome [2]; this paper analyses why and how the contract model became main mode of strategic purchasing of the SHI and UC scheme.

2 Why did SHI adopt the capitation contract model?

One of the authors [VT] had hands-on experiences working with the preparatory team and managed to convince, using existing evidence, the first Secretary General of the Social Security Office (SSO) to adopt capitation at a level of 700 Baht[1]; this was adopted by the SSO in 1991.

[1] Approximately US$ 28, Exchange rate, US$ 1 = 25 Baht in 1991

The arguments made in favour of capitation were:

First, Capitation of 700 Baht per member per year in 1991 would allow the purchase of both outpatient and admission services for members. The capitation rate was based on a simple formula: 3 visits per capita per annum multiplied by a unit cost of 150 Baht per visit + 0.1 admissions per capita per annum multiplied by a unit cost of 3,000 Baht per admission – which in fact gives a capitation rate of 750 Baht [3 * 150 + 0.1 * 3000 = 750 Baht per capita]. However, the Social Security Committee approved 700 Baht. The total resources required using the capitation model were found to be affordable, as it matched with the revenue collected from contributions [3].

Second, the formulae allows some margins for contractor providers, as the utilization rate might not reach three visits per year, and admission rates might be lower, as workers are young adults who tend to be healthier and use less health services .

Third, instead of covering admission only by using fee-for-service, the same amount of funding could purchase additional outpatient services, thus minimizing members' health expenditure burden. Social Security Office gains social credits, as it delivered more benefit than promised, hence protection the benefit of workers.

Fourth, under fee-for-service, a ceiling must be introduced to safeguard the financial stability of the Social Security Fund, while copayment is a burden for low income wage earners. Copayment was not allowed in the capitation model.

Fifth, the administration cost of managing the capitation system was simple, with a monthly wire transfer of the capitation fee to the contractor hospital. This was in marked contrast to a fee-for-service system where a huge workload could be foreseen (3 visit + 0.1 admissions * 1.8 million members = 5.6 million transactions) with exhausted claims review staff ending up rubber stamping claims.

Sixth, capitation may come with registration as opposed to free choice under a fee-for-service system. However, limited choice is available under the contract model, when members make their annual choice of preferred contractor.

Seventh, capitation ensures a smooth income flow to contractor providers and facilitates their business plan; this was confirmed by hospital key informants.

After the capitation contract model was adopted, evidence showed that public and private contractor hospitals made a good margin in the first four or five years as the utilization rate was well below the formula estimate; the 700 Baht capitation rate was maintained until the first revision in 1998, made in the wake of the 1997 Asian financial crisis.

3 Why the UC Scheme adopted the capitation contract model?

The SHI contract model produced a decent quality of service and gradually improved utilization rates to the optimum level [4 5], having gone through various adjustments to the Thai health systems over a decade, and was the predecessor for the UC scheme, with some modifications.

Instead of inclusive capitation for outpatient and inpatient services in the SHI scheme, the UC scheme applies capitation for outpatients only, and a global budget with case based payment (DRG) for inpatients. This is to prevent the under-provision of admission services which can occur with inclusive capitation, where expensive admission can be dumped into ambulatory care, resulting in a loss of patient welfare. Under the global budget and DRG payment systems, hospitals can only be reimbursed based on the relative weight of each DRG for admission cases.

Meanwhile the free choice, fee-for-services model pertaining under the Civil Servant Medical Benefit Scheme sends was not pursued, due to serious cost escalation, supplier induced demand [6] and systems inefficiency. Reformists perceived that free consumer choices did not outweigh the cost of inefficiency [7]. In addition, free choice may not be enjoyed by rural people who pay travelling costs to provincial hospitals, bypassing primary health care in their home district. Fee-for-service undermines the functioning of primary health care in district health systems and is only enjoyed by urban elites.

It is important to note that the same group of health systems and policy researchers and reformers involved in the design, monitoring and evaluation of SHI in the 1990s, influenced the design of the UC scheme in 2001.

The introduction of the capitation model in the UC scheme in 2001-02, met no resistances by either public or private providers as they were used to working within the SHI systems since 1991. In contrast, efforts to push the fee-for-service CSMBS towards a capitation model has consistently failed since 1995, due to entrenched benefits accruing to all concerned parties.

4 Discussion and conclusion

A number of factors contributed to the successful introduction of a contract model for SHI and to its later extension to the UC scheme with a favourable outcome.

The context: After the Social Security Act was endorsed by the Parliament in September 1990, there were only 180 days for organizational preparation such as setting up a system for collecting premiums, registering employers and employees, and the development of information systems. The Secretary General of the SSO recognized the complexity of fee-for-services reimbursement methods, the high number of claims, and the need for auditing systems as applied by the Workmen Compensation Scheme. A new proposal based on the simplified management of the capitation contract model was compelling in the light of the very short time frame allowed for organizational start-up and the huge workload deemed necessary.

In addition, with the same contributions (4.5% of payroll), instead of covering only admission services in the fee-for-service model, the capitation model could give cover for both outpatient and inpatient services – an argument in its favour and a reason for it gaining political support.

The role of evidence: The capitation formulae allows for quite a favourable margin given the utilization rate. In practice, the employees were not aware of their rights and entitlements; thus the utilization rate in the first three to four years was lower than the formulae estimate. This resulted in a substantial profit margin for both public and private contractor hospitals, gave a good impression of the capitation contract model and resulted in an adequate service provision – with auditing and monitoring systems well in place.

Evidence and policy decisions: Evidence on its own was not enough, and it was very important to present the Secretary General of the SSO with all the information he needed as well as compelling arguments. Trust between decision makers and the technical team members played a significant role.

The reformers for the 1990 SHI and the 2001 UC scheme were the same group of health systems and policy researchers and policy entrepreneurs. Their values and background in health systems, and work experiences determined their attitude in favour of the poor and primary health care.
Finally, it wasn't just about evidence; it was lucky that the utilization rate by SHI members in the first few years was low and that there was no resistance from public and private contractor providers. Thailand introduced capitation to SHI very early in 1990s and managed successfully to maintain a

decent quality capitation model which satisfied the providers in terms of their margin in the initial years. The SHI contract model served as a predecessor for the UC scheme.

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