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REPUBLIC OF KENYA
THE NATIONAL ASSEMBLY
THIRTEENTH PARLIAMENT – SECOND SESSION – 2023
DIRECTORATE OF DEPARTMENTAL COMMITTEES
DEPARTMENTAL COMMITTEE ON HEALTH

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REPOR ON

UNIVERSAL HEALTH COVERAGE BENCHMARKING VISIT TO THAILAND FROM 7TH TO 12TH MARCH, 2023

Directorate of Departmental Committees,
Clerk's Chambers,
Parliament Buildings,
NAIROBI.

May, 2023

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List of Abbreviations

UHC	:	Universal Health Coverage
NHSO	:	National Health Security Office
SDG	:	Sustainable Development Goals
UN	:	United Nations
UCS	:	Universal Coverage Scheme
SHI	:	Social Health Insurance
CSBMS	:	Civil Servant Medical Benefit Scheme
GRG	:	Diagnosis related group

LIST OF ANNEXURES

CHAIRPERSON'S FOREWORD

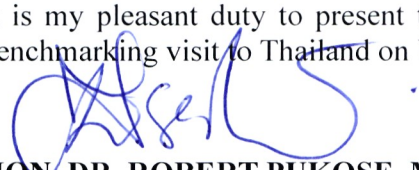
Universal Health Coverage, as committed to by UN Member States in the Sustainable Development Goals (SDG), can contribute to health equity if it is properly designed and implemented. Generally, UHC has two explicit goals of improving access to health services and financial protection where use of these services does not create catastrophic financial hardship.

The Kenyan Parliamentary Health Committee in collaboration with National Health Insurance Fund, in the run-up to scaling up the implementation of UHC in Kenya, undertook a learning and benchmarking tour to Thailand between 7th and 12th March, 2023 in Bangkok, Thailand.

The Committee aim of benchmarking was to study the critical success factors for UHC implementation from Thailand and establish the UHC implementation governance and financing structures, to understand benefits package development and implementation processes, to understand beneficiary identification and care access processes, to establish claims management infrastructure and processes, to understand the Primary Health Care model and how this interacts with secondary and tertiary health care provision and finally to establish the role of private sector in the success of UHC implementation.

The Committee is thankful to the Office of the Speaker and the Clerk of the National Assembly for the logistical and technical support accorded to it during its Sittings.

It is my pleasant duty to present the Report of the Departmental Committee on Health on its benchmarking visit to Thailand on Universal Health Coverage (UHC).



HON. DR. ROBERT PUKOSE, MP.

CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

1.0 PREFACE

1.1 Establishment of the Committee

The Departmental Committee on Health is established pursuant to Standing Order 216.

1.2 Mandate of the Committee

The Committee is mandated under Standing Order 216 (4) and (5) to inter alia-

a) *investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations and estimates of the assigned ministries and departments;*

b) *study the programme and policy objectives of ministries and departments and the effectiveness of the implementation and effectiveness of the implementation;*

c) *study and review all legislation referred to it;*

d) *study, assess and analyze the relative success of the ministries and departments as measured by the results obtained as compared with their stated objectives;*

e) *investigate and inquire into all matters relating to the assigned ministries and departments as they may deem necessary, and as may be referred to them by the House;*

f) *vet and report on all appointments where the Constitution or any law requires the National Assembly to approve, except those under Standing Order 204 (Committee on Appointments);*

g) examine treaties, agreements and conventions;

h) *make reports and recommendations to the House as often as possible, including recommendation of proposed legislation;*

i) *consider reports of Commissions and independent offices submitted to the house pursuant to the provisions of Article 254 of the Constitution; and*

j) *examine any questions raised by Members on a matter within its mandate.*

In executing its mandate, the Committee oversights the Ministry of Health;

According to second Schedule of the Standing Orders, the Committee is mandated to consider the following subjects:

i. Health;

ii. Medical care and Health insurance including universal health coverage.

1.3 Committee Membership

The Committee comprises the following fifteen (15) Members;

4. The Committee was constituted by the House on 27th October, 2022 and comprises the following Members;

Chairperson
Hon. (Dr.) Robert Pukose, MP
Endebes Constituency
UDA Party

Vice-Chairperson
Hon. Ntwiga, Patrick Munene MP
Chuka/Igambang'ombe Constituency
UDA Party

Members

Hon. Owino Martin Peters, MP
Ndthiwa Constituency
ODM Party

Hon. Muge Cynthia Jepkosgei, MP
Nandi (CWR)
UDA Party

Hon. Wanyonyi Martin Pepela, MP
Webuye East Constituency
Ford Kenya Party

Hon. Kipngok Reuben Kiborek, MP
Mogotio Constituency
UDA Party

Hon. Nyikal James Wambura, MP
Seme Constituency
ODM Party

Hon. Kibagendi Antoney, MP
Kitutu Chache South Constituency
ODM Party

Hon. Julius Ole Sunkuli Lekakeny, MP
Kilgoris Constituency
KANU

Hon. Maingi Mary, MP
Mwea Constituency
UDA Party

Hon. Mathenge Duncan Maina, MP
Nyeri Town Constituency
UDA Party

Hon. Lenguris Pauline, MP
Samburu (CWR)
UDA Party

Hon. Oron Joshua Odongo, MP
Kisumu Central Constituency
ODM Party

Hon. (Prof.) Jaldesa Guyo Waqo
Moyale Constituency
UPIA Party

Hon. Mukhwana Titus Khamala, MP
Lurambi Constituency
ANC Party

1.4 Committee Secretariat

1. The following are the Secretariat who support the Committee;

Mr. Hassan Abdullahi Arale
Clerk Assistant I/Head of Secretariat

Mr. Gladys Jepkoech Kiprotich
Clerk Assistant III

Ms. Salat Abdi Ali
Senior Serjeant-At-Arms

Ms. Faith Chepkemoi
Legal Counsel II

Mr. Yakub Ahmed
Media Relations Officer II

Mr. Rahab Chepkilim
Audio Recording Officer II

Ms. Abigel Muendi
Research Officer III

Mr. Hiram Kimuhu
Fiscal Analyst III

Mr. Benson Kimanzi
Serjeant-At-Arms III

1.INTRODUCTION

2. Universal Health Coverage, as committed to by UN Member States in the Sustainable Development Goals (SDG), can contribute to health equity if it is properly designed and implemented. Generally, UHC has two explicit goals of improving access to health services and financial protection where use of these services does not create catastrophic financial hardship.
3. The Kenyan Parliamentary Health Committee in collaboration with National Health Insurance Fund Staff, in the run-up to scaling up the implementation of UHC in Kenya, undertook a learning and benchmarking tour to Thailand between 5th and 12th March 2023 in Bangkok, Thailand.

1.1 Benchmark Visit Justification

4. The Kenyan Government is committed to the attainment of UHC. The Kenya Kwanza Government, under the leadership of H.E president Ruto, recognizes the critical role a healthy population plays towards socio-economic and political development of a country. The "Plan" observes that "the most urgent concern in the health sector is the growing burden of non-communicable diseases such as cancers, heart disease and diabetes-related complications that, if not addressed urgently, will become a threat not only to health but also to the socio-economic wellbeing of the country.
5. Presently, 36 per cent of Kenyans are at risk of being impoverished by the financial burden of catastrophic illness." Specifically, the government observes that they are committed and determined to realise the constitutional right to health in the shortest time possible by delivering a Universal Health Coverage (UHC) system built on three pillars as follows: Provide National Health Insurance Fund coverage for all of Kenyans without exclusion in the policy of "Leaving No One Behind". Additionally, the government is cognizant of the fact that: -

... the NHIF still falls far short of the social health insurance scheme that it ought to be, both in its design as well as operational performance. These shortcomings includethe fact that NHIF is primarily designed to be funded by statutory payroll deductions from employees in the formal wage economy- at only 15 per cent of Kenya's workforce. While NHIF has sought to expand coverage to the vast majority who are self-employed through voluntary enrolment, this has come with challenges notably intermittent payments of people typically enrolling when they are unwell i.e., adverse selection. The statutory payroll system is also inequitable because deduction is on individuals while benefits accrue to households. Thus, households with one payroll worker and those with two or more receive the same benefits even though they contribute different amounts. Moreso, the shift towards curative at the expense of preventive care, with the share of inpatient expenditure increasing from 23 per cent to 29 per cent over the last decade (2010 - 2020), while the preventive care spending declined from 24 to 12 per cent. The shift from cheap to expensive is a systemic problem with insurance financed healthcare systems. Fragmented overlapping schemes within the NHIF, for example, Linda Mama, civil servants' scheme, school children and elderly support, undermine the principle and benefits of the widest possible risk pooling that a social health insurance scheme is supposed to provide. The operational capacity has not grown in tandem with the enrolment, leading to inefficiency, high administrative costs, and poor responsiveness to its customers and service providers.

6. The decision for Thailand's visit was thereby informed by the following facts: - that,

1. Thailand is an upper-middle income country which has demonstrated exemplary outcomes of Universal Health Coverage (UHC). After four decades of health infrastructure

development and three decades of extending financial risk protection targeting different population groups with a comprehensive benefits package, Thailand finally achieved UHC in 2002, through implementing three public health insurance schemes: -
(a) The Civil Servant Medical Benefit Scheme (CSBMS) for government employees and retirees and their dependents.
(b) Social Health Insurance (SHI) for private-sector employees; and
(c) The Universal Coverage Scheme (UCS): The UCS, launched in 2002, is financed by general tax revenue through annual budget allocation. The SHI is financed by tri-partite payroll contributions, equally shared by the employee, employer, and government, while the CSMBS is financed by general tax revenues.

2. UHC in Thailand has remarkedly improved health-utilisation outcomes and economic merit. The implementation of UCS has reduced the probability that a sick Thai would not receive formal treatment by increasing the probability of both outpatient (OP) and inpatient (IP) services utilization at public hospitals. The greatest increase in OP utilisation has been witnessed amongst the poorest part of the population.

1.2 Terms of Reference

7. The Committee relied the following terms of references for its study visit: -
   i. To study the critical success factors for UHC implementation from Thailand.
   ii. To establish the UHC implementation governance and financing structures.
   iii. To understand benefits package development and implementation processes.
   iv. To understand beneficiary identification and care access processes.
   v. To establish claims management infrastructure and processes.
   vi. To understand the Primary Health Care model and how this interacts with secondary and tertiary health care provision.
   vii. To establish the role of private sector in the success of UHC implementation.

8. The delegation of the National Assembly consisted of four Members of Parliament and a Clerk Assistant as follows: - Hon. Patrick Ntwiga Munene, MP Vice-Chairman and the leader of delegation, Hon. Prof. Guyo Jaldesa Waqo, MP, Hon. Joshua Oron Odongo and Hon. Maina Mathenge, MP and Hassan A. Arale as delegation Secretary.

9. The delegation was also accompanied by delegation from the National Hospital Insurance Fund led by Mr. Dennis Muthomi a board member, Mr. Wambugu Kariuki Ag. Director BPM Ms. Judith Otele the manager Case Management.

1. Background Information

10. Universal health coverage (UHC) by 2030 is a laudable goal, yet alarmingly off track for many countries. Studies show that llimited access to health services was the main factor in the failure to achieve the Millennium Development Goals in low and middle-income countries; this failure may be repeated in achieving UHC and other health-related sustainable development goals by 2030. Slow progress towards UHC is often because only small-scale projects are developed rather than comprehensive policy approaches and reforms.

11. There are both technical and political constraints to UHC implementation. This notwithstanding, other countries' experiences have demonstrated that it is not impossible with strong and sustained political goodwill and actions. UHC requires a 'whole of government' approach on coordinated legal and policy frameworks that focus on both health and socio-economic policies to achieve equity and access. The political will to increase population and service coverage is critical and requires actions from a range of stakeholders, including civil society and technical expertise engagement. Additionally, ensuring financial protection for people using health services requires increased fiscal space and commitments to public financing for health.

UHC Philosophies: -

12. Health is considered as an important component of the quality of life.

13. Health security is a system of life security which gives a person confidence that they will be able to indulge in appropriate health behaviour and would be able to get complete access to health promotion and disease prevention services. They should also be able to access the quality health services without any obstacles when they are ill and in need of medical care.

14. Equity in health can take place only when those with different social, economic, and cultural status have the equal opportunity to get access to quality health care, whereby their responsibility to pay for the expenses should depend on their ability to pay.

15. Universality indicates the basic philosophy under the national health security for which all people should have the right to obtain universal access. For whatever reason, nobody should be left out, oven on one's own, based on equal respect of the status and right of the human dignity of people.

a. Thailand UHC Implementation Governance Structure

16. Before UHC policy was adopted and enshrined as a government agenda in Thailand, there were several multi-health insurance schemes covering 70% of population with different benefit packages, government budget subsidies and payment methods as follows: -

Scheme	**Low Income Card (LIC)**	**Civil Servant Medical Benefit Scheme (CSMBS)**	**Voluntary Health Card (VHC)**	**Social Health Insurance (SHI)**
Introduced in	**1975s**	**1980s**	**1983s**	**1991s**
Target beneficiaries	Poor, elderly, children under 12 years,	Govt employees & dependents, retirees	Non-poor, predominantly rural	Private sector employees:
Population Coverage	32%	32%	20%	7%
Funding	Govt budget	Govt budget	Govt budget and household	Payroll contribution, Tripartite
Payment to health facilities	Budgeting	Fee-for-service, reimbursement	Budgeting	Capitation

17. Thailand eventually attained UHC in 2002 under the stewardship of National Health Security Office (NHSO).

2.2 National Health Security Office

18. As the body charged with UHC implementation, the NHSO **Vision** is to ensure everyone who lives in Thailand is covered by UHC and has access to health care with confidence when they need it. Their **Mission** is to ssecure Thai residents' health needs through an effective, equitable and responsive coverage, access, and utilization grounded on evidence-informed decisions and participation.

2.2.2 NHSO Goals

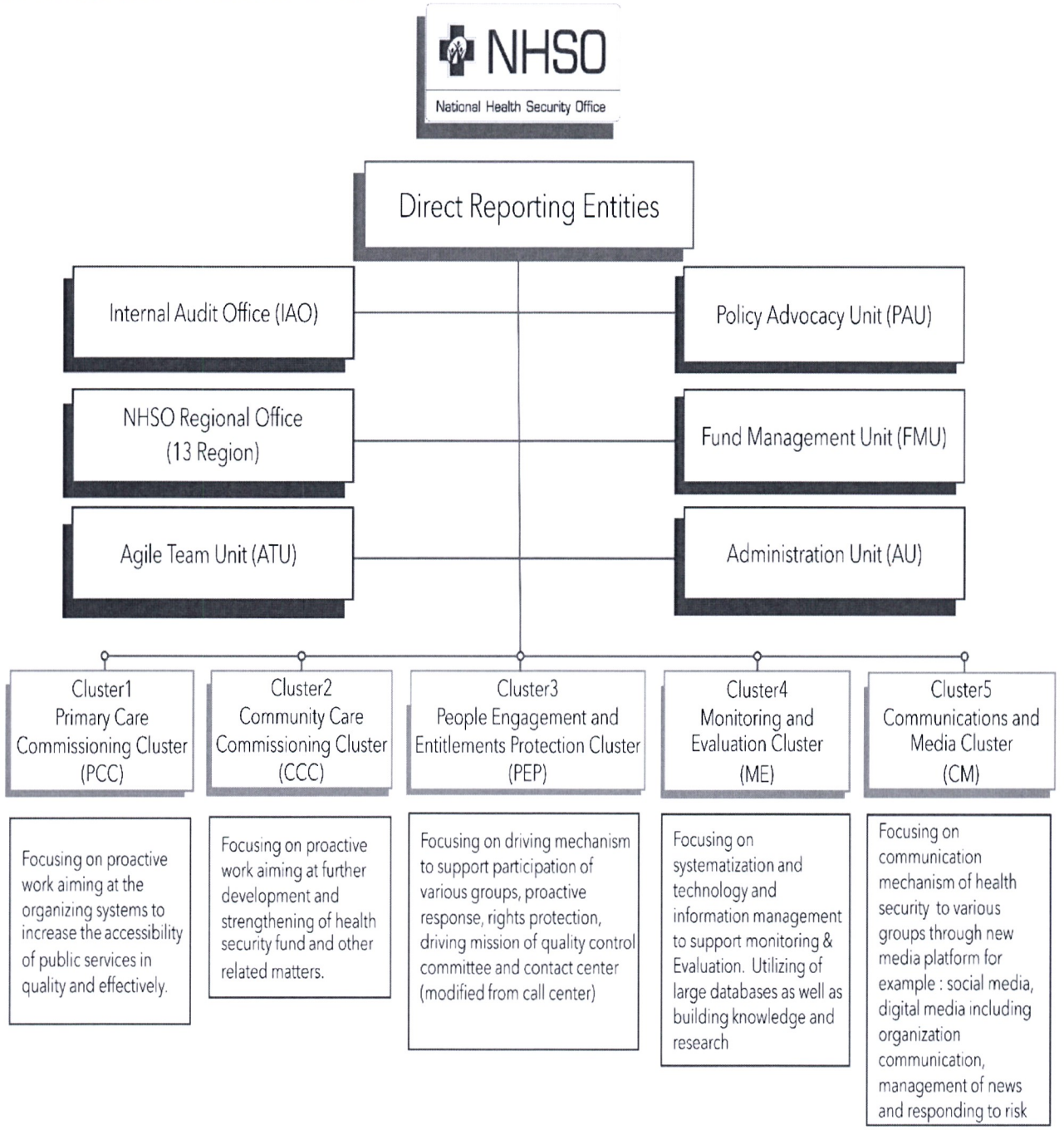
19. Are abbreviated as "CSG" for: -
    a) Coverage that is effective, equitable and responsive
    b) Safe Financing System and
    c) Good Governance
20. The NHSO uses five ensure strategies to achieve their goals to realize their mission and vision:
    a) Ensure coverage and access for vulnerable and underutilization groups.
    b) Ensure quality and adequacy of health services.
    c) Ensure financial efficiency.
    d) Ensure participation and ownership of all stakeholders and
    e) Ensure good governance.

2.2.3 NHSO Responsibilities

21. The National Health Security Act. 2002 Section 26 authorizes the National Health Security office (NHSO) with the following responsibilities: -

a) Administration of the National Health Security Committee, and the National Committee for Quality Accreditation.
b) Compile and analyse data on health services.
c) Organize systems for registration of beneficiaries, service provider and their networks.
d) Administer the Fund according to the regulations.
e) Pay service expenses to health providers and their network under regulation determined by the National Health Security Committee.
f) Carry out claiming process for medical services provided by the service providing units.
g) Make service registration for people and allow them to change their registration as required.
h) Monitor and control service quality to be at standard level and make convenience to people when complaining.
i) Process authority, ownership, and assets.
j) Organize rights and legal procedures concerned with its assets.
k) Collect relevant fees related to its functions and
l) Authorize other organizations to carry out activities under the responsibility of the office.

2.3 NHSO Governance Structure



2.3.1 NHSO's Board

22. The National Health Security Office was established in 2002 and was set up as one of public organizations to respond to the public in relation to UHC implementation in Thailand. It is made up of National Health Security Board and Standard and Quality Control Board

2.3.1.1 National Health Security Board

23. Under the National Health Security Act. 2002. Section 13 "National Health Security Board" is made up of:
    a) The Minister of Public Health as a Chairman,
    b) The Permanent Secretary for Defence, Permanent Secretary for Finance, Permanent Secretary for Commerce, Permanent Secretary for the Interior, Permanent Secretary for Labour and Social Welfare, Permanent Secretary for Public Health, Permanent Secretary for University Affairs, and the Director of the Office of the Budget,
    c) A representative of each Municipality, a representative of each local Provincial Administrative Organization, a representative of each local Tambo Administrative Organization, and a representative of other local government organizations elected by executives of its organization,
    d) Five representatives of, elected by, representatives each of which from a non-profit private organization implementing activities for the following groups: Children and adolescents, Women, Elderly, Disabled or mental health patients, HIV or other chronic disease patients, Labour, Populous communities, Agriculturists and Minorities
    e) Five representatives of health professionals each of which shall be from the Medical Council, the Thailand Nursing Council, the Pharmaceutical Council and the private hospital association.
    f) Seven qualified persons appointed by the Cabinet each of which shall be experts from the fields of health insurance, medical science and public health, Thai traditional medicine, alternative medicine, finance, law and social sciences and
    g) The Secretary General shall be the Secretary of the Board.

2. .3.1.1.1 The National Health Security powers and duties

24. Under National Health Security Act. 2002 Section 18 the duties of the National Health Security Board" include: -
    a) To prescribe the health service provided by a Health care unit and Network of health care units and to prescribe the standard of implementation, regarding national health security, to be effective.
    b) To provide advice to the minister on the appointment of officials and the enactment of ministerial regulations and notifications on execution of this Act.
    c) To prescribe limits and types of Health service necessary to health, sustainability, and the rate of Cost sharing.
    d) To prescribe the rules of fund management and implementation.
    e) To prescribe rules, procedures, and conditions in discharging the Secretary General and to prescribe qualifications and forbidden qualifications of the Secretary General.
    f) To issue rules on money receipt and payment, saving money, and making benefit of the Fund.

g) To prescribe rules, procedures, and conditions on payment of preliminary assistance to reimburse a beneficiary who is subject to damage or injury caused by any service provided by a Health care unit where the wrongdoer is non-apparent, or the wrongdoer is apparent, but such beneficiary cannot be reimbursed within a period deemed appropriate in accordance with section 41.
h) To encourage and cooperate with local government organizations in implementing and managing the health security system in local areas by considering their readiness, reasonableness, and need, in order to establish national health security residents of such areas as prescribed in Section 47.
i) To encourage and prescribe rules making it possible that non-profit community organizations, non-profit private organizations and non-profit private sectors implement and manage local funds by considering their readiness, reasonableness, and need by means and encouraging procedures of participation in order to establish national health security residents of such areas as prescribed in Section 47.
j) To prescribe rules in hearing opinions of providers and beneficiaries in order to improve the quality and standard of Health service.
k) To prescribe rules on the punishment of administrative fines and revocation of enrolment.
l) To create reports on implementation and obstacles to implementation, and all accounts and finances of the Board to annually submit to the Cabinet, the House of Representatives, and the Senate within 6 months from the last day of the fiscal year.
m) To hold an annual meeting to make it possible that the Board hears general opinions of providers and beneficiaries and
n) To perform such other duties as prescribed by this Act, the Minister, or other laws.

2.3.1.2 Standard and Quality Control Board

25. According to the National Health Security Act. 2002 Section 13, the Standard and Quality Control Board shall consist of: -
    a) The Director General of Department of Medical Services, the Secretary General of the Food and Drug Administration, the President of the Hospital Development and Accreditation Institute, and the Director of Division of Medical Registration.
    b) A representative of the Medical Council, a representative of the Thailand Nursing Council, a representative of the Pharmacy Council, and a representative of the Law Society of Thailand.
    c) A representative of private hospitals who is a member of the Private Hospital Association.
    d) A representative of the Municipality, a representative of the Provincial Administrative Organization, a representative of the Tambo Administrative Organization, and a representative of other local government organizations elected by executives of its organization.
    e) A representative of professional nurses, a representative of midwives, a representative of dentists, and a representative of pharmacists.
    f) representatives of the Royal College of Medical Specialty, each of which is from the field of obstetrics and gynaecology, surgery, internal medicine, and paediatrics.
    g) Three representatives elected by, among, representatives of health care professionals, each of which is from the field of applied traditional medicine,

physical therapy, medical technique, radiological technology, occupational therapy, cardio-thoracic therapy, and communicative disorders.

h) Five representatives of, elected by, representatives each of which is from a non-profit private organization implementing activities for the following groups: Children and adolescents, Women, Elderly, Disabled or mental health patients, HIV or other chronic disease patients, Labour, Populous communities, Agriculturists and Minorities.

i) Six qualified persons appointed by the Minister, each of which, at least, is a qualified person in tropical family medicine, a qualified person in mental health, and a qualified person in Thai traditional Medicine and

j) The Secretary General shall be the secretary of Standard and Quality Control Board.

2.3.2 The Standard and Quality Control Board shall have powers and duties as follows:

26. The Board will be able to: -

a) To control the standard and quality of Health care units and Networks of health care units pursuant to Section 45.

b) To monitor the health service provided by Health care units to meet the standard and quality in the case where such Health care units provide a level of services higher than the health service pursuant to Section 5.

c) To prescribe the measurement, controlling, and encouraging of quality and standard of Health care units and Networks of health care units.

d) To submit standard prices of treatment of all diseases to the Board to set up regulations prescribing expenses of Health service to Health care units pursuant to Section 46.

e) To prescribe rules, procedures, and conditions for the complaint of a person if their right is violated due to the health service, procedures for such complaint, and rules and procedures for assisting a person, if their right is violated due to the health service, as well as to determine a Complaint Unit to facilitate people in freely submitting complaints, irrespective of the person who is complaining.

f) To report the results of inspecting and controlling quality and standard of Health care units and Networks of health care units to the Board and notify such result to Health care units or their authorizing agency to improve, modify, monitor, and evaluate the effect of quality and standard improvement.

g) To encourage people' participation in inspecting and controlling Health care units and Networks of health care units.

h) Provide payment of preliminary assistance to a beneficiary who is subject to damage or injury caused by any service provided by a Health care unit and the wrongdoer is non-apparent or the wrongdoer is apparent, but such beneficiary cannot be reimbursed within a period deemed appropriate pursuant to such regulations, procedures, and conditions as prescribed by the Board.

i) To encourage establishing of an information system for decision making of people to get health service and

j) To perform other duties for the execution of this Act and other laws or such duties as prescribed by the Board.

1. BENCH MARKING EXERCISE: ACTIVITIES, FINDINGS AND LESSONS

27. The learning and benchmarking visits started on 7th March, 2023 with a courtesy call to the Kenyan Ambassador to Thailand, Mr. Lindsay Kiptiness. The Ambassador apprised the team about the international relationship Kenya had with Thailand, and the most prominent areas of collaboration, which includes: Agriculture, Health, Training and Expatriate assignments
28. The team was assigned an employee of the embassy, Mr. Mutunga, to be the liaison person between the Embassy, the National Health Service Organization, and different healthcare institutions the team was to visit. The Kenyan delegation, in its experiential visits, was beefed up to include: -

	Name	Position	Institution
1	Hon. Lindsay Kimwole Kiptiness	Ambassador	Kenya Embassy, Thailand
2	Mr. Sebastian Mutunga Ileli	First Counselor	Kenya Embassy, Thailand
3.	Ms. Patricia Nyokabi	HTA Master's Student	Mahidol University (Under Thailand Government Scholarship)
4	Ms. Tabby Oketch	HTA Master's Student	Mahidol University (Under Thailand Government Scholarship)

29. The benchmarking exercise included engagement with key Thailand government and private sector stakeholders in the health sector. Information sharing was through presentations and site visits.

3.1 Visit to NHSO 10th March 2023: Pictorial

Photo: Vice Chair PHC, Hon Patrick Ntwiga Kenya Ambassandor to Thailand, H.E. Lindsay Kiptiness during a Presentation

Photo: Vice Chair PHC, Hon Patrick Ntwiga with the Head, NHSO and Kenya Ambassandor to Thailand, H.E. Lindsay Kiptiness

Photo: The NHIF Team with the Head, NHSO and Kenya Ambassandor to Thailand, H.E. Lindsay Kiptiness

Photo: The PHC members with the Head, NHSO and Kenya Ambassandor to Thailand, H.E. Lindsay Kiptiness

30. The most critical strategic direction for NHSO to sustain the successful implementation of UHC in Thailand is through consistently: -

1. Promoting the use of primary care
2. Employing close-end and performance-based payment methods: capitation for out-patient and PP, DRG weighted global budget for inpatient.
3. Ensuring good quality of care through:
    a. Hospital accreditation
    b. Registration of provider
    c. Hospital profiles
    d. Standard practice guidelines
    e. Ensuring beneficiaries have access to services under National Health Security Act including the Promotive and preventive care, Diagnosis, Curative care, Medicine, medical supplies, organ substitutes, and medical equipment, Delivery, Boarding expense within health care unit, Newborn and childcare, Ambulance or transportation for patient, Pphysical and mental rehabilitation and other necessary expenses as prescribed by the Committee.

3.1.1 **Population Coverage under NHSO**

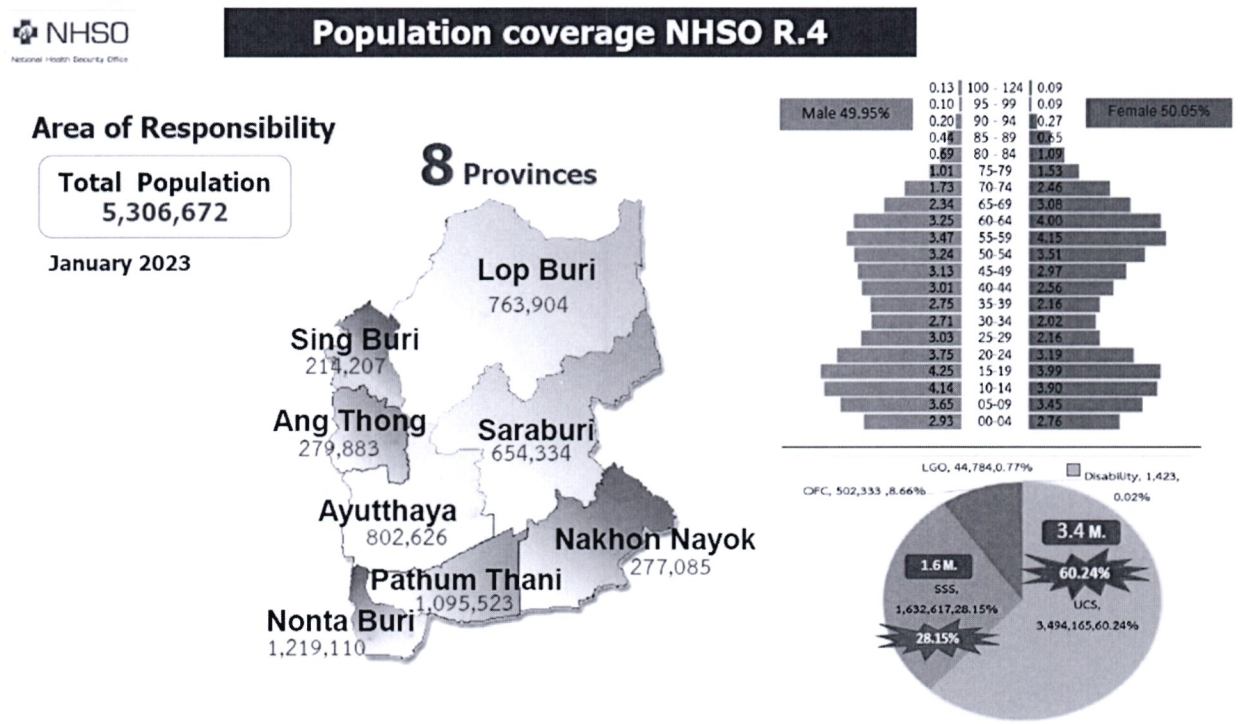


Fig 1: Population coverage as at Jan 2023

3.1.2 Distribution of Service Units under NHSO

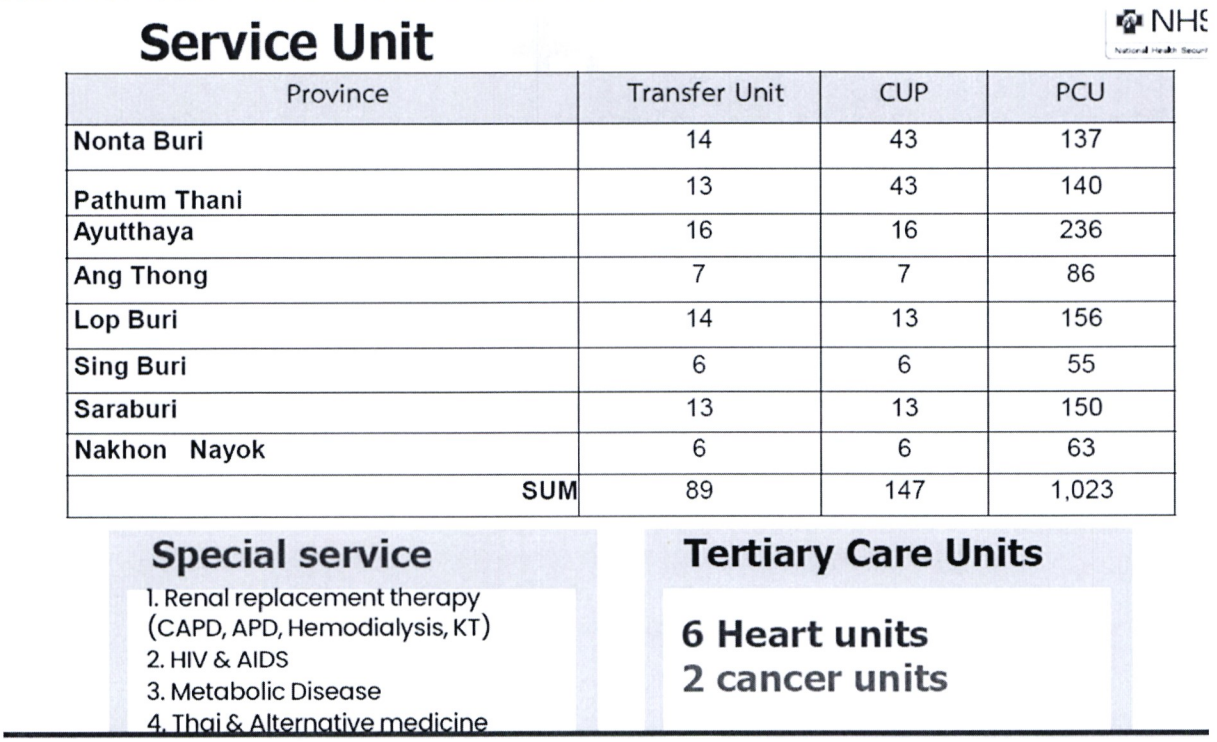


Fig 2: Service units

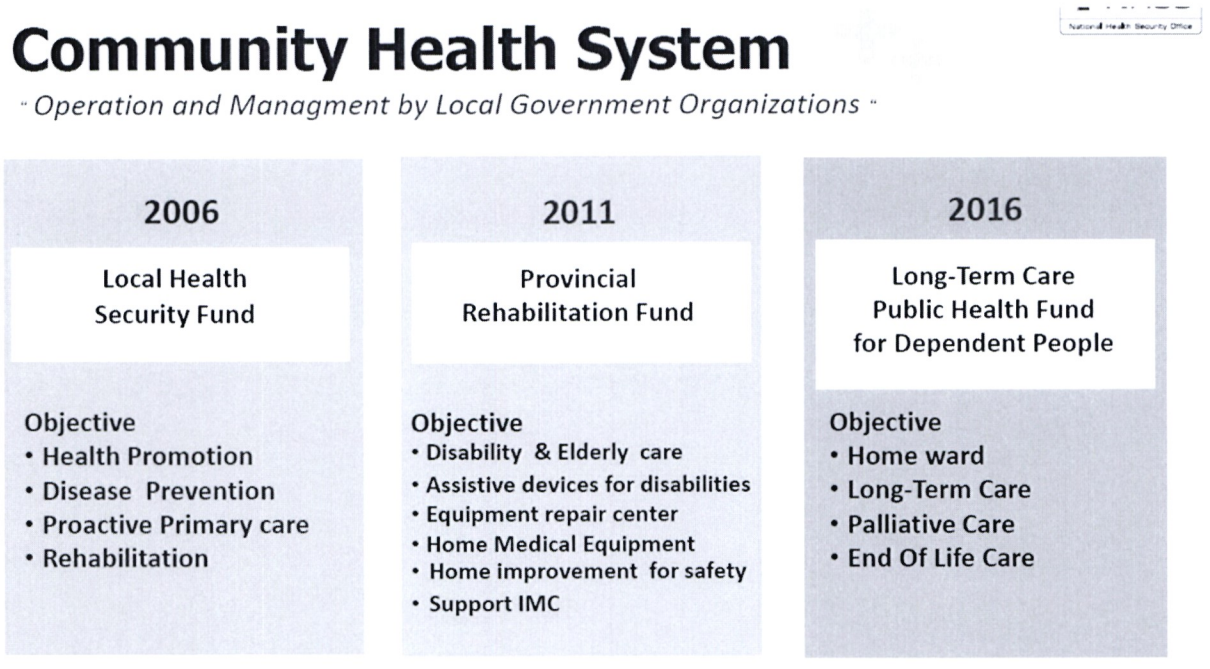


Fig. 3: Health Systems Organization

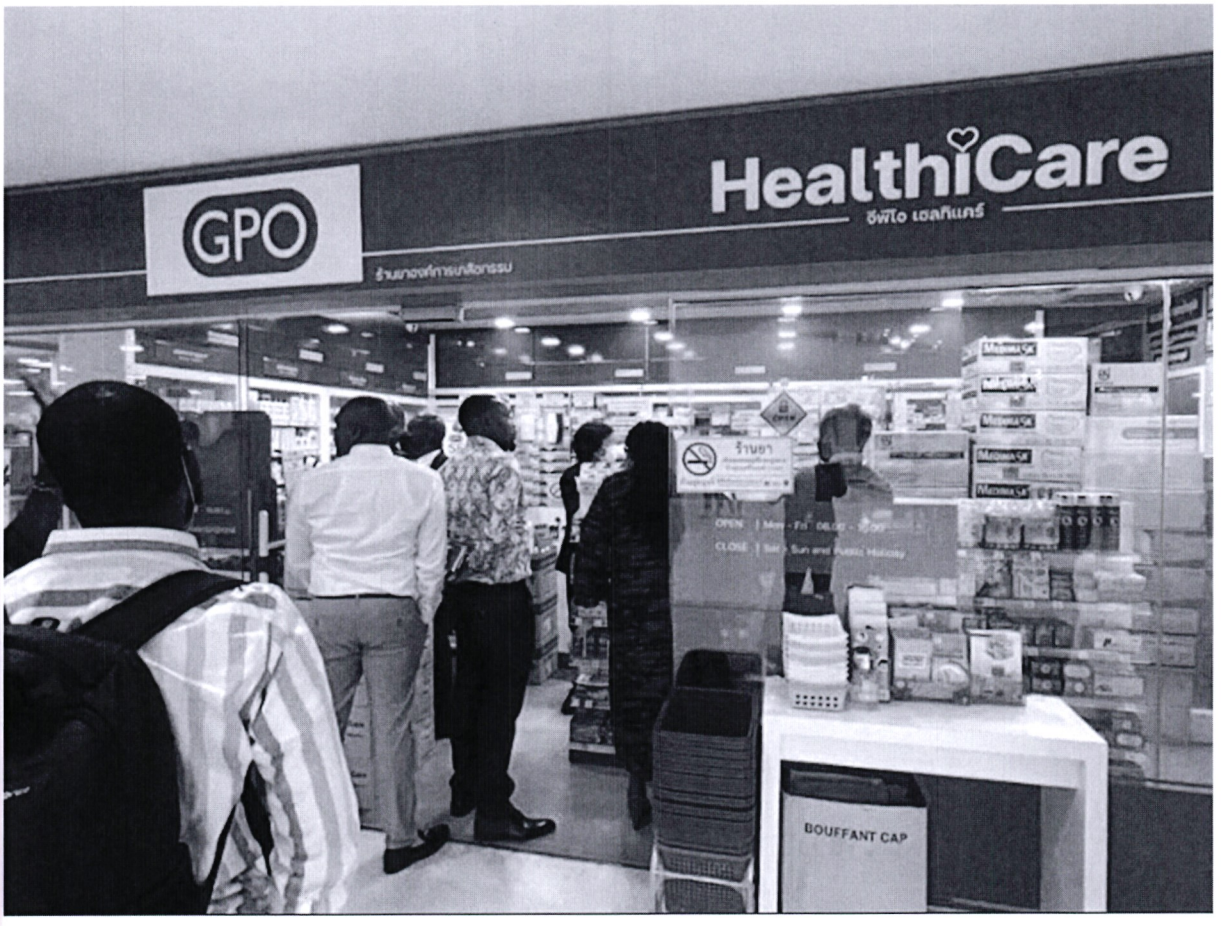
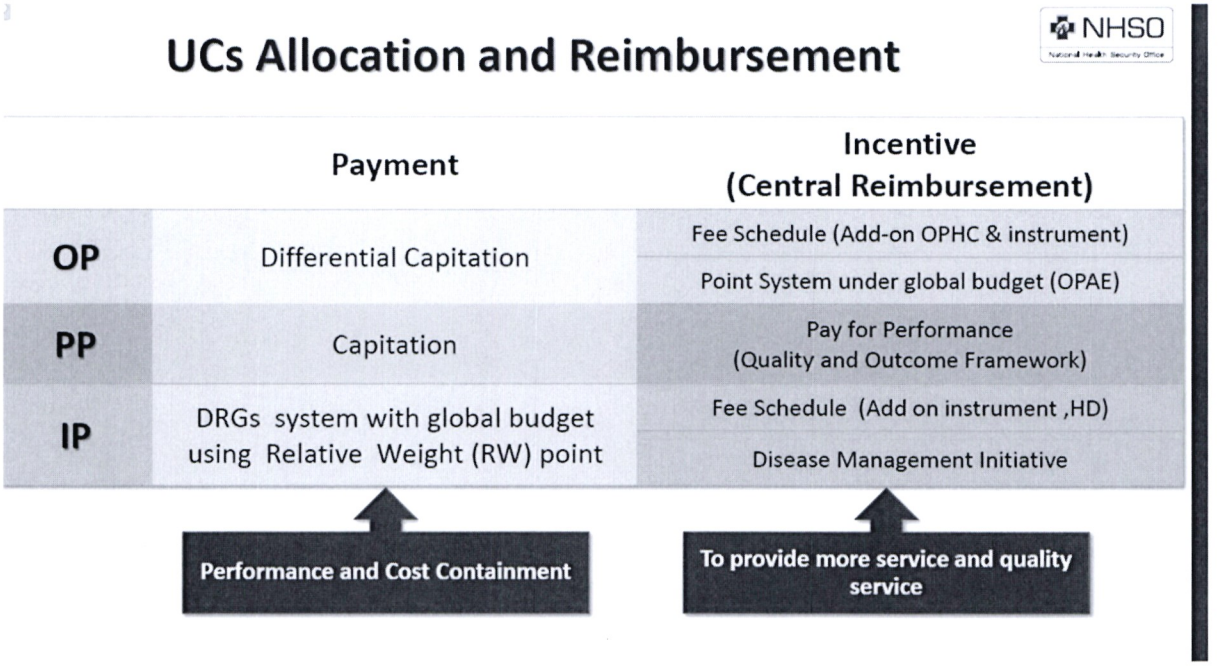


Photo: A Visit to one of the pharmacy provider outlet under NHSO

3.1.3 Provider Payment and Cost Containment Methods

31. Thailand employs budget allocation" for all UCS hospitals, which has two main objectives: -to ensure performance and cost containment and provide more quality services. To ensure performance and cost containment, the NHSO transfers an initial budget to all UCS hospitals by calculating the recent year data.
32. For OP/PP services using differential capitation in each age group, and then multiply with registered populations.
33. For IP services using DRGs system by relative weight point, in accordance with hospital workload in last year.
34. For workload data of each hospital, the NHSO receives it from an electronic-claim system they also perform Central Reimbursements to incentivize hospitals to provide more service and quality service to target UCS beneficiaries such as pay for Performance in terms of gained quality and outcome framework.



35. There are five provider payment methods applied for the UCS.

1. Differential capitation, which is applied for outpatient and health promotion and prevention activities.
2. DRG with global budget which is applied for hospitalizations or inppatient services.
3. Fee schedule payment, which is applied for many health services for example, central reimbursement, rehabilitation, Thai Traditional medicines, HIV Aids, and chronic kidney disease.
4. Performance based payment which is used as financial incentives for health providers to increase efficiency and quality of health care services.
5. Matching Fund between NHSO and local government or municipalities on disease prevention, health promotion and rehabilitation services.

Provider Payment methods in UCS

	Payment method				
	differential capitation	DRG with global budget	Fee schedule	Pay for Performance	Matching fund with local gov.
1. Capitation					
1.1 Outpatient service					
1.2 Inpatient service					
1.3 Central Reimbursement					
1.4 Health promotion & disease prevention service					
1.5 Rehabilitation service					
1.6 Thai traditional medicines and massage service					
1.7 No fault liability for patient and health personal					
2. HIV&AIDs					
3. Chronic kidney disease					
4. Control chronic disease eg. DM HT, Chronic psychiatric					
5. Long term care service					
6. Primary care cluster					

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36. Differential capitation is applied for outpatient and health promotion & prevention activities as seen in yellow highlight.
37. DRG with global budget is applied for hospitalizations or In Patient services.
38. Fee schedule payment is applied to many health services for example; - central reimbursement, rehabilitation, Thai Traditional medicines, HIV AIDS and Chronic kidney disease.
39. Performance base payment It is used as financial incentives for health provider to increase efficiency and quality of health care service.
40. The last method is Matching fund between NHSO and local government or municipalities on disease prevention, health promotion and rehabilitation services.

3.1.3.1 Cost containment

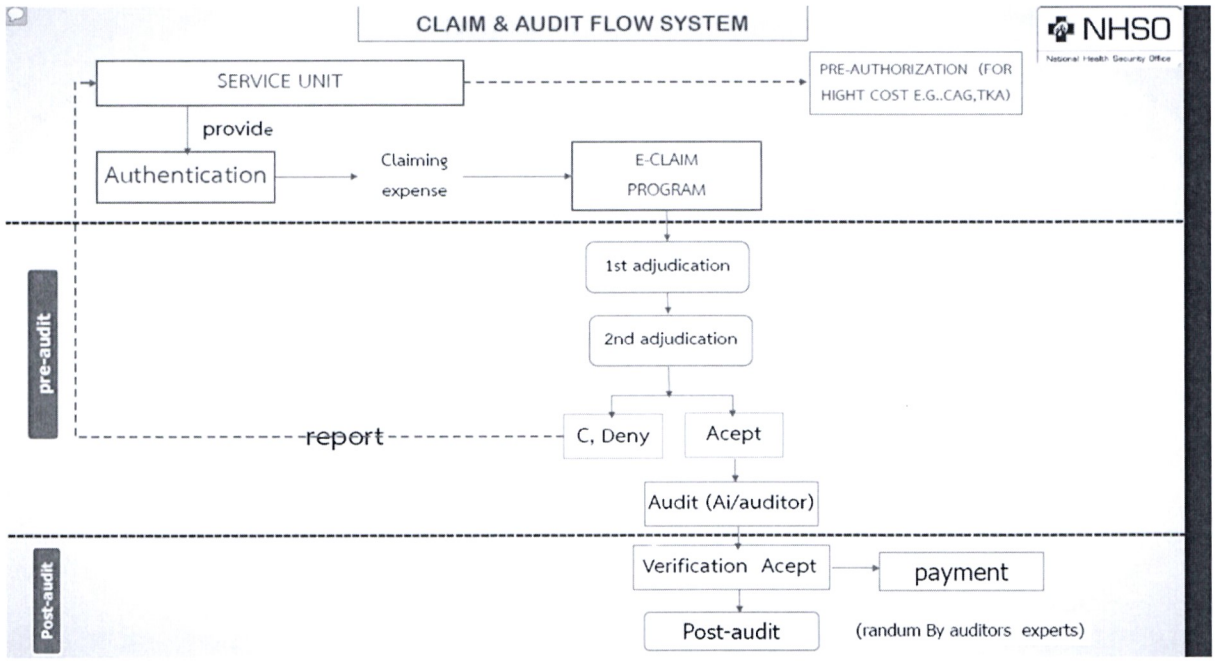
41. Under the UCS there are at least five (5) interventions that are applied to control the cost of care:
    a) Primary Health Care networks and providers act as a gatekeeper to manage the utilization of higher-level of care.
    b) The use of close-end provider payment methods such as capitation, DRG with global budget, fee schedule and fee for service.
    c) The pharmaceutical benefit under the UCS which is based upon the National Essential Drug List, and which includes medicines that are selected based on their effectiveness, safety, and cost-effectiveness.
    d) central price negotiation system is in place for high-price equipment and medicines, to collectively bargain for best-priced items and
    e) Finally, the NHSO sets priority before expansion of benefit packages.

Cost Containment strategies

42. The following are the cost containment strategies NHSO applies in its health care provisions;
    a) Primary Healh Care- a gatekeeping system to manage the utilization of high- level care

b) The clse-end provider payment method: Capitation, DRG with global budget, fee schedule and fee for service.
c) The National Essential Drug list which includes medicines that are selected based on their effectiveness, safety and cost effectiveness.
d) High-price equipment and medicine a central price negotiation systemes is in place to collectively bargain for best-priced items and
e) Priority- setting for expansion of benefits.

3.2 Access to Benefits and Claims Management



Consumer' right protection: Regional acts

43. The following are consumer rights protection strategies;
    a) Beneficiary registration/Provide information (Q&A) and file complaints
    b) Active communication through various channels
    c) Ensure standard and quality of care through promoting and supporting quality improvement program/measure, monitoring, visiting, etc.
    d) Complaint management handling and
    e) No fault compensation

Partner networks participation

44. The following are the partner network participations centres in Thailand
    a) 73 Customer Service Centers in CUP
    b) 8 Center for Coordination of UCS (provincial MOPH)
    c) 17 Independent Complaint Units

Challenges

45. The challenges NHSO meets in its daily provision of health care services includes;
    a) the scarcity of health resources
    b) Inequitable distribution of health facilities, particularly in remote areas

c) Inaccessibility of deprived people and
d) Over-workloads of providers.

3.2.1 Visit to Bang-Pa-In on 10th March 2023

46. The delegation visited Bang-Pa-In Hospital Phra Nakhon Si Ayutthaya Province on 10th March, 2023 which NHSO has 5-yr budget allocation. The Hospital has a vision of "The health security system to which the people have confidence on access" and a Mission of "Secure people toward effective equitable responsive coverage, access, and utilization by evidence-informed decision and participation".

47. It is located at the South of Ayutthaya and borders Wanganui, Bangsai, PraNa Khon Sri Ayutthaya, Uthai and Klongluang. It covers an area of about 229.1 square Kms and is divided into 18 Sub-districts with a registered population of around 110,000 people. It has two (2) major industrial estates.

3.2.2 Learning Objectives

48. The following were the learning objectives of the Committee tour
    a) Healthcare Services and Reimbursement
    b) Authentication System
    c) Claim System and
    d) Audit System

3.2.2.1 Healthcare Services and Reimbursement

49. The team was taken through a practical demonstration of: -
    a) Authentication process before getting a service.
    b) Necessary Healthcare services based on Benefit package.
    c) Data arrangement to reimburse the budget (global) based on NHSO Criteria and
    d) How information is checked, and payments reported to be in accordance with NHSO's billing cycle.

3.1.1.2 Authentication System Platform Hospital

50. Thailand currently uses 5 authentication Platforms. Which are:
    a) The QR Code
    b) The ERM System
    c) The New Authentication Code System (for PP)
    d) The Kios Machine and
    e) The NHSO API

3.1.1.3 Claim System

50. E-Claim and DMIS are the two claim Programs used to get budget reimbursement in NHSO. For E-Claim the following Data are keyed in, IP data, OP data, Emergency Patient data and specific purpose services while under DMIS program and other for specific diseases, TB, AIDS and down Syndrome data are keyed in for reimbursement.

3.1.1.4 Audit System

51. There are both internal and external Audit systems in place in NHSO. Internal audit is done by PCT Team and the Medical Auditor Committee for Medical Record. There are Pre and Post Audit processes.

4.0 COMMITTEE OBSERVATIONS

52. The Committee having considered the report observed as follows: that,

1. The most critical strategic direction for NHSO was to sustain the successful implementation of UHC in Thailand is through consistently Promoting the use of primary care and employing close-end and performance-based payment methods, capitation for out-patient and promotive and preventive care (PP) and Diagnostic related groups (DRG) weighted global budget for inpatient.

2. NHSO ensures good quality of care through:
   a) Hospital accreditation
   b) Registration of provider
   c) Hospital profiles and
   d) Standard practice guidelines.

3. NHSO ensures beneficiaries have access to services under National Health Security Act including: Promotive and preventive care, diagnosis, curative care. Medicine, medical supplies, organ substitutes, and medical equipment. delivery. boarding expense within health care unit, new born and childcare, ambulance or transportation for patient, physical and mental rehabilitation and other necessary expenses as prescribed by the Committee.

4. Under NHSO there are five provider payment methods applied for the UCS. Which are,

a) Differential capitation, which is applied for out-patient and health promotion and prevention activities.

b) DRG with global budget which is applied for hospitalizations or in-patient services.
c) Fee schedule payment, which is applied for many health services for example, central reimbursement, rehabilitation, Thai Traditional medicines, HIV Aids, and chronic kidney disease.

d) Performance based payment which is used as financial incentives for health providers to increase efficiency and quality of health care services.

e) Matching fund between NHSO and local government or municipalities on disease prevention, health promotion and rehabilitation services.

5. Thailand currently uses 5 authentication Platforms which includes the QR Code, the ERM System, the New Authentication Code System (for PP), the Kios Machine and the NHSO API.

6. There is need for the parent Ministry to accompany future Committee delegation and not only the SAGAs so that it owns up the outcome.

7. All NHSO card holders are treated in government health facilities across the Country without restrictions on which facility they are registered with.

5.0 COMMITTEE RECOMMENDATIONS

53. The Committee recommends: - that, for the critical success for UHC implementation in Kenya.

1. The Cabinet Secretary for health through NHIF should establish the UHC implementation governance and financing structures.

2. The Cabinet Secretary for health through NHIF should establish strong and reliable beneficiary identification, care access processes, benefits package development, implementation processes and eventually establish clear and reliable claims management infrastructure and processes.

3. The Cabinet Secretary for health should establish elaborate Primary Health Care model and how it interacts with secondary and tertiary health care provisions.

4. The Ministry of health should establish the role of private sector in the success of UHC implementation.

5. The Ministry of Health should establish structured referral process in the Country.

6. There should be a uniformity in the healthcare set up in our Country and uniformity in the kind of quality of offered healthcare services across the Country.

7. All National Health Insurance Fund card Holders should be allowed to be treated across government health facilities in the Country without restricting them to register at a particular facility.

Signed..... **Date**.25/4/2023.....

HON. DR. ROBERT PUKOSE, MP.

CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

MINUTES OF THE SITTINGS

MINUTES OF FOURTY THIRD SITTING OF THE DEPARTMENTAL COMMITTEE ON HEALTH HELD IN COMMTTEE ROOM 7 IN PARLIAMENT BUILDING ON TUESDAY 25 TH APRIL, 2023 AT 10.30 A.M.

PRESENT

1. The Hon. Dr. Pukose Robert, M.P - **Chairperson.**
2. The Hon. Ntwiga Patrick Munene, M.P -**Vice-Chairperson**
3. The Hon. Dr. Nyikal James Wambura, M.P
4. The Hon. Sunkuli Julius Lekakeny Ole, EGH, EBS, M.P
5. The Hon. Kibagendi Antony, M.P
6. The Hon. Prof. Jaldesa Guyo Waqo, M.P
7. The Hon. Wanyonyi Martin Pepela, M.P
8. The Hon. Oron Joshua Odongo, M.P.
9. The Hon. Muge Cynthia Jepkosgei, M.P

ABSENT WITH APOLOGY

1. The Hon. Kipngor Reuben Kiborek, M.P
2. The Hon. Lenguris Pauline, M.P
3. The Hon. Mary Maingi, MP
4. The Hon. Mathenge Duncan Maina, M.P
5. The Hon. Owino Martin Peters, M.P
6. The Hon. Titus Khamala, M.P

COMMITTEE SECRETARIAT

1. Mr. Hassan A. Arale - Clerk Assistant I
2. Ms. Gladys Kiprotich - Clerk Assistant III
3. Ms. Faith Chepkemoi - Legal Counsel II
4. Ms. Rahab Chepkilim - Audio Officer
5. Ms. Abigel Muinde - Research Officer III
6. Mr. Benzon kimanzi -Serjeant At Arms

MIN. NO. NA/DC-H/2023/183: PRELIMINARIES/INTRODUCTION

The meeting was called to order at 10.30 a.m. with a word of prayer by the Hon. Dr. Robert ukose, M.P - Chairperson.

MIN. NO. NA/DC-H/2023/184: CONFIRMATION OF MINUTES

The following minutes were confirmed: -

1.Minutes of the 37th siting were confirmed as the true record of the Committee deliberations after it was proposed by the Hon Oron Joshua Odongo, M.P and seconded By The Hon. Wanyonyi Martin Pepela, M.p.

2.Minutes of the 38th Sitting were confirmed as the true record of the Committee deliberations after it was proposed by the Hon. Dr. James Nyikal, MP and seconded by the Hon. Sunkuli Julius Lekakeny Ole, EGH, EBS, M.P

3.Minutes of the 39th siting were confirmed as the true deliberations of the Committee after it was proposed by the Oron Joshua Odongo, M.P and seconded by the Hon. Wanyinyi Martin Pepela, M.P.

4.Minutes of the 40th siting were confirmed as the true record of the Committee deliberations after it was proposed by the Hon. Muge Cynthia Jepkosgei, M.P and seconded by the Hon. Oron Joshua Odongo, M.P.

5.Minutes of the 42nd siting were confirmed as the true record of the Committee deliberations after it was proposed by the Hon. Oron Joshua Odongo, M.P and seconded by the Hon. Muge Cynthia Jepkosgei, M.P

MIN. NO. NA/DC-H/2023/185: CONSIDERATION OF THE UNIVERSAL HEALTH COVERAGE BENCHMARKING VISIT TO THAILAND FROM 7TH TO 12TH MARCH, 2023

The following report was considered during the meeting;

1. universal health coverage benchmarking visit to Thailand Report from 7th to 12th march, 2023

MIN. NO. NA/DC-H/2023/186: ADOPTION OF THE FOLLOWING REPORTS

The following reports were adopted during the meeting;

1. Report on the benchmarking visit to South Africa Medical Research Council from 13th to 23rd March, 2023 was confirmed and adopted as the true reflection of the committee deliberations after it was proposed by the Hon. Kibagendi Antony, M.P and seconded by The Hon. Dr. Pukose Robert, M.P - Chairperson.

2. Report on Network of African Parliamentary Committees of Health (NEAPACOH) in Uganda from 22nd to 23rd February, 2023 was confirmed and adopted as the true reflection of the committee deliberations after it was proposed by the The Hon. Dr. Pukose Robert, M.P – Chairperson and seconded by The Hon. Titus Khamala, M.P.

3. Report on 2nd African Public Health Conference in Kigali, Rwanda from 13th to 15th December, 2022 confirmed and adopted as the true reflection of the committee deliberations after it was proposed by the The Hon. Ntwiga Patrick Munene, M.P - Vice-Chairperson and seconded by Hon. Lenguris Pauline, M.P

4. Universal health coverage benchmarking visit to Thailand Report from 7th to 12th march, 2023 confirmed and adopted as the true reflection of the committee deliberations after it was proposed by the The Hon. Prof. Jaldesa Guyo Waqo, M.P and seconded by the Hon. Oron Joshua Odongo, M.P.

OBSERVATIONS FROM THE REPORT

The following observations were made from the universal health coverage benchmarking visit to Thailand Report; that;

1. For universal health coverage to be successful, there is need for the government to finance NHIF instead of NHIF depending fully on contributions.

2. The reimbursements from NHIF to the hospitals be reinvested back to the hospitals and not be expended on other county activities. It was noted that the Facilities Improvement Fund Bill proposed by MOH seeks to address this by ringfencing all hospital user fees.
3. There is need for all NHIF card holders to be treated in government health facilities across the country without restriction to the selected hospital.

COMMITTEE RECOMMENDATIONS ON THE REPORTS

The Committee recommends: - that, for the critical success for UHC implementation in Kenya.

1. The Ministry of health through NHIF should establish strong and reliable beneficiary identification, care access processes, benefits package development, implementation processes and eventually establish clear and reliable claims management infrastructure and processes.
2. There should be a uniformity in the healthcare set up in our Country and uniformity in the kind of quality of offered healthcare services across the Country.
3. All National Health Insurance Fund Card Holders should be allowed to be treated across government health facilities in the Country without restricting patients to register at a particular facility.
4. Growing Africa's Research & Development sector will benefit the world and science can unlock the wellbeing of the population, and unlock the progress of the economy.
5. Health research in the country should focus on the key health priorities and diseases burden in Kenya both the prevalent and emerging, so as to have credible information on the disease burden. KEMRI to have a research agenda that addresses the key health priorities in Kenya. All research should be anchored towards this agenda.
6. Providing health services without guaranteeing a minimum level of quality is ineffective, wasteful, and unethical. National governments need to invest in high-quality health systems for their people and make such systems accountable to people through legislation, education on rights, regulation, transparency, and greater public participation

MIN. NO. NA/DC-H/2023/187: ADJOURNMENT

There being no any other business, The Chairperson, adjourned the meeting at exactly 12.30 p.m.

Sign.....Date 27/4/2023

HON. DR. ROBERT PUKOSE, M.P.

CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

ADOPTION LIST OF THE REPORT

THE NATIONAL ASSEMBLY

13TH PARLIAMENT – SECOND SESSION (2023)

DIRECTORATE OF DEPARTMENTAL COMMITTEES

DEPARTMENTAL COMMITTEE ON HEALTH

REPORT ADOPTION LIST OF THE DEPARTMENTAL COMMITTEE ON HEALTH ON THE UNIVERSAL HEALTH COVERAGE BENCHMARKING VISIT TO THAILAND

We, the undersigned Members of the Departmental Committee on Health do hereby append our signatures to adopt this Report **Date:** 25/5/2023

NO	NAME	SIGNATURE
1.	The Hon. Dr. Pukose Robert, M.P -**Chairperson**	
2.	The Hon. Ntwiga Patrick Munene, M.P -**Vice-Chairperson**.	
3.	The Hon. Dr. Nyikal James Wambura, M.P.	
4.	The Hon. Titus Khamala, M.P	
5.	The Hon. Sunkuli Julius Lekakeny Ole, EGH, EBS,M.P.	
6.	The Hon. Prof. Jaldesa Guyo Waqo, M.P.	
7.	The Hon. Owino Martin Peters, M.P.	
8.	The Hon. Wanyonyi Martin Pepela, M.P	
9.	The Hon. Lenguris Pauline, M.P	
10.	The Hon. Mary Maingi, MP	
11.	The Hon. Muge Cynthia Jepkosgei, M.P	
12.	The Hon. Oron Joshua Odongo, M.P.	
13.	The Hon. Kibagendi Antony, M.P.	
14.	The Hon. Mathenge Duncan Maina, M.P	
15.	The Hon. Kipngor Reuben Kiborek, M.P	