Thailand

Social health protection

Report of study visit
24 - 27 June 2014

Thomas Rousseau

Project collaborator
COOPAMI
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### Programme Agenda

#### Tuesday, June 24th

**Morning:** Arrive Thailand

**Afternoon:** Visit of Mit-Maitree Warm Community Clinic in Nonthaburi (Sanambinnam),
- Observe and discuss activities of the Clinic
  
  *By Mr. Montol Manit, Chairman of the network of Mit-Maitree Clinics*

#### Wednesday, June 25th

**Morning:** Visit of Comptroller General’s Department (CCD)
- Observe and discuss activities of CSMBS
- Structure, Roles, and Functions of CSMBS
  
  *By Ms Apitsama Chaneupkul, Expert in CSMBS, CCD*
  
  *Ms Viriya Pooncom, Expert in CSMBS, CCD*
  
  *Mr Rachot Ounsuk, Legal Expert, CCD*

**Afternoon:** Visit of Ayutthaya Urban Health Centers
- Observe and discuss activities of Ayutthaya Urban Health Centers
  
  *By Dr Arpanuch Puntient, Family doctor of Ayutthaya UHC*
  
  *Dr Niti Aromchean, Family doctor of Ayutthaya UHC*

#### Thursday, June 26th

**Morning:** Visit of NHSO
- Structure, Roles, and Functions of National Health Security Office including Role and Function of Branch Office
- Health care system in Thailand in comparison with Belgium health care system
- General discussion on the findings, and preparation of the debriefing.
  
  *By Dr Yongyuth Pongsupap, Senior expert, NHSO*

**Afternoon:** Visit of Health Centre No. 64 (Bangchan) of Bangkok Metropolitan Administration (BMA)
- Observe and discuss activities of the Health Centre
  
  *By Dr Kiatikul, Director Health Centre No. 64*

#### Friday, June 27th

**Morning:** Visit of NHSO
- Debriefing and meeting with the executives of NHSO
- Discussion about audit and medical supply by NHSO with Dr Panomwan Bunyanmanop and Dr Duangtip Hongsamoot
- Lunch with NHSO SG Dr Winai, Dr Jadet Thammatacharee and Dr Pongpisut

**Afternoon:**
- Wrap up and plan for next steps
- Farewell dinner with Dr Yongyuth Pongsupap, Dr Atthaporn Limpanyalerd, Dr Weraphan Leethnakul and Dr Martiny

#### Saturday, June 28th

**Morning:** Leave Thailand
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
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<tbody>
<tr>
<td>CGD</td>
<td>Comptroller General’s Department</td>
</tr>
<tr>
<td>CSMBS</td>
<td>Civil Servant Medical Benefits Scheme</td>
</tr>
<tr>
<td>CUP</td>
<td>Contracting Unit for Primary Care</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis Related Group</td>
</tr>
<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MoPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>MWS</td>
<td>Medical Welfare Scheme</td>
</tr>
<tr>
<td>NEDL</td>
<td>National essential drug list</td>
</tr>
<tr>
<td>NHSB</td>
<td>National Health Security Board</td>
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<tr>
<td>NHSO</td>
<td>National Health Security Office</td>
</tr>
<tr>
<td>NIHDI</td>
<td>National Institute for Health and Disability Insurance</td>
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<td>NISSE</td>
<td>National Institute for the Social Security of the Self-employed</td>
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<tr>
<td>NSSO</td>
<td>National Social Security Office</td>
</tr>
<tr>
<td>PCU</td>
<td>Primary Care Unit</td>
</tr>
<tr>
<td>SSF</td>
<td>Social Security Fund</td>
</tr>
<tr>
<td>SSO</td>
<td>Social Security Office</td>
</tr>
<tr>
<td>SSS</td>
<td>Social Security Scheme</td>
</tr>
<tr>
<td>UCS</td>
<td>Universal Coverage Scheme</td>
</tr>
<tr>
<td>WCF</td>
<td>Workmen’s Compensation Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
Background

At the end of 2012, National Health Security Office (NHSO) of Thailand and National Institute for Health and Disability Insurance (NIHDI) of Belgium signed an agreement to reinforce the capacity of the staff of the institutions to play their role in the management and the supervising of a health insurance in their country.

As a result of the signature of this collaboration agreement, NHSO had sent in November 2013 three staff members to Belgium. The objective of this study visit was to learn about the Belgian health care system, the Belgian health insurance and the role of NIHDI.

During several two hour meetings with managers and experts from NIHDI and partner institutions, the Thai delegation had discussions on key issues to identify what could be transferable to Thailand and what could support the reflection in Thailand. The report of the study visit can be consulted on www.coopami.org.

Still in the framework of the agreement, I've visited Thailand from 24 to 27 June 2014 to learn about the Thai system of social health protection. To achieve an effective collaboration between the two institutions, basic knowledge of each other system is required and it is import to be aware of each other’s similarities and differences. In this report I will try to put forward these differences and similarities.

The intention was to visit together with Patrick Martiny (International Guest Expert of NHSO) and Yongyuth Pongsupap (Senior Expert of NHSO) the different institutions that have responsibility in the Thai social health protection system. Due to unforeseen circumstances, it was not possible for me to visit the Health Insurance System Research Office (HISRO) and the Social security Office (SSO). I was informed afterwards about the presentations of these two institutions. During my stay in Bangkok, I've visited 2 government agencies (Comptroller General’s Department (CGD) of Ministry of Finance (MoF) who is responsible for the Civil Servant Medical Benefit Scheme (CSMBS) and National Health Security Office (NHSO) who is responsible for the Universal Coverage Scheme (UCS)) and three health facilities (Mit-Maitree Warm Community Clinic in Nonthaburi (Sanambinnam), Ayutthaya Urban Health Centre and Health Centre No. 64 (Bangchan) of Bangkok).

Like every health system, the Thai health system is very complex. After a study visit of three days, it is quit impossible to explain the Thai social health protection in detail. Moreover, there exists already a lot of other documents that describe the situation very well. I don’t have the intention to repeat all these documents but I will try to provide a general overview by comparing the Thai system with the Belgian system. Therefore, I will consciously leave out certain details, nuances and exceptions in this report.

I am very grateful to NHSO and in particular to Yongyuth Pongsupap who made the visits possible and remained inexhaustible to provide us the necessary translations. I also like to thank all the people that I have met during this mission. I was truly in the land of the smiles. All the people were very friendly and took the necessary time to explain and to answer all of us questions. Finally, thanks to Patrick Martiny who was a perfect guide mission and who made it possible for me to check the relevance of some of my impressions about Thailand.
1. Two countries at a glance

As Table 1 shows Thailand is not like Belgium or vice versa.

Table 1: basic facts

<table>
<thead>
<tr>
<th></th>
<th>Thailand</th>
<th>Belgium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surface area, km²</td>
<td>513,120</td>
<td>30,530</td>
</tr>
<tr>
<td>Total population, millions (2013)</td>
<td>67.01</td>
<td>11.20</td>
</tr>
<tr>
<td>Income level</td>
<td>Upper middle income</td>
<td>High income</td>
</tr>
<tr>
<td>GDP (current US$), millions (2013)</td>
<td>387.3</td>
<td>508.1</td>
</tr>
<tr>
<td>GDP per capita (current US$) (2013)</td>
<td>5,779</td>
<td>45,387</td>
</tr>
<tr>
<td>Median age (years) (2012)</td>
<td>36</td>
<td>41</td>
</tr>
<tr>
<td>Aged under 15 (%) (2012)</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Aged over 60 (%) (2012)</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>Life expectancy at birth, both sexes (years) (2012)</td>
<td>75</td>
<td>80</td>
</tr>
<tr>
<td>Life expectancy at 60, both sexes (years) (2012)</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>Healthy life expectancy at birth (years) (2012)</td>
<td>66</td>
<td>71</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births) (2013)</td>
<td>26</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: Worldbank and WHO (World Health Statistics 2014)

Thailand is 17 times bigger than Belgium and has a population that is 4 times larger than that of Belgium. Over eight million people (12.6 % of the country's population) are living in the capital Bangkok. Belgium has in total 11.20 million people.

Thailand is an upper middle income country by World Bank definition, Belgium is a high income country.

The proportion of people aged over 60 is in Belgium (24 %) much higher than in Thailand (14 %). The proportion of people aged under 15 is similar (17-18 %) in both countries.

In 2012, life expectancy at birth was 75 years in Thailand and 80 years in Belgium. Life expectancy at 60 for both sexes, which is a better estimate of survival within the adult life course than life expectancy at birth, is almost the same in the two countries: 21 in Thailand and 23 in Belgium.
2. Health care delivery system

The healthcare delivery systems of Thailand and Belgium are very different. The Thai health care system is dominated by the public sector, while the delivery of health care in Belgium is mainly private.

There is also considerable variability concerning the density of health professionals between the two countries. There are almost eight times more physicians and nursing/midwifery personnel per 10,000 people in Belgium than in Thailand (see table 2). When we compare the workforce of Thailand with the group of upper middle income countries (15.5 physicians per 10,000 population – 25.3 nursing and midwifery personnel per 10,000 population), we see an important understaffing of physicians (3.9 per 10,000 population) and nursing and midwifery personnel (20.8 per 10,000 population) in Thailand. Belgium has a little more physicians and a lot more nursing and midwifery personnel in comparison with the group of higher income countries (29.4 physicians per 10,000 population – 86.9 nursing and midwifery personnel per 10,000 population) (World Health Statistics 2014).

The density of hospital beds can be used to indicate the availability of inpatient services. In Belgium there are 3 times more hospital beds per 10,000 population than in Thailand.

**Table 2: health professionals and hospital beds**

<table>
<thead>
<tr>
<th></th>
<th>Thailand</th>
<th>Upper middle income countries</th>
<th>Belgium</th>
<th>Higher income countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians per 10,000 population</td>
<td>3.9</td>
<td>15.5</td>
<td>29.9</td>
<td>29.4</td>
</tr>
<tr>
<td>Nursing and midwifery personnel per 10,000 population</td>
<td>20.8</td>
<td>25.3</td>
<td>157.8</td>
<td>86.9</td>
</tr>
<tr>
<td>Hospital beds per 10,000 population</td>
<td>21</td>
<td>65</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: WHO (World Health Statistics 2014)

**Thailand**

The Thai health care system is made up of sub-district health centers, district hospitals and general/regional hospitals. The sub-district health center (primary care unit - PCU – tambon health promoting hospital) is the smallest unit; it provides health services at the front line in an integrated manner. These services include curative care, health promotion, disease prevention, and rehabilitation either in a health facility or in the community. The sub-district health center is usually staffed by nurses and primary care workers (with sometimes the support of a doctor); their major role is to take care and look after the population in a designated area, or to people who have registered. They each cover approximately 10,000-15,000 people while district hospitals staffed by doctors and health teams each serve a population between 50,000 and 200,000 people. District hospitals are supposed to serve as an essential link between health centers and general or regional hospitals by implementing effective referral systems.
The infrastructure of health services in Thailand can be divided into three types:

1. Health services provided through the public sector under the supervision of the Ministry of Public Health (MoPH) for the whole population in both urban and rural areas. The structure can be classified as centrally based with local and rural administration.
2. Health services provided through other public agencies for officials and their family members and to provide services to the general public. Examples include hospitals under supervision of Bangkok Metropolitan Administration, Ministry of Defense, the Ministry of University Affairs, etc. (Siriruttanapruk, 2006).
3. Health services provided through the private sector.

**Belgium**

In Belgium health care is provided mostly by independent ambulatory care professionals. Physicians are self-employed, as are most dentists, pharmacists and physiotherapists. Less than 1% of physicians with a clinical practice are salaried. Even most medical specialists who work in hospitals or in private practices on an ambulatory basis, are usually self-employed.

The majority of hospitals in Belgium are private non-profit-making hospitals. Public hospitals are for the most part owned by a municipality, a province, a community or an inter-municipal association. Hospital legislation and financing mechanisms are the same for both the public and private sectors. The only differences are that for public hospitals internal management rules are more tightly defined and their deficits are covered, subject to certain conditions, by local authorities or inter-municipal associations.
3. Social health protection

3.1. Overview

Thailand, as well as Belgium, provides financial protection against catastrophic health expenditures for almost the entire population.

By law, Thai citizens belong to one of the 3 country’s social health protection schemes:
- The Civil Servants Medical Benefits Scheme (CSMBS) covers civil servants, permanent government employees, pensioners who used to work as civil servant and their dependents (± 5 million insured persons or 8 % of the total population);
- The Social Security Scheme (SSS) covers private sector employees of enterprises with 1 or more employees and persons that contribute on a voluntary basis (± 10 million insured persons or 16 % of the total population);
- The Universal Coverage Scheme (UCS) covers all the Thai population that are not covered by CSMBS or SSS (± 47 million insured persons or 75 % of the total population).

More than 99 % of the Belgian population is covered by the compulsory health insurance. The compulsory health insurance covers active and non active people and their dependants. The main insured members are entitled to health insurance on the basis of their current or previous profession. All individuals entitled to health insurance must join or register with a sickness fund. There are two main schemes: (1) the general scheme for the whole population except for the self-employed, and (2) the scheme for the self-employed. The difference between these two schemes concerning the benefit package has disappeared since 1 January 2008. Everyone has the right to the same benefit package. The only difference between the two schemes for the compulsory health insurance is in the financing.

3.2. History

The road to universal health coverage was very different for the two countries.

Thailand

With the introduction of the Universal Coverage Scheme (UCS), the year 2001 was an important year in the history of social health protection in Thailand. The graph below shows the evolution of the population coverage in a schematic way.

Before the introduction of the UCS, more than 25 % of the Thai population was not covered for their health care expenses. The rest were covered by at least one of four schemes.

The Medical Welfare Scheme (MWS) was the largest and offered coverage to the poor and was funded by general taxation and managed by the Ministry of Public Health (MoPH). The voluntary Health Card Scheme (VHCS), which began as community-based health insurance in 1983 administered by village communities, provided access to health care for the non-poor self-employed through a flat-rate fee per household, and was also funded by general taxation and run through the MoPH.
Civil servants, permanent government employees, pensioners who used to work as civil servant and their dependents were covered by the Civil Servants Medical Benefits Scheme (CSMBS), while the Social Security Scheme (SSS) started in the 1990s for private sector employees.

**Belgium**

The origins of the health insurance system in Belgium can be traced to the late 19th century, when workers created themselves mutual benefit societies to protect affiliated members against the risk of disease, unemployment and incapacity for work. These societies evolved to what we know now as sickness funds. It was a subsidized voluntary health insurance and stayed small-scale in terms of membership.

A compulsory health insurance was implemented after the Second World War based on an agreement that had been clandestinely negotiated during the war between representatives of the employers and the unions. The compulsory health insurance was first for the wage-earners, but has gradually evolved towards universal coverage.

In 1964, the self-employed were obliged to insure themselves against major risks in medical care. Health insurance coverage was extended to public sector workers for both major and minor risks in 1965; to those physically incapable of working in 1967; to the mentally ill in 1968; and to everyone not yet protected in 1969.

From 1998, all beneficiaries of compulsory health insurance were covered either under the general scheme (for minor and major risks) or the scheme for self-employed workers (for major risks) and since 2008, all beneficiaries are covered for both minor and major risks (Gerkens et al., 2010).
3.3. Institutional and organizational arrangements

Thailand

In Thailand, the MoPH has held before 2001 both a service delivery role and financing management role. The MoPH invested in the infrastructure of health units to every district and sub-district, and hospitals and health centres were gradually built up in all areas of the country during 1981-1991. (Pitayarangsarit, 2004)

With the introduction of the UCS in 2001, the role of purchaser was separated from the MoPH. A new, independent organization, the National Health Security Office (NHSO), was created, which serves as a state agency. Instead of the previous model of budget allocation from the central MoPH to health care providers based on facility size, staff numbers, and historical performance, the UCS has NHSO as its purchaser, which contracts with the health care providers to provide health services for its beneficiaries (Hanvoravongchai, 2013).

The NHSO is under the authority of the National Health Security Board (NHSB). The NHSB is chaired by the Minister of Public Health, and is responsible for setting policy, making decisions on the benefits package, deciding on appropriate provider payment methods, and setting rules and guidelines. The NHSB’s 29 other members include representatives from various stakeholder groups (government officials, local governments, NGOs, health professionals, private hospitals, experts in insurance, medical and public health, …) The NHSB also has 11 subcommittees that assist in policy development. The Benefit Package Sub-committee takes the decision on the new medical interventions that have to be included in the package.

The CSMBs is managed by the Civil Servant Medical Benefit Scheme Groupe, a division of the Comptroller General's Department (CGD) of the MoF. A committee was proposed by the MoF in order to suggest policies to MoF related to financing, benefits and management of the CSMBs.

The Social Security Office (SSO) manages the SSS. The primary responsibility of the SSO is to manage the Social Security Fund (SSF) and Workmen’s Compensation Fund (WCF). The SSF is providing seven types of benefit, i.e., non-work-related sickness, maternity, invalidity, death, old-age pension, unemployment benefits and child allowance. The WCF provides coverage for the employees of enterprises for work related illness and injuries. The Social Security Committee gives advice on social security policies and measures, gives opinions to the Minister, reviews balance sheet and finance statement of the Fund and reports on operational performance. This Committee consists of 5 representatives each from employers, employees, government and 5 extraordinary experts. The Medical Committee that consists of 16 medical experts gives advice on medical care to the Social Security Committee and determines the criteria and the benefit package.
Numerous public authorities are responsible for the funding of health care and the oversight of its organization. I will limit my explanations to the Federal Public Service Health, Food Chain Safety and Environment, the National Institute for Health and Disability Insurance (NIHDI) and the sickness funds.

The Federal Public Service Health, Food Chain Safety and Environment is accountable to the Minister of Social Affairs and Public Health and is in charge, as concerns health care, of the organization, planning rules, recognition criteria, evaluation of the quality of medical and nursing practices in health care facilities, registration of data and financing of inpatient health care facilities, as well as the implementation of patients’ rights. It is also responsible for the recognition and planning of activities for health care professionals.

The National Institute for Health and Disability Insurance (NIHDI) plays an important role in the Belgian health care system. NIHDI is an public social security institution and is supervised by the Minister of Social Affairs. NIHDI organizes, manages and supervises the correct application of that «compulsory insurance». The rules for the reimbursement and determines the tariffs of the health care services and medicines for example are decided at NIHDI. The General Council and the Committee for Health Care Insurance of the Health Care Department of NIHDI take the decisions concerning the health insurance.

In the General Council, decision-making power is shared between the financial contributors to the system (government, employers, salaried employees and self-employed workers) and the sickness funds. Representatives of health care providers have an advisory role. The General Council decides on general policy matters concerning health insurance, approves the annual global budget target for health benefits on the basis of a proposal from the Committee for Health Care Insurance, establishes the budget of the health insurance, determines the distribution of the budget for the different health care sectors and monitors the financial balance of the health insurance. The government has a power of veto over decisions made in the General Council.

The Committee for Health Care Insurance reports to the General Council and is made up of an equal number of representatives of sickness funds and health care providers. Representatives from employer and employee (salaried and self-employed) organizations and representatives of the government have an advisory role. One of the tasks of the Committee for Health Care Insurance is drafting the annual global budget target for the General Council. This committee also decides on the transmission of proposals to modify the nomenclature of health benefits and approves agreements and conventions, subject to the decision of the General Council.

The NIHDI does not actually provide insurance. That is done by the sickness funds. The sickness funds are private non-profit-making organizations with a public interest mission and pay the patients or health professionals on the basis of the rules of the compulsory health care insurance. The benefit package of the compulsory health care insurance is the same for everyone regardless of the sickness fund. Sickness funds receive their financial resources from the NIHDI. They are active members of both the executive and the advisory committees of the NIHDI. They are also in charge of medical auditing: they verify that services have really been carried out and that the fees charged comply with regulations.
3.4. Financing

As shows data from World Health Organization (WHO) (table 3), the expenditure on health in Belgium is much higher than in Thailand.

Table 3: Health expenditure

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Total expenditure on health in million current US$</td>
<td>14,365</td>
<td>52,264</td>
</tr>
<tr>
<td>Total expenditure on health / capita at Purchasing Power Parity (National currency unit per US$)</td>
<td>385</td>
<td>4,320</td>
</tr>
<tr>
<td>Total health expenditure (THE) as % of GDP (2012)</td>
<td>3.93</td>
<td>10.79</td>
</tr>
</tbody>
</table>

Source: WHO (Global health expenditure database)

Of course all these data must be viewed with some caution. A number of the indicators presented in the WHO databases are associated with significant uncertainty.

The share of current healthcare expenditure in Belgium exceeded 10.0 % of gross domestic product (GDP) and is one of the highest of the European Union Member States (with France, the Netherlands, Germany, Denmark and Austria). This share is almost three times the share of current healthcare expenditure relative to GDP recorded in Thailand (below 4.0 % of GDP), which is relatively low to reach universal health coverage.

It is important to mention that the data on total expenditure on health not only covers the provision of health services but also family planning activities, nutrition activities, and emergency aid designated for health.

Thailand

UCS and CSMBS are both financed through general tax revenue. UCS expenditure is transferred from the government budget to the National Health Service Office (NHSO), which is the purchaser of health care services.

Contributions are the main source of the SSS (72.10 % in 2012), 21.45 % were from interests and 6.45 % from others. The contribution for the employers and the employees accounts for 1.5 % of the reference income for sickness, maternity, invalidity and death. The government pays also 1.5 % for these benefits.

Belgium

Social security contributions, subsidies from the state, and alternative financing (mainly value added taxes) are the main funding sources for the compulsory health insurance system. The alternative financing aims to limit government subsidies and to reduce employers’ contributions.

Nor NIHDI, nor the sickness funds are collecting the social contributions. In the employed workers’ scheme, both employees (13.07 % of gross income) and employers (24.77 % of gross income) have to pay social contributions to the National Social Security Office (NSSO). These contributions are
collected for different social security benefits: health and disability insurance, old age and survivors pensions, unemployment, insurance for accidents at work, work-related health and occupational diseases, and family allowances. This overall financial management finances the sectors according to their needs, and not with fixed percentages.

The self-employed pay their quarterly social security contributions to the social insurance fund they are affiliated with, which in turn forwards the funds to the National Institute for the Social Security of the Self-employed (NISSE).

NSSO and NISSE redistribute the social security budget to the payment institution for each social security sector (i.e. the NIHDI for health insurance). Then, NIHDI redistributes the budget to the different sickness funds. They receive a prospective budget to finance the health care costs of their members and are held financially responsible for a proportion of any discrepancy between their actual spending and their so-called normative, that is, risk-adjusted health expenditures. However, their financial accountability for the deficit can never exceed 2% of the total budget.

3.5. Benefits Package

Thailand

The three schemes in Thailand provide comprehensive benefits packages.

The SSS benefits can be classified into three groups: the curative package, covering outpatient and inpatient services (with some exclusions); high-cost care; disease prevention and health promotion, entailing immunizations, annual physical checkups, counselling, voluntary HIV counselling and testing, and antenatal care and family planning services (Wibulpolprasert and Thaiprayoon, 2008).

The benefit package of CSMBS is slightly better than SSS and UCS, including coverage for inpatient and outpatient services, emergency treatment, and pharmaceuticals. The package does not include expenses spent on beauty treatment, pregnancy test, temporary contraception and planned parenthood, any fee or compensation that paid directly to individual health professionals in the private sector and any expense that is not related to treatment (e.g. meals for careers, telephone costs).

The UCS package in 2001 was almost identical to that of the SSS, covering outpatient, inpatient and accident and emergency services; dental and other high-cost care; and diagnostics, special investigations, medicines (no fewer than are included in the National List of Essential Medicines) and medical supplies.

The UCS also included clinic-based preventive and health-promotion services provided in health centers. As the CSMBS and SSS did not include these in their benefits packages, the UCS filled the gap by including these services for the whole Thai population within its annual budget (Evans et al., 2012).

Over the years new services have been included in the UCS benefit package. Table 4 provides an overview of the services that have been added.
Table 4: Evolution of the UCS benefit package (2002-2013)

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>Universal health coverage for Thai citizen including health promotion, disease prevention, diagnosis, treatment, dental care, drug listed in national drug list, rehabilitation</td>
</tr>
<tr>
<td>2005</td>
<td>Benefit package for HIV/AIDS include ARV, laboratory, counseling, Voluntary Counseling and Testing, condoms</td>
</tr>
<tr>
<td>2007</td>
<td>Thai traditional medicine services</td>
</tr>
<tr>
<td>2008</td>
<td>Renal replacement therapy (CAPD, HD, KT)</td>
</tr>
<tr>
<td></td>
<td>Methadone drug as a replacement drug in drug addicts</td>
</tr>
<tr>
<td>2009</td>
<td>High cost drug in J2-National drug lists</td>
</tr>
<tr>
<td></td>
<td>Seasoning Influenza drug list</td>
</tr>
<tr>
<td>2010</td>
<td>Orphan drug, Thai traditional medicines</td>
</tr>
<tr>
<td></td>
<td>Psychosis admission without limitation</td>
</tr>
<tr>
<td>2012</td>
<td>Liver transplantation in patient age &lt;18 years</td>
</tr>
<tr>
<td></td>
<td>Heart transplantation</td>
</tr>
<tr>
<td>2013</td>
<td>Expand target group for seasoning influenza vaccines</td>
</tr>
<tr>
<td></td>
<td>Stem cell transplantation in Leukemia and lymphoma with indication</td>
</tr>
<tr>
<td></td>
<td>Strategic plan for long-term care in frail elderly in Home care and community care</td>
</tr>
</tbody>
</table>

Source: Presentation of Yongyuth Pongsupap

Belgium

Part of the services that are covered by compulsory health insurance are described in the nationally established fee schedule, called the “nomenclature”. This list is very detailed with more than 8000 services. It is an index of reimbursable (para-)medical health care acts (intellectual, material, technical or mixed). These services are for example the consultations and visits by GP’s, dental care, special technical provisions, physiotherapy sessions, nurse care, wheelchairs, prosthesis and implants, ... For each service, the identification number, contractual fee and reimbursement rate are specified. Services not included in the fee schedule are not reimbursable.

There is also a positive list of reimbursed medicinal products. Only pharmaceutical products included on the positive list of reimbursement are covered by the compulsory health insurance.

The compulsory health insurance intervenes also for hospital stay or for treatment in a health care institution.

Plastic surgery, spectacles and orthodontics are only reimbursable under certain conditions. Moreover, certain types of health care are not covered by the compulsory health insurance. For example, alternative therapies such as acupuncture, homeopathy and osteopathy are excluded but may be partially covered by complementary insurance.
3.6. Selection of health care providers and co-payments

Table 5 shows a similar picture of governments’ engagement of both countries with respect to expenditure on health. The general government expenditure on health is in the two countries around the 76% of total health expenditure. That means that around 24% of the total health expenditure is coming from private sources.

The share of out-of-pocket payment is much higher in Belgium (almost 20%) than in Thailand (around 13%). But the private insurances in Thailand are more important than in Belgium.

**Table 5: Public and private health expenditure**

<table>
<thead>
<tr>
<th></th>
<th>Thailand</th>
<th>Belgium</th>
</tr>
</thead>
<tbody>
<tr>
<td>General government expenditure on health as % of THE (2012)</td>
<td>76.43</td>
<td>75.91</td>
</tr>
<tr>
<td>Private expenditure on health (PvtHE) as % of THE (2012)</td>
<td>23.57</td>
<td>24.09</td>
</tr>
<tr>
<td>Out of pocket expenditure as % of PvtHE (2012)</td>
<td>55.76</td>
<td>81.69</td>
</tr>
<tr>
<td>Private insurance as % of PvtHE (2012)</td>
<td>30.77</td>
<td>17.47</td>
</tr>
<tr>
<td>Out of pocket expenditure as % of THE (2012)</td>
<td>13.14</td>
<td>19.68</td>
</tr>
</tbody>
</table>

*Source: WHO (Global health expenditure database)*

**Thailand**

**UCS** members must register with a Contracting Unit for Primary Care (CUP), based on their address. Most common CUP is a district health provider network linked to the local district hospital. Therefore UCS members have limited choice of provider, especially in rural areas.

Up until 2006, a co-payment of 30 Baht (approximately € 0.70 (2014)) was required both for inpatient and outpatient services, with exemptions for previous beneficiaries of the MWS (the poor households, old age, children under 12). This co-payment of 30 baht was terminated in November 2006.

Beneficiaries are not allowed into secondary or tertiary care units without referral from the primary contractor, except for accidents or emergency situations. Patients can be referred to provincial and regional hospitals when they need care which is beyond the capacity of the district health system. They may however consult directly the community hospital without passing by the health centre.

UCS members are liable to full payment for service rendered by providers outside their network.

**SSO contracts** for the **SSS** members with main contractors (hospitals with more than 100 beds) to cover all services. The main contractor may contract with hospitals providing lower levels of care—subcontractors - or high levels of care –supra contractors. In 2014, SSO has contracted with 242 main contractors: 156 public hospitals and 86 private hospitals.

SSS members have free choice of public and private contractors within the contracted network. The services are free at the point of delivery within this network. In case of emergency, the insured can choose any hospital, even outside the contracted network.
**CSMBS** members have free choice of health care provider for ambulatory and inpatient care in mainly public hospitals. They don’t have to pay any co-payment in the public hospitals except for expenses that are not related to the treatment (e.g. telephone costs).

The members can only access contracted private hospitals for elective surgeries in the case of specific indications (47 diseases and 77 procedures) and for life-threatening emergency conditions. In these situations co-payments for patients are possible (e.g. doctor fees).

A public hospital can also refer patient to a contracted private hospital in the case of hemodialysis (chronic renal failure patients) or radiotherapy (cancer patients).

**Belgium**

Patients in Belgium have at any moment free choice of health care professionals and health care institutions. The right to free choice of health care professional gives patients the choice to contact several different health care professionals before choosing one. Patients can always choose to consult with another health care professional and may change their choice of health care professional (right to a second opinion).

For outpatient care, patients are in principle required to pay upfront the full fee and then claim reimbursement from their sickness fund. Generally the reimbursement is a partial one. Part of the medical care cost has to be supported by the insured person – the personal co-payment or out of pocket payment.

Co-payments vary from service to service but are equal for everyone, with the exception of patients with preferential reimbursement who pay reduced co-payments. Co-payment rates are about 25% for GP consultations, 35% for GP home visits and 40% for specialist consultations.

In order to compensate the personal co-payment, and more especially the increase of this personal share, measures were taken to reduce the personal share of the socio-economic weaker categories. In 2002 the Maximum Billing was introduced and is a measure offering a general limit to health care costs, especially for families with high health cost and lower, if not modest income. The Maximum Billing puts a ceiling on the total amount of co-payments to be paid and is set according to the family’s net income, such that each household has an annual out-of-pocket maximum for all “necessary health care expenses”. As soon as expenses reach the set ceiling, any further health care costs are covered in full by the compulsory health insurance for the remaining part of the year.

For inpatient care and medicines purchased in pharmacies, the third-party payer system applies and patients only pay user charges.

For medicines, the percentage of the co-payment is determined by the pharmaceutical category, which reflects the social importance of the pharmaceutical, pharmacotherapeutic criteria and price criteria. A distinction is made between category A (pharmaceuticals for serious and long-term illnesses), B (socially and medically useful pharmaceuticals), and C (socially and medically less useful pharmaceuticals).
For inpatient care, a patient’s out-of-pocket payments consist of:
- a flat rate per day for hospitalization;
- a room supplement when the patient has requested a single room;
- the physician’s fee supplements for non-conventioned (not-contracted) physicians or for conventioned physicians (conventioned physicians can only ask for a fee supplement when the patient has requested a single room);
- costs of certain non-reimbursable medical products or pharmaceuticals;
- flat rate charge per day for pharmaceuticals (0.62 euro/day), and flat rate charges per inpatient stay for biological tests, for radiology and for technical acts.

About 24 % of total health expenditure in Belgium is borne by the patients (Out-of-pocket + private insurance).

3.7. Purchasing of services and provider payment

Thailand

NHSO acts as the purchaser for UCS. The Ministry of Public Health (MoPH) and its network of hospitals are the main contractors of the NHSO. The contractors can have subcontractors, such as private clinics or health centers, to provide primary care and preventive and promotive health services. For private and other public providers, an individual contracting process is required. The NHSO regional office has the authority to contract with the non-MOPH providers in their regions. The NHSO also contracts with private hospitals, but the number of private hospital contractors continuously declined. (Hanvoravongchai, 2013).

For primary care, in order to get budget, providers have to be organized as a Contracting Unit for Primary Care (CUP). The CUPs are primary health facilities offering curative, promotive, preventive, and rehabilitative services such as ambulatory care, home care, and community care. Each CUP has its own catchment area and population. Health services providing primary care must fulfil some criteria to be recognized as a CUP, particularly in terms of human resources: they must have a doctor, a pharmacist, a dentist. In rural areas, where qualified staff is only available in hospitals, the health centres must associate with the district hospital to constitute a CUP.

NHSO uses many different methods of provider payment, among which the most common are capitation for outpatient services and case-based payment (DRG) for inpatient care with a global budget\(^1\) ceiling. The contract between each facility network and the NHSO allows for some variation in conditions: for example, the board of the network can decide to direct funds to the community hospital or to particular health interventions at specific health centres depending on the local health needs.

\(^1\)A closed-end (global) budget is a budget with pre-defined services, cases and costs per case. If it turns out that demand for services is higher than budgeted, in theory no additional funds will be made available
Historically, the CSMBS adopted a fee-for-service reimbursement model as its mode of provider payment.

For outpatient services in public hospitals, CGD reimburses beneficiaries or health providers retrospectively on a basis of fee-for-service (as hospitals charged), except for some services or items for which the MoF has announced reimbursement fee schedules (ceiling prices). The beneficiaries can choose to pay the amount upfront and to be reimbursed by CDG afterwards. If they want to benefit from the third-party payment mechanism, they have to register with one preferred hospital.

A Diagnosis Related Groups (DRG) based payment system via an electronic payment system is used for inpatient care in public and private hospitals, except for the items that are announced by the MoF: i.e. room and board, artificial organs (fee schedule) and some high cost medicines such as cancer medicines (fee-for-service).

The Social Security Office (SSS) purchases health services from both public and private hospitals. Hospitals enter the SSS as main contractors with licenses issued by the SSO upon meeting certain standards set out by the Medical Committee. In broad terms, the hospital must have at least 100 beds, a good referral system, and be well equipped with all types of necessary facilities. The main payment method that SSO applies to reimburse the medical costs to contracted hospitals is capitation (1,446 baht/insured person/year in 2012). For inpatient care, SSO uses Diagnostic Related Groups for all admissions.

For some special high cost services (open heart surgery, brain surgery, …), SSO pays fee-for-service based on fixed fee schedules.

**Belgium**

Payment mechanisms are mainly characterized by fee-for-service payment. For salaried employees in the health sector, salaries and career evolution are negotiated through a series of collective agreements.

Tariffs and fees for services provided by for GPs, specialists and other health care providers are determined collectively by the conventions and agreements commissions within the NIHDI after negotiations between representatives of health care providers and sickness funds. These price agreements (for physicians and dentists) and conventions (for other health care professionals) are embedded within a budgetary procedure. One example is the National Committee of Representatives of Physicians and Sickness Funds who fix the fees and reimbursement tariffs for physicians in a agreement. Physicians who do not agree with this agreement (non-conventioned physicians) can set fees freely.

Less than 1 % of physicians with a clinical practice are salaried. Most of these salaried physicians work in medical practices of integrated health care which are owned and managed by the physicians themselves, and where usually (though not always) the physicians are paid by the NIHDI through capitation based financing of the medical practice (Gerkens et al., 2010).
Nurses working in hospitals are salaried, while those providing home care are either self-employed or salaried. Different payment systems contribute to the financing of home nursing, most importantly lump sum payment and fee-for-service (Gerkens et al., 2010).

Since April 2010, a new system of remuneration for pharmacists has come into force. The objective of this new system is to reinforce the intellectual role of the pharmacist and to partly disconnect the pharmacists’ remuneration from the drug price. The remuneration in 2014 is composed of a basic fee of € 4.16 per reimbursed product (per box) and an economic margin of 6.04% of the ex-factory price (€ 3.62 + 2% for ex-factory prices above € 60) (Gerkens et al., 2010). There are additional fees for specific pharmaceutical care.

Hospital financing in Belgium is very complex and it would lead us too far to explain this in detail. The hospital financing has a dual remuneration structure according to the type of services provided: accommodation costs, nursing activities in the nursing units, operating room, and sterilization are financed via a fixed prospective budget system; while medical services, polyclinics and medico-technical services (laboratories, medical imaging and technical procedures) and paramedical activities (physiotherapy) are mainly paid via a fee-for-service system to the health care providers who retrocede a part to the hospital. Together, these two remuneration systems account for almost 80% of a hospital’s revenue (Gerkens et al., 2010).

Hospitals receive additional funding from:
- outpatient and inpatient sale of pharmaceutical products (financed per unit or pack);
- a prospective budget for pharmaceuticals for inpatient care;
- specific ambulatory activities, such as day care, dialysis and rehabilitation, which are mainly reimbursed per patient via lump sums;
- subsidies for investments from the federated authorities (communities);
- supplements charged to patients;
- non-hospital activities, such as commercial operations and homes for the elderly, nursing homes, cafeteria, newspaper shop, etc.;
- private legacy or corporate grants. (Gerkens et al., 2010)
4. Conclusion

- Summary of Social health protection in Thailand

Next figure gives an overview of the architecture in Thailand:

![Overview of architecture in Thailand](image)


There are three schemes who covers almost the whole population of Thailand and these schemes are managed each by a social security institution: SSS for employees in the private sector is managed by SSO, CSMBs for selected workers in the public sector is managed by Comptroller General Department (CGD) of the Ministry of Finance (MoF) and UCS for persons who are not covered by the SSS and CSMBs is managed by NHSO.

The benefit package for the three schemes is very comprehensive: outpatient, inpatient, accident and emergency, dental and high-cost care, diagnostics, special investigations, medicines and medical supplies with very minimal exclusion list. The benefit package for CSMBs is slightly better than SSS and UCS. There is an important focus on primary care in UCS. UCS includes also prevention and health promotion for the whole population.

CSMBs and UCS are financed through general taxes. Workers and employers are paying social contributions for SSS, next to contributions of the government.

The Thai health care system is dominated by the public sector. Most health care providers in the public sector (hospitals and health centers) are under the MOPH. Overall, the public sector accounts for about two-thirds of total hospital numbers and total hospital beds in the country. The private sector has continued to grow over the last two decades and private health care providers are mostly concentrated in big cities and urban areas, without much regulation.

CSMBs members can go to the public hospitals of their choice, but can only go to some private hospitals in some specific situations (elective surgeries and emergency) or after referral from public hospitals (haemodialysis and radiotherapy). Patients of SSS have free choice within the contracted network of hospitals. UCS members must register with a Contracting Unit for Primary Care (CUP), based on their address. The primary health facilities are the gatekeepers of the
system. The patient first have to go to the primary health care unit before going to secondary or tertiary care, except in case of emergencies. The health care services are free at the point of delivery for UCS members and SSS members, except when they go to providers outside their network. CSMBS members don’t have to pay any co-payment except for expenses in public hospitals that are not related to the treatment (e.g. telephone costs) or when they go to private hospitals.

NHSO uses for outpatient care a capitation payment mechanism based on the number of beneficiaries registered with a provider network and a global budget allocation plus DRG for inpatient care. CSMBS adopted a fee-for-service reimbursement model as its mode of provider payment for outpatient care in public hospitals with fee schedules (ceiling prices) for some services that are listed by the MoF. A DRG based payment system via an electronic payment system is used for inpatient care in public and private hospitals, except for the items that are announced by the MoF. A capitation payment mechanism is also the main mechanism for outpatient care in SSS. For inpatient care, SSO uses DRG for all admissions. For some special high cost services, SSO pays fee-for-service based on fixed fee schedules.

- **Some personal impressions**

There are some remarkable features to the system that I have noticed during my visit and after reading documents on Thailand.

First, the historical development of the social health protection system in Thailand is very interesting. In contrast to Belgium, that followed a bottom-up process from small-scale voluntary movements to a centralized compulsory and bureaucratic health insurance system, Thailand experienced a more top-down approach controlled by the government. Two schemes were first successful to cover a part of the Thai population: SSS for employees in the private sector and CSMBS for selected workers in the public sector. But like in a lot of other countries, it was very difficult to expand coverage to the uninsured population, especially in the informal sector. Voluntary schemes were unsuccessful. But rather than changing the structure of the whole system, Thailand chose to add the UHC as another independent public health insurance scheme. The Thai UHC scheme was then to cover everyone that was not covered. This was only possible with strong political commitment. Thailand achieved universal health coverage with a relatively low share of healthcare expenditure relative to GDP (less than 4.0 % of GDP). Political involvement is perhaps more important than the financial possibilities for a country to progress to universal coverage. But without an extensive geographical coverage of health-care facilities it wouldn’t be possible neither for Thailand to reach universal health coverage in 2002. A lot of UCS members lived in rural areas and financial access is useless without physical access to services. Thailand invested during decades in the development of the district health system and his facilities and human resources.

Second, the system is fragmented. While the existence of different schemes for different population groups makes sense historically, such fragmentation inevitably leads to duplication of administrative systems and inefficiency arising from differences in payment, reporting, and monitoring arrangements. The question can be asked if these fragmentation does not lead to inequity problems due to unequal government subsidy in each scheme. This fragmentation is also a burden for health care providers who need to take into account different rules and procedures.
The Thai government is well aware of this fragmentation and put in place a committee who have to suggest policies that are related to the management of the 3 main health insurance schemes, including auditing and monitoring system of medicines, medical supplies and health care services reimbursement. There is also cooperation among the institutions of the three schemes in order to improve quality of health care and efficiency of management and resources allocation with a focus on high cost chronic diseases management (chronic renal failure, HIV/AIDS, and cancer).

Third, primary health care and family medicine is well implemented in UCS, but is less so or is even absent in CMBCS and SSS. In Belgium the development of interdisciplinary ‘community health centres’ or ‘medical houses’ has begun since a couple of years but is still very limited and mainly in urban areas. These integrated health care practices operate as a multidisciplinary team, including several GPs, administrative and reception staff, nurses, a physiotherapist and a psychotherapist. The primary care units close to the communities in Thailand are much more developed with a lot of voluntaries who are providing care for persons in the community. It was and still is a clear health policy to link universal health coverage with the development of primary care. A health system dominated by hospitals is very expensive and will have insurmountable problems to sustain. Moreover, this system is not patient-centred enough and cannot be fully responsive to people demands and needs. Thailand understood this very well though CSMBS and SSS are still focusing on hospital health care.

Finally, at last, a word on the management of the social security institutions. It was for me not very clear how strong the three social security institutions are in terms of negotiations with the health care providers, imposing rules, auditing, monitoring … But what is clear is that the expenditures of CSMBS are increasing very vast and during my visit to CGD it was pointed out that the management of CSMBS is not very strong due to insufficiency of human resources with medical knowledge, inadequacy of budget and lack of information on what is happening on the field. NHSO can more easily control costs by their close-end payment methods, but during a discussion with a responsible of NHSO it was also clear that the auditing or controlling power of NHSO is very weak and that it is very difficult to take sanctions to health care providers and especially individual doctors. Universal health coverage is an important and difficult objective to reach, but once universal health coverage of the population is reached, the work is not over to achieve an effective universal health coverage. There is still an enormous work to keep the system healthy, of good quality and sustainable for the long future.

I hope that the collaboration between NIHDI and NHSO can contribute to a better system of social health protection in both countries.
Key resources and references

- Siriruttanapruk Sat. 2006. Integrating occupational health services into public health systems: a model developed with Thailand's primary care units. Bangkok, Office IL.
- WHO, Global health expenditure database
- WHO, World Health Statistics 2014
### Annex 1: A comparison between Thailand’s three public health insurance schemes and the compulsory health insurance in Belgium

<table>
<thead>
<tr>
<th></th>
<th>Civil Servant Medical Benefit Scheme (CSMBS)</th>
<th>Social Security Scheme (SSS)</th>
<th>Universal Coverage Scheme (UCS)</th>
<th>Compulsory health insurance in Belgium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target group</strong></td>
<td>Government employees plus dependents</td>
<td>Employees in the private sector, excluding dependents, and former employees who voluntarily pay contributions</td>
<td>Everyone not covered by CSMBS or SSS</td>
<td>The whole population</td>
</tr>
<tr>
<td><strong>Population coverage</strong></td>
<td>6.7 % of the total population</td>
<td>15.4 % of the total population</td>
<td>75.1 % of the total population</td>
<td>&gt;99 % of the total population</td>
</tr>
<tr>
<td><strong>Benefit package</strong></td>
<td>A comprehensive benefit package which includes ambulatory and inpatient care at public hospitals. Inpatient care at registered private hospitals is allowed only under certain conditions and with copayments. Emergency inpatient and haemodialysis outpatient services in private hospitals, with limitations. Excludes prevention and health promotion.</td>
<td>A comprehensive benefit package which includes ambulatory and inpatient care, accident and emergency, high-cost care, with very minimal exclusion list; excludes prevention and health promotion.</td>
<td>A comprehensive benefit package: curative services, health-promotion and disease-prevention services, rehabilitation services, and services based on traditional Thai or other alternative medicine practices. The Scheme also provides personal preventive services and health-promotion services to all Thai citizens.</td>
<td>A comprehensive benefit package. Services that are covered by compulsory health insurance are described in the nationally established fee schedule.</td>
</tr>
<tr>
<td><strong>Selection of providers</strong></td>
<td>Patients can go to any public hospitals of their choice</td>
<td>Patients select one health care provider within the contracted network of hospitals.</td>
<td>Patients have to go to the registered contractor provider, notably within the district health system</td>
<td>Free choice of health care provider</td>
</tr>
<tr>
<td><strong>Payment mechanism</strong></td>
<td><strong>Outpatient care</strong></td>
<td>Capitation (number of registered insured members in the hospital multiplied by the per capita amount with a risk-adjusted formula)</td>
<td>Capitation (number of registered insured members)</td>
<td>Fee-for-service (Some capitation based financing.)</td>
</tr>
<tr>
<td><strong>Payment mechanism</strong></td>
<td><strong>Inpatient care</strong></td>
<td>DRG’s for all admissions, Fee-for-service for some special high cost services</td>
<td>Global budget allocation plus Diagnostic Related Groups (DRGs)</td>
<td>Global budget allocation plus Diagnostic Related Groups (DRGs) Fee-for-service for medical and medical-technical services</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Non contributory scheme: general taxes</td>
<td>Contributory scheme: contributions of employer, employee and government (each 1.5 % of salary) Interests</td>
<td>Non contributory scheme: general taxes</td>
<td>Social contributions, state subsidies and alternative financing (mainly from indirect tax revenues)</td>
</tr>
<tr>
<td><strong>Management Institutions</strong></td>
<td>CDG of MoF</td>
<td>SSO</td>
<td>NHSO</td>
<td>NIHDI and Sickness funds</td>
</tr>
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