CROSS-BORDER HEALTHCARE SERVICES IN THE UNITED KINGDOM UNDER EU DIRECTIVE 2011/24/EU AND REGULATION (EC) NO. 883/2004: LESSONS FOR THAILAND

BY

MISS CHAYAPHAT AMPAVAT

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF MASTER OF LAWS
IN BUSINESS LAWS (ENGLISH PROGRAM)
FACULTY OF LAW
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ENTITLED

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was approved as partial fulfillment of the requirements for
the degree of the Master of Laws in Business Laws (English Program)
on August 11th, 2016

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Academic Years	2015

ABSTRACT

At the present time, Thailand has problems that need to be solved which are inequity in accessing to healthcare services and difference of the benefits packages of insured persons under the three Thailand's healthcare models: National Health Security Scheme, Civil Servant and State Enterprise Scheme, and Social Security Scheme. The system that covers most Thai people is the National Health Security Scheme, which is aimed to create security in healthcare for all Thai people. Thai people should have efficient healthcare treatment, and they should not have problems pertaining to monetary or financial issues as an obstacle to receiving basic healthcare treatment. Besides, management in healthcare system still needs to be developed to take care of people. Patients' rights, including reimbursement right, should not be ignored but be considered in both the domestic and international perspectives.

Healthcare itself on domestic level involves complex issues, but when it is on the international context or cross-border context, it becomes even more complicated. Therefore, there should be legal mechanisms to facilitate cross-border healthcare services. The possible solution is learning from the United Kingdom under European Union's experience. EU legislation might be an appropriate model for

arrangements of cross-border healthcare services including patient's reimbursement, control quality and safety, and cooperation across borders. Many principles from EU Directive, Regulation, and European Court of Justice Rulings might be adaptable to our Thai healthcare system under the ASEAN's context such as the reference network group, e-health, quality control mechanism, providing information by establishing National Contact Points, etc.

Having inspected ASEAN's current cooperation, as the ASEAN is just in the first stage of aggregation – economic aggregation – the patients' reimbursement rights among countries in the ASEAN and healthcare cooperation on the international level still need further and heightened attention. Currently, there are cross-border arrangements between Singapore and Malaysia. In Singapore, patients can go to seek healthcare treatment in Malaysia and they can reimburse by using their Medical Savings Account registered in Singapore. This signifies that cross-border healthcare in mutual arrangements may occur more in the future.

The reasons to establish cross-border healthcare services are on grounds of the undeniability that in the current situation where people enjoy convenience to go across borders due to the advancement of technologies and lower cost of transportation fees, cross-border healthcare services are important in many perspectives, for example, helping patients receive healthcare treatment in time when their health is at mortal risk and simultaneously there is a shortage of high-technology healthcare to treat people domestically; in the case of long waiting list domestically; and it creates confidence of patients that they could receive healthcare treatment when they travel or work abroad, at least in case of emergency. Therefore, the analyses of cross-border healthcare services and health laws in Thailand under the ASEAN's context and the United Kingdom under the European Union's context would be beneficial for the development of healthcare system and heighten the quality of people's lives.

Keywords: Cross-border healthcare, Patients' rights, Healthcare services, Treatment, Reimbursement, Equity, Social security, Universal healthcare coverage, Hospitalization, Prior authorization

ACKNOWLEDGEMENTS

My master degree study at the Faculty of Law, Thammasat University, has been an invaluable experience both to my academic life and self-improvement toward the future. I have acquired abundance of knowledge and encountered a wide range of concerns that need discussions. This thesis is a product of my intellectual commitment as much as interactions with great people in the arena of Business Law. Therefore, I hereby would like to express my gratitude to the following people who have supported me all along.

Firstly, I would like to show my sincerest gratitude to my advisor Dr. Jaruprara Rakpong for her thorough guidance and recommendations on the concern of law. She has been an instructor who keeps broadening my perspective and providing insights into my studies. In consultation with her, I also obtained advice regarding future career paths which I deem priceless. Besides, studying in an international program has not been easy; nevertheless, she offered me encouragement and assisted me in language correction to improve the quality of my work.

Secondly, I would like to acknowledge the support of Director of Program Dr. Munin Pongsapan. I am indebted to his gratitude for introducing me to the method of writing a thesis which bears a great significance to formulating this piece of work. Beyond that, he has specially recommended me to scrutinize the possibility of law enforcement and look from an economic perspective in creating a well-rounded thesis.

Next, I am grateful to Committee Associate Professor Suda Visrutpitch and Dr. Niramai Phitkhae Manjit who offered me much assistance from the beginning. Both persons contributed a great deal to this thesis by framing the scope and extent for an effective outcome. In addition, the knowledge of health law built in this work was sourced from them.

Additionally, I would like to express thanks to my family and the colleagues at Roedl & Partner, Thailand, for encouraging and understanding me over the period of conducting this thesis.

And my thesis would not be fulfilled without the main supporter and my best friend forever, Mr. Napaht Chatrungrangsri, who taught me the grammatical knowledge and essay writing.

Last but not least, this thesis could not be completed without the help of Mr. Chanon Silparasmee. His provision of electronic facilities without charge was conducive to generating this thesis.

Miss Chayaphat Ampavat
Thammasat University
Year 2015

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CHAPTER 1
INTRODUCTION

1.1 Background and problems

In general, the healthcare systems can be divided into three main systems,[1] which are Bismarck system, Beveridge system, and private insurance model.[2] The Bismarck system or sickness fund is the system which employers and employees fund national health social insurance through compulsory contribution. The providers are public and private providers. The countries that apply the Bismarck scheme are Germany, France, Belgium, etc.[3] The second system is private insurance model which can only be found in the United States.[4] Its funding is based on premiums paid to private insurance companies, and predominantly, the providers are private sectors. The last model is the Beveridge system: the system which is funded from general government revenues.[5] The services are provided mainly by public health providers. It is a universal healthcare which covers all people.[6] The

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[1]Health Care for All Texas. *"Models of National Health Insurance."* http://www.healthcareforalltexas.org/models-of-health-care-systems.html, (Accessed on November 1, 2015.)

[2]Robert Kulesher, Elizabeth Forrestal. *"International models of health systems financing."* **Journal of Hospital Administration**, 2014, Vol. 3, No. 4. http://www.ecu.edu/ah/upload/Kulesher-Forrestal-2014-International-Models-of-Health-Systems-Financing.pdf, (Accessed on November 1, 2015.)

[3]Penguin Press. *"The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care."* http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html, (Accessed on November 1, 2015.)

[4]N. Lameire, P. Joffe1 and M. Wiedemann. *"Healthcare systems — an international review: an overview."* http://ndt.oxfordjournals.org/content/14/suppl_6/3.full.pdf, (Accessed on November 1, 2015.)

[5]Physicians for a National Health Program. *"Health Care Systems - Four Basic Models."* http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php, (Accessed on November 19, 2015.)

[6]Joseph Kutzin. *"Bismarck vs. Beveridge: is there increasing convergence between health financing systems?."* http://www.oecd.org/gov/budgeting/49095378.pdf, (Accessed on November 1, 2015.)

Beveridge system offers healthcare service as benefits in kind, which patients can receive healthcare services for free.[7] This system covers most people in Thailand through the "Golden card Project.

In Thailand, there are three health insurance systems,[8] which are the Social Security system (SSS), the Civil Servant system (CSS), and the National Health Security Program (NHSP).

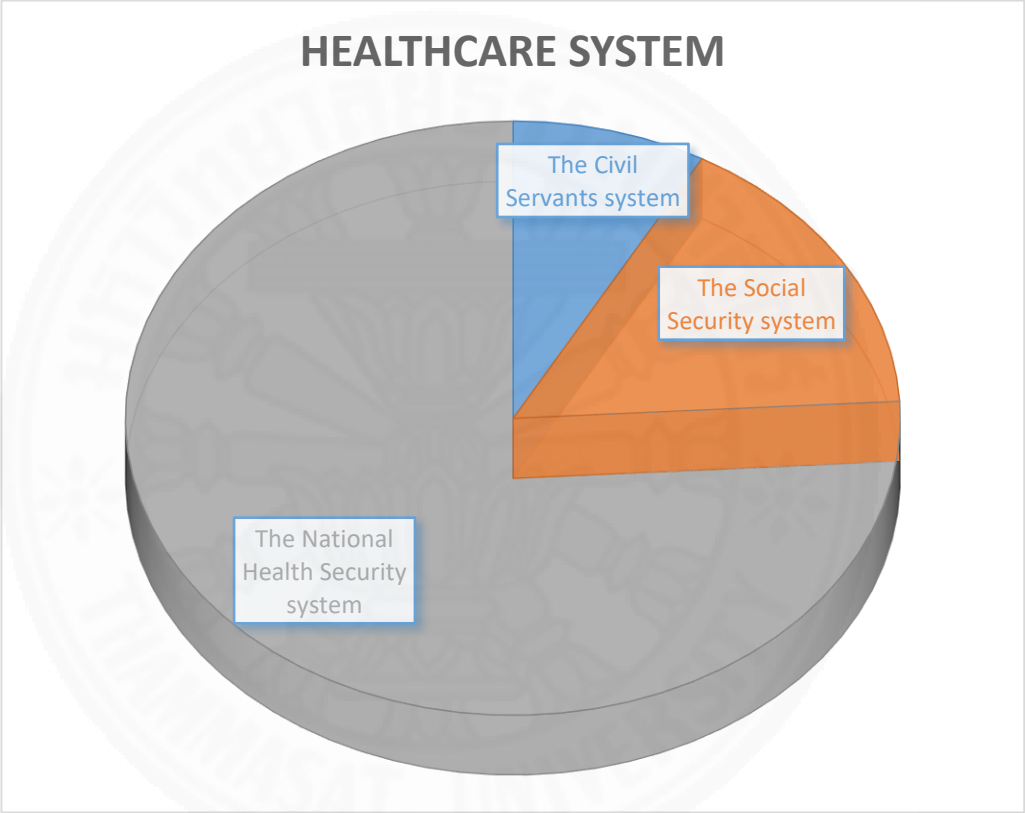

Figure 1.1 Healthcare System in Thailand

[7]Laura Nistor. *"Public Services and the European Union."* https://books.google.co.th/books?id=V_NYaVhgNzUC&pg=PA20&lpg=PA20&dq=reimbursement+system+benefit+in+kind+system&source=bl&ots=Zi3PxZqTxt&sig=vW_TSYw3sX-qRuses0dkgLev6l8&hl=th&sa=X&ved=0ahUKEwixv8SbkpLKAhWFBY4KHZlVD2IQ6AEILjAD#v=onepage&q=reimbursement%20system%20benefit%20in%20kind%20system&f=false, (Accessed on November 1, 2015.)

[8]Health Insurance System Research Office. *"Health Insurance system in Thailand."* http://www.hisro.or.th/main/?name=knowledge&file=readknowledge&id=14, (Accessed on November 19, 2015.)

The chart above illustrates population in Thailand who have the rights under each system: 5 millions people (8%) benefit from the Civil Servants system; 9.84 millions people (15.8%) benefit from the Social Security system; 47 millions people (75%) benefit from the National Health Security system, which is the Beveridge system.

In the United Kingdom the concept of the rights to healthcare has been changed from labor right to one of the human rights after World War 2. This right is embedded in the constitution.[9] Consequently, the National Health Service or NHS was set up in 1946 in order to respond to the ideal that good healthcare should be provided for all persons free of charge, except for some types of healthcare treatment that would require some charges such as prescriptions and optical and dental services. The National Health Service has a responsibility to manage the public healthcare sector in the United Kingdom with no discrimination according to the NHS Constitution.[10]

The United Kingdom is one of the twenty-eight Member States of the European Union. As a single market, people in the European Union can move around within its national territory and also outside their homeland or residence. Although, in theory, most people choose to receive healthcare in their homeland or the country of residence or the country in which they are covered or insured,[11] some of them choose to receive healthcare in other countries within the European Union.

Some people travelled within the European Union and found a necessity to get a treatment in such country within the European Union. For example, Mr. A who resides in France travelled to Germany (on vacation or business visit), and got into a car accident; he then needs to receive a healthcare treatment in Germany. Some

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[9]*Ibid.*

[10]NHS. *"Guide to the Healthcare System in England Including the Statement of NHS Accountability."* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194002/9421-2900878-TSO-NHS_Guide_to_Healthcare_WEB.PDF, (Accessed on November 19, 2015.)

[11]Department of Health of England. *"Cross-Border Healthcare and Patient Mobility in Europe."* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252940/Cross_Border_Healthcare_Information.pdf, (Accessed on November 1, 2015.)

people plan to receive a healthcare treatment in a country within the European Union due to cheaper cost, availability of expertise, or avoidance of long waiting-list in their countries. For example, Ms. B who resides in Belgium wanted to have a hip replacement, but it has to be waited for one year. She suffered from the pain and decided to have an operation in the Netherlands, due to the shorter waiting-list in there. Some people require specific medical needs or highly specialized treatments which may be not provided in their country or may be available but they have uncertainty to get those treatments in their land. These situations are examples of the various factors that patients determine to travel for care.[12]

The world is more integrated. In recent years there is an increasing mobility of patients across international borders.[13] When this phenomenon occurs, there are many legal issues arising. Variations in education and professional standard between countries may impact the quality of care. Moreover, healthcare services are not like other services because patients who receive healthcare services need continuity of care. It means patients need a follow-up in their home countries. Thus, it becomes the reason why cross-border healthcare needs collaboration and communication between countries.

Cross-border healthcare services have both positive and negative effects. In the European Union, the recent Member States such as Czech Republic, Slovakia, Slovenia, and Croatia have less potential at providing healthcare services than other Member States. And they also have problems accessing to healthcare services domestically. Thus, people from these countries choose to use healthcare services elsewhere within the European Union[14] because countries in the European Union

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[12]Willy Palm and Irene A. Glinos. *"Enabling patient mobility in the EU: between free movement and coordination."* http://www.euro.who.int/__data/assets/pdf_file/0004/138181/E94886_ch12.pdf, (Accessed on November 1, 2015.)

[13]Matthias Helbe. *"The movement of patient across border."* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3040015/#, (Accessed on November 1, 2015.)

[14]Österle A. Health care across borders: Austria and its new EU neighbours. **Journal of European Social Policy** 2007;17(2):112–24.

share similarities in language and culture.[15] They also can cross the boundaries with convenience as there is no need for visa and there are many modes of transportation. Due to the wide extension of cross-border healthcare services within the European Union, the European Union has researched problems especially reimbursement on cross-border healthcare services and launched their legislations and policies in order to achieve the goal of efficient cross-border healthcare by determining administrative procedures and establishing the reimbursement system.[16] Besides, they attempt to increase the potential of providing healthcare services with the same healthcare standard throughout the European Union, focusing on safety and quality standard.[17]

The problem is that the Member States want to control their budget on healthcare. If they allow patients to receive healthcare abroad while having to pay for higher price, it will cause the imbalance of their controlling budget. On the other hand, patients have the rights to healthcare. If the Member State cannot provide healthcare within a reasonable time, patients have the rights to seek healthcare anywhere within the European Union. In the past, the European Court of Justice established that health care is a national policy. If patients seek healthcare anywhere in the European Union, they need to be allowed by the Member State of affiliation through the pre-authorization process.

Later, pre-authorization policies were contested by citizens, who successfully challenged the refusal of national social insurance system to reimburse the costs of planned, unauthorized treatments undertaken in another Member State. ECJ decided that prior authorization acts as a barrier to the principle of free movement.[18] In the case of Watts,[19] ECJ established the principles of reimbursement for cross-border healthcare services: it should be done regardless of what system of

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[15]Legido-Quigley H, Glinos I, Baeten R, McKee M. Patient mobility in the European Union. BMJ2007 Jan 27;334(7586):188-90.
[16]Evers S, Paulus A, Boonen A. Integrated care across borders: possibilities and complexities. Int J Integr Care2001;1:e18.
[17]Cucic S. European Union health policy and its implications for national convergence. Int J Qual Health Care2000Jun;12(3):217-25.
[18]Katharine Footman. *"Cross-border health care in Europe."* http://www.euro.who.int/__data/assets/pdf_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf, (Accessed on November 19, 2015.)
[19]Case C-372/04 *Watts* [2006] ECR I-04325.

individual country is, and a treatment can proceed in spite of no prior authorization on the ground that the refusal has no justified reason. If it is not possible in the State of residence to receive a healthcare service within a period compatible with the disease and the clinical situation of the patient, the national institution cannot refuse to allow cross-border healthcare.[20] The ECJ scrutinized the ultimate goal of the freedom to supply and receive services as a higher interest.[21]

As a result from this case, the EU legislations which concern the cross-border healthcare services, including the planned care, need to be crystal-clear, to scrutinize which situations require a prior authorization, and to assure that there should not be any barriers and should be no restrictions of patients' rights to obtain cross-border healthcare. Consequently, the Directive 2011/24/EU of the European Parliament on the application of patients' rights in cross-border healthcare was launched.

The Directive has been launched to clarify the legal certainty of reimbursement criteria and also confirm the entitlement of the patients' rights when they seek healthcare services abroad in order that they acknowledge the cost and level of the cost of their medical treatment that can be reimbursed. Many essential principles of cross-border healthcare have been formed in the Directive, for instances, the doctrine of undue delay. Its definition is that the treatment must be provided within a time limit which is medically justifiable by measuring the patient current state of health and probable course of illness. It is also based upon an objective clinical assessment of the patients and their individual circumstances.[22]

The reimbursement of cost is only one of the issues of cross-border healthcare services. Beyond that, there are provisions concerning the responsibilities

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[20]Monica Cappelletti. Healthcare Right and Principle of *"Minimum Standards: The Interpretation of the Judiciary in A Comparative Perspective."* Switzerland: Springer International Publishing, 2015.)

[21]Flaminia Tacconi. *"Freedom of Health and Medical Care Services within the European Union."* http://www.zaoerv.de/68_2008/68_2008_1_b_195_208.pdf, (Accessed on November 12, 2015.)

[22]Claire Donovan and others. *"Requests For Treatment In Countries Of The European Economic Area Wales Procedure."* http://www.wales.nhs.uk/sitesplus/862/opendoc/231756, (Accessed on November 1, 2015.)

of the Member States, and the cooperation in healthcare among the Member States are comprised in the Directive as well. The EU seems to have adopted the readiness of applying its economy to make the improvement of healthcare for all European patients.[23] Accordingly, the healthcare services in the United Kingdom under the EU laws and regulations are interesting for study and research – they will be lessons for future healthcare services in Thailand which is a part of the ASEAN Economic Community (AEC).

The current situation in Thailand appears that the Thai government supports the country to be a medical hub of the Southeast Asian region. There is a medical tourism which is a sub-set of cross-border healthcare, and it generates much income to Thailand. However, there is no concrete legal instrument to facilitate cross-border healthcare services. Therefore, if we analyze the EU law, it will be useful for Thailand in creating a model law for guaranteeing the cross-border patients' rights and placing obligations on healthcare service providers.

While the Thai government's policy supports healthcare business, it also helps foreign patients on the principle of humanity. In areas near the border of Thailand, Thai hospitals and facilities are confronting with the problems of inflowing Lao patients seeking healthcare in Thailand without ability to pay for the treatment fee, thus affecting the controlling budget in Thailand. Therefore, if we have a reimbursement system, it will help Thailand manage its resource and budget more effectively and increase the potential in providing healthcare service by finding a consensus between these two countries.[24] Cooperation between healthcare providers in border regions can avoid duplicate tasks and wasting resources.

The ASEAN has initiated coordination and harmonization of laws in many areas. There is a directive concerning medical device and a cosmetic directive, while healthcare services which are important for the ASEAN's economy still lack

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[23]Miek Peteers. *"Free Movement of Patients: Directive 2011/24 on the Application of Patients' Rights in Cross-Border Healthcare."* http://booksandjournals.brillonline.com/content/journals/10.1163/157180912x615158, (Accessed on November 1, 2015.)

[24]Research Institute for Thai Healthcare Security. *"Effect of Laotian seek healthcare in Thailand."* http://www.hisro.or.th/main/modules/research/attachservices/174/Full-text.pdf, (Accessed on November 24, 2015.)

cooperation in this field to support cross-border healthcare services. The benefits will be for patients to exercise their rights within the ASEAN. Besides, it will be beneficial for managing and delivering healthcare services among the Member States in the ASEAN. Like the EU, the ASEAN also supports the free movement of services and, in the future, a plan to be a single market. The principles experienced in the EU might be useful for establishing ASEAN cross-border healthcare services structure, and it will be a guideline for Thailand and the ASEAN to implement a model law that is efficient and appropriate for Thailand and ASEAN's context.

As Thailand has the policy toward becoming a medical hub of the Asian region and participation in the ASEAN Economic Community (AEC), it is likely that legal problems regarding cross-border healthcare services might emerge in the future. These problems could be the results of patients from the neighboring countries entering Thailand to receive medical services as well as Thai residents moving or travelling to other countries in the ASEAN to seek medical treatment.

1.2 Hypothesis

Cross-border healthcare service of the United Kingdom under the EU legislation is an appropriate system and thus it is a good example for Thailand to implement its legal mechanism to facilitate cross-border healthcare service and patient mobility.

1.3 Objectives of study

1.3.1 To study and analyze the patients' rights and access to cross-border healthcare services, including the guarantee of the safety, quality, and efficiency of care that patients receive in the United Kingdom and in the Member States within EU

1.3.2 To study and analyze the legislations, both substantive and procedural provisions, in relevance to facilitating patients in receiving medical treatment in another Member State rather than their Member State of residence.

1.3.3 To study the promotion of cooperation among the Member States within the EU on cross-border healthcare services through the EU regulations and the Directive

1.3.4 To suggest suitable concepts for Thailand to enable patient mobility and to propose principles and legal criteria that tend to be compatible with Thailand's perspective in cross-border healthcare services by applying lessons learned in the United Kingdom

1.4 Scope of study

The thesis will study the cross-border healthcare system in the United Kingdom which is influenced by the EU laws, in particular regulation (EC) 883/2004 and EU directive 2011/24/EU on application of patient's right in cross-border healthcare. The writer will focus on the healthcare system in Thailand, excluding private insurance and the probable rights of Thai patients when seeking healthcare across borders in the ASEAN. However, dispute solutions will be excluded from the scope of study. And the aim of the writer is to promote the patients' right to healthcare, which does not include a care for surgical beauty.

1.5 Methodology

The writer would like to reform the current problems of Thai healthcare system to be more accessible in healthcare and to see the possible solution of cross-border healthcare in Thailand and ASEAN, the study of this thesis will be conducted through literature review and documentary research. It will obtain information from government data and other online databases. The main model law which has been chosen is the United Kingdom model as a research-target country due to three major reasons. Firstly, most people in Thailand are covered by the National Health Security which was originated from the United Kingdom since December, 1942.[25] Moreover,

[25]Brave New World. *"The welfare state."*

the United Kingdom is a Member State of the European Union which bears a similarity to Thailand which is an ASEAN's Member Country. Therefore, there might be some common grounds and legal bases that can be adapted to Thailand's context. The second reason is that the United Kingdom is an interesting country for research as it has the best performance in the field of healthcare. It is also regarded as the best country in terms of efficiency and effectiveness of healthcare.[26] And it is ranked second in safe care "equity"[27] i.e. providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographical location, and socioeconomic status.[28]

1.6 Expected results

1.6.1 Understand the legal problems regarding cross-border healthcare services in the United Kingdom under EU legislation

1.6.2 Understand certain legal mechanisms which are both substantive and procedural legislations for facilitating the free movement of patients or enabling patient mobility in cross-border healthcare services in the United Kingdom and the EU

1.6.3 Be able to suggest suitable concepts and legal mechanisms for Thailand to enable patient mobility and support cross-border healthcare services

1.6.4 Be able to propose principles and legal criteria that tend to be compatible with Thailand's perspective in cross-border healthcare services by applying lessons learned in the United Kingdom

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http://www.nationalarchives.gov.uk/pathways/citizenship/brave_new_world/welfare.htm, (Accessed on November 1, 2015.)

[26]NHS. *"Guide to the Healthcare System in England Including the Statement of NHS Accountability."* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194002/9421-2900878-TSO-NHS_Guide_to_Healthcare_WEB.PDF, (Accessed on November 19, 2015.)

[27]*Ibid.*

[28]Robert M. Mayberry. "*Improving quality and reducing inequities: a challenge in achieving best care."* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1426185/, (Accessed on November 19, 2015.)

CHAPTER 2
CROSS-BORDER HEALTHCARE SERVICES IN THE EUROPEAN UNION AND THE UNITED KINGDOM

In this chapter, the writer would like to scrutinize the cross-border healthcare services in the European Union and the United Kingdom by initially studying the rights of patients from the human rights perspective and also patients' rights in the European Union law. From these perspectives, we should be able to see how the United Kingdom system, under the European Union law, uses various legal instruments to achieve the goal of promoting patients' rights across the European Union, especially in the aspect of the cross-border patients' rights. This issue, in my opinion, is a valuable comparator for the patients' rights under Thai law under the ASEAN framework (as will be elaborated in the next chapter). Besides, the principles that we gain from this chapter will help us acknowledge useful criteria for designing a system of cross-border healthcare in the near future.

2.1 The rights to health in human rights perspective

The human rights to health mean "everyone has the right to the highest attainable standard of physical and mental health.[29] It also includes access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.[30]

The first time that healthcare was recognized as human rights is under the 1946 Constitution of the World Health Organization (WHO). Two years later, the 1948 Universal Declaration of Human Rights also stated that health is a part of right

[29]UNITED NATION. *"Human Rights."* Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx, (Accessed on November 19, 2015.)

[30]National Economic and Social Rights Initiative, New York. *"What is the Human Right to Health and Health Care."* http://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care?, (Accessed on June 10, 2016.)

to adequate standard of living.[31] From that time, other international instruments also recognized healthcare as human right. Therefore, every State ratified at least one international human rights treaties which they have committed themselves the duty of protecting the right to health.

The right to health consists of both freedoms and entitlements.

"**Freedoms** consists of the right to control one's health and body, for example, sexual and reproductive rights and to be free from interference, for example, free from torture and from non-consensual medical treatment and experimentation.

Entitlements consists of the right to a system of health protection that provides everyone an equal opportunity to enjoy the highest attainable level of health." [32]

The healthcare must meet the key human rights standards:

"1. Universal Access means that all persons can access to healthcare with equitability. Therefore, people can access to healthcare with affordability wherever and whatever they need.

2. Availability means that in all areas and all communities, there must be available healthcare infrastructures, goods, and services which are enough for all. The examples of healthcare infrastructures are hospital and healthcare facilities.

3. Acceptability and Dignity means that dignity of people must be respected. A healthcare provider must provide care for people properly depending on their gender, age, culture, and different way of rights and abilities. Privacy and confidentiality are also respected.

4. Quality means that healthcare with good quality under the control mechanism and standard guidelines is provided in an appropriate time and safe by focusing on patients as the center of cure.

5. Non-Discrimination means that all people can receive healthcare without discrimination no matter in direct discrimination or indirect discrimination.

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[31]Article 25 of the 1948 Universal Declaration of Human rights.
[32]WHO. *"Health and human rights."*
http://www.who.int/mediacentre/factsheets/fs323/en/
Fact sheet NO. 323, (Accessed on December 2015.

6. Transparency means that people can access to healthcare information easily. And the way that healthcare providers provide healthcare is organized, financed, and delivered transparently.

7. Participation means that people can have an active role in making decision concerning their health.

8. Accountability means that public and private sectors are accountable for protecting the right to health with enforceable standards, regulation, and monitoring process."[33]

In conclusion, human rights are entitlement that every country agrees to grant the right to health for its people. It must be responsible for respecting, protecting, and fulfilling the right to health. Under international instruments, countries are also bound to fulfill their obligations. Human rights including the right to health used to be discussed for arrangement and planning in international context such as in the European Union.

2.2 The rights of patients in the European Union

The originality of cross-border healthcare is based on legal rights under the international instrument such as the 2000 Charter of Fundamental Rights. The patients' rights apply to all European citizens including citizens in the United Kingdom. The Charter was created by the Active Citizen Network in 2002. The fourteen rights were established on the European Charter of Patients' Rights. Although the charter is not a law and has no legal binding,[34] many strong networks of patients' rights groups within Europe have successfully pushed forward their governments to recognize and adopt these rights. Similar patients' rights charters have been developed in other regions.

According to the European Charter of Patients' Rights, there are fourteen rights of patients, which are the confirmation that the rights of patients are considered

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[33]*Ibid.*

[34]Active Citizenship Network. *"Patients' rights have no Border."* http://www.cittadinanzattiva.it/files/corporate/europa/carta/European_Charter_of_Patients_Rights_england.pdf, (Accessed on November 19, 2015.)

legal or constitutional or human rights.[35] These rights are listed and explained as follows:

"First, right to preventive measures means that individual person has the right to an appropriate service so as to prevent illness. For example, vaccinations, and adopting a healthy lifestyle. For example diet, avoidance of smoking, avoidance of excess alcohol, avoidance of drug abuse. This right refers to the right to health of human rights.

Second, right of access means that individual person has the right of access to the health services that his or her health needs require. The health services must guarantee equal access to everyone, without discriminating on the basis of financial resources, place of residence, kind of illness or time of access to services. This right refers to the right to non-discrimination and equality of human rights.

Third, right to information means that each person has the right to access to all kind of information concerning their state of health, the health services and how to use them, and all that scientific research and technological innovation makes available. The patients can obtain the information about their right to healthcare within the European Union by contacting their national contact point, which is the unit to facilitate cross-border healthcare overall the European Union. This right refers to the right to information of human rights.

Fourth, right to consent means that each person has the right of access to all information that might enable him or her to actively participate in the decisions regarding his or her health; this information is a prerequisite for any process and treatment, including the participation in scientific research. This right refers to the right to bodily integrity, right to liberty and security of person, freedom from torture and cruel, inhuman, degrading treatment, right to privacy, and right to health of human rights.

Fifth, right to free choice means that each individual has the right to freely choose from among different treatment procedures and providers on the basis of enough information. The patients have the rights to receive the healthcare service in another Member State which they are satisfied. However, patients need to ask for

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[35] *Ibid.*

prior authorization in some type of medical treatment that has been determined by the Member State of affiliation's legislation. For example, if the patients want the reimbursement of treatment C, the treatment C is provided in the Country F's legislation that if the patients want to get the reimbursement, the patients have to get the permission by Country F (the Member State of affiliation) first. So, the patients must be granted by the authority the prior-authorization. This right refers to the right to bodily integrity, right to liberty and security of person, freedom from torture and cruel, inhuman, degrading treatment, right to privacy and right to health of human rights.

Sixth, right to privacy and confidentiality means that each individual has the right to the confidentiality of personal information, including information regarding his or her state of health and potential diagnostic or therapeutic procedures, as well as the protection of his or her privacy during the performance of diagnostic exams, specialist visits, and medical or surgical treatments in general. Besides, the patients have the right to obtain a copy of their medical record (paper form or electronic form) in order to assure the continuing of care, when they want to be treated by another healthcare provider. This right refers to the right to privacy of human rights.

Seventh, right to respect of patients' time means that each individual has the right to receive necessary treatment within a swift and predetermined period of time. If the Member State of affiliation cannot provide the medical treatment to the patients without undue delay. The patients have the right to receive the medical treatment in another Member State with the expense reimbursed by that Member State of affiliation. This right applies at each stage of the treatment. This right refers to the right to health of human rights.

Eighth, right to the observance of quality standards means that each individual has the right of access to high quality health services on the basis of the specification and observance of precise standards. This right refers to the right to health and right to life of human rights.

Ninth, right to safety means that each individual has the right to be free from harm caused by the poor functioning of health services, medical malpractice and

errors, and the right of access to health services and treatments that meet high safety standards. This right refers to the right to health and right to life of human rights.

Tenth, right to innovation means that each individual has the right of access to innovative procedures, including diagnostic procedures, according to international standards and independently of economic or financial considerations. This right refers to the right to health and right to benefit of scientific progress of human rights.

Eleventh, right to avoid unnecessary suffering and pain means that each individual has the right to avoid as much suffering and pain as possible, in each phase of his or her illness. This right refers to the right to health and freedom from torture and cruel, inhuman, degrading treatment of human rights.

Twelfth, right to personalized treatment means that each individual has the right to diagnostic or therapeutic programs tailored as much as possible to his or her personal needs. This right refers to the right to health and right to non-discrimination and equality of human rights.

Thirteenth, right to complain means that each individual has the right to complain whenever he or she has suffered harm and the right to receive a response or other feedback. This right refers to the right to remedy of human rights.

Fourteenth, right to compensation means that each individual has the right to receive sufficient compensation within a reasonably short time whenever he or she has suffered physical or moral and psychological harm caused by a health service treatment. This right refers to the right to remedy of human rights."[36]

2.3 The European Union and healthcare

There is an argument that the European Union has the competence to act in the field of healthcare or not. In the Treaty of Maastricht, the European Union institutions have no crystal-clear competence in the area of healthcare. Later, many treaties were amended, and these

[36]Active Citizenship Network. *"Patients' rights have no Border."* http://www.cittadinanzattiva.it/files/corporate/europa/carta/European_Charter_of_Patients_Rights_england.pdf, (Accessed on November 19, 2015.)

treaties tried to create an area of law that the competence would be shared between the European Union and its Member States. The issues became clear following the implementation of the Lisbon Treaty of 2009 which illustrates the integration of healthcare services in the European Union.

One of the main works of the Union shall be the creation of an internal market. This internal market rule is one of the rules that the Union applies to regulate the healthcare.[37] "The Union shall establish an internal market. It shall work for the sustainable development of Europe based on balanced economic growth and price stability, a highly competitive social market economy, aiming at full employment and social progress, and a high level of protection and improvement of the quality of the environment. It shall promote scientific and technological advance…"

The competence in public health elements shall be shared between the European Union and the Member States.[38] And The Union shall have competence to carry out actions to support, coordinate or supplement the actions of the Member States regarding the protection and improvement of human health.[39] Article 168 of the TFEU is provided for the cooperation between the Member States in the area of health, which states that "The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas." And the Union action shall complement the national policy.

However, the concluding paragraph of Article 168 states that the responsibilities in organizing healthcare belong to the Member States. "Union action in the field of public health shall fully respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care and the allocation of the resources assigned to them."

Consequently, the Member States are interested in keeping their powers to regulate their own healthcare because healthcare expense is an important matter in

[37]Article 3 of TFEU.
[38]Article 4 of the TFEU.
[39]Article 6 of the TFEU.

controlling national budget. The European Court of Justice has confirmed the respect of national responsibilities in the field of healthcare. The rulings state that healthcare is not harmonized at EU level. It is the national rules to determine in the following matters:

-the conditions relevant to the right and duty to be insured with a social security scheme

-which insurance schemes are offered for each Member State's citizens

-the terms and conditions for patient's entitlement and benefits

Later, the social security coordination Regulation 1408/71 was launched to confirm the right to receive healthcare in another Member State at the expense of the Home State.

2.3.1 Patients' free movement rights under EU legislation

In European Union, there is the development of patients' rights in cross-border healthcare. Formerly, cross-border healthcare is considered as the granting system or the country of person that are insured must give the permission to patients to obtain healthcare aboard to reimbursement the expense of planned treatment. Currently, the patients' rights in cross-border in the European Union are clearer with the more concrete criteria in the form of EU Directive and EU Regulations.

2.3.1.1 Patients' free movement rights under EU regulations

The Regulation 1408/71 on the application of social security schemes to employed persons and their family moving within the community and its implementing Regulation 574/72 set out the right to receive healthcare in another Member State at the expense of the Home State. It is the first time of establishing entitlements to social security benefits for citizens who move to another Member State. The main purpose of the Regulations is to make sure that insured persons do not lose their social security protection when moving to another Member State. The regulation has been applied to citizens who have a nationality of the Member State, stateless persons, refugees who reside in the Member State, and also their family members. The regulation 1408/71 is not applied only to employed persons but also self-employed persons, civil servants, and students.

Not only the Member States of the European Union are covered by this regulation, nationals from Iceland, Liechtenstein, and Norway are also covered by way of the European Economic Area (EEA) Agreement.

The regulation was replaced by the social security Regulation 883/2004, with detailed procedural and administrative matters being dealt with in Regulation 987/2009. These regulations are called modernized coordination of the social security systems in the European Union. Yet, the social security systems of the Member States within the European Union were not harmonized due to the difference in each country's system and their individual cultural root.

As a result, every Member State is free to decide who is to be insured under its legislation, whose benefits are permitted, and what conditions are to be met, how these benefits are calculated, and the amount of premium that should be paid.[40] A person to seek healthcare in another Member State is entitled to the benefits in kind provided in its national legislation. The regulations aim at ensuring access to healthcare in various situations such as temporary stay abroad and residence outside the competent Member State (Article 19). The Regulations also include provisions for planned healthcare (Article 20).

(1) Necessary treatment when patients stay in another Member State

The persons urgently require medical benefits when they are abroad (just temporary) can present European Health Insurance Card (EHIC) to obtain state-funded medical treatment at a respective medical facility where emergency treatment is needed. EHIC is issued by each national health insurance provider considered by the country of residence.

For example, Mr. Z who resides in France was taking a vacation in Germany. He got into a car accident. His legs were injured. He needs a leg operation. He can present EHIC in order to obtain medical treatment in a state

[40]International Labour Organization. *"Coordination of Social Security Systems in the European Union: An explanatory report on EC Regulation No 883/2004 and its Implementing Regulation No 987/2009."* http://www.ilo.org/wcmsp5/groups/public/---europe/---ro-geneva/---sro-budapest/documents/publication/wcms_166995.pdf, (Accessed on November 19, 2015.)

hospital in Germany. He does not have to pay upfront because the cost will be paid by France. No prior authorization for treatment is required.

(2) Planned treatment in another Member State

The persons intending to access to medical treatment in another Member State require prior authorisation.[41]

"The insured persons and members of their family travelling to another Member State with the aim of receiving benefits in kind during the stay must seek an authorisation from the competent Member State." [42]

The person shall receive the benefits in kind that are provided by the Member State of treatment as if he was insured under the Member State of treatment's legislation.[43] The costs for treatment are mostly paid by the Member State of affiliation to the Member State of treatment directly. If the prior authorization is granted, the patients do not need to pay upfront.

The Member State of affiliation has to grant prior authorization when these following two conditions are met.

-the planned treatment is under the benefits provided in the Member State of affiliation.

-the planned treatment cannot be provided in the Member State of affiliation within a medical justifiable timeframe by considering the current state of patient's health and the probable course of illness.[44]

The ECJ confirmed that EU community law does not affect the power of the Member States to organize their social security systems.

Later, in the case of Kohl, the regulation was challenged by the free movement of services under the Treaties. The internal market rule is one of

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[41]Primary Care Commission. *"Seeking Healthcare in Europe."* http://www.pcc-cic.org.uk/external?url=http://www.england.nhs.uk/ourwork/part-rel/x-border-health/europ-x-border-health/, (Accessed on November 28, 2015.)
[42]EUROPEAN COMMISSION. *"Guidance note of the Commission services on the relationship between Regulations on the coordination of social security systems and Directive on the application of patients' rights in cross border healthcare.",* (Accessed on May 21, 2012.
[43]Paragraph 2 of Article 20 of Regulation (EC) 883/2004.
[44]Article 56 of the TFEU.

the rules that the ECJ applied to the case and explained its interaction with the social security coordination regulation.

2.3.1.2 The internal market of the European Union

The internal market of the European Union is based on four freedoms: free movements of goods, persons, services, and capital. In order to achieve the four key freedoms, cross-border healthcare must be succeeded.

(1) Free movement of services

"The free movement of service prohibits restriction on the freedom of providing service within the Union."[45] Article 57 of TFEU specifies the services that are under the scope of the Treaty: The service that has an economic link between service provider and service recipient. The service provider getting remuneration from the service recipient falls into the scope of the Treaty. The ECJ's ruling states that medical service is under the scope of Article 57 of TFEU.

In the case of *Kohl*, Mr. Kohl who has a Luxemburg nationality took his daughter to receive dental treatment in Germany. But before his daughter went to Germany, she had not asked for prior authorization which was a necessary requirement when receiving the planned care in another Member State under the regulation 883/2004.

The ECJ states that national rules on prior authorization which fall within the social security regulation are not an excuse to exclude the application of the treaty rules from the free movement of services. The prior authorization is a barrier to the freedom of providing services. On the other side, Luxemburg argued that prior authorization is the way that its State applied to avoid financial risk and ensure a balanced medical service available for all.

The ECJ decided that the prior authorization is a breach of the treaty rules on the free movement of services. Besides, the money that Mr. Kohl asked for reimbursement is equal to the rate in Luxemburg. There is no financial risk for the social security system.

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[45] *Ibid.*

Therefore, the treaty rules prevail the secondary legislation, and the free movement of services prevails the prior authorization in maintaining financial expense of state budget in each Member State.

The ECJ's ruling provides a new route for claiming reimbursement. Although patients do not have to seek prior authorization before going to receive medical treatment in another Member State, patients can claim for reimbursement up to the rate of their home Member State. When comparing to the claim under Regulation 883/2004, if prior authorization is granted, patients can claim for full amount of medical treatment cost.

The ECJ sets the new approach that patients can reimburse their medical treatment cost. However, there are still some questions that need to be answered. For instance, whether this approach can apply to hospital treatment or not.

In the case of *Vanbraekel*, a woman was insured in Belgium and received hospital treatment in France. The court stated that healthcare falls within the scope of free movement of services and there is no need to exclude hospital service from this free movement of services. Therefore, this approach (claiming reimbursement under the Treaty) can be applied to hospital service as well.

In the case of *Yvonne Watts*,[46] Ms. Watt was diagnosed with osteoarthristis. Due to the long waiting list in her British local hospital, she had to wait for one year to get a hip replacement. Therefore, she decided to receive medical treatment in France although prior authorization had been refused by the British authority. The ECJ granted reimbursement for her based on the doctrine of undue delay, since the British hospital cannot provide the medical treatment to its patient by appropriate time when considering the health state of the patient and the probable course of illness.

In the case of *Commission v France*, in France patients who seek healthcare abroad have to ask for a prior authorization granting if they need major medical equipment. The court stated that the restriction of prior authorization when the patients need to use major and expensive equipment is reasonable.

[46]Case C-372/04 *Watts* [2006] ECR I-04325.

Therefore, it is justifiable to restrict the patients to ask for prior authorization in the case that major and costly equipment is needed.

The ECJ has ruled many principles concerning cross-border healthcare. However, there is still reluctance, and all those rules have to be clarified systematically in order to ensure the entitlements of patients receiving healthcare in other countries within the European Union. Therefore, there was a preparation that healthcare service is to be under the Service Directive or Bolkestein Directive (Directive 2006/123/EC on services in the internal market), which reflects European Union's endeavor to foster its free movement like other services. But this preparation was not carried out. The European Parliament and the council voted the healthcare service out of the scope of the Service Directive, because of the complication of the nature of healthcare service and the sensitivity of this area by public opinion. The council also considered that patients are not ordinary consumers but they are in vulnerable position.[47] Later, cross-border healthcare service was presented in another separate Directive, which is Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.

2.3.1.3 Directive 2011/24/EU on the application of patients' rights in cross-border healthcare

In addition to the ECJ's ruling, Directive 2011/24/EU was established to ensure the free movement of healthcare services by placing Member States' responsibilities at delivering and organizing healthcare services, and to establish a legal framework in safe, high quality, and efficient cross-border healthcare in the European Union.[48]

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[47]European Patients Forum. *"EU Directive 2011/24/EU on the application of patients' rights in cross-border healthcare: Legislation Guidance for Patient Organisations."* http://www.eu-patient.eu/globalassets/policy/cross-borderhealthcare/2013-11-18_cbhc_guidance-final.pdf, (Accessed on November 15, 2015.)

[48]The European Commission. DIRECTIVE 2011/24/EU on the application of patients' rights in cross-border healthcare. http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF, (Accessed on November 19, 2015.)

The Directive covers all healthcare services provided by health professionals to patients to assess, maintain, and restore their health, including the prescription and dispensation of medical products and medical devices.

The Directive comprises a legal framework focusing on these following three main areas:

-Establishing the rules which are relevant to reimbursement of costs of cross-border healthcare

-Granting responsibilities to the Member States concerning cross-border healthcare

-Establishing cooperation among the Member States regarding the healthcare systems

Comparison between patients' rights under Regulation (EC) 883/2004 and the Directive

Coverage	**Regulation (EC) 883/2004**	**the Directive**
Planned Treatment	Yes	Yes
Unplanned Treatment	Yes (By using EHIC)	Yes
Obtain treatment in state-run healthcare provider	Yes	Yes
Obtain treatment in private healthcare provider	No	Yes
Require prior authorization	Yes, always in the case of planned treatment.	No, only some treatment
Require payment in full up front	No	Yes
The amount of reimbursement	Full costs	Equal to the cost in Member State of affiliation, not exceeding the actual cost.

Table 2.1: Patients' rights under Regulation (EC) 883/2004 and the Directive

2.4 EU legal framework in cross-border healthcare under the Directive: Key elements in the Directive and their implementation in National Health Service (Cross-border healthcare) Regulations 2013[49]

The National Health Service (Cross-border healthcare) Regulations 2013, hereafter called the Regulation, is a statutory implementation of the Directive. Its definition of healthcare is "health services provided by health professionals to patients to assess, maintain or restore their state of health, and includes the prescription, dispensing and provision of medicinal products and medical devices."[50]

2.4.1 Control and promotion of healthcare business

In the EU Directive, there are provisions to describe service provider's obligations and the provisions of affirmation of quality and safety in healthcare. The details are as follows.

2.4.1.1 Healthcare service provider's obligations[51]

In order to ensure that cross-border healthcare can proceed with efficiency and patients can access to healthcare with a guarantee of their rights, the rights of patients must be protected, although they receive healthcare in other Member States within the European Union. The Directive places the obligations to healthcare service providers.

In the United Kingdom, most healthcare providers have to register to the Care Quality Commission (CQC). The CQC regulates healthcare service providers to meet the requirements that are set in the Directive as follows: [52]

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[49]2013 No. 2269 National Health Service, England And Wales The National Health Service (Cross-Border Healthcare) Regulations 2013, implement provisions of Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252944/NHS_cross_border_regulations_2013.pdf, (Accessed on May 17, 2016.)

[50]2013 No. 2269 NATIONAL HEALTH SERVICE, ENGLAND AND WALES The National Health Service (Cross-Border Healthcare) Regulations 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252944/NHS_cross_border_regulations_2013.pdf, (Accessed on May 17, 2016.)

[51]Healthcare provider means natural or legal person e.g. company legally providing healthcare in the territory of the Member State.

"1. The service providers must give the related information on treatment alternatives and quality and safety to the patients.

2. The service providers must give the information about the price and invoice. Healthcare service providers cannot charge the price because the patients reside in another Member State rather than the Member State of treatment.

3. The service providers must set the fee based on non-discrimination criteria. When comparing incoming patients and the domestic patients, the price must be calculated equally. When there is no domestic patient fee that would help in the comparison, the fee must not be calculated subjectively.

4. The service providers must assure that there are complaint processes, or process to get the compensation, and ensure the legal mechanisms of dispute settlement.

5. The service providers must respect patients' privacy and supply the patients with a copy of medical record in order to be beneficial for continuity of care.

6. The service providers must register a healthcare professional liability insurance or other systems that have equal standard.

7. The service providers must respect the privacy of patients including their personal information."

2.4.1.2 Ensure quality and safety in healthcare[53]

The service providers must conform to the law both in the Member State of treatment and the European Union law. Every Member State in the European Union must supply the patients with information through its National Contact Point.[54] The information that the National Contact Point has to provide consists of the following issues:[55]

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[52]Department of Health of England. *"How the Directive affects your NHS trust How to manage payment pathways for visiting European patients."* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/349219/Information_about_the_cross-border_healthcare_directive_final.pdf, (Accessed on December 02, 2015.)

[53]Article 4(1) of the Directive.

[54]Article 2 (1) of the National Health Service (Cross-Border Healthcare) Regulations 2013, "National contact point: designation".

(1) The National Contact Point shall give the information about the quality and safety standard to the patients both under its Member State's law and the European Union law.

(2) The National Contact Point shall give the information on provisions for the supervision and assessment of healthcare professionals.

(3) The National Contact Point shall give the information on the standard of each healthcare provider and the restriction of its practice.

(4) The National Contact Point shall give the information on hospital accessibility for disabled persons.

The patients who will go to receive medical treatment abroad can check credentials of the providers by contacting the National Contact Point. This will help the patients make the right decision on the healthcare that they will receive abroad whether it is safe and satisfies their need.

For example, Mr. A who lives in France wants to receive treatment Z in Greece. But he is not sure that the doctor A who is in a Greek hospital can provide the treatment Z in the same standard as the treatment Z in France. Therefore, he asks the National Contact Point in Greece to get the information about the standard of treatment Z in Greece. Also, he can check the credentials of doctor A to make sure that he can obtain a safe care.

2.4.2 The rights of patients in cross-border healthcare

In the European Union, there is the confirmation of entitlement of patients' rights across borders and also the criteria of reimbursement having been set in the EU legislation; the details of which have been developed and interpreted by the main actor - the European Court of Justice.

2.4.2.1 Entitlement of patients' rights

Patients are entitled to reimburse for the medical treatment cost if they are entitled to reimburse that medical treatment in the Member State of

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252944/NHS_cross_border_regulations_2013.pdf, (Accessed on May 17, 2016.)

[55]Article 3 of the National Health Service (Cross-Border Healthcare) Regulations 2013, *"NCP: information about treatment in England and Wales."* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252944/NHS_cross_border_regulations_2013.pdf, (Accessed on May 17, 2016.)

affiliation. Therefore, the patients' entitlement is under the scope of the benefits in their Home Member State.[56] The rights of patients are in accordance with the sentence stating that *"If you are entitled to it here, you can get it there."*[57]

In order to guarantee the rights of patients,[58] the law or administrative procedure in the Member State of affiliation has to explicitly and clearly say about what the citizen's entitlement is by defining types of medical treatment. If the same medical treatment does not exist in the Member State of affiliation, the Member State of affiliation must consider that the medical treatment is corresponding to the benefits provided in its legislation. If the medical treatment is corresponding to the benefits provided in its legislation, the patients have the right to reimbursement such medical treatment.

2.4.2.2 Reimbursement of costs in cross-border healthcare[59]

Reimbursement of costs in cross-border healthcare or the amount of reimbursement is explained here to describe the rights to reimbursement of patients when they seek healthcare abroad as well as the terms and conditions that they must follow before obtaining such reimbursement.

(1) The right to reimburse under the insurance that the patients are insured

Member States have the discretion in clarification of their own details in the Social Security "benefits basket", which is composed of the provided benefit, the eligibility condition, and the reimbursement status of the benefits. The costs of treatment that patients can claim abroad within the European Union are equal to the costs they can get in the Member State of affiliation, but not exceed the actual amount that they pay. If the cost exceeds, the patients have to be responsible for that exceeding cost themselves.

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[56]Article 7(Recital 33) of the Directive.
[57]*Supra Note 7*.
[58]Article 4, 5, and 6 of the Directive.
[59]Article 7(3) of the Directive and Article 7 of the National Health Service (Cross-Border Healthcare) Regulations 2013.

For example, Mr. X resides in country Y, which is his Member State of affiliation. In country Y, Treatment Z costs €500, and Mr. X have the right to reimburse the costs of €300.

-In country A, the treatment Z costs €520. The patient will still receive €300 reimbursement. Therefore, the total cost of the treatment that the patient has to pay himself is €220.

-In country B, the treatment Z costs €310. The patient will still receive €300 reimbursement. Therefore, the total cost of the treatment that the patient has to pay himself is €10.

-In country C, the treatment Z costs €200. The patient will receive only €200, which is the actual cost of the treatment. Therefore, the total cost of the treatment that patient has to pay himself is none.

Other costs such as accommodation and transportation tickets cannot be reimbursed; the patients have to pay themselves. But the Member States may reimburse for such extra cost in case of disabled persons. For example, regarding the disabled persons who need another person for their assistance, the cost of an assisting person can be reimbursed depending on the Member State of affiliation's policy.

(2) The right to reimburse under the insurance that the patients are insured: methods to determine reimbursement rate for Diagnosis Related Groups in United Kingdom and the European Union

According to the provision of the Directive, patients have the right to reimburse only the amount equal to the reimbursement rate under their insurance system. How those Member States set the price for the reimbursement is an important key to make a fair and just price when they claim reimbursement after coming back from seeking healthcare overseas.

Almost half a century ago, DRGs was a similar grouping system which does not need plenty of information. Most of the Member States in the EU used to determine the hospital reimbursement by this system.

Country	*Year of DRG introduction*	*Original purpose(s)*	*Principal purpose(s) in 2010*
Austria	1997	Budgetary allocation	Budgetary allocation, planning
England	1992	Patient classification	Payment
Estonia	2003	Payment	Payment
Finland	1995	Description of hospital activity, benchmarking	Planning and management, benchmarking, hospital billing
France	1991	Description of hospital activity	Payment
Germany	2003	Payment	Payment
Ireland	1992	Budgetary allocation	Budgetary allocation
Netherlands	2005	Payment	Payment
Poland	2008	Payment	Payment
Portugal	1984	Hospital output measurement	Budgetary allocation
Spain (Catalonia)	1996	Payment	Payment, benchmarking
Sweden	1995	Payment	Benchmarking, performance measurement

Figure 2.1 Years of introduction and purposes of DRG systems[60]

Diagnosis Related Groups does the function of categorizing patient classification to inform that the patients who get the same disease or group of diseases will spend a similar period of time; in other words, identifying how much time that the patients who got the same disease will spend and how much resources will be used. There are three processes for setting the price as the following details:

"1. Definition of data sample

2. Use of trimming methods and possibility checks

3. Definition of price" [61]

[60]European Observatory on Health Systems and Policies Series. *"Diagnosis-Related Groups in Europe Moving towards transparency, efficiency and quality in hospitals."* http://www.euro.who.int/__data/assets/pdf_file/0004/162265/e96538.pdf, (Accessed on June 10, 2016.)

[61]Jonas Schreyögg. *"Methods to determine reimbursement rates for diagnosis related groups (DRG): A comparison of nine European countries. Health Care Management Science."* August 2006, Volume 9, Issue 3, pp 215-223, http://link.springer.com/article/10.1007%2Fs10729-006-9040-1, (Accessed on June 01, 2016.)

The main purposes of Diagnosis Related Groups are described as follows:

1. To encourage efficient healthcare service delivery

2. To discourage the provision of unnecessary services so as to overcome some disadvantages of traditional hospital reimbursement system

3. To enable a case payment system that implements both balanced incentives and a methodologically reasonable system.

4. To precisely illustrate the resources and costs of treating a group of similar patients.

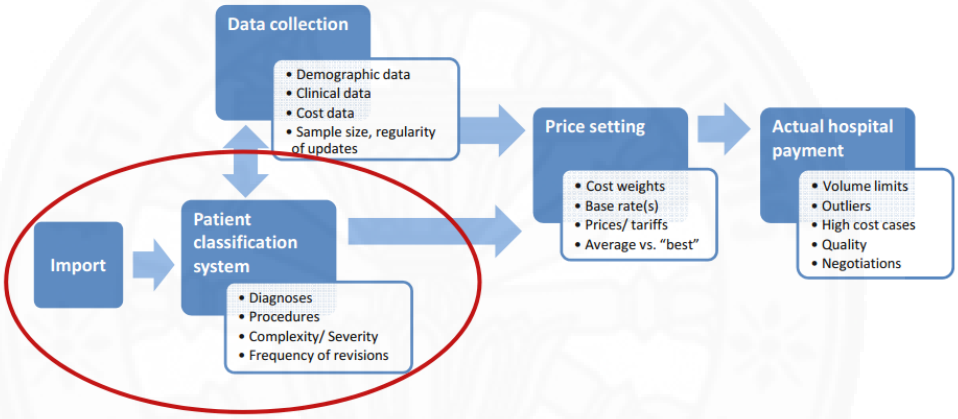

Figure 2.2 DRGs process[62]

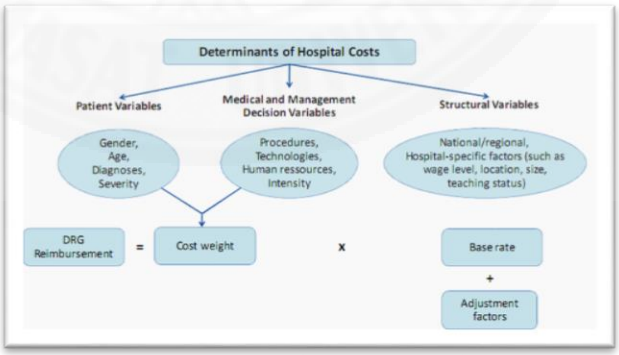

Figure 2.3 Determinants of Hospital Costs

[62]Dipl.-Ing. Alexander Geissler. *"Provider Payment Improvements in Selected Regions of the Russian Federation: Feasibility Analysis and Preliminary Recommendations Implementation of DRG in Europe."* https://www.mig.tu-berlin.de/fileadmin/a38331600/2012.lectures/Moskow_2012.04.25.pdf, (Accessed on June 10, 2016.)

Remark: DRGs systems differ greatly between European Member States due to the difference in patient classification systems and adjustment of cost weight or conversion rates. [63]

1. The First Stage is Data Collection

The information that is needed for DRGs development is composed of production of the hospital; diagnosis, procedure code, age, sex; the characteristics of hospital; size, geography, status such as teaching hospital; capital information of hospital, labour, material, capital, etc.

In this stage of data collection, there are needs of clinical data which is the classification system for diagnoses and procedures; cost data which can be imported or collected within the country and is required for standardizing cost accounting; and sample size and update, which may come from the whole population or just a small group of people.

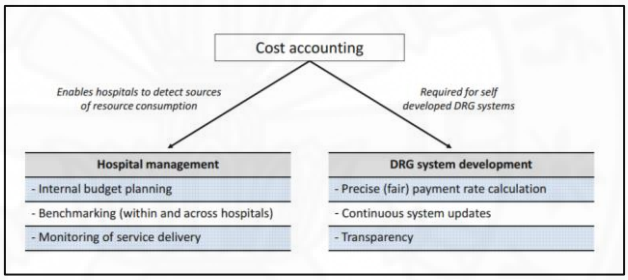

Figure 2.4 DRGs improves the cost accounting utilization[64]

[63]Diagnosis-Related Groups in Europe. *"Towards Efficiency and Quality."* http://eurodrg.eu/about.html, (Accessed on June 10, 2016.)

[64]Dipl.-Ing. Alexander Geissler. *"Provider Payment Improvements in Selected Regions of the Russian Federation: Feasibility Analysis and Preliminary Recommendations Implementation of DRG in Europe."* https://www.mig.tu-berlin.de/fileadmin/a38331600/2012.lectures/Moskow_2012.04.25.pdf, (Accessed on June 10, 2016.)

Country	Presence of mandatory cost accounting system	Presence of national costing guidelines	Presence of own cost data
Austria	---	---	X
England	X	X	X
Estonia	---	---	X
Finland	---	---	X
France	---	X	X
Germany	---	X	X
Ireland	---	X	---
Poland	---	---	---
Portugal	X	X	---
the Netherlands	X	X	X
Spain/Catalonia	---	---	---
Sweden	---	X	X

Figure 2.5 The United Kingdom is the country that has the cost guideline

According to the chart above, the United Kingdom is the country that has the cost guideline by having compulsory cost accounting system, national costing guidelines, and own cost data.

The method that the United Kingdom uses is the number of cost collecting hospital of all hospitals. Overhead allocation uses direct method. Indirect cost allocation uses the weighting of statistics. And data checking on the reported cost data has been inspected by national officers every year.

2. The Second Stage is price setting

Price setting is based only on good quality data. The imported data cannot be based on. The calculation method comes from the function of cost weights multiplying base rate or the tariff plus adjustment.[65]

	"cost weight" (varies by DRG)	"base rate" or adjustment
Relative weight (e.g. Germany)	1.0	€ 3000 (+/-) (varies slightly by state)
Raw tariff (e.g. France)	€ 3000	1.0 (+/-) (varies by region and hospital)
Raw tariff (e.g. England)	£ 3000	1.0 – 1.32 (varies by hospital)

Table 2.2 DRG's price setting

[65]Dipl.-Ing. Alexander Geissler. *"Provider Payment Improvements in Selected Regions of the Russian Federation: Feasibility Analysis and Preliminary Recommendations Implementation of DRG in Europe."* https://www.mig.tu-berlin.de/fileadmin/a38331600/2012.lectures/Moskow_2012.04.25.pdf, (Accessed on June 10, 2016.)

Note: 1. **RW** stands for Relative Weight meaning the average rate of resource uses in patients cure according to DRGs. It is the comparison of the average cost of all patients cure.

2. **Base rate** comes from the amount of money paid per unit or the relative weight adjusted from the number of days spent on staying in hospital.

3. The final stage is the result of actual hospital payment (or reimbursement rate)

According to EuroDRG Website,[66] which informs about DRGs in the European Union, it is found that many European DRG systems may get lost in their policy by focusing too much on uniquely refining the medical classification of DRGs. Besides, over the last decade the Europeanization of health service markets put pressure on national reimbursement systems.

2.4.2.3 Prior authorization[67]

The Member State of affiliation may provide a system of prior authorization for reimbursement of costs of cross-border healthcare.[68] But the Member State has to publish the information[69] pertaining to the specified medical treatments which require prior authorization.[70] And those specified medical treatments must be in accordance with the conditions in Article 8(2) of the Directive, which states that "the healthcare that may be subject to prior authorization shall be limited to healthcare which:[71]

(a) is made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality

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[66]Diagnosis-Related Groups in Europe. *"Towards Efficiency and Quality."* http://eurodrg.eu/about.html, Acceessed on June 10, 2016.)

[67]Section 7(6)(a)(b)(c) of the National Health Service (Cross-Border Healthcare) Regulations 2013.

[68]Article 8 of the Directive.

[69]National Health Service, England National Health Service (Cross-Border Healthcare) (England) Directions 2013. *"Duty to publish information about healthcare services subject to prior authorization."* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497073/Cross_Border_Directions.pdf, (Accessed on June 10, 2016.)

[70]Article 4 of the National Health Service (Cross-Border Healthcare) (England) Directions 2013 in exercise of the powers conferred by section 6D of the National Health Service Act 2006(a).

[71]Article 8(2) of the Directive.

treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical, and human resources and:

(i) involves overnight hospital accommodation of the patient in question for at least one night; or

(ii) requires use of highly specialized and cost-intensive medical infrastructure or medical equipment;

(b) involves treatments presenting a particular risk for the patient or the population; or

(c) is provided by a healthcare provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care, with the exception of healthcare which is subject to Union legislation ensuring a minimum level of safety and quality throughout the Union."

The prior authorization can be refused only on grounds of the following conditions:

-the patient would be exposed to an unacceptable risk that outweighs the potential benefit from cross-border healthcare.

-the treatment would expose the general public to a safety hazard.

-the healthcare provider is suspected of not respecting safety and quality standards.

-the healthcare can be provided at home within a justifiable time limit.[72]

The justifiable time limit is determined on an objective medical assessment of the patient's condition, patient's history, probable course of their illness, the degree of pain, and the nature of the disability.[73]

[72]Article 8(6) of the Directive.

[73]European Patients Forum. *"EU Directive 2011/24/EU on the application of patients' rights in cross-border healthcare: Legislation Guidance for Patient Organizations."* http://www.eu-patient.eu/globalassets/policy/cross-borderhealthcare/2013-11-18_cbhc_guidance-final.pdf, (Accessed on November 26, 2015.)

Figure 2.6 Cross-border healthcare services processes. [74]

(MS: Abbreviation of Member State)

2.4.3 Cross-border healthcare and responsibility of the Member States in the European Union

Since cross-border healthcare services concern an interaction between at least two countries, information outside the patient's country of residence may be difficult to obtain than domestic information. Therefore, mechanisms for dealing with important matters should be prepared for patients.

2.4.3.1 National Contact Point[75]

National Contact Point is one of the instruments that all Member States in the European Union have to set up in order to subsidize patients.

National Contact Point of the United Kingdom has two major functions. First, it has to offer information in reachable formats including an electronic format and a format that the handicapped can access to. Second, when there is a necessity, it has to coordinate with other Member States' National Contact Points.

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[74]Dr. Éva Lukács Gellérné Ph.D.Ministry of Human Capacities, Hungary. *"Directive 2011/24/EU Topic 2. Responsibilities of EU Member. States."* http://ec.europa.eu/enlargement/taiex/dyn/create_speech.jsp?speechID=35325&key=4c89b71bda1eb69f8fbb6a4e95db0388, (Accessed on May 8, 2016.)

[75]Article 2 (1) of the National Health Service (Cross-Border Healthcare) Regulations 2013 and Article 6 of the Directive.

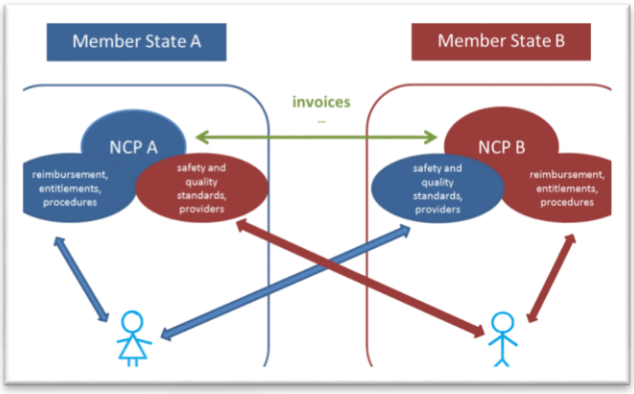

Figure 2.7 National Contact Point's functions[76]

2.4.3.2 Information to patient[77]

The National Contact Point of the United Kingdom is under the responsibility of NHS England. The National Contact Point is required to give information as follows: [78]

"The information that National Contact Point must provide for outgoing patients who want to receive the healthcare in another Member State within the European Union[79]

-The rights and entitlements of patients

-The terms and conditions of patients for reimbursement

-The administrative procedures for patients who would like to use cross-border healthcare

-The procedures for appealing and redressing if patients consider that their rights have not been respected

-Clear information about the patients' rights under the cross-border healthcare Directive, and the rights they have under the Regulation (EC) No.

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[76]European Commission. *"Directive on patients' rights in cross-border healthcare."* http://www.ipopi.org/uploads/Directive%20on%20patients%E2%80%99%20rights%20-%20Annika%20Novak.pdf, (Accessed on November 28, 2015.)

[77]Article 3 of the National Health Service (Cross-Border Healthcare) Regulations 2013 and Article 4, 5, and 6 of the Directive.

[78]NHS England. *"European cross border healthcare: Information for commissioners."* https://www.england.nhs.uk/wp-content/uploads/2013/07/eu-cross-border-hc-commissioners-0614.pdf, (Accessed on November 28, 2015.)

[79]Part2, Section 4 of the Regulation.

883/2004. The National Contact Point must explain to patients which one is the best choice for them.

-Detail of the National Contact Point's contact of other Member States." [80]

"The information that National Contact Point must provide for the incoming patients receiving the healthcare in the Member State within the European Union[81]

(1) Ensure that the following information is available for patients:

-Information about healthcare providers in that country

-Information about patients' rights in that country

-Information about complaints procedures and mechanisms for seeking remedies

-Information about legal and administrative options existing to settle disputes

(2) Ensure that the following information is available for patients on request:

-Information about a specific healthcare provider's right to provide services and any restrictions on a specific healthcare provider's right to provide services.

-Information about the quality and safety standards that apply in that country, including provisions for supervision and assessment of healthcare providers and which providers are subject to those standards and guidelines

-Information about the accessibility of hospitals for persons with disabilities

-Information about cross-border prescriptions."

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[80]EPF. *"EPF 4th Regional Conference on the EU Directive on Cross-Border Healthcare."* http://www.eu-patient.eu/globalassets/policy/cross-borderhealthcare/cbhc_conf-report_4est-jul2014.pdf, (Accessed on November 28, 2015.)

[81]Part2 Section 3 of the National Health Service (Cross-Border Healthcare) Regulations 2013.

2.4.3.3 Duty to consult

The National Contact Point must consult with the organizations to assure that patients can get the best interest by the healthcare provider who provides the healthcare services for patients in an appropriate manner.

2.4.4 Cooperation in healthcare

In the Directive there are many provisions concerning cooperation in the field of healthcare. Cooperation is one of the keys in helping cross-border healthcare to work well in the European Union. The goal is for patients in the European Union to be able to receive healthcare services with high efficiency as much as supplementary treatment of healthcare that might not be available in their own country.

2.4.4.1 Recognition of prescription issues in another Member State

The Member States have to accept and dispense prescription that has been issued in other Member States. For example, British General Practitioner can issue the prescription, and patients can take this prescription to ask for the prescribed medicine in another Member State. Another Member State has to accept and dispense the prescription. However, it does not affect the national rules on national price of medicine and ethical rules.

The Directive requires the Commission to adopt appropriate measures in identifying prescribed medicinal product and identity of the prescriber. The conditions of the prescription are that the prescription must be signed by the prescriber in ink or in advanced electronic signature; the prescription must contain an indication of the prescriber’s occupation (doctor, pharmacist, dentist, etc.) including their address; name of the patient needs to be identified in the prescription.

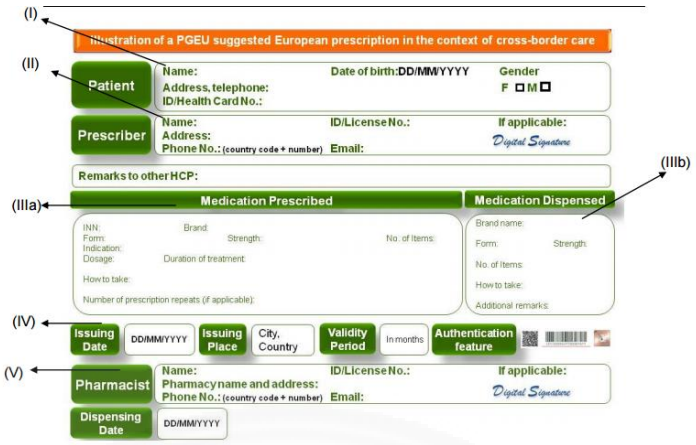

Figure 2.8 Illustration of the list of essential elements for cross-border prescription[82]

2.4.4.2 European Reference Network[83]

European Reference Network brings together specialized centers across the European Union, helps patients access to highly-specialized treatment, and escorts the exchange of information and expertise. It also provides sickness-prevention knowledge and focuses on rare diseases, especially in advancement of diagnosis and treatment, for patients.

For example, Mr. A lives in Czech Republic and got disease A which has never found treatment in Czech Republic before. Therefore, Czech Republic can use this network to find highly-specialized treatment among the Member States within the European Union. By using this network, it is found that there is an expertise to cure the disease A in Germany. So, Czech Republic can send Mr. A for treatment in Germany. This is useful for patients by increasing the chance of finding efficient treatment especially the treatment that cannot be found in their homeland.

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[82]Pharmaceutical Group of European Union. *"Recognition of Cross-Border Prescriptions."* http://ec.europa.eu/health/cross_border_care/docs/cons_prescr_pgeu_policy_en.pdf, (Accessed on November 19, 2015.)

[83]Article 12 of the Directive.

2.4.4.3 E-health and Common Electronic Medical Record[84]

E-health is defined by the World Health Organization as "the combined use of electronic communication and information technology in the healthcare sector."[85] It refers to the healthcare components delivered, enabled or supported through the use of information and communication technology. It may involve clinical communications between healthcare providers such as online referrals, electronic prescribing, and sharing of electronic health records. It can also provide access to information databases, knowledge resources, and decision support tools to guide service delivery.

Electronic Medical Records or Electronic Health Records (EMR/ EHR) is one form of e-health enabling the communication of patient data between different healthcare professionals such as general practitioners, specialists, etc. E-health is often referred to information that can assist health professionals in decision-making and treatment. Data found in the record may include patient demographics, past medical history, vital signs, examination and progress notes, medications, allergies, immunizations, laboratory test results, radiology reports, living wills, and a health power of attorney. It can be made available rapidly through ICT to authorized personnel providing care in different locations including across national boundaries or cross-border healthcare. It can also support the collection of data for other uses such as billing, quality management, public health disease surveillance and reporting.

The United Kingdom and the Member States in the European Union concern about the continuity of care and follow-up process. For example, Mr. A was cured in Germany and finally came back to his home in France. But his treatment still needs to be continued in France. So, there is a problem since he is not sure if he can transfer his medical data from Germany to France or not. His rights in medical record are not clear. So, the Directive makes clear that he can have a copy of his medical record to support cross-border healthcare so that he can continue his treatment in his homeland.

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[84]Article 14 of the Directive.

[85]The World Health Organization. *"E-health."* http://www.who.int/topics/ehealth/en/, (Accessed on November 18, 2016.)

Electronic health (e-health) facilitates cooperation and exchange of information among the Member States. The objectives of the e-health network are these following details:

(1) To ensure the interoperability of e-health system

(2) To assure that patients' medical data can be shared among the Member States within the European Union.

(3) To enable the use of medical information for public health and scientific research.

(1) E-health privacy law in the European Union

The protection of privacy and security of health data is essential for any electronic health system to reach its full potential. How to implement privacy and security in this unique environment is not evident, still, as balancing individual and societal interests can be difficult. The current European Union treatment of individual privacy builds upon fundamental human rights, and it is found primarily in two directives: the 1995 Directive on the protection of individuals with regard to processing personal data and the free movement of such data (Data Directive),[86] and the 2002 Directive concerning the processing of personal data and the protection of privacy in the electronic communication sector.[87]

Additionally, in the form of international instruments, the Council of Europe's 1981 Convention for the Protection of Individuals with regard to the Automatic Processing of Personal Data, and the Organization for Economic Cooperation and Development (OECD)'s 1980 Guidelines Governing the Protection of Privacy and Trans-Border Data Flows of Personal Data. These rules describe

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[86]EUR-Lex: Access to European Union law. *"Protection of personal data. European Parliament and Council Directive 95/46/EC of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data."* http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=URISERV%3Al14012, (Accessed on May 10, 2016.)

[87]EUR-Lex: Access to European Union law. *"Data protection in the electronic communications sector. Directive 2002/58/EC of the European Parliament and of the Council of 12 July 2002 concerning the processing of personal data and the protection of privacy in the electronic communications sector (Directive on privacy and electronic communications)."* http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=URISERV%3Al24120, (Accessed on May 10, 2016.)

personal information as data that are afforded protection in every step, from collection to storage and dissemination.

Although the expression of data protection requirements varies across the jurisdiction, all require that personal information must be:

-obtained fairly and lawfully

-used only for the original specified purpose

-adequate, relevant, and not excessive to purpose

-accurate and up to date

-accessible to the subject

-kept secure

-destroyed after its purpose is completed

4. The network on Health Technology Assessment

In order to decide on a worthy healthcare investment, the United Kingdom participates in Health Technology Assessment (HTA) [88] which is the assessment of health technology by systematically researching medicinal products, medical devices, vaccines, or medical treatments that are effective and safe for patients.[89] The purpose is to build up cooperation in HTA at EU level via a series of EU-funded project. It is the international cooperation in the European Union. It helps the United Kingdom determine its healthcare policy accurately.

[88]World Health Organization defined that Health technology assessment (HTA) refers to the systematic evaluation of properties, effects, and/or impacts of health technology. It is a multidisciplinary process to evaluate the social, economic, organizational and ethical issues of a health intervention or health technology. The main purpose of conducting an assessment is to inform a policy decision-making.

[89]Health Intervention and Technology Assessment Program. *"What is HTA?."* http://www.hitap.net/139584, (Accessed on December 7, 2015.)

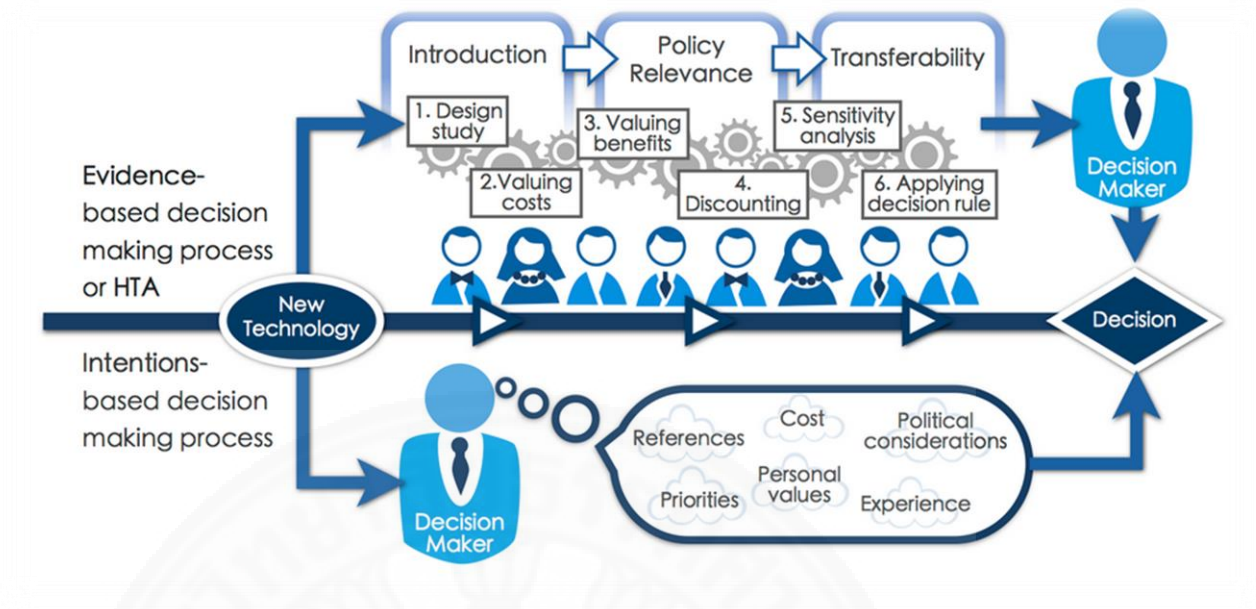

Figure 2.9 HTA processes[90]

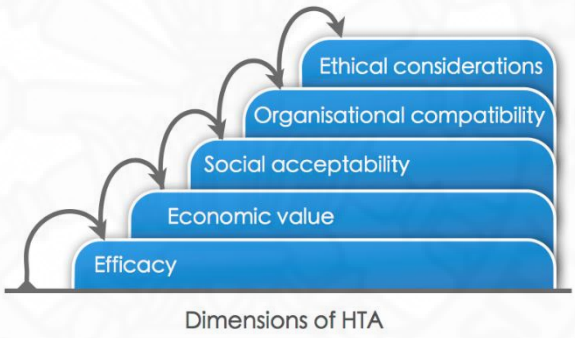

Figure 2.10 HTA's dimension[91]

[90]Shamseya for innovative community and healthcare solution. *"HTA processes."* http://shamseya.org/?page_id=386, (Accessed on December 7, 2015.)
[91]*Ibid.*

2.5 The effect of cross-border healthcare Directive in the European Union[92]

Many questions have been raised after the launch of the Directive. Does the Directive motivate patients to receive healthcare abroad, although it is not the aim of the Directive, due to the availability of cross-border healthcare? Does the Directive support people to obtain better quality of care with a rising expectation of healthcare treatment result? The effect of cross-border healthcare Directive should be submitted to the European Parliament and to the European Council every three years after the adoption of the Directive following the obligation of Member States in the European Union regarding Article 20 of the Directive. According to reports, the Directive affects healthcare in the European Union considerably, not only cross-border healthcare but also domestic health care.

2.5.1 Creating legal security in the reimbursement of cross-border healthcare

The Directive places an obligation to the Member States to incorporate the Directive's provisions into their national legislation. Besides, the European Court of Justice is also a main leader in enforcing the Directive in the form of case law to turn legal security in theory into practice and more concrete. For example, Member State A lists the types of healthcare treatment requiring prior authorization. If the European Court of Justice considers that the type of healthcare treatment is not reasonable for requiring prior authorization,[93] and it is an obstacle to the free movement of services, the European Court of Justice can allow the reimbursement for patients.

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[92]Miek Peeters. Free Movement of Patients: Directive 2011/24 on the Application of Patients' Rights in Cross-Border Healthcare. *European Journal of Health Law* 19 (2012) 29-60.

[93]The criteria to consider whether it is reasonable or not is under section 7.7 of the Directive.

2.5.2 Heighten quality and safety in National Healthcare System

As patients can obtain information about quality and safety of the country that they intend to receive healthcare abroad, patients can know their choices and comparisons of their choices. Therefore, this will lead to the final result that many states try to increase their standard to be an attractive choice for patients.

2.5.3 Create common values in cross-border healthcare in the European Union

Common values in cross-border healthcare are responsibilities of the Member States which are relevant to cross-border healthcare. These values bring about concrete patients' rights especially the rights related to special characteristics of cross-border healthcare. For instance, the patients' entitlement of the right to obtain information from the National Contact Point; information about healthcare providers; standard of care in the intended Member State to receive healthcare; complaint and remedy procedures; settlement of dispute solution; contacting list of the National Contact Points. However, the access to information in the European Union still has some problems at communication. According to the Directive, there is no requirement for providing information in other languages rather than the official language in the country. Such availability may be useless if there is no translation that facilitates patients to have a crystal-clear understanding.

2.5.4 Prohibition of discrimination

The prohibition of discrimination has been specified in the Directive in the case that no higher price for foreigners is allowed. In many countries including the United Kingdom, the government is a key player for supporting healthcare expense. Therefore, inapplicability of higher charges will mean that patients of other Member States can get healthcare at the actual price the government would like to support the quality of life of its citizens. Therefore, Member States in the European Union can adopt the measure of controlling the inflow of patients which is harmful to the access of healthcare of domestic patients.

2.5.5 Create cooperation opportunities

In border regions in the European Union, hospitals are encouraged to enter into cross-border agreement. This will bring about the chances for co-planning, mutual recognition and adjustment of guidance and standard, interoperability of information, and health with IT, etc. The Directive is one of the factors to encourage hospitals to have cooperation projects in border areas. Hospitals also try to set up the Healthcare Reference Network.

In conclusion, cross-border healthcare Directive has gone beyond its initiative plan. There are not just reimbursements, patient and professional mobility issues. There are also effects in the aspect of healthcare development on an international level. The facilitation in cross-border healthcare has been established for the sake of patients. Their free movement is more convenient. Their rights are clearer and concrete.

The framework of cooperation triggers benefits for patients in many healthcare perspectives as summarized in the following table:

1. The effects on cooperation across border	1.1 Necessary instrument for organizing the patient mobility	1.1.1 The recognition of prescription
		1.1.2 The E-health Network
	1.2 Improve Europe's medicine	1.2.1 Health Technology Assessment
		1.2.2 European Reference Network
2. The effects on safety and quality in the region		
3. The effects on patients' rights	3.1 The right to reimbursement	
	3.2 The right to information	

Table 2.3: The effects of the Directive

CHAPTER 3
THAILAND'S HEALTHCARE

This chapter exhibits the writer's study on the issues of healthcare system in Thailand and patients' rights under Thai law by describing the three healthcare systems in Thailand. Starting with the tabulated form, then follows analyses of the learned models that might be adopted in our Thai context, the writer hereby provides the provisions of law that are deemed important when we establish cross-border healthcare. Other model laws and the reform of current Thai healthcare system are also proposed in this chapter to construct principles that might help lessen the current problems in our Thai healthcare system.

3.1 Patient's rights to health in Thailand

In our age of globalization, healthcare around the world has been developed by virtue of the advancement of technology and knowledge. Patients' rights are also mentioned in our legal instruments, as the writer already explained in the earlier chapter that the rights to health are also categorized as human rights which are important to human-beings. Therefore, the writer wrote about the patient's rights in Thailand to study the rights we currently have and the rights that should deserve more attention.

3.1.1 Rights to health under the Constitution of Thailand

The State shall achieve the goal of directive principles of State policies in relation to Social Affairs, Public Health, Education, and Cultural Affairs:[94]

" to promote, support, and develop the health system that emphasizes the health promotion for people to enjoy a sustainable state of happiness; provide and promote the standardized public health service to people universally and efficiently; and encourage private sector and community to participate in the health development and

[94]Section 80 (2) of the constitution of kingdom of Thailand B.E. 2550 (2007).

provision of public health services, provided that persons who deliver such services and perform their duties as to the professional standard and ethics, shall be protected by law."

3.1.2 Rights to health under Declaration of patients' rights

"Declaration of patients' rights, for good understanding between a patient and healthcare personnel, the Medical Council, Nurse Council, Pharmacist Council, Dentist Council, and Medical Licensing Committee of Thailand have announced the patients' rights as below:

1. Every patient has the rights under the constitution law to receive basic medical care.
2. Every patient will receive health services from healthcare personnel, regardless of race, nationality, religion, social status, sex, age, political belief, and her/his disease or sickness.
3. Except in emergency, every patient has the rights to know sufficient information regarding his or her sickness from the healthcare personnel in order to decide to allow any treatment from the healthcare personnel.
4. In life threatening situation, every patient has the rights to receive needed treatments from healthcare personnel regardless of the patient's request.
5. Every patient has the rights to know the name, surname, and profession of the healthcare personnel in charge.
6. Every patient has the rights to get second or more opinions from other healthcare personnel, and he or she has the rights to change his/her healthcare provider.
7. Unless the patient's permission or approved legal authorization, healthcare personnel cannot disclose the patient's information. [95]
8. In order to be in a medical trial or experiment or not, every patient has the rights to know thorough information. [96]

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[95]Penal code section 323.

[96]Medical Council regulations concerning the ethical treatment of medical professional B.E. 2526 section 6.

9. Per his or her request, every patient has the rights to know the information in his or her medical records. However, he or she cannot infringe the rights of others. [97]

10. In the case of a child under 18 years old or a patient with limited mentality, his or her father, mother, or legal guardian can exercise his or her patient rights." [98]

3.1.3 Patients' rights in relevance to healthcare

Patients' rights are protected in aspects of confirmation of equality, right to receive public health services, right to obtain information, and right to privacy in information and protection of personal data.

3.1.3.1 The confirmation of equality

Unjust discrimination against a person on grounds that he or she is different in origin, race, language, sex, age, disability, physical or health condition, personal status, economic or social standing, religious belief, education or constitutionally political perspective, must not be permitted.[99]

3.1.3.2 Right to receive public health service

A person shall enjoy the right to equality to receive proper public health services and up to the quality.[100] Besides, the indigent shall have the right to receive medical treatment from public health center of the State without payment. A person has the right to receive efficient and thorough public health services from the State. A person has the right to be properly protected by the State in order to fight against harmful contagious diseases, and to have such diseases eradicated for free and in a timely manner.

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[97]Information Act B.E. 2540.
[98]Mahidol University Faculty of Medicine Ramathibodi Hospital. *"Patient rights."* http://med.mahidol.ac.th/en/patient/patient_right, (Accessed on December 20, 2015.)
[99]Section 30 paragraph 3 the constitution of kingdom of Thailand B.E. 2550 (2007).
[100]Section 51 of the constitution of kingdom of Thailand B.E. 2550 (2007).

3.1.3.3 Right to obtain information

In providing healthcare services, public health personnel must provide health information adequately, and they must connect with the service receivers so that the latter can make a decision for appropriate options of services. If the patient decline to get the service, no one is allowed provide the service to that patient.[101]

3.1.3.4 Right to privacy of healthcare information

Right to privacy has been protected under the Constitution of Thailand, by Section 32, which deals directly with right and liberty in life of a person, as put that "A person shall enjoy the right and liberty in his life…Search of person or act affecting the right and liberty under paragraph one shall not be made except by virtue of the law." [102] Section 33 is a guarantee of liberty of dwelling. And Section 34 is a guarantee of liberty of travelling. [103]

Information privacy and personal information is endorsed by Section 35: "A person's family rights, dignity, reputation and **the right of privacy shall be protected.**

The assertion or circulation of a statement or picture in any manner whatsoever to the public, which violates or affects a person's family rights, dignity, reputation **or the right of privacy, shall not be made** except for the case which is beneficial to the public.

Personal data of a person shall be protected from the seeking of unlawful benefit as provided by the law." [104]

At present, Thailand does not have any general statutory law governing data protection or privacy. But the universal personal data privacy law draft has been proposed.

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[101]The National Health Act B.E. 2550.
[102]The constitution of kingdom of Thailand B.E. 2550 (2007).
[103]*Ibid.*
[104]*Ibid.*

Currently, there is a protection of health information in Section 7 of National Health Act, B.E. 2550, which states that "personal health information shall be kept confidential.

No person shall disclose it in such a manner as to cause damage to him or her, unless it is done according to his or her will, or is required by a specific law to do so. Provided that, in any case whatsoever, no person shall have the power or right under the law on official information or other laws to request for a document related to personal health information of any person other than himself or herself."

However, in the writer's opinion, healthcare information, which is very sensitive data, should be protected under a separated privacy law that is the privacy of healthcare information law. For instance, in a case of emergency that a minimum of healthcare information could save a patient's life but the patients cannot perform their consent because of their paralyzed condition, there should be some exceptions in the law which allows the use of such data. Therefore, the general privacy law that is now being proposed still lacks efficient enforcement in accordance with the reality and special cases of healthcare information's nature.

In the writer's opinion, there should be a government authority or representative unit who is responsible for oversight, enforcement, and health information privacy protection.

3.2 Patients' right to reimbursement under three models of Thailand's healthcare system[105]

Thailand constitutes three health insurance models which are arranged for all people. The three systems are Medical Welfare of Civil Servant and State Enterprise Employees System, Universal Health Insurance System in Thailand, and the Social

[105]Reform the health insurance system. *"Legislative intuitional repository of Thailand."* http://library2.parliament.go.th/giventake/content_nrcinf/nrc2557-pr14.pdf, (Accessed on May 8, 2016.)

Security System. Each system has different target group and is varied in benefits package, which is detailed as follows.

3.2.1 Medical Welfare of Civil Servant and State Enterprise Employee System

This is the system of employer (government) and employee who are government officials and state enterprise employees.[106] The healthcare welfare is provided for these people as a part of the remuneration which can be competitive in the labor market.

Government as the employer will be a payer for government hospitals according to the actual price that has been spent (pay as you go). In order to save the budget, the government is assigned to spend the budget on drugs used in the national lists. If there is a need to use other drugs outside the drugs used in the national lists, it will be subject to a sound reason. In the case of in-patients, the government is responsible for hospital room rates and charges at the rates stipulated by the disease diagnosis. Patients can choose to receive healthcare from state hospitals anywhere in the country. Therefore, the total amount paid in medical expenses cannot be calculated precisely due to the basing on the number of patients who exercise their rights on medical expenses each year. But it still does not reflect the true cost of healthcare, because it does not include salary and remuneration of doctors and hospital personnel and other various utilities.

Besides, the effect from the government providing the right for civil servants and state enterprise employees to use the service from any state hospital is a negative performance for follow-up treatment; in order words, it causes a negative effect on the continuity of care. Moreover, another effect is that patients may also get a duplicated cure or a cure that exceeds medical necessity.

The main problem in this system is that the payer is the people who work and have to be responsible for the taxes. But the beneficiaries are both taxpayers and those who do not pay taxes. When there is a high proportion of older people in the

[106]Section 4 of Royal Decree on welfare payments to healthcare. B.E. 2553.

society. The burden will be placed on the working men. This will be risky for a sustainable development in healthcare in the long term.

3.2.2 National Health Security System in Thailand (Golden Card Project)

This program was launched in 2545 B.E. The purpose of this project is that every citizen in the country who is not under other coverage schemes has healthcare welfare. Originally, healthcare service recipients had to pay 30 Baht per time when receiving healthcare. The exception is that the impoverished do not have to pay. Later on, during the tenure of Mongkol Na Songkhla as the Public Health Minister in 2549 B.E., because the 30 Baht Project was a helpful project for providing healthcare for low-income service receivers, the pattern of small co-payment charge for treatment was changed into free of charge, which means that patients do not have to pay any money for receiving healthcare services.

The healthcare providers of this universal coverage scheme are public and private sector. [107] Public hospitals and facilities are registered as a delivery of network automatically. Private hospitals and facilities have to consider their quality to be a contractor with the government. Theoretically, people are free to choose their own facilities to obtain primary care. Practically, the number of designated facilities is limited especially in rural areas where there are not so many facilities to be prepared for offering primary care to people. People in rural areas are mostly designated to public facilities nearby their home.

The intention of this project is the attempt to establish social security for everybody and decrease inequality in the society. This inequality enables conflicts in the society and is also an obstacle to sustainable economic development.

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[107]WHO. "*Session 5: Health Situation and Health Systems Analysis: Cambodia, Lao PDR, Myanmar, Thailand, Viet Nam."*
http://www.searo.who.int/thailand/news/Session_5_five_country_health_systems_profiles.pdf, (Accessed on May 8, 2016.)

Although this system consists of the good intention, to provide healthcare welfare for all including ones who can bear the costs themselves triggers the inefficiency of government budget spending.

In 2556 B.E., there are 49 Million people who were under this coverage program. With the limited budget that the government has set for paying medical bills for the hospitals paid in the low rate, several hospitals suffered severe losses.

The importance of National Health Security Act, B.E. 2545 (A.D. 2002)

The reason to enact this act, with regard to Section 52 of the Constitution, Thai people have equal rights to receive healthcare which meets the standard. And the people in need have the right to obtain healthcare from government hospitals without payment, according to the law. The service arranged by the government must be accessible and efficient by supportive local administration and private sector. According to Section 82 of the Constitution, the government has to set and support sanitation. Therefore, there should be a healthcare system that is necessary for people's health and survival - with the quality of life - by having an organization that supervises and operates the mission with the participation of the government sector and private sector in order to have an efficient healthcare system throughout the country. And all Thai citizens have the right to receive healthcare services with the same standard.

Besides, nowadays in Thailand there are many systems supporting healthcare, which results in a complication in reimbursement. There should be the harmonization of the three systems to be supervised by one designated organization in order to reduce the expenses overall.

The rights under National Health Security Act, B.E. 2545 (A.D. 2002) [108]

The Thai citizens are entitled to receive health service with such standard and efficiency. [109] Types and restrictions of health service for beneficiaries are in the prescribed list as determined by the Board.

In this Act the term of health service is clarified as the medical and public health services that are provided to a person directly and have the purpose of promotional, preventive, and curative cares; diagnosis; rehabilitation; including the Thai traditional and alternative medicines approved by the Medical Registration law. [110]

3.2.3 The Social Security System

This system is initiated by the consideration to strengthen the lives' security so as to well suit the change in economic structure, where agricultural sector has been succeeded by the industrial, and rural community by the urban. In response to the waning notion of other individuals as a family member, a new system is required to ensure the security of life, thus binding the employer and the employee to contribute to the fund known as the Social Security Fund.

The Social Security Fund covers expenses outside work domain for employees including sickness, getting harmed, disability, or death. The benefits of maternity allowance, pension age, and unemployment are also provided for by the fund. A patient getting harmed at work, however, will only receive compensation fund from the employer.

The Social Security Office administers both funds and selects qualified hospitals. The registered hospitals are then listed as contractors where employees can receive healthcare. The money paid for each qualified hospital is determined by the agreed rate and number of employees choosing that hospital. Employees must receive

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[108]National Health Security Office. *"The rights under National Health Security Act, B.E. 2545."* http://law.nhso.go.th/files/content/a1b95cd4-e902-4aa5-998f-33c044a3cd50-130464164196250000.pdf, (Accessed on May 8, 2016.)
[109]Section 5 of National Health Security Act B.E. 2545 (A.D. 2002).
[110]Section 3 of National Health Security Act B.E. 2545 (A.D. 2002).

healthcare treatment from the chosen hospital, except for emergency cases when non-chosen hospitals (as well the registered contractors) can be a provider of healthcare.

Despite the fact that the income of the Social Security Fund comes from particular sources, this system retains the problem of the asymmetry of income and expense. The rising number of aged population in the future will precipitate the increase of expenditure in relation with revenue, unless the rate of contribution to the fund is adjusted.

The problems of the stability and ability to maintain a sustainable system, likewise, await solutions, even though the government is not bound to be committed to unlimited spending as in the welfare of officials system (civil servants and state enterprise employees) and the national health security system. After all, the government will be at risk to cover the expense, provided that the three parties do not contribute sufficiently.

However, there are private health insurance companies to assist the healthcare in the form of private individual health insurance and group health insurance, aside from the three availabilities by the government. Nevertheless, only a few people in Thailand would opt for them due to relatively expensive costs.

The rights under Social Security System in Thailand[111]

The Social Security Fund (SSF) was established under the Social Security Act B.E. 2533[112], in order to enable the society security and stability of livelihood for employee.[113]

The Social Security Office was found accordingly by the Act.[114] It has a mission to manage the Social Security Fund to best benefit all members. The coverage

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[111]The Office of Securities and Exchange Commission. *"The Social Security System."* http://www.thaipvd.com/content_en.php?content_id=00313, (Accessed on June 8, 2016.)

[112]Section 21 of Social Security Act B.E. 2533.

[113]เกษมสันต์ วิลาวรรณ. (2558). พิมพ์ครั้งที่ 22. คำอธิบายกฎหมายแรงงาน. กรุงเทพมาหานคร: วิญญูชน. (Kasamsan Vilawan. (2015). Twenty-two edition. The explaination of labour law. Bangkok: Vinyuchon.)

[114]Section 19 of Social Security Act B.E. 2533, By virtue of the Act on the Organization of Ministries, Sub-Ministries and Departments (No.8) B.E. 2536 (1993),

is separated into seven types, which are injuries or sickness including promotion of health and prevention of disease benefits, maternity benefits, invalidity benefits, death benefits, child benefits, old-age benefits, and unemployment benefits. [115]

Under Section 33 of Social Security Act B.E. 2533 as amended by section 9 of Social Security Act B.E. 2537, the qualification of the insured person are detailed as follows;

(1.) The employee who are at least fifteen years of age and not exceeding sixty years old.

(2.) The insured persons according to (1.) who are over sixty years of age and still working as an employee, are deemed as an employee who is an insured person.

Employee under Section 4 of the Social Security Act B.E. 2558 means ones who work for employer and gain remuneration. Therefore, employee under this Act also includes foreigners who work in company and state enterprise in Thailand as well.

The rate of contribution of the Social Security fund has been determined in the Ministerial Regulations, B.E. 2543 [116], which is regulated in accordance with Section 46 of Social Security Act, B.E. 2533 as edited by Section 5 of Social Security Act, B.E. 2542 which states that "The Government, an employer and an insured person under section 33 each shall pay contributions equally to the Fund at the rate prescribed in the Ministerial Regulations for payment of benefits relating to injury, sickness, invalidity, death and maternity, but the contributions thereof shall not exceed the rate of contributions appended to this Act.

The Government, an employer and an insured person under section 33, shall pay contributions to the Fund at the rate prescribed in the Ministerial

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the Ministry of Labour and Social Walfare. is established and in this regard the Social Security Office is now under the Ministry of Labour and Social Welfare.

[115]Section 24 of Social Security Act (No. 4) B.E. 2558 cancelled Section 54 of Social Security Act B.E. 2533 as amended by section 18 of Social Security Act (No. 3) B.E. 2542.

[116]Account 2 of Ministerial Regulations, B.E. 2543, contribution rates for Social Security Fund.

Regulations for payment of benefits relating to child benefit, old-age benefit, and unemployment benefit, but the contributions thereof shall not exceed the rate of contributions appended to this Act…"[117]

Moreover, there is also the voluntary insured person, under section 39 of Social Security Act B.E. 2533 which must meet the following requirements;[118]

1. He or she is an insured person under section 33 and has paid contribution for a period of not less than twelve months and, subsequently ceases to be insured person

2. If he or she wishes to continually be insured person, he or she shall inform his or her wish to the Social Security Office within six months from the date of his or her termination to be insured person.

The benefits of insured person from the Social Security Fund under the Social Security Act are as follows;

[118]Section 39 of Social Security Act B.E. 2533.

Categories[119]	Employers	Employees	Government
1. Injuries or Sickness including promotion of health and prevention of disease benefits **2. Maternity benefits** **3. Invalidity benefits** **4. Death benefits**	**1.5 %**	**1.5 %**	**1.5 %**
5. Child benefits **6. Old-Age benefits**	**3 %**	**3 %**	**1 %**
7.Unemployment benefits	**0.5 %**	**0.5 %**	**0.25 %**

Table 3.1: The Rate of Distribution to Social Security Fund[120]

Categorized under the Defined Benefit System, the Social Security Fund permits member benefits from the beginning regardless of the amount of contribution or return on investment of any parties. Every employer with at least one employee and all workers except those exempted by the Act such as civil servants, state enterprise employees, and private school teachers are obliged to contribute equally with the government supporting additional levy to the fund.

When the wages are paid, employers then need to submit the contributed sum to the Social Security Office by the deadline of the 15th of the following month after the contribution was deducted.

[119]Section 24 of Social Security Act (No. 4) B.E. 2558 cancelled Section 54 of Social Security Act B.E. 2533 as amended by section 18 (No. 3) of Social Security Act B.E. 2542.

[120]Section 46 and 47 of Social Security Act B.E. 2533.

3.2.3.1 Package of benefits[121]

(1) Injuries, sickness Benefits[122]

Income replacement[123]: the insured person suffers from non-occupational injuries or sickness can get income replacement at the rate of fifty per cent of wages employed for a period the insured person has take work-leave to receive medical treatment under the instruction of doctor (limit to 90 days on each occasion and not more than 180 days in a calendar year).

But the sickness from chronic disease that has prescribed in the Ministerial Regulations, the insured person can get income replacement for more than 180 days but not exceeding 365 days.

Medical services, including prosthetic devices announced by the Social Security Office, exclude injuries or sickness that resulting from occupation:

1. Normal sickness

2. Emergency illness or accident

3. Medical services in case of dental services (extraction, tooth fillings, and scaling)). The insured person is entitled to receive medical services as actual necessary expense they have paid but not exceeding 300 baht per time and not exceeding 600 baht per year.[124]

4. In case of renal replacement therapy, including dialysis with artificial kidneys, clearing the abdomen with a permanent solution, kidney transplant surgery, giving medicine of Erythropoietin.

5. Bone marrow transplantation (limit of 750,000 baht).

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[121]Worawan Chandoevwit. *"Social Security System in Thailand."* http://tdri.or.th/wp-content/uploads/2012/12/h106.pdf, (Accessed on May 15, 2016.)

[122]Social Security Office of Thailand. *"Social Security System."* http://www.sso.go.th/wpr/content.jsp?lang=th&cat=868&id=3628, (Accessed on May 15, 2016.)

[123]Section 64 of Social Security Act B.E. 2533.

[124]Section 3 of the declaration of Medical Board in accordance with the Social Security Act B.E. 2533, the rules and rates for benefits in case of sickness, which is not due to an occupational work.

6. Change organ cornea (limit of 25,000 baht).

7. Prosthetic and the device of diseases treatment (such as artificial foot or arm crutches according to the notification of the Office of Social Security Office's determination).

8. AIDs

Compensation benefits in case of injury or illness which is not resulting from occupation:

"1. Diagnosis or medical examination expense

2. Promotion of Health and Prevention of Disease.

3. Medical treatment and rehabilitation expense.

4. The cost of living and medical care in a nursing home.

5. Medications and medical pharmaceutical.

6. Ambulance or transportation for patients.

7. The monetary assistance as the aid to the insurer in case of insured person gets damages from receiving healthcare services. If the insured person gets damage from medical services, the office will pay the money to the insured person and the Office will claim back from an offender.

8. Other services which is necessary for insured person." [125]

Eligibility requirement: The insured persons have paid contributions for 3 months out of the 15 months before receiving medical service.[126]

(2) Maternity benefits

-Maternity benefits are composed of:

"(1) medical examination and child bearing expenses

(2) medical treatment expense

(3) medicine and medical supplies expenses

(4) confinement expense

[125]Section 30 of Social Security Act (No.4) B.E. 2558 (Formerly is section 63 of Social Security Act B.E. 2533).

[126]Section 62 of Social Security Act B.E. 2533 as amended by section 23 of Social Security Act (No. 2) B.E. 2537.

(5) lodging, meals and treatment expenses in hospital

(6) new – born baby nursing and treatment expenses

(7) cost of ambulance or transportation for patient

(8) other necessary expenses" [127]

-A payment in lump sum of 13,000 Thai Baht for each delivery, unlimited of times. [128]

-Maternity compensation, 50 percent of monthly average wages for 90 days[129]

The third pregnancies cannot get Maternity compensation, 50 percent of monthly average wages for 90 days.[130]

Eligibility requirement: The insured persons have paid contributions at least for 5 months.[131]

(3) Invalidity benefits

-Invalidity benefits are composed of

"(1) medical examination expense

(2) medical treatment expense

(3) medicine and medical supplied expenses

(4) in-patient, meals and treatment expenses in hospital

(5) cost of ambulance or transportation for invalid person

(6) physical, mental and occupational rehabilitated expenses

(7) other necessary expenses"[132]

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[127]Section 4 of the declaration of Medical Board according to the Social Security Act B.E. 2533 on the issue of the rules and rates for maternity benefits. And Section 66 of Social Security Act B.E. 2533.

[128]Section 3 of the declaration of Medical Board according to the Social Security Act B.E. 2533 on the issue of the rules and rates for maternity benefits. And Section 66 of Social Security Act B.E. 2533.

[129]Section 67 of Social Security Act B.E. 2533.

[130]Section 75 Ter of Social Security Act B.E. 2533.

[131]Section 31 of Social Security Act (No.4) B.E. 2558.

[132]Section 70 of Social Security Act B.E. 2533.

-A lifetime invalidity compensation, 50 percent of each month's wages.[133]

-Lifetime medical care reimbursement, up to 2,000 Thai Baht per month

-Reimbursement for artificial parts and other related materials.

-Money for a funeral of which amount is 30,000 Thai Baht, when the beneficiary is dead.

-Compensation equals to 1.5 times of the monthly wages payable to relatives if the dead or invalid persons had paid contributions for 36-119 months, or 5 times of the monthly wages if they had paid contributions for 120 months.

- losing bodily potential that does not exceed 50 percent of the whole body is qualified to gain the benefits in terms of invalidity, but the rate and duration are determined by the medical board without exceeding 50 percent of each month's wages.[134]

Eligibility requirement: The insured persons have paid contributions for 3 months out of the previous 15 months.[135]

(4) Death and survivors' benefits

-A payment in lump for funeral arrangements.

-Compensation equals to 1.5 times of the monthly wages payable to relatives if the dead insured persons had paid contributions for 36-119 months, or 5 times of the monthly wages if they had paid contributions for 120 months.

- if the dead insured persons had paid contributions for at least 36 months but not exceed 120 months, the compensation will be paid equal to two monthly salary.

[133]Section 32 of Social Security Act (No.4) B.E. 2558.
[134]Section 32 of Social Security Act (No.4) B.E. 2558.
[135]Section 69 of Social Security Act B.E. 2533 as amended by section 27 of Social Security Act (No. 2) B.E. 2537.

Eligibility requirement: The insured persons have paid contribution for a period of not less than one month during the period of six months before his death.[136]

(5). Child benefits

-Child allowance of 400 Baht per child who has the age of 0-6 years old, the maximum is 3 children.[137]

-The child allowance eligibility status is not ended upon the death of an insured person.[138]

Eligibility requirement: The insured persons have paid contributions for 12 months out of the previous 30 months.[139]

(6) Old-age benefits

The payment in the form of monthly living cost is called as "Superannuation Pension".[140]

The one-time payment in lump sum is called as "Superannuation Gratuity".[141]

-A pension is equal to 15 percent of the average of 60 months' wages received.

-A one-percentage point increase for every 12 months of additional contribution

-Compensation (10 times of the monthly pension) payable to relatives if the pensioner is dead within 60 months of retirement.

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[136]Section 73 of Social Security Act B.E. 2533.
[137]Section 35 of Social Security Act (No.4) B.E. 2558 cancelled section 75 Ter of Social Security Act B.E. 2533 as amended by Social Security Act (No.3) B.E. 2542.
[138]Section 75 quarter of Social Security Act B.E. 2533.
[139]Section 74 of Social Security Act B.E. 2533.
[140]Section 77 of Social Security Act B.E. 2533 as amended by Section 8 of Social Security Act(No. 3) B.E. 2542.
[141]*Ibid*.

-A payment in lump sum is equal to the employee's contribution payable to the retiree (age 55 and older) who has been contributing for less than 12 months.

-A payment in lump sum is equal to the employee's and employer's contribution including interests accrued from that amount, payable to the retiree who has contributed for more than 12 months, but less than 180 months.

-A payment in lump sum, of which amount depends on the period of contribution and base income, payable to relatives of the insured person who is dead before the age of 55.

Eligibility requirement: The insured persons have paid contributions for at least 180 months (in both case consecutive and not consecutive period of 180 months)[142] when they are 55 years old except they still have the insured person's status under this act. Therefore, if the status of insured person still exists, the old age benefit will not be paid. The person shall be entitled to old-age benefit as from the month following the month his or her insurance is terminated.[143]

(7) Unemployment benefits

-For those who are involuntary unemployed such as laid off, the replacement rate is 50 percent of the highest three-month average wages in the last nine months. The maximum duration to receive the benefit is 180 days in calendar year.

-For those who are willing to be an unemployed person such as quitting work without justified causes, the replacement rate is 30 percent of the highest three-month average wages in the last nine months. The maximum duration to receive the benefit is 90 days in calendar year.

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[142]Section 76 of Social Security Act B.E. 2533as amended by section 8 of Social Security Act (No. 3) B.E. 2542.

[143]Section 9 of Social Security Act (No. 3) B.E. 2542 and Section 77 Bis of Social Security Act B.E. 2533.

- Benefits are also payable when employer stops running business if resulted from force majeure and employer did not cancel the employment contract, for example, a flood in establishment[144]

Eligibility requirement: Having paid contributions for 6 months out of the previous 15 months before unemployment.[145]

3.2.3.2 Benefit payouts[146]

Benefits that are paid out to insured persons can be divided into two categories:

1. Old-age money is paid out under the conditions below:

(1) Insured persons have paid equal contributions for less than 180 months

(2) Cancellation of insured status

(3) Insured persons are fully 55 years of age

1.1 Insured persons paying equal contributions for less than 12 months can gain the benefits equal to their contributions in case of old age and child allowance.

1.2 Insured persons paying contributions for no less than 12 months can obtain the benefits equal to their contributions in case of old age and child allowance and also the interests set by the Social Security Office (SSO).

2. Old-age pension paid each month for a lifetime under the conditions below:

(1) Insured persons have made consecutive contributions for no less than 180 months.

(2) Cancellation of insured status

(3) Insured persons are fully 55 years of age.

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[144]Section 38 of Social Security Act (No. 4) B.E. 2558 and Section 79/1 of Social Security Act B.E. 2533.
[145]Section 38 of Social Security Act (No. 4) B.E. 2558.
[146]Social Security Office. *"Social Security Knowledge."* http://www.sso.go.th/wpr/eng/index.html, (Accessed on June 06, 2016.)

The old-age pension benefit is equal to 20 percent of the average monthly wages of the last 60 months. The remark is that the salary base used for calculation must range between 1,650 and 15,000 Thai baht. Besides, for every additional 12 months of contribution above the consecutive 180-month obligation, the benefit will collect by 1.5%.

Despite the advantages of steady savings in post-retirement, one might not find the Social Security Fund reliable and sufficient for supplying the same quality of life. Instead, workers are advised to take into consideration other choices such as provident funds and retirement mutual funds for additional security.

	The Civil Servant System	**The Social Security System**	**The National Health Security System**
Quantity of people who have the rights under each system (number of members)	5 millions people (8%)	9.84 millions people (15.8%)	47 millions people (75%)
Fund	State budget	Contributions from the employers and employees, 1.5 percent of the monthly salary	State budget
Source of fund	General tax	Tripartite contribution	General Tax
Pattern of financing	Public reimbursement	Public contract	Public service unit registration and contract
Idea	Fringe benefit	Social security	Entitlement right

Responsible unit	Comptroller General's Department, Ministry of Finance	Social Security office ,Ministry of Labour and Social Welfare	National Health Security office, Ministry of Public Health
Benefits	All aspects: in-patient, out-patient, dentistry, medicine, food, room fee, and maternity cost.	All aspects: in-patient, out-patient, dentistry, medicine, food, room fee, and maternity cost.	All aspects: in-patient, out-patient, dentistry, medicine, food, room fee, and maternity cost.
Service provider	Public sector and private sector[147]	Public hospital, private contractual hospital, and in-network infirmary.	Public hospital, private contractual hospital, and in-network infirmary.
Notes	Service cost reimbursement at private health facilities is restricted and only for an accident or an emergency threatening life. [148]	Service cost reimbursement at private health facilities is limited and only as needed.	When they are eligible for National Health Security Scheme, the first service is covered, and registration is is required at the health facilities. (only registered National Health Security Scheme is

[147]Section 4 and Section 8 of Royal Decree on welfare payments to healthcare B.E. 2553.
[148]Section 8 of Royal Decree on welfare payments to healthcare B.E. 2553.

			counted for government's budget allocation.)
Summary of service benefit package			
Ambulatory	Public only	Public and private	Public and private
In-patient	Public and private	Public and private	Public and private
Choice of provider	Free	Contractual basis	Contractual basis
Inclusive conditions	All	Non-work related illness	All
Exclusive conditions	No	With 15 conditions	With 15 conditions
Chronic and high costs	Full reimbursement except special room	Fee-schedule (30 conditions)	Except special room

Table 3.2 Summary in a comparison form of the three healthcare systems in Thailand

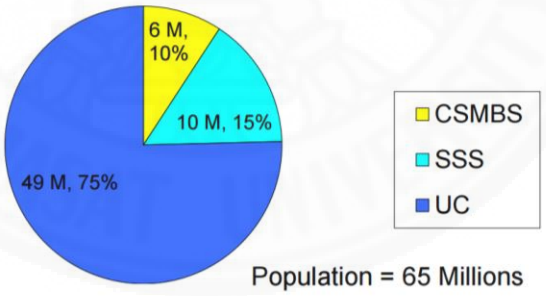

Figure 3.1 Comparison of the quantity of people who are insured under the three healthcare systems[149]

[149]Professor Doctor Aphisit Natchariya. *"Thai health system Health Policy & Law."* http://www.med.cmu.ac.th/secret/edserv/curriculum/file/2557/%E0%B9%84%E0%B8%9F%E0%B8%A5%E0%B9%8C%E0%B8%82%E0%B8%B6%E0%B9%89%E0%B8%99%E0%B9%80%E0%B8%A7%E0%B9%87%E0%B8%9B%202557/ICH1_2557/Thai%

In the writer's opinion, because there are gaps in insurance benefits in the public healthcare programs, some persons then also buy private health insurance to implement their coverage. Besides, substantial sums are paid out-of-pocket for health services. Some persons do not join in either of the public insurance schemes; the reason might be because they live in remote areas and have limited access to public health providers, and they must pay for a care themselves. Also, some health services may be difficult to obtain within the insurance schemes but are available with direct payment. For instance, pharmaceuticals that are in limited supply by hospital pharmacies (which are provided for free for patients) might be received through private pharmacies that are not covered by the Universal Healthcare Coverage. Some persons prefer to pay the cost of pharmaceuticals bought at private pharmacies rather than obtaining through doctors and hospitals for their medications. Besides, traditional medicine is normally paid out-of-pocket rather than via insurance.[150]

3.3 Problems of healthcare reimbursement system in Thailand

Due to the fact that these three systems vary in many aspects, they cause some problem as will be described in the following details.

3.3.1 Gaps in benefit package

Due to the difference in benefit package, it creates inequality of patents' rights in Thai healthcare system. Despite some high-cost treatments, people who are insured under the Civil Servant and State Enterprise and Social Security System can receive such treatments, while people who are insured under the Universal Health Coverage cannot afford. For example, Renal Replacement Therapy (RRT) is excluded from the Universal Health Coverage because of its high cost, but it can prolong life and

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20health%20system%20%20Health%20Policy%20&%20Law%2010.3.58.pdf, (Accessed on May 18, 2016.)

[150]Joseph R. Antos. "*Health Care Financing in Thailand: Modeling and Sustainability Mission Report to the World Bank."* http://siteresources.worldbank.org/INTTHAILAND/Resources/333200-1182421904101/2007aug-health-financing-modeling.pdf, (Accessed on June 7, 2016.)

improve quality of life. This problem also leads to ethical concerns as well, since some healthcare treatments are excluded from the coverage, but they actually can save life of people.

3.3.2 Difference in facilities of healthcare

Payment method affects incentives of service providers to provide healthcare treatment. The Civil Servant Medical Benefit Scheme is on the basis of free service. Therefore, the budget is open and leads to an increase in healthcare spending from the healthcare service providers. Besides, service providers are likely to be prompted to provide high-technology treatment for patients, because they can get repayment from the government no matter how much they spend on providing the service. On the other hand, the Universal Health Coverage is a closed-end payment service. Some service providers may not be willing to offer high technology treatment in order to reduce the cost and gain more profits. Therefore, determining a proper rate of payment needs a balance between restricted budget spending and consideration of appropriate access and quality of care of patients.

3.3.3 Limited access to healthcare

Under the Universal Healthcare Coverage and Social Security Scheme, patients must go to the registered hospital or healthcare facility that they chose. Some people who live in rural areas are not convenient to go to the registered hospital that is far away from their home. On the other hand, patients under the Civil Servant and State Enterprise scheme's benefits can go to any public hospital and get reimbursed. Further convenience tis that, if they go to the registered public hospital, they do not have to pay upfront.

3.4 Model of Thai reimbursement reform in arrangements for the Thai reimbursement reform

3.4.1 United Kingdom under EU Directive Model

After the writer learned about the United Kingdom's Model and the current healthcare system in Thailand, in the writer's opinion, appropriate principles that may be adapted to Thai healthcare's context and will promote efficient cross-border healthcare are the following topics.

3.4.1.1. Provision of information

The information must be accessible including in the formats for disabled persons such as braille, large print, and audio. Also, nowadays' technology has an important role in providing information; therefore, electronic format should be available. The information that should be arranged does the function of informed choice. Moreover, the information about quality and safety of providers, complaints and redress procedure, and price should be arranged for patients.

Suggested information of other countries that should be available for patients is as detailed below:

- The healthcare system in other Member States
- Professional standard and guideline
- Treatment price and choices
- Healthcare provider's registration status
- Assurance of professional indemnity
- Complaints and redress procedure
- How reimbursement will be performed (direct payment on government-and- government level, or the patient has to pay upfront)

3.4.1.2 Provision of direct payment from the government

There is a drawback in claiming under the Directive that patients have to pay upfront. This will lead to an incapability of payment. There should be a provision those exceptional cases, such as in emergency cases, can get direct payment

from the government. Similarly, in the case of treatment with high cost, people should be able to request for direct payment, otherwise they will not have enough money for paying upfront. The vulnerable groups such as low-income people should be able to request for direct payment as well. This will decrease equity issues and eliminate fraudulent claims. It will be very useful for patients who seek treatment of addictive diseases so that they do not have to claim for the reimbursement many times.

3.4.1.3 Provision of clarity of patients' rights

The United Kingdom's model shows us that there is the problem of uncertainty in recognizing what are the rights that patients have or not. Therefore, there must be crystal-clear information about what healthcare services they are entitled to seek abroad.

3.4.1.4 Provision of prior authorization

Some may disagree with the prior authorization system which is considered as a barrier to obtain healthcare abroad. In the writer's opinion, it goes on the contrary that the prior authorization can diminish the risk of fraud. However, the discretion of authority has to be set by the regulatory, otherwise it may create bureaucracy. But certain healthcare of which cost is not high can leave the room for receiving healthcare without permission from the government.

3.4.1.5 Administrative procedure

The lesson learned from the United Kingdom shows that the procedure needs to determine an appropriate limit of time for decision making from the government, otherwise it will be too slow for patients to receive healthcare abroad. However, some cases cannot adopt the normal timeframe due to the complexity in case-by-case basis of healthcare treatment.

3.4.1.6 Shared information by establishing network for medical professionals' qualification.

-Registered status of medical professionals including notification of limitations of his practice or conditions of his license

-Medical professionals' history of education and practices

3.4.1.7 Reimbursement

Cross-border healthcare needs the clarity of national tariff. In the United Kingdom, there is a good example for monitoring cost accountability and of setting up the national tariff every year, in which there normally are consultations among healthcare sectors. However, the national tariff can just be used as guidance but not a compulsory amount that patients will get reimbursed. The exact amount of payment is required to present to the government authority before going to get healthcare abroad.

3.4.1.8 Continuity of care

There is a need of cooperation between the sending country and the receiving country; otherwise healthcare service will be short of continuity and diagnosis for side-effect. The National Contact Points will do the function of elaborating; however, the healthcare providers are also required to contact with one another with willingness for participation and regards for the interests of patients.

3.4.1.9 Translation of information

In the United Kingdom, despite the National Contact Points having translated the information, the question still remains whether they have the duty of care for precision of that translation, or it is just to escort but not raising the duty of care.

3.4.1.10 Transfer of medical record information

In the EU, there is the arrangement of transferring information including healthcare information through another directive. And it makes sure that the medical record or e-prescription can be well-understood in another Member State by using encoding process. However, the code may not cover all cases; that's why we need a communication with good relationship on the international level.

3.4.2 Other models

3.4.2.1 Bilateral arrangement for reimbursement: Singaporeans seeking healthcare treatment in Malaysia by reimbursement under Singapore's Medical Savings Account

In the ASEAN, there is the cooperation of cross-border healthcare between Singapore and Malaysia by integrating their healthcare markets. Patients can move freely between Singapore and Malaysia: the two mains factors are the shared historical background of British colonization and the proximity of their geography.

Singapore is now advanced in the progress of cross-border healthcare. Singaporeans can obtain healthcare in Malaysia by using a healthcare saving account from the Singapore's healthcare system.

The main objective of this facilitation is that "It provides more choices for those who want to seek treatment from private hospitals yet want to stretch their dollars to do so by seeking cheaper but good quality treatment overseas. And there are also people who travel and work in Malaysia and the current policy, which restricts them from using their Medisave, is a strain on their pockets."[151]

(1) Background [152]

Although healthcare expenses are rapidly increased in many countries, it is mainly because of health financing systems. Traditional indemnity insurance, which confirms third-party payment for service attributed, contributes to these cost pressures, because patients and doctors are shielded from the real cost of those payments. In an effort to contain costs, the government, employers, and insurers have

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[151]Healthxchange. *"Medisave can be used in 12 Malaysian hospitals."* http://www.healthxchange.com.sg/News/Pages/Medisave-can-be-used-in-12-Malaysian-hospitals.aspx, (Accessed on June 7, 2016.)

[152]WHO. *"Medical Savings Accounts: Lessons Learned from Limited International Experience."* http://www.who.int/health_financing/documents/dp_e_02_3-med_savings_accounts.pdf, (Accessed on June 6, 2016.)

modified payment schemes and coverage. This increasingly leads to rationing, restricted consumer choice and, in the worst case, patients getting a refusal of care.

"The 3M of Singapore's healthcare financing system consists of universal Medical Savings Accounts, which is abbreviated as MSAs, with supplementary programs to provide social protection for the poor and address potential market failures in health financing."[153] The results have been marvelous with good health outcomes, low costs, and full consumer choices of providers and quality of care.

Originally in 2527 B.E., the Singaporean government set up their own healthcare system of medical accounts, whereby each person is responsible for management of payment of healthcare service. It is composed of the 3M: Medisave, Medishield, and Medifund. The 3M is designed to pay for medical expenses, but it is categorized to perform slightly different functions as demonstrated below.

(2) The Medisave Program[154]

The Medisave Program is a national savings scheme. It helps Central Provident Fund (CPF) members save for future medical expenses including after retirement.[155] The Medisave was established in 2527 B.E. It is the compulsory program that individuals in Singapore have to pay contribution to their healthcare savings account. When they receive healthcare treatment, they can use it to pay both as in-patient and out-patient in both before and after retirement. Medisave contribution is calculated

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[153]Justine HSU. *"World Heath Report (2010). Medical Savings Accounts: What is at risk?."* http://www.who.int/healthsystems/topics/financing/healthreport/MSAsNo17FINAL.pdf, (Accessed on June 6, 2016.)

[154]Government of Sigapore. *"Central Provident Fund Act(Chapter 36, Section 77(1)(J)),Central Provident Fund (Medisave Account Withdrawals) Regulations."* http://statutes.agc.gov.sg/aol/search/display/view.w3p;query=CompId%3A903bb472-afa3-4797-83fc-54519b33342f%20ValidTime%3A20160103000000%20TransactionTime%3A99991231000000;rec=0#legis, (Accessed on June 6, 2016.)

[155]Central Provident Fund Board. *"CPF."* https://www.cpf.gov.sg/Members/Schemes/schemes/healthcare/medisave, (Accessed on June 10, 2016.)

approximately from 8 to 10.5 percent in relevance to the age of an insurer in detailed in the following table.[156]

Age	Contribution rate (% of wage)
35 and below	8%
Above 35 to 45	9%
Above 45 to 50	10%
Above 50	10.5%

Table 3.3 Medisave contribution rates

Note: the Medisave contribution rates shown are only applicable for employees earning ≥ $1,500 per month. Besides, persons are considered to be 35, 45, 50, 55, 60, or 65 years old in the month of your 35th, 45th, 50th, 55th, 60th, or 65th birthday respectively. After your birthday month, you will be above 35, 45, 50, 55, 60, or 65 years respectively.

For Example, Mr. A will be 55 years old on January 15th which is his birthday. The rate applied to him is the above 50 to 55 years' age group until January 15th, 2015. And, the above 55 to 60 years' rate will be applied from February 1st, 2015, up to his 60th birthday month.

[156]Ministry of Public Health Sigapore. *"Medisave."* https://www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/medisave.html, (Accessed on June 6, 2016.)

(3) The limitation of amount withdrawn from the Medisave[157]

The Medisave is limited to certain types of treatment and the amount of withdrawal specified by the Singaporean government. The chart above also applies for the reimbursement rate when patients seek healthcare in designated hospitals in Malaysia.

An example of the type of treatment and Medisave's withdrawal limits:

In-patient hospitalization is restricted to $450 per day + surgical limits according to the Table of Surgical Procedures. (Please see the full list of limitation table in Annex 3).

(4) The Medishield Program

The Medishield was established in 2533 B.E. to perform the function of "Catastrophic Insurance Program." The Medishield was established to implement the Medisave. The reason to have Medishield is that the Medisave alone is not enough for covering serious or prolonged illnesses. But the applied condition is that this program pays for exceptional hospital expenses for people under 70 years old only.

(5) The Medifund Program

Due to the fact that low-income patients do not have enough money to pay for healthcare treatments, the Singaporean government thus tries to

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[157]Government of Singapore. *"Central provident fund act(chapter 36, section 77(1)(j)(4)),central provident fund (medisave account withdrawals) regulations."* http://statutes.agc.gov.sg/aol/search/display/view.w3p;query=CompId%3A903bb472-afa3-4797-83fc-54519b33342f%20ValidTime%3A20160103000000%20TransactionTime%3A99991231000000;rec=0#legis, (Accessed on June 6, 2016.)

subsidize more funds to them.[158] The proposal of this fund is to provide financial assistance for paid workers.[159]

Starting from March 1st, 2010, the Singaporeans can use their Medisave for payment in designated hospitals in Malaysia. But there are only two types of healthcare and certain conditions to apply as follows:

(6) Use of the Medisave in cross-border areas[160]

Starting from March 1st, 2010, the Singaporeans can use their Medisave for payment in designated hospitals in Malaysia. But there are only two types of healthcare and certain conditions to apply as follows:

(1.) Elective hospitalisation for treatment overseas[161]

Condition 1. Only for receiving emergency healthcare treatment

Condition 2. Medisave usage will be restricted to hospitalization and day surgeries only and in the case of out-patient the Medisave cannot be used.

Condition 3. The hospital that patients can use the Medisave must get the approval of working arrangement with a Medisave-accredited institution or from a referral centre in Singapore.

Condition 4. The patients are referred from a Medisave-accredited institution or a referral centre in Singapore.

Condition 5. The local center must give pre-admission clinical assessment and financial consultation to the interested patients.

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[158]Ministry of Manpower. *"3M Framework for Healthcare Needs."* http://www.mom.gov.sg/newsroom/press-replies/2009/3m-framework-for-healthcare-needs, (Accessed on June 6, 2016.)

[159]Thomas A. Massaro. *"Medical Savings Accounts: The Singapore Experience."* http://www.ncpa.org/pdfs/st203.pdf, (Accessed on June 6, 2016.)

[160]Ministry of Health Singapore. *"Medisave for Approved Overseas Hospitalisation".* https://www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2010/Medisave_for_Approved_Overseas_Hospitalisation.html , (Accessed on June 6, 2016.)

[161]Ministry of Health Singapore. *"Further Medisave Liberalisation."* https://www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2009/further_medisave_liberalisation.html, (Accessed on June 6, 2016.)

Condition 6. The local centre will be responsible for patient satisfaction and the clinical result.

(2.) Home palliative care

Palliative care gives a program of coordinated medical and nursing care to the terminally ill. The purpose is to improve the quality of life for the ill persons via pain control, symptom relief, nursing care, consulting, and bereavement supports.

Palliative care can be provided in house or in a hospice. Nowadays, the Medisave can be used for in-patient hospice stays, but there is the limit of withdrawal amount of $160 per day. Many patients who do not require in-patient hospice treatment always want to spend their final stages at their own house. The Ministry of Health would like to encourage this. It tries to facilitate this by supporting them to use their Medisave for home palliative care. In other words, it tries to provide the patients with enhanced choices for the palliative care.

This arrangement of using the Medisave overseas started with the two main providers in Malaysia, which are Health Management International (HMI) and Parkway Holdings Pte ltd. Patients who would like to use this cross-border program are able to contact with these two healthcare providers directly.

The first healthcare provider, HMI, has established its local Medisave-accredited referral centre at its Balestier Clinic and Health Screening Centre. It will cooperate with its two overseas subsidiaries: Regency Specialist Hospital in Johor Bahru and Makhota Medical Centre in Malacca, Malaysia.

The second healthcare provider, Parkway Holdings Pte. ltd., has set up a Medisave-accredited referral center at East Shore Hospital. It will partner with 9 hospitals under the Pantai Group in different states across Malaysia, as well as the Gleneagles Intan Medical Centre, Kuala Lumpur.

Although Singapore is successful in its healthcare system, the cross-border healthcare is still limited, but it is a good signal of the cross-border arrangement that in the near future the conditions of using the Medisave abroad tend to

be more flexible due to the cooperation process such as the plan to extend the name lists of elective hospitalisation abroad in order to give patients broader options.[162]

The Singaporean government seems to be satisfied to take advantage of the lower cost of hospitalisation abroad. The Singaporeans also enjoy using their Medisave in Malaysia according to the statistics depicting that the Medisave program allows approximately 100,000 Singaporean workers who live in Malaysia to use their funds. Apart from the cheaper price, supplementing each country's specialization in healthcare type is also the key to cross-border healthcare. Singapore is good at healthcare that consists of high and complicated technologies. On the other hand, Malaysia is dominant in daily-life healthcare with impressive and competitive price.[163] Mostly, Singaporeans who want to get simple routine healthcare go to obtain healthcare treatment in Malaysia. While Malaysians who want to obtain high-technology and complex healthcare choose to obtain healthcare treatment in Singapore.[164]

3.4.2.2 Thailand's healthcare reimbursement system reform and the introduction of Drafted Harmonization of Health Security System Act[165]

Each healthcare fund is different in law, target group of people, method, and reimbursement. Therefore, there is an unavoidable problem of inequality. For instance, in-patient under the Civil Servant and State Enterprise Scheme can receive the medicines that are excluded from the national medicine list, the medicines that are imported from foreign countries, and also receive operative services such as caesarean

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[162]HMI. Patient Service Centre. *"Use Your Medisave Overseas."* http://www.hmipsc.com.sg/patient-guide/how-to-use-your-medisave-overseas/ , (Accessed on June 6, 2016.)

[163]The Commission United States International Trade Commission Washington, DC. USITC Publication 4176 August 2010. *"ASEAN: Regional Trends in Economic Integration, Export Competitiveness, and Inbound Investment for Selected Industries."* https://www.usitc.gov/publications/332/pub4176.pdf, (Accessed on June 6, 2016.)

[164]Straits Times, *"Use of Medisave Overseas."* February 10, 2010; industry representative, interview with USITC staff, (Accessed on June 6, 2016.)

[165]Thailand Development Research Institute (TDRI). *"Central Development Mechanism In order to reduce the disparity in the health sector."* http://tdri.or.th/tdri-insight/20150605/, (Accessed on May 8, 2016.)

sections (C-section), endoscopic surgery, of which benefits are more than the benefits under other schemes.

Besides, many funds cause the problem of duplication of rights. A lack of efficiency in healthcare system due to the form of payment should not be an expanded budget. Payment in the Civil Servant and State Enterprise Scheme has been increased from 10 percent up to 20 percent in 2549 B.E.

The problem will be solved, if the administration and procedure are developed. Insurance premium and benefit package should not be totally different. To separate the funds is only about financial management, but the package of benefits and insurance premium that patient have to pay have to be similar. At present, people who are insured under the Social Security System have to pay more money than those insured under the National Security System. On the contrary, the benefits that they get are less than those of people getting insured under other funds.

These problems reflect that we need a national governance to solve the problems of inequality of healthcare receive. Instead of determining the price by each fund, the Ministry of Public Health or another designated unit has to be the mechanism of the nation. This is why we have the new strategy for solving these problems.

(1) Summary of the Draft Act related to healthcare fund[166]

The name of the Act has not yet been decided. But the following names have been proposed:

(A.) Control and Supervision of Healthcare System In Government Sector Act

(B.) Establishing the Harmonization Of Healthcare System In Government Sector Act

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[166]Thailand Development Research Institute (TDRI*). "Central Development Mechanism In order to reduce the disparity in the health sector."*
https://www.dropbox.com/s/er85t31i2oku30z/Attach%202.pdf?dl=0, (Accessed on May 28, 2016.)

(C.) Management of Healthcare System in Government Sector Act

(D.) Good Governance of Healthcare System in Government Sector Act

(2) Reasons and criteria of the Draft Act

Background: The problem of inequality of access to healthcare in 1) Civil Servant and State Enterprise Healthcare System Act 2) Social Security Act 3) Universal Healthcare System. They are under the supervision of different administrative procedures and units – a lack of unity.

Solution: To solve the problem it will require this Act to establish a national health insurance council (central unit) to be a department of government under control of the Office of the Prime Minister and command of the Prime Minister. This council will do the function of the three units' management and integration.

(3) Establishment of two commissions in the following details

1. The national healthcare policy commission

It has the role of determining health policy of the country to enable people in the country to receive efficient healthcare services and propose a budget of health insurance of people throughout the country.

-Setting up the rules, policies, and practices that will lead to a harmonized healthcare system on the issues of corresponding basic benefit package, healthcare service system, financial support system, information and management system, quality and safety control in order to guarantee fairness, quality, and efficiency

-Determine budget of the health insurance system in the public sectors as a whole annually and propose the amount of budget to be approved by the Cabinet

-Track and monitor the performance of healthcare service contractors to ensure compliance of the terms and conditions. Besides, it will do the

function of imposing fines in case that service contractors breach such terms and conditions

-Do the annual report of performance, spending on healthcare, outcomes of people's health including justice in healthcare for the Cabinet, at least 1 time per year

2. The national health insurance commission

It has the role of decreasing inequality of people and supporting healthcare insurance to be more efficient.

-Determine corresponding basic benefit package for healthcare insurance by negotiation of people concerned

-Determine criteria for payment of the healthcare service providers and criteria for the allocation of personnel cost by allowing stakeholders to join in negotiations

-Impose sanctions if the funds or the providers do not comply with the terms of the commission's resolution

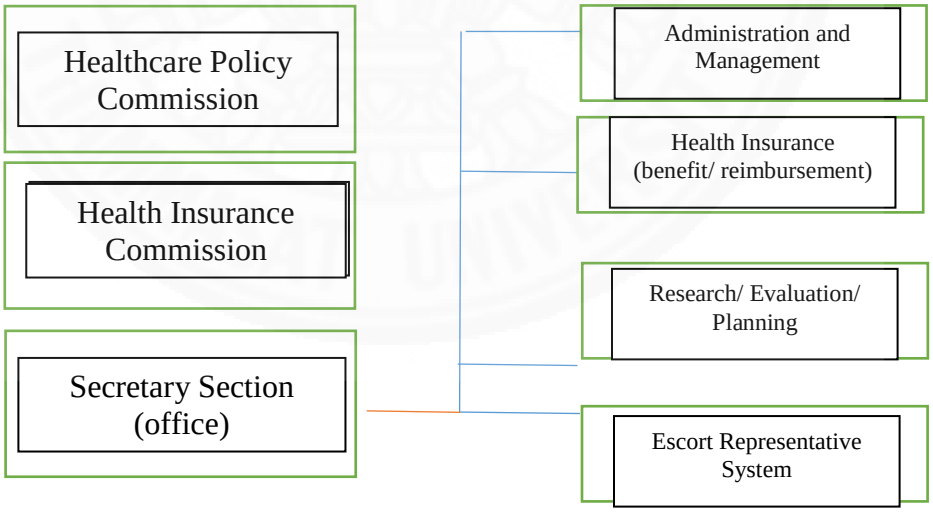

Figure 3.2 The national health insurance commission

This act has specified important definitions; for example, the government's health insurance means the insurance under the law of the Civil Servant

System, National Health Insurance System, and Social Security System. Benefit package means any rights to receive healthcare: the right to diagnosis, the right to primary care, the right to disease prevention, the right to control disease, the right to receive necessary drug, and the right to make a decision in one's own health. Insurer unit means the units that insure people which are Comptroller General's Department, Social Security Office, and National Health Security Office.

In the writer's opinion, this Act is an initiative start-up for Thailand's healthcare harmonization. The initiative steps of the harmonization of healthcare systems in Thailand is the interesting issues because from the past up to present we try to provide the healthcare for all regardless of the economic status of people, which is some people needed for special assistances in issues of healthcare welfare from the government such as people who have low-income, or people who get diseases that need long term treatment or people who are disabled. Sometimes, people do not have the choices because health problems can occur to them in every situation and time without the signal. For example, Mr. Z who is a salary man working for company (under the Social Security System) who get income 18,000 baht per month. If he gets the accident and becomes a disabled person, he should get the health benefits and support from the government, which such benefits should not be totally different from the benefits of other health coverage scheme.

For example, Mr. X get salary 100,000 baht per month and Mr. Z get salary 18,000 baht per month. Although they both have different income and they are insured in different coverage scheme, when they go to receive healthcare, at least the benefit packages that provided by the government have to be the same, pattern of healthcare that are available for them have to be the same, and the service providers have to give the services under the obligations prescribed by law.

However, in writer opinion, when the writer analyses this Draft Act, despite of a reasonable background and principle of this Draft Act, the main contents that should be amended have been lacked and some provisions of the Draft Act may be some problems for managing healthcare system as follows;

The formation of National Health Security Council: according to Chapter 2, Section 12, the Council shall be formed as a legal entity according to regulations on government administration, but the formation of this council is still inconsistency, while it will be a public organization or it will be the a department under the permanent secretary, office the president.

The officials who work for the Council: According to the Draft Act, the qualification of the official seems uncertain, too board of qualification may not be appropriate for the positions in the organization. For example, Section 6 that the National Health Security Committee according to (4)(5)(7) must come from the proposed name lists which come from the diversity of field of study.

Administrative Measures: Under Section 30 of the Draft Act, the private hospitals or hospitals in the university have to follow resolution of the Committee under this act, the provisions seems giving a power for the Committee in the notification and perform administrative measures.

In conclusion, although the Draft Act based on the initiation for Healthcare in Thailand reform, the contents are needed for amendment in the important elements, which the writer would like to suggest the provisions that leaned from the United Kingdom laws under EU's Directive. The Benefit Package under the three healthcare systems should be the same set in the basic healthcare i.e. the benefits that all regardless of the system that they are insured can receive as the same, which they should be determined by the central law which specified the details that what are the items or healthcare under the lists that can be reimbursed, and how much they can reimburse. Besides, the laws have to provide the exception that in which cases or what are the lists of healthcare treatment that can be open-ended for the amount that can reimburse. The harmonization of the supervision by the one unit can help in more easily manage the healthcare systems, however, the governance and transparency should be regarded by not giving boundless discretion of the authorities. Shortly, in writer opinion, the Draft Act still need the amendment of the same standard of benefit package and the more details of them including the boundary of the supervision of the future designated unit.

CHAPTER 4
HEALTHCARE IN THE ASEAN

In this chapter, the writer will discuss the opportunities in establishing cross-border healthcare services in Thailand under ASEAN's context by analyzing ASEAN's current economic status, cohesiveness of the ASEAN community, and current cooperation in the ASEAN, especially in the domain of healthcare cooperation and other relevant issues of healthcare in the ASEAN. Besides, the writer has related the potential benefits that would come about provided that the cross-border healthcare services could be realized.

4.1 Background of the ASEAN

The Association of South East Asian Nations (ASEAN) was formed in 2510 B.E. The Member States of the ASEAN consist of Brunei Darussalam, the Kingdom of Cambodia, the Republic of Indonesia, the Lao People's Democratic Republic, Malaysia, the Union of Myanmar, the Republic of the Philippines, the Republic of Singapore, the Kingdom of Thailand, and the Socialist Republic of Vietnam.[167] It is composed of the countries with diversity in politics, culture, economics, and social characteristics. It was aimed to improve regional cooperation in South East Asia, promote peace, freedom, and prosperity for its citizens.

[167]ASEAN. *"ARTICLE 4 of ASEAN Charter."* http://www.asean.org/storage/images/ASEAN_RTK_2014/ASEAN_Charter.pdf, (Accessed on June 10, 2016.)

4.1.1 ASEAN's current economic status[168]

One of many reasons that countries in the ASEAN are integrated is that they try to establish a competitive market. It has an objective to have a single market including a free flow of goods, services, investment capital, and skilled labor. Plenty of businesses have started to prepare for challenges and opportunities of the ASEAN Economic Community. In light of supporting economic integration, healthcare was one of the identified priority sectors.[169]

Until now the ASEAN has only achieved 73.6% of Phase 1 goals. However, the integration offers an opportunity for the ASEAN to be a single large market and also heighten economic strength with other neighboring countries such as China and India. The less-developed countries such as Cambodia, Laos, Myanmar or Burma, and Vietnam still have to fulfill the financial integration. According to the US International Trade Commission report on AEC, [170] the challenges were seen in the area of importing and exporting which vary widely among the ASEAN members. For instance, methods for trading are not complicated in Singapore, Thailand, and Malaysia. On the other hand, it is very difficult in Laos and Cambodia.

Additionally, the ASEAN still has the challenges in healthcare. There are many levels of development in access to healthcare, healthcare supplies, and resources spent on health, etc. High-income countries tend to have healthier people with lower mortality rate, while lower-income countries such as Lao People's Democratic Republic (PDR), Cambodia, and Myanmar have higher mortality rate with the lower spending in healthcare cost.

Besides, aging population is increasing. People who are 65 years old, around 10 percent of the population in the ASEAN, will two-fold increase, and the

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[168]Christopher W. Runckel. *"Asia Opportunities: Asean Economic Community (AEC) in 2015."* http://www.business-in-asia.com/asia/asean_economic_community.html, (Accessed on May 5, 2016.)

[169]ASEAN Secretariat. *"ASEAN Mutual Recognition Arrangement on Nursing Services."* http://www.aseansec.org/19210.htm, (Accessed on May 5, 2016.)

[170]US-ASEAN Business Council. "The US International Trade Commission report on AEC." www.usasean.org/ASEAN/pub4176.pdf, (Accessed on June 10, 2016.)

healthcare cost tends to increase as well.

According to the World Health Organization's information, the estimated subtotal healthcare expense per capita in the ASEAN is US$ 544 or around 4 percent of GDP. [171] Singapore is the ultimate country with expenditure per capita of US$ 2,273. Brunei is the second-runner with expenditure per capita of US$ 1,449. The ASEAN has its high goal to support health spending with better healthcare services.

Public Private Sector Partnership or PPP is the mechanism to enhance and extend healthcare services. In the Philippines, the government is now open for bidding the construction of a 700-bed capacity super specialty tertiary hospital. The project costs around US$ 135 millions.

4.1.2 Fundamental freedom and healthcare as a priority sector

The ASEAN got an impressive success in liberalizing trade of goods via the ASEAN Free Trade Agreement or AFTA. Under the AFTA, the tariffs on all imports within the ASEAN are reduced to zero. But in terms of liberalizing service it is not much successful. The efforts of the ASEAN are through the GATs and the Mutual Recognition Arrangement (MRAs) of professional service. The ASEAN Framework Agreement on Trade in Services (AFAS) occurred in 1995. But it failed in liberalizing service trades among ten members countries of the ASEAN. The ASEAN is based on three pillars which are the ASEAN Security Community, the ASEAN Economic Community (AEC), and the ASEAN Socio-Cultural Community.

According to the AEC blueprint, ASEAN's aim is not only to be a single market but also a single production base. Therefore, the principles of the AEC provide for fundamental freedom with relevance to international business to ensure a single AEC market and an opening of an AEC single production base. The ASEAN Economic Community has key characteristics as follows: [172]

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[171]The official of the Associate of South East Asia Nation investment promotion. http://investasean.asean.org/index.php/page/view/healthcare, (Accessed on May 6, 2016.)

[172]KPMG. *"The ASEAN Economic Community 2015."* http://www.kpmg.com/CN/en/IssuesAndInsights/ArticlesPublications/Documents/The-ASEAN-Economic-Community-2015-O-201406.pdf, (Accessed on May 17, 2016.)

1. Single market and production base, which is composed of a free flow of goods, a free flow of service, a free flow of investment, a free flow of capital, and a free flow of skilled labour[173]

2. Competitive economic region, [174] which is composed of competition policy, consumer protection, intellectual property rights, infrastructure development, taxation, and e-commerce

3. Region of equitable economic development, which is composed of SME development, and initiative for ASEAN integration

4. Region fully integrated into the global economy, which is composed of a coherent approach towards external economic relations, and enhanced participation in global supply networks

The ASEAN prioritizes healthcare sector because of its potential of GDP growth. Besides, it is important for providing people's welfare with the better quality of healthcare in the ASEAN region. According to the ASEAN Charter, the ASEAN aims to set up a human rights body with the purposes and principles of the ASEAN Charter relating to the support and protection of human rights and fundamental freedom. [175] Healthcare is one of the fundamental goals of trade in services. Such freedom cannot be accessed to if people still have a restriction in healthcare expense. In the ASEAN, there is a lack of human resources in healthcare such as medical professionals. The survey shows that only Singapore, the Philippines, and Brunei Darussalam have a number of physicians per 10,000 population more than the average of lower-middle income countries. The question is that can the ASEAN provide enough medical professionals for its own states and region? If the Member State cannot provide enough medical professionals for itself, it cannot provide enough medical professionals for the

[173]ARTICLE 1 of ASEAN Charter.
http://www.asean.org/storage/images/ASEAN_RTK_2014/ASEAN_Charter.pdf,
(Accessed on June 10, 2016.)
[174]*Ibid.*
[175]ARTICLE 14 of ASEAN Charter.
http://www.asean.org/storage/images/ASEAN_RTK_2014/ASEAN_Charter.pdf,
(Accessed on June 10, 2016.)

ASEAN region. Therefore, inadequacy of medical human resources is one of the restrictions in liberalizing trade in services in the ASEAN.

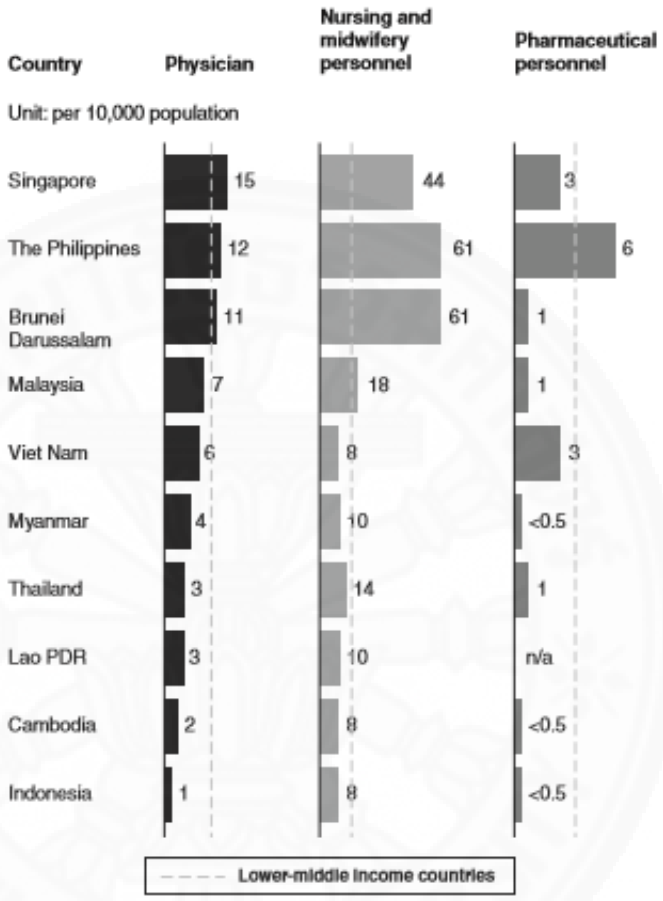

Figure 4.1 The inadequacy of medical human resources in the ASEAN.[176]

4.1.3 Current cooperation in healthcare in the ASEAN

Nowadays, ASEAN in the stage of AEC mostly cooperate in the ecomic aspects. Some cooperation is initially in this Regoin such as launch of AEAN Directice and ASEN Mutual Recognition (MRAs).

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[176]Deunden Nikomborirak and Supannavadee Jitdumrong. *"Chapter 3: ASEAN Trade in Services."* In The ASEAN Economic Community, ed. Sanchita Basu Das et al. ISEAS Publication. http://www.adb.org/sites/default/files/publication/31147/aec-work-progress.pdf, (Accessed on June 10, 2016.)

4.1.3.1 ASEAN Directive

There is not much cooperation in ASEAN's healthcare system. But there are some aspects that are now in preparation for the advent of the ASEAN Economic Community (AEC). So far, the ASEAN Medical Device Directive or AMDD has been launched in 2012. The unofficial time of its implementation was anticipated by 2015 with all of the ten Member States' compliance. But now there is only Singapore who is the first leading country to implement its national law in compliance with this AMDD, while the second country that has implemented the AMDD is Malaysia. At least it shows that the ASEAN is interested in the field of healthcare and tends to establish a harmonized legal framework. They see the importance of a unified system that could support cross-border healthcare, not only for financial benefit but also for improving ASEAN people's health quality.

The origin of this AMDD was adjusted from the European Medical Devices Directive (MDD 93/42/EEC) and other European guidelines. Therefore, researching on the European Union Directive would be helpful as an introduction for a directive of the ASEAN on cross-border healthcare as well. In spite of the fact that in the near future the Directive may not be spontaneously appropriate for the ASEAN's context due to differences in cultural, economic, technological, and political situation, the approaches from European Union legislation study would be adaptable to Thai law pertaining to agreements such as in bilateral treaty or multilateral treaty with other countries that are ready for cross-border healthcare.

Although the government policy nowadays highlights medical tourism and tries to attract foreigners to receive healthcare in Thailand, the advent of the AEC and its free trade in services include the Thais mobility to other countries in the ASEAN as well. It means that when the Thais move to other countries, whether permanently or temporary, it cannot be considered as a free movement without adjustment of health policy.

4.1.3.2 Thailand and the ASEAN do the Mutual Recognition Arrangements (MRAs) in services on medical practitioner

"To support the free movement of professionals the Agreement on Services stated that the ASEAN Member States may recognize the education or experience obtained, requirements met, or licenses or certifications granted in another ASEAN Member State, for the purpose of licensing or certification of service supplier."[177] Besides, it was aimed to exchange information and enhance cooperation in the respect of mutual recognition of medical practitioners, to promote adoption of best practices on standard and qualifications, to provide opportunities for capacity building and training of medical practitioners. All of these goals are under responsibility of the Medical Council of Thailand. In the near future, there are more roadmaps for implementation on the ASEAN Framework Agreement Service.[178] There is a trend to have malpractice insurance in case those medical practitioners go to provide service in other Member States in the ASEAN.

Although there is the recognition of medical practitioners in the permanent registration, a barrier exists at getting a license provided that medical practitioners have to pass an examination which is in the local language of the Member State of treatment. In order to practice as a nurse in Thailand, a Filipino nurse has to pass the national license exam in the Thai language, from which can be clearly seen that it is a barrier of mobility of foreign nurses[179] because that nurse may practice in Sukhumvit area, where all patients are English speakers and there is no need to use Thai in any communication with patients at all. Moreover, they have to follow domestic laws and regulations of the host country such as the equity of foreigner rule. For example, in

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[177]Article 5 of ASEAN Framework.

[178]Prasobsri Ungthavorn. *"Roadmap for Implementation of ASEAN MRA on Medical Practitioners."* http://www.med.nu.ac.th/PGF2013/dfd/25Jun2013/AEC%20PIT%20Version%2015-Prasobsri.pdf, (Accessed on December 6, 2015.)

[179]Deunden Nikomborirak. Service Liberalization under the ASEAN Economic Community: Myth and Reality, Opportunities and Challenges. Vol. 28 No. 2 Thailand Development Research Institute, June 2013. http://tdri.or.th/wp-content/uploads/2013/08/t5j2013.pdf, (Accessed on June 10, 2016.)

Thailand there is a foreigner's business establishment Act: if foreigners want to have shares of more than forty-nine percent, they have to get permission from the foreigner's business establishment commission.

From the project of the government, there is an aim for Thailand to turn into a medical hub. It will bring about both negative and positive effects in many perspectives such as economy, professionals brain flow, ethics of healthcare professionals, including the right to protection. [180]

The right to protection in each county is different. The rights to protection in a host country may be less than in a residence country. The evaluation of efficiency in each country is different. Therefore, high expectation leads to cases between healthcare service providers and patients. Patients, as consumers, realize that they have the justified rights in the claim of proficiency healthcare.

However, there is a restriction of patients mobility concerning immigration law. Immigration law and visa requirements across Member States in the ASEAN do not provide preferential treatment for medical travelers. Visas are still required beyond a typical thirty-day stay. But Malaysia implements a green lane in its entry points and airports to facilitate easier travel for medical tourists. [181]

[180]Channarong Sankoryut. *"International Trade and Health series."* http://ihppthaigov.net/ith/images/ith_series_health%20service2.pdf, (Accessed on December 05, 2015.)

[181]*Ibid.*

4.2 The trend of establishing cross-border healthcare services in Thailand and the ASEAN focusing on economic perspective

Health diplomacy[182]

The international community recognizes the importance of diplomacy for public health or Health Diplomacy, which is another dimension of foreign policy for responding to the current health issues. They are not specific issues of each country. Therefore, protection and solutions for healthcare problems require international cooperation between countries. There is a push for health policy to be an international policy to encourage the use of public health issues as a tool of foreign policy. Moreover, it also can be used as a tool to enhance public health within the country.

Foreign Policy and Global Health Initiative

Thailand saw the abovestated importance; therefore, it participated in the Foreign Policy and Global Health Initiative, or FPGH, which is the cooperation of countries highlighting health diplomacy. The cooperating countries are Norway, France, Brazil, Indonesia, South Africa, Republic of Senegal, and Thailand for responding to the current health issues which are not domestic issues of each country but there is a need of international cooperation.

The FPGH was founded in 2549 B.E. during the 61th UN General Assembly. The activity which FPGH operates annually is the proposal of resolution in the UNGA under the Agenda Global Health and Foreign Policy. There are various focused issues each year. In 2556 B.E., Indonesia proposed the issue of "Strengthening Partnership for Global Health: Global Heath Partnership (GHP)" in order to be a mechanism in the subsidiary of health operation.

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[182]Department of International Organizations. *"Health Diplomacy."* http://www.mfa.go.th/main/th/issues/9897-%E0%B8%81%E0%B8%B2%E0%B8%A3%E0%B8%97%E0%B8%B9%E0%B8%95%E0%B9%80%E0%B8%9E%E0%B8%B7%E0%B9%88%E0%B8%AD%E0%B8%AA%E0%B8%B2%E0%B8%98%E0%B8%B2%E0%B8%A3%E0%B8%93%E0%B8%AA%E0%B8%B8%E0%B8%82-%28Health-Diplomacy%29.html, (Accessed on December 5 , 2015.)

The issues of the GHP are in harmony with Thailand's direction in health support and development. The issues are also connected with the report of the High Level Panel of Eminent Persons on the Post 2015 Development Agenda, in which the President of Indonesia proposed " A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development."

The Thai agency has begun to be awarded of its own role in the international arena. Healthcare is not only a technical platform; therefore, it established an advisory committee on the policy of health system in order to be the center of supporting and gathering point for making speeches, statements, and comments for various international conferences that have implications for public health.

Universal Health Coverage in international meeting

Universal Health Coverage or UHC is one of the issues in the meeting of the 66th UNGA in September 2554 B.E. Thai, Brazil, and Rockefeller Foundation cooperated to raise this issue during the High-Level Meeting on Non-Communicable Diseases (NCDs) as well as to push the issue in the High Level Meeting (HLM) or the UNGA Special Session (UNGASS) and in the next UNGA.

At the same time, the group of the FPGH also supports the principle and importance of t he UHC in every country, especially the connection between foreign policy and international health policy. There is the aimed issue of " Moving towards Universal Health Coverage" in the 67th UNGA. Since 2555 B.E., the conference has been co-sponsored by 91 countries, including major economic countries such as the USA, China, Japan, the European Union, South Korea, Myanmar, and the Philippines.

The main content is the UHC, which is a part of the rights of people in public health. By calling the Member States to focus on public health issues and build links between UHC, issues of foreign policy as well as other issues including globalization, security, and sustainable development are promoted. Encouragement of the Member States increases their efforts in enabling access to healthcare with equity and fairness to all groups of people in society without discrimination. Also, the Member States ought to establish partnership with other agencies and organizations involved in the UHC issues.

The abovestated resolution highlights importance and benefits which states and people will get from the UHC policy, not only in public health perspective but also in sustainable development and decrease of poverty, to achieve the Millennium Development Goals (MDGs) and the protection of human rights by being aware of the difference in context and economic form of each country in taking the UHC policy into practice. Besides, the UHC will put the UHC issue in post-2015 development agenda and the Economic and Social Council (ECOSOC). It requires consultations for supporting the UHC both in regional level and global level.

Thailand supports the UHC in international level continuously such as parallel activities during the annual meeting of Economic and Social Commission for Asia and the Pacific (ESCAP) in the issue of Universal Health Coverage, sharing Thai experiences and driving the UHC agenda, and promoting the right to health through Universal Health Coverage in the meeting of the 23rd Human Rights Council. Moreover, UHC is one of the issues that World Health Organization (WHO) focuses on.

In the writer's opinion, health diplomacy is an interesting channel for raising the cross-border healthcare issue which can be expanded from UHC issues. However, to have a concrete cooperation, there must be law or entry into agreement with countries that are ready to adjust their policy and law in order to achieve the real probable goal of enforcement. To comply with law and agreement will need to consider whether the current agreement is an appropriate mechanism or we should have a new agreement specifying cross-border healthcare directly, due to its complexity and importance.

4.3 Comparison between regional governance in the European Union and the ASEAN: an approach from legal perspective

4.3.1 ASEAN's legal framework

Agreements among the ASEAN Member States set up legal obligations among parties in dispute. There is an absence of supranational legal basis, even though

certain important agreements, including Treaty of Amity and Cooperation in Southern Asia (TAC) and Framework Agreements for Enhancing ASEAN Economic Cooperation, are already in action. Despite the attempt to regulate its entity to be more legal-based by prescribing detailed procedures, markedly in dispute settlement and decision-making process, the ASEAN Member States remain reliant on intergovernmental negotiation with negative consensus procedure as a mechanism for settling dispute and reaching decision, even after the ASEAN Charter was enacted. To put it differently, it is politics, not strongly determined legal procedures, that runs the ASEAN. This leads Member States to turn to WTO's settlement procedure instead of ASEAN's dispute settlement procedure, which virtually has never been counted on for resolution. Yet, this is rooted in the consideration that final saying to a dispute ought to be grounded on unanimous agreement.

4.3.2 European Union's strong legal system

In comparison with the ASEAN, the European Union legal framework establishes a stronger legal regulation pertaining to decision-making and dispute settlement, as evident in the European Union Treaties. Besides, sovereignty of the Member States can be limited by a supranational legal system such these Treaties bring into effect. This locates Member States' legal obligations under the Treaties and helps enhance European Union's economic integration as well. Furthermore, decision-making process of the European Union has a basis on legally prescribed procedures in which unanimous agreement of the Member States can be bypassed.

4.3.3 Positive and negative effects on regional governance of both legal frameworks

The difference of legal frameworks between the European Union and the ASEAN has been shown distinct. This difference beckons notice at its effect on regional governance in the European Union and Asia, particularly in regional coordination for economic crisis and Member States' implementation of their obligations.

On part of the regional coordination for economic crisis, Dr. Petr Blizkovsky, in the discussion at the European Commission, maintains that ASEAN's

legally soft institution plays a positive role in regional governance to get over economic crisis, mainly due to its flexible decision-making that is capable of tackling with the issues in due time. It is evident in the Asian currency crisis that the ASEAN became disentangled by involving non-ASEAN neighborhood within the regional coordination. Therefore, relatively flexible legal basis facilitated the ASEAN to form up a special financial support system even with assistance of Japan and Korea. Comparatively, ASEAN's soft-law approach could be preferable at the time of financial crisis.

Anyhow, ASEAN's soft-law system hinders strict implementation of obligations by the Member States. Consistent economic growth, however, requires Member States' implementation. Thus, European Union's hard law fares better than the soft-law approach by virtue of its regional legal basis that ensures Member States' implementation of their obligations, including the duty not to make quantitative restriction.

The above features have proven positive effects of both legal frameworks. To think about a future coordination in the ASEAN (or Asia), one is required to understand thoroughly this difference and its effects. It is likely that the ASEAN institution would continue its soft-law legal framework, as influenced by few legally cultural similarities and political disputes among members. However, this phenomenon does not predict a failure in economic integration and regional coordination. The ASEAN's soft-law system rather has a potential to be a new model of soft-law approach to regional coordination in the future.

4.4 Obstacles to cross-border healthcare in Thailand and ASEAN's context

4.4.1 Absence of harmonized models of healthcare system in Thailand

In Chapter 3, we can see that even in the domestic level of reimbursement of healthcare in Thailand, there are many problems of inequality. Before we promote cross-border healthcare, we have to make sure that it will not intensify the problem of inequality. In our healthcare, Thailand tries to promote healthcare as a

universal right that can be enjoyed by all citizens regardless of their economic status. Therefore, the principle is on how we can harmonize the models of healthcare system in Thailand under one supervising unit, and after that we can set up a cross-border healthcare arrangement through legal instruments.

4.4.2 Difference in economic status and cohesiveness in the ASEAN community

The European Union can have cross-border healthcare because there is cohesiveness of the European Union, which supports mobility of persons across Members' territories. For example, there is no visa requirement. Additionally, cross-border healthcare works well perhaps because there is not much difference in economic status. From the European Union's experience, although the European Union is harmonized in economic perspective, the small country still gets problems from the effects of cross-border healthcare. The principle is that although patients need to get treatment within appropriate time of access, which is about the life of people and human rights, resources allocation, government's administrative procedure, including finance management have to be considered. Healthcare spending has been high in recent years; therefore, cross-border healthcare certainly could save life in the view of a country that lacks medical treatment. On the other hand, how we balance public management and people's life is quite a difficult and complex issue which needs interdisciplinary consideration.

4.4.3 No central judicial organization to promote cross-border healthcare

The first concrete cross-border healthcare rule came out in the form of European Union Regulation, which originally did not give much freedom in seeking cross-border healthcare; in other words, receiving healthcare abroad within the European Union countries needs permission from the state that one is insured – only in exceptional cases is there no need of such permission, for example on an emergency basis. Later, the European Court of Justice took another role, an active role, as a true promoter of cross-border healthcare by granting the right to receiving healthcare abroad – this time the

scope was broader than it had been provided in the Regulation. Therefore, it came out later in the form of the Directive, whereby each Member State of the European Union has to implement in its own domestic legislation.

Comparing to Thailand and the ASEAN, we do not have the central court which will be the main actor in cross-border healthcare. According to the ASEAN Charter, the way we settle disputes is also reliant on arbitration. Moreover, if we try to promote cross-border healthcare in the ASEAN, it will need more progress in legal instruments, whereas in the ASEAN we normally use negotiation which takes time to find consensus because of our diversity in healthcare system. However, bilateral arrangement of the countries that have similar contexts can occur such as the Singapore and Malaysia Arrangement.

4.5 Problems that may arise from cross-border healthcare services and solutions to those problems

Potential problem 1: Cross-border healthcare may widen the inequality of patients' rights between patients in wealthy countries and patients in less-developed countries in the ASEAN.

Cross-border healthcare may create more inequality among people due to financial issues such as upfront payment, habit of travelling abroad, non-reimbursement expense e.g. accommodation, ticket fare, and visa arrangement.

In reality, inequality in healthcare is a widespread issue that occurs not only in the ASEAN region but also in almost every region around the world including Europe. This problem comes from "the fact that people's life chances differing so widely is not simply a problem of poverty, but one of socioeconomic inequality."[183]

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[183]The Lancet–University of Oslo Commission on Global Governance for Health. *"The political origins of health inequity: prospects for change."* http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2813%2962407-1.pdf?dialogRequest=, (Accessed on May 6, 2016.)

From the European Union's experience which includes both small and big potential countries, adopting a single model of the Directive or implementation of patients' rights and the cross-border healthcare Directive also triggers negative effects especially in the small countries such as Malta. Studying impact of the European Union on its health system can be important to furthering our understanding of the manner in which the Europeanisation of health systems occurs.

Solution: A possible solution is multidisciplinary and directs attention towards health education and balance of social deprivation.[184] Since healthcare is not purely an economic activity or only a trade for gain, a solution needs interdependent factors or a connecting infrastructure involving economic, socio-cultural, as well as political developments. However, to decrease these inequality issues, the legislation would need to allow discretion for supporting specific needed people or vulnerable persons such as the disabled who need assistance, or the poor who cannot support travel and accommodation fees. But the proof that they actually need extra support has to be investigated; this would place the burden on the government or people concerned with the investigation. Therefore, there is a need to decrease possible frauds such as creating false evidence to the authority by putting a sanction on such kind of fraud claim.

Potential problem 2: Subjective issues

The indicators of quality, safety, and waiting time are varied and subjective when there are cross-border healthcare services. Providing of information by the National Contact Point is one of the facilitators for patients. But if there is no consensus in certain definitions, offering of such information may be useless.

Solution: The Member Countries of the ASEAN have to hold a meeting in order to consult about the agreed values and principles that will be applied on grounds of balancing consensus among considerable cultural differences and individuals' context.

Potential problem 3: Empowerment of discretion of the authority

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[184]European parliament directorate general for research working paper. *"Health Care Systems in the EU."* http://www.europarl.europa.eu/workingpapers/saco/pdf/101_en.pdf, (Accessed on May 6, 2016.)

Since healthcare concerns people's health, sometimes it needs case-by-case basis which may heighten the authority's power. Limitation of such discretion is needed, but the criteria are normally hard to set. For example, if the authority examines that a healthcare can be received domestically without undue delay, then the patient is not allowed to receive reimbursement from getting healthcare abroad.

Solution: Establishing a transparent and accountable mechanism for inspecting the authority's operation in the legislation such as the domestic regulations. Good governance shall be applied and inspected by another designated unit.

Potential problem 4: Reimbursement rates tend to vary, due to the difference in economic status of each country and its value of currency. "The question of reimbursement is very complicated in cases where a national sought medical treatment in a country that bases its healthcare system on principles that are largely different from the principles of healthcare system of the country of residence."[185]

Experienced in the European Union, in the case of *Müller-Fauré,*[186] she received treatment abroad and could claim reimbursement of the cost of treatment paid only within the limit provided by the sickness insurance scheme of her Member State of affiliation. According to the Netherlands' reimbursement rate, she could claim only up to the maximum of EUR 221.03. But in reality when she received healthcare in Germany, she had to pay the healthcare fee of EUR 3,806.35.[187]

Solution: The DRG (Diagnosis-Related Group) system has been introduced in the setting of reimbursement rate in details as follows:

1.) Definition of a data sample

2.) Use of trimming methods and plausibility checks

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[185]Johan w. Van de gronden. Wisconsin international law journal. "*Cross-Border Health Care in the EU And The Organization Of The National Health Care Systems Of The Member States: The Dynamics Resulting From The European Court Of Justice's Decisions On Free Movement And Competition Law*." http://hosted.law.wisc.edu/wordpress/wilj/files/2012/02/vdg.pdf, (Accessed on May 6, 2016

[186]Müller-Fauré, 2003 E.C.R. at I-4576, paras. 105-07.

[187]*Id.175*

3.) Definition of prices

In Europe, there is cooperation in consultation of reimbursement price setting, in which there is an analysis of the aggregation of information of the DRG of each country. To collect profiles of the DRG of countries in the European Union may lead to more efficient price setting on the international level in the near future.[188]

Potential problem 5: Inequality of benefits of some countries in the ASEAN

Comparing the quality and efficiency care among the competitive markets, Singapore, Malaysia, and Thailand are the top three in the ASEAN region in healthcare sector. The support of free movement of services may cause the poorer countries to be unable to compete with the wealthier countries at attracting clients in healthcare business.

Solution: An objective should be noted that everyone cannot gain benefits equally, because that achievement is an impossible myth.[189] The disadvantages of the integration of cross-border services should be managed by policies and programs that will support healthcare sector or communities that are negatively affected. Of course, the programs need long-term development. An example of such programs could encourage increasing efficiency at financing well-trained professionals in healthcare sector.

Potential problem 6: Risk of the movement of healthcare professionals

The supportive policy of cross-border healthcare might trigger the problem of brain flow. Many health professionals may seek better benefits of remuneration when work abroad in terms of better opportunities and carrier path. Some countries may be scared to invest in health professionals' training, for training is useless if they graduate and work somewhere else outside the country of training. This will cause a problem of human resources development.

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[188]Reinhard Busse. *"Diagnosis-Related Groups in Europe."* http://www.euro.who.int/__data/assets/pdf_file/0004/162265/e96538.pdf, (Accessed on May 6, 2016.)

[189]The Wharton School University of Pennsylvania. "Is ASEAN Ready to Become a Single Market?." http://knowledge.wharton.upenn.edu/article/is-asean-ready-to-become-a-single-market/, (Accessed on May 6, 2016.)

Solution: Not only incentives can motivate health professionals, the pride of serving the society can do as well. Recognition of love for their nation would be the way to make them stay at with their friends and family.

Potential problem 7: Language barrier might be a potential problem.

While sharing information in cross-border healthcare services is quite important especially in the continuity of care, how can the professionals communicate with each other if different languages are applied? Sharing information is needed in many aspects, such as treatment practices and pharmaceutical principles.[190] In the European Union, there is an encoding system to solve this problem. However, some information might not be encoded properly and thus triggers the problem of misunderstanding the meaning because of misinterpretation.

Solution: There should be a meeting when the words are encoded, for the definitions to be understood on the international level. And the new generations of healthcare professionals are encouraged to learn English as well, as it is the language that can be used for communication among the ASEAN Member Countries.

Potential problem 8: Lack of a single model among the countries in the ASEAN

When we look at the European Models, they are based on the principles of solidarity, fairness, and universality. The Models are of different systems, mostly are the Bismarck or Beveridge system, as well as using a mixed system. The Bismarck comes from the relationship of employment, but the Beveridge system comes from general state budget or tax contribution by people. The variety of models causes the problem of the right of access to the system, and the benefits are different. But to adopt a single model is unrealistic, because each country has its own development and context in healthcare services.

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[190]Federico de Montalvo. *"A European common framework for health: a real possibility or an improbable myth? Lessons for the future healthcare systems in United States."* http://via.library.depaul.edu/cgi/viewcontent.cgi?article=1025&context=jhcl, (Accessed on May 17, 2016.)

Solution: Setting up shared values or principles in healthcare. Although systems among the countries are different, the goals and respective values are the same. It will make the countries achieve the same goals with willingness for cooperation.

4.6 Reasons to establish cross-border healthcare services principles in Thailand

Thailand with the ASEAN has its policy to support free trade in services, which means the free trade of service recipients (patients). Although patients mobility and health professionals mobility are in the early stage of ASEAN economic integration, these phenomena are happening nowadays and may increase in the future due to the linearization of trade in services. In the writer's opinion, there are three perspectives of benefits which are the benefits for citizens

4.6.1 Benefits for citizens

In the writer's opinion, cross-border healthcare services legislation would be beneficial for patients when they seek healthcare aboard. They will know their rights and they can use their rights as long as it does not affect other people' rights. Besides, they will be informed of choices of healthcare across border as the standard of care is also explained to patients before they decide to receive healthcare aboard.

4.6.1.1 Clarifying patients' entitlements to cross-border healthcare

According to the ASEAN Charter, the ASEAN tries to set up a single market in which there definitely is facilitation for free flow of goods and services. Free flow of services includes healthcare services. Besides, subsidiary of business and persons movement is one of the purposes of the ASEAN community.[191] The Thai people are likely to use the services in the ASEAN Member Countries because health is one that is attached with human body. It means that we cannot choose where we get sick in both cases when we travel abroad or live permanently abroad. Therefore, cross-border healthcare services will help the Thai people find out the many questions that need to be

[191]The ASEAN Charter. *"Jakarta: ASEAN Secretariat, January 2008."* http://www.asean.org/storage/images/ASEAN_RTK_2014/ASEAN_Charter.pdf, (Accessed on May 17, 2016.)

answered. What are the rights they have when they get sick abroad? Do they have to pay the price themselves? Imagine people who operate business abroad, or perform their duties outside Thai jurisdiction which may benefit the Thai society as a whole. Should they have any rights offered or at least the rights not lessened when they go abroad. As evident in the example from the European Union, people who are EU citizens can claim for reimbursement under the criteria set up in the EU Regulation and the EU Directive. First of all, those laws and regulations clarify the people's rights. At least, people have to know what the rights they have are. Legislations concerning cross-border healthcare services would help in clarifying patients' entitlements to cross-border healthcare.[192] For example, Mr. A is a lawyer who went to Singapore arbitration venue. Mr. A would like to know if he has any rights when he goes to Singapore or how much he can reimburse, provided that there is an agreement between Thailand and Singapore in the case of reimbursement of cross-border healthcare. The legislation would say what are the rights he has and what are the terms and conditions that apply.

4.6.1.2 Informed choices and standard of care

Since differences of professional standards between countries may affect the quality of care, cross-border healthcare has the National Contact Point which is the mechanism for obtaining information about the standard of care and informing people of necessary information that they want to know before they go (not in the case of emergency care). The EU legislation has set the information for in-patients and out-patients, which means that the National Contact Point of each country does the function of providing information for people who would like to obtain healthcare services abroad and foreigners who would like to obtain services in that country as well. Therefore, cross-border healthcare services are important in terms of offering information for patients for the avoidance of misunderstanding and increasing more information for patients. For example, Mr. A, who is a Thai, would like to obtain a hip operation in

[192]Katharine Footman, Cécile Knai, Rita Baeten, Ketevan Glonti, Martin McKee. *"Cross-border health care in Europe."* http://www.euro.who.int/__data/assets/pdf_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf?ua=1, (Accessed on May 17, 2016.)

Myanmar because he is married to a Burmese girl and she is the only one he has since other relatives of his have already passed away. How could Mr. A obtain such information as the standard of care in Myanmar if there is no National Contact Point? Likewise, in the ASEAN we do have the problems of language barrier. Therefore, in the writer's opinion, it is very necessary to have a contacting unit to offer reliable information to the patients because healthcare information, one which concerns people's life, has to be accurate.

4.6.1.3 Continuity of care and interaction between health professionals for people who obtain healthcare services abroad

Healthcare is unlike other businesses. Most of the time, there is a requirement for continuity of care. For example, Mr. A got an accident in country A. He had a leg operation in country A, but he would like to go back home after finishing the operation. Therefore, when Mr. A gets back home in country B, there is a need for transfer of health information and also a contact between health professionals, if necessary. Cross-border healthcare legislation will create a channel for more convenience in contacting among the countries, which would help the patients' mobility achieve the goal of supporting the quality of life of people. Besides, privacy in processing personal information is respected by people concerned due to the enforcement of the law, and there is the confirmation of the right of copying of healthcare owner's information.

4.6.1.4 Ensure the ASEAN countries work closer together in the interest of patients' treatment that is not available at home, and to receive better quality treatment and create network for supporting the quality of life in healthcare

Some treatments are available in one country but that country may be short of other kinds of treatment. Exchanging information about the availability of treatments in each country would help patients save their lives in time especially in the urgent case that patients need to receive healthcare immediately, otherwise death. For example, Mr. A got a disease and had to get a specific laser therapy, but in the country that he lives has no such treatment. Therefore, he can contact the National Contact Point for searching an appropriate place abroad that it is possible for him to obtain that therapy.

Imagine Mr. A needs the treatment immediately because of the final stage of the disease, working closer together could save his life. To send people for seeking healthcare abroad is the advantage for patients in cure, but the drawback is that some countries may lack a motivation for setting up their own treatment in the long term.

Besides, the network will help in building preventive measures for communicable diseases. This network will be the potential instrument as an inter-connecting alarm of the diseases.

4.6.2 Benefits for health professionals

Healthcare professionals can get benefits from the crystal-clear rules when they give healthcare services to foreign patients such that they will not prioritize them, and if they refuse to provide services, it is not grounded on discrimination. In addition, without considering healthcare professional's status, the rules applicable to healthcare are those of the country of treatment or the country where the care is offered. But the cross-border healthcare will not affect provisions regarding the recognition of professional qualifications, which have been discussed that some barriers should be eliminated such as language barrier. The health professionals should not have to take the examination of qualifications in local language if they can provide sound reasons. For example, Thai health professionals working in Myanmar do not have to take the examination of qualifications if they prove that the patients who receive healthcare in Myanmar are only Thai or other nationalities that do not use the Burmese language at all.

From the European Union Member States' experience, the health professionals must have indemnity insurance. The Directive requires health professionals to have professional indemnity insurance in order that if a patient gets harm in some way because of the negligence of health professional, the patient is able to recover any compensation they may be entitled to.[193] Although this may increase the expense of health professionals, normally this expense will be passed by putting in the cost of patients, which is useful for health professionals in terms of avoiding the risk of

[193]Health and Care Profession Council. *"Professional indemnity insurance."* http://www.hpc-uk.org/registrants/indemnity/, (Accessed on May 5, 2016.)

bankruptcy from their negligence or malpractice, and also useful for patients for getting claims from the damages.

4.6.3 Benefits for country and the ASEAN region

Cross-border healthcare legislation will create common principles between Member Countries in the ASEAN and also establish obligations for facilitating cross-border healthcare. On the other hand, as a facilitator who has the duty to support healthcare, the cross-border healthcare legislation could set out excluded obligations such as the function of monitoring the standard of care of the country that patients wish to obtain healthcare but not liable to malpractices of professionals in that country. Although it is on international standard that the standard and quality of care is subject to domestic legislations and regulations, advancing clear provisions could be a preventive measure for avoiding disputes in the future.

Common principles trigger a specific framework for cross-border healthcare in terms of patient's entitlements and restrictions that the Member Countries are able to place on cross-border healthcare services such as the condition of prior authorization and also the level of reimbursement in order to control their budget and finance.

Cross-border healthcare legislation also creates concrete cooperation in the ASEAN region such as the recognition of prescription, reference networks, health technology assessment, and data collection, in order to support the cooperation to be realized effectively and on sustainable criteria.

CHAPTER 5
CONCLUSION: LESSONS LEARNED FROM CROSS-BORDER HEALTHCARE SERVICES IN THE UNITED KINGDOM UNDER THE EU LEGISLATION AND CONCLUSION FOR THAILAND AND THE ASEAN

Considering the United Kingdom under the EU model, on the concern of reimbursement, it is the responsibility of the Member States that patients are insured for reimbursement in the scenarios in accordance with the EU regulations and Directive such that healthcare cannot be rendered within an appropriate time (undue delay) domestically or when patients need emergency treatment abroad. Additionally, the ECJ will be the guardian of patients' rights to guarantee patients' rights across borders. The healthcare system in the United Kingdom is welfare for its citizen. In other words, the development of its domestic legislation leads to protection of patients' rights when they want to seek healthcare abroad. The EU regulations and Directive help patients exercise their rights to reimbursement for healthcare received in any other European Union countries. The rate of reimbursement is still calculated by the country that they are insured in, due to finance management in healthcare. However, a difference in the prices of healthcare in each country may lead to the question of inappropriate rate of reimbursement, in which patients cannot achieve the enjoyment in seeking healthcare elsewhere in the European Union countries. However, in the European Union, there is the ECJ who will be the main actor to assure patients of cross-border healthcare including determining reimbursement rates. Patients can bring the case to claim their rights, and European Court Of Justice's ruling has s binding effect on the Member Countries because the nature of the European Union has a supranational function to help on the protection of patients' rights when there is cross-border healthcare. Beside the European Court Of Justice, the cooperation through the project "EURODrg" is how the European Union Member States inspect their calculation amount. On the positive side, the European Court Of Justice protects patient's

rights across borders. On the other hand, European Court Of Justice rulings may invade the financial management of healthcare system in each country. However, in the European Union it is found that the quantity of cross-border healthcare is not substantial to invade the financial aspect of management in the healthcare system, as most people still want to receive healthcare at home country rather than going to another place they are not much familiar with.

Comparing to Thailand, in our healthcare reimbursement system, there is still a lack of corresponding benefits package. It is important because if the benefits are not similar and the systems are not harmonized, it will lead to intensifying inequality in patients' rights in cross-border healthcare.

Besides, we cannot deny that cross-border healthcare will play an important role in the future because we try to promote liberalization and free movement. When there is the free movement of patients, patients' rights to health should also be arranged. Therefore, rules for reimbursement should be created; as well as on the regard of prior authorization where limited reasons for discretion and refusal to it are identified. The suggested main principles that should be adopted have been discussed in the earlier chapters.

Beside the function on reimbursement, the Directive also establishes the rules for providing assistance for persons in need in terms of travel cost or cost of assistance of disabled persons to eliminate barriers to cross-border healthcare. Because of the existing argument that cross-border healthcare was established for the rich or the persons who have opportunity in life, therefore, to decrease such inequality, there should be a legal base of financial assistance provided for the persons who need financial support. However, mostly the matter is on case-by-case basis, so the bureaucracy of officials should be regarded, and there is the need for transparency and good governance mechanism.

In the aspect of the quality and safety of care, it is the duty of the Member States to control the quality and safety of healthcare in individual country. However, the cross-border healthcare Directive helps patients achieve the goal in obtaining such

information on quality and safety including professional guidance and practices in the country that they intend to seek healthcare. National Contact Points perform the function of providing the information to both incoming patients and outgoing patients. The confirmation of accuracy of information will be one factor that makes patients comfortable to seek healthcare abroad because they can know the standard of care of the intended healthcare country. It also helps patients dissolve arguments about the standard of care when there is a dispute as well. Moreover, translated versions of the information by the National Contact Points will also facilitate patients in seeking healthcare abroad – it shows an example having set up this unit in case that we have the cross-border healthcare services law. However, the liability for of mistranslation still remains questionable whether this unit does the function of pure facilitation or there should be the confirmation of accuracy in translation as well.

In the aspect of formal form of cooperation, the cooperation in healthcare is a very important issue. In the cooperation of information transfer, while healthcare service itself needs the transfer of information between countries, especially for the continuity of care, patients can receive healthcare with the continuity of their health information interoperability. However, the privacy has to be concerned. The European Union has another Directive to ensure the privacy in transferring data. Besides, the cooperation in the pooling of knowledge in healthcare research is very useful for patients' rights especially the deficiency of treatment and healthcare professionals in rare diseases.

For all these three perspectives, I would say that cross-border healthcare law is one of the laws that promote the patients' rights and protect the patient's rights when they travel across borders. However to adopt the principles in the ASEAN we have to look at other perspectives as well including the different formations of the European Union and the ASEAN.

The European Union has its starting point from harmonization of the region to avoid wars and create peace. Nowadays, not only social security but also other issues have been enhanced. Healthcare service was formerly considered as a national responsibility to provide for its citizen. When there was the integration of market, not

only economic activities were cooperated but also the rights of citizens attached in the plan of integration as well. Therefore, providing healthcare services and patients' rights are two of many issues concerned in the European Union. The European Union launched the Directive to draw the rules and guidance to be in tandem as one union. Healthcare, which was formerly considered as a responsibility in individual nations, became the issue on the international level. While the European Union had the European Court of Justice to be the main actor for pushing patients' rights in cross-border healthcare, following was the concrete legislation in European Union regulation and Directive.

The question is that Do the European Union and the ASEAN have the same context to support patients' rights in cross-border healthcare? The answer is not, because of the differences in the Member Countries in the ASEAN where they are mostly different in background, economic status, social structure, etc.

On the legal basis, the community law in the European Union is a telling reason why cross-border healthcare could have occurred. In other words, the supranational legal basis in the European Union is the origin of further patients' rights beyond borders. In the writer's opinion, it is because of the European Court of Justice's role which is the judiciary part becoming the policy maker that each Member State has to respect the rulings. Finally, they became laws that each Member State has to implement in its own legislation.

In the writer's opinion, although ideally the principle of community aggregation of the ASEAN puts that healthcare should be freely available across borders without restriction – For example, Mr. A as a lawyer goes to work in Myanmar. He should be able to claim reimbursement of the healthcare treatment under the healthcare system in Thailand. It could be done, only if the cooperation here created. – in reality, however, only legal cooperation is not enough since we have to inspect other perspectives such as the economy as well. Moreover, the factor that cannot be overlooked is the political driving force.

The example of cross-border healthcare already happening in our ASEAN region is the cooperation between Singapore and Malaysia. This cross-border healthcare

became real, not just in the principle, as a result of their shared historical background and their geographical proximity. The writer has noted that the networks of hospitals that belong to private sector in both countries are the key players, but without the government's policy that allows claiming across borders, cross-border healthcare by reimbursement under its national healthcare system could not have been realized. However, in the ASEAN, we still have barriers in business equity; for example, in Thailand foreigners could not hold more than 49 percent of shares of the company.

In the writer's opinion, the launch of public policy and law cannot be realized without a real cooperation between healthcare sectors regardless of private or public. Such cooperation in cross-border healthcare might exist in the future, if we can manage the healthcare system in our country properly. At least the three coverage schemes have to be providing the equal right of patients and need to be under a single designated unit, otherwise the control of healthcare sectors will be fragmented and reimbursement methods will be duplicated.

In the United Kingdom, there is the universal health coverage that covers the entire population in the country. Therefore, one healthcare system is not complex for the management of healthcare including cross-border healthcare as well. Comparing to Thailand, we are absent of a single model of healthcare system. However, to restructure the three systems into one is going to be a problem because our development in healthcare system came from a pluralistic system. We have long developed our three healthcare systems with each system has its own principle behind. To adopt a single model is not possible and not appropriate for Thailand. The reason is not about the theory, but the writer looks at the reality that it is not possible to just abolish them while each division controlling each healthcare system does not want to lose its management and control. Therefore, we need transparency and good governance to supervise the systems. Besides, we need to tackle the problem of inequality in Thai patients' rights by harmonizing the three main schemes for the same benefits package and payment system. Because cross-border healthcare needs clarification of the rights that patients have in order to proceed to other procedures including reimbursement across borders. And for the

assurance that cross-border healthcare will not intensify the problem of inequality in Thai patients' rights.

There must be provisions of the cross-border healthcare legislation. In order to achieve cross-border healthcare services, the implementation of laws and regulations concern two perspectives.

First, there should be the needed organization to perform the function of cross-border healthcare cooperation. There should be the establishment of necessary institutions such as the National Contact Point which is an obligation under directive. It has to provide the minimum or compulsory information that are laid down in the legislation. All of the information must be accessible, and it should be provided in the form that the disabled could access to. According to the ICT world nowadays, in the writer's opinion, the information should be kept online through websites. Besides, call centers and personal counseling should be possible. However, the privacy should be protected, even while our privacy law is still in the proposed draft. And as in the earlier discussion, the general privacy law cannot sufficiently protect the patients' privacy right, because healthcare has specific nature and very sensitive data that need a separate healthcare privacy law.

Besides, in order to support cross-border healthcare services, voluntary task is a reference network to create the potential network for supporting healthcare including the availability of expertise. These organizations should operate under the common values in ASEAN good governance.

Second, there should be a regulatory framework on the screening process up to the impact assessment for out-patients.

In the legislation, there should be the list of healthcare types that require prior-authorization and those do not. There should be the provision of administrative procedures before going to receive healthcare abroad and after returning from obtaining healthcare services. For example, Mr. A willing like to receive healthcare abroad needs to fill the form provided by the insured country. And after coming back, he has to inform

the authority for reimbursement with the applied conditions as already detailed in the previous chapters.

At present, the United Kingdom has launched the policy "Brexit," which is abbreviated from "Britain exits." The United Kingdom will cease to be a Member State of the European Union. But now there is no legal consequence until at least one year ahead. However, the United Kingdom is a common law country of which ruling is the main interpretation. Although the United Kingdom will choose which EU laws to be adopted in the country, there is still the question whether the European's principle will still remain in the United Kingdom's court; for example, "If the courts have concluded that the correct approach to X is Y, if you just take the statute away, that approach will continue." [194] Please be noted that at the time of doing this thesis, the United Kingdom is still a member state of European Union and the lesson learned from the United Kingdom under EU legislation is still an interesting for being a researched country.

Considering the Singaporean and Malaysian cross-border healthcare arrangement: the principle behind the Singapore's Medical Account came from the responsibility of each person for his or her healthcare, which is on the contrary to our healthcare principle that provides healthcare for all, the form of the Medical Account is also an interesting model, as it is used in the form of private insurance model rather than under the healthcare system provided by the government. Because Singapore holds shares in Malaysian hospitals, the network between Singapore and Malaysia will support cross-border healthcare and also the reimbursement by deducting from the Singapore's Medical Savings Account, according to the Central Provident Fund Act (CPF ACT).

As discussed earlier that these two countries have different forms of healthcare treatment styles whereby Singapore healthcare costs higher with more complex and high technology, while in Malaysia it costs cheaper for daily-life healthcare

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[194]Sarah Gordon, Business Editor. Financial Time.
"Untangling Britain from Europe would cause constitutional 'havoc'
EU laws are incorporated into the devolution statutes in Scotland, Wales and Northern Ireland."
https://next.ft.com/content/d7ae7b70-361a-11e6-9a05-82a9b15a8ee7, (Accessed on June 20, 2016.)

with less advanced technology. Therefore, it is the interesting example of supplementing each other's advantages and eliminating drawbacks. Nowadays, Thai hospitals (Bumrungrad Hospital) have also expanded its market to Myanmar; hence, we can envision that in the future there could be such arrangement having occurred between Singapore and Malaysia. And if we could unlock this impasse gradually in the form of bilateral arrangement, we would be able to manage the problem of our restricted healthcare resources and workforce in the region. Thailand as the leader in healthcare will also be the leader in solving problems, and soon our ASEAN will become a very potential economic region of the world.

From all of the abovestated reasons, cross-border healthcare services in the United Kingdom under EU legislation are an interesting legal issue to study for laying the foundation for the future of Thailand's healthcare. However, other relevant perspectives, such as economic factors, still need further analysis. To become efficient laws under the Thailand's context, other dimensions have to be studied in order to adjust the model laws in proper alignment with the current situations and to ascertain that such laws would be beneficial for people without precipitating problems such as the intensification of inequity.

Please be noted that in this thesis, the writer examines cross-border healthcare services in the aspect of the Thais going abroad to the ASEAN countries. If an interested individual would like to study further the case of citizens of other countries coming to receive healthcare in Thailand, additional details need to be researched. Besides, in the human rights perspective, if people of the neighboring countries, for examples, the CLMV countries (Cambodia, Laos, Myanmar, and Vietnam) come to Thailand, the provisions of healthcare regarding such people are likewise an interesting issue for research, as it is advantageous to developing the quality of life of people. Finally, the effects of such development may potentially be an incentive to attract people from other countries to be employee in Thailand, so that our business could grow and prosper.

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APPENDICES

APPENDIX A
SELECTED INTERNATIONAL TREATIES TO THE RIGHT TO HEALTH (IN CHRONOLOGICAL ORDER)

Charter of the United Nations (1945), Constitution of the World Health Organization (1946), European Social Charter (1961), International Convention on the Elimination of All Forms of Racial Discrimination (1965), International Covenant on Economic, Social and Cultural Rights (1966) , International Covenant on Civil and Political Rights (1966), and its two optional protocols (1966 and 1989), Convention on the Elimination of All Forms of Discrimination against Women (1979) and its Optional Protocol (1999), African Charter on Human and Peoples' Rights (1981), Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) and its Optional Protocol (2002), Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (1988), Convention on the Rights of the Child (1989) and its two optional protocols (2000), ILO Convention No 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989),International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990), Convention on the Rights of Persons with Disabilities (2006) and its Optional Protocol (2006)

APPENDIX B

LIST OF EUROPEAN ECONOMIC AREA (EEA) COUNTRIES COMPRISING THE EUROPEAN ECONOMIC AREA

- Austria
- Belgium
- Bulgaria
- Croatia
- Cyprus (south only)
- Czech Republic
- Denmark
- Estonia
- Finland
- France
- Germany
- Greece
- Hungary
- Iceland
- Ireland
- Italy
- Latvia
- Liechtenstein
- Lithuania
- Luxembourg
- Malta
- Netherlands
- Norway

- Poland
- Portugal
- Romania
- Slovakia
- Slovenia
- Spain
- Sweden
- United Kingdom

APPENDIX C
LIST OF SERVICES SUBJECT TO PRIOR AUTHORIZATION UNDER UNITED KINGDOM LEGISLATION

1. Adult ataxia telangiectasia services.
2. Adult congenital heart disease services.
3. Adult highly specialist pain management services.
4. Adult highly specialist respiratory services.
5. Adult highly specialist rheumatology services.
6. Adult secure mental health services.
7. Adult specialist cardiac services.
8. Adult specialist eating disorder services.
9. Adult specialist endocrinology services.
10. Adult specialist intestinal failure services.
11. Adult specialist neurosciences services.
12. Adult specialist ophthalmology services.
13. Adult specialist orthopaedic services.
14. Adult specialist pulmonary hypertension services.
15. Adult specialist renal services.
16. Adult specialist services for patients infected with HIV.
17. Adult specialist vascular services.
18. Adult thoracic surgery services.
19. Alkaptonuria service.
20. Alström syndrome service.
21. Ataxia telangiectasia service for children.
22. Autoimmune paediatric gut syndromes service.
23. Autologous intestinal reconstruction service for adults.
24. Bardet-Biedl syndrome service.
25. Barth syndrome service.

26. Beckwith-Wiedemann syndrome with macroglossia service.
27. Behcet's syndrome service.
28. Bladder exstrophy service.
29. Blood and marrow transplantation services.
30. Bone anchored hearing aid services.
31. Breast radiotherapy injury rehabilitation service.
32. Child and adolescent mental health services –Tier 4.
33. Choriocarcinoma service.
34. Chronic pulmonary aspergillosis service.
35. Cleft lip and palate services.
36. Cochlear implantation services.
37. Complex childhood osteogenesis imperfecta service.
38. Complex Ehlers Danlos syndrome service.
39. Complex neurofibromatosis type 1 service.
40. Complex spinal surgery services.
41. Complex tracheal disease service.
42. Congenital hyperinsulinism service.
43. Craniofacial service.
44. Cryopyrin associated periodic syndrome service.
45. Cystic fibrosis services.
46. Diagnostic service for amyloidosis.
47. Diagnostic service for primary ciliary dyskinesia.
48. Diagnostic service for rare neuromuscular disorders.
49. Encapsulating peritoneal sclerosis treatment service.
50. Epidermolysis bullosa service.
51. Extra corporeal membrane oxygenation service for adults.
52. Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure.
53. Ex-vivo partial nephrectomy service.

54. Fetal medicine services.
55. Gender identity development service for children and adolescents.
56. Gender identity disorder services.
57. Heart and lung transplantation service (including bridge to transplant using mechanical circulatory support).
58. Highly specialist adult urinary and gynaecological surgery services.
59. Highly specialist allergy services.
60. Highly specialist colorectal surgery services.
61. Highly specialist dermatology services.
62. Highly specialist metabolic disorder services.
63. Highly specialist pain management services for children and young people.
64. Highly specialist palliative care services for children and young people.
65. Highly specialist services for adults with infectious diseases.
66. Hyperbaric oxygen treatment services.
67. Insulin-resistant diabetes service.
68. Islet transplantation service.
69. Liver transplantation service.
70. Lymphangioleiomyomatosis service.
71. Lysosomal storage disorder service.
72. Major trauma services.
73. McArdle's disease service.
74. Mental health service for deaf children and adolescents.
75. Middle ear implantable hearing aid services.
76. Neurofibromatosis type 2 service.
77. Neuromyelitis optica service.
78. Neuropsychiatry services.
79. Ocular oncology service.
80. Ophthalmic pathology service.
81. Osteo-odonto-keratoprosthesis service for corneal blindness.

82. Paediatric and perinatal post mortem services.
83. Paediatric cardiac services.
84. Paediatric intestinal pseudo-obstructive disorders service.
85. Pancreas transplantation service.
86. Paroxysmal nocturnal haemoglobinuria service.
87. Positron Emission Tomography –Computed Tomography services.
88. Primary ciliary dyskinesia management service.
89. Primary malignant bone tumours service.
90. Proton beam therapy service.
91. Pseudomyxoma peritonei service.
92. Pulmonary hypertension service for children.
93. Pulmonary thromboendarterectomy service.
94. Radiotherapy services.
95. Rare mitochondrial disorders service.
96. Reconstructive surgery service for adolescents with congenital malformation of the female genital tract.
97. Retinoblastoma service.
98. Secure forensic mental health service for young people.
99. Severe acute porphyria service.
100. Severe combined immunodeficiency and related disorders service.
101. Severe intestinal failure service.
102. Severe obsessive compulsive disorder and body dysmorphic disorder service.
103. Small bowel transplantation service.
104. Specialist burn care services.
105. Specialist cancer services.
106. Specialist cancer services for children and young people.
107. Specialist dentistry services for children and young people.
108. Specialist ear, nose and throat services for children and young people.

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109. Specialist endocrinology and diabetes services for children and young people.
110. Specialist gastroenterology, hepatology and nutritional support services for children and young people.
111. Specialist genetic services.
112. Specialist gynaecology services for children and young people.
113. Specialist haematology services for children and young people.
114. Specialist haemoglobinopathy services.
115. Specialist immunology services for patients with deficient immune systems.
116. Specialist mental health services for deaf adults.
117. Specialist morbid obesity services.
118. Specialist neonatal care services.
119. Specialist neuroscience services for children and young people.
120. Specialist ophthalmology services for children and young people.
121. Specialist orthopaedic surgery services for children and young people.
122. Specialist paediatric intensive care services.
123. Specialist paediatric liver disease service.
124. Specialist perinatal mental health services.
125. Specialist plastic surgery services for children and young people.
126. Specialist rehabilitation services for patients with highly complex needs.
127. Specialist renal services for children and young people.
128. Specialist respiratory services for children and young people.
129. Specialist rheumatology services for children and young people.
130. Specialist services for children and young people with infectious diseases.
131. Specialist services for complex liver, biliary and pancreatic diseases in adults.
132. Specialist services for haemophilia and other related bleeding disorders.
133. Specialist services for severe personality disorder in adults.
134. Specialist services to support patients with complex physical disabilities.
135. Specialist surgery for children and young people.
136. Specialist urology services for children and young people.

137. Spinal cord injury services.

138. Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders.

139. Stickler syndrome diagnostic service.

140. Vein of Galen malformation service.

141. Veterans' post traumatic stress disorder programme.

142. Wolfram syndrome service.

143. Xeroderma pigmentosum service

***Interpretation[195]:** An individual is a child if they have not yet attained the age of 18 years old; an individual is a young person if they are aged 13 years old or above but have not yet attained the age of 21 years old; and an individual is an adult if they are aged 18 years old or over, unless, for the purposes of a service specified in this Schedule, the Board, or the person providing such a service pursuant to a commissioning contract with the Board, considers on clinical grounds that an individual should otherwise be treated as a child, a young person or an adult.

[195]Specialised Services Commissioned by the NHS CB. Services subject to Prior Authorisation. http://www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment/Documents/services-subject-to-prior-authorisation.pdf, Access on May 14. 2016.

APPENDIX D

MEDISAVE WITHDRAWAL LIMITS[196]

Types of Treatments	Medisave Withdrawal Limits
Acute Care	
Inpatient hospitalisation	$450 per day + Surgical limits according to the Table of Surgical Procedures
Approved day surgeries	$300 per day + Surgical limits according to the Table of Surgical Procedures
Inpatient hospitalisation (for psychiatric treatment)	$150 per day up to $5,000 a year
Rehabilitative Care	
Stay in approved community hospitals	$250 per day up to $5,000 a year
Day rehabilitation centres	$25 per day, up to a maximum of $1,500 per year
End-of-Life Care	
Stay in approved hospices	$200 per day
Home palliative care	$2,500 per patient per lifetime For patients diagnosed with cancer or end stage organ failure, there will not be any withdrawal limit if the bill is paid using the patient's own Medisave account.

[196]Government of Sigapore. Central Provident Fund.https://www.cpf.gov.sg/Members/Schemes/schemes/healthcare/medisave, Access on June 10, 2016.)

Outpatient Treatment	
Approved chronic conditions • Diabetes • Hypertension (high blood pressure) • Lipids disorders (e.g. high cholesterol) • Stroke • Asthma • Chronic obstructive pulmonary disease • Major depression • Schizophrenia • Dementia • Bipolar disorder • Osteoarthritis (degenerative joint diseases) • Anxiety • Benign prostatic hyperplasia (enlargement of the prostate gland) • Parkinson's disease • Nephrosis/nephritis (chronic kidney disease) • Epilepsy • Osteoporosis • Psoriasis • Rheumatoid Arthritis	$400 per year per account Cash co-payment of 15% applies to treatments for approved chronic conditions

Approved vaccinations • Pneumococcal vaccinations for children under the age of 6 years • Hepatitis B vaccination • HPV vaccinations for females aged 9 to 26 years • Measles, Mumps and Rubella (MMR), Tuberculosis (BCG), Diptheria, Pertussis & Tetanus (DTaP/Tdap), Poliomyelitis, Haemophilus Influenza Type B (Hib) • Influenza and pneumococcal vaccinations for persons with higher risk of developing influenza-related complications and severe pneumococcal disease respectively Approved health screening • Screening mammograms for women aged 50 and above • Selected screening tests for newborns in the outpatient setting a. Hearing test b. G6P deficiency screening	

c. Metabolic screening d. Thyroid function test	
Flexi-Medisave (for elderly patients aged 65 and above)	Up to $200 per year per patient Only the patient's own or patient's spouse's (if also aged 65 and above) Medisave may be used.
Outpatient scans and other diagnostics for cancer treatment	Up to $600 per year per patient
Outpatient scans for diagnosis or treatment of a medical condition	Up to $300 per year per patient
Assisted conception procedures	• 1st withdrawal - $6,000 • 2nd withdrawal - $5,000 • 3rd and subsequent withdrawals - $4,000 Subject to a lifetime limit of $15,000 per patient Only the patient's own or patient's spouse's Medisave may be used.
Renal dialysis treatment	$450 per month per patient Only the patient's own Medisave may be used. For patients aged 18 and below, the parents' Medisave may be used.
<u>Radiotherapy</u> • External Radiotherapy • Brachytherapy with external radiotherapy	 • $80 per treatment • $300 per treatment

• Brachytherapy without external radiotherapy • Superficial X-ray • Stereotactic radiotherapy	 • $360 per treatment • $30 per treatment • $2,800 per treatment
Chemotherapy (includes analgesic medication and suppressive treatments such as neuroendocrine and nuclear medicine treatments)	$1,200 per month per patient
Anti-retroviral drugs for treatment of HIV/ AIDS (includes drugs used to treat opportunistic infections)	$550 per month per patient Only the patient's own Medisave may be used. For patients aged 18 and below, the patient's parents' Medisave may be used.
Desferrioxamine drug and blood transfusion for treatment of thalassaemia	$350 per month per patient
Hyperbaric oxygen therapy	$100 per treatment
Outpatient intravenous antibiotic treatment	$600 per weekly cycle, up to $2,400 a year
Rental of devices for long-term oxygen therapy and infant continuous positive airway pressure therapy	$75 per month per patient
Immuno-suppressant drugs for organ transplant	$300 per month per patient

APPENDIX E
DRAFTED THE HARMONIZATION OF HEALTH SECURITY SYSTEM ACT BY TDRI[197]

-ร่าง-

พระราชบัญญัติ

(ก) กำกับระบบประกันสุขภาพภาครัฐ

(ข) เพื่อสร้างความกลมกลืนในระบบหลักประกันสุขภาพภาครัฐ

(ค) จัดระบบหลักประกันสุขภาพภาครัฐ

(ง) อภิบาลระบบหลักประกันสุขภาพภาครัฐ

พ.ศ. .....

ภูมิพลอดุลยเดช ป.ร.

ให้ไว้ ณ วันที่ ...

เป็นปีที่ .... ในรัชกาลปัจจุบัน

.....

โดยที่เป็นการสมควรให้มีกฎหมายว่าด้วยสภาประกันสุขภาพแห่งชาติ

อาศัยอำนาจตามความในมาตรา ..... ของรัฐธรรมนูญแห่งราชอาณาจักรไทย .....

ดังต่อไปนี้

มาตรา ๑ พระราชบัญญัตินี้เรียกว่า “พระราชบัญญัติ..... พ.ศ. .....”

มาตรา ๒ พระราชบัญญัตินี้ให้ใช้บังคับตั้งแต่วันถัดจากวันประกาศในราชกิจจานุเบกษาเป็นต้นไป

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[197]Thailand Development Research Institute (TDRI*). “Central Development Mechanism In order to reduce the disparity in the health sector.”* https://www.dropbox.com/s/er85t31i2oku30z/Attach%202.pdf?dl=0, (Accessed on August 07, 2016.)

มาตรา ๓ บรรดากฎหมาย กฎ ระเบียบ และข้อบังคับอื่น ในส่วนที่บัญญัติไว้แล้วในพระราชบัญญัตินี้ หรือซึ่งขัดหรือแย้งกับบทแห่งพระราชบัญญัตินี้ให้ใช้พระราชบัญญัตินี้แทน

มาตรา ๔ ในพระราชบัญญัตินี้

“ระบบประกันสุขภาพของรัฐ” หมายความว่า ระบบสวัสดิการรักษาพยาบาลข้าราชการ ระบบประกันสุขภาพตามกฎหมายว่าด้วยประกันสังคม หลักประกันสุขภาพแห่งชาติ และรวมถึงระบบประกันสุขภาพอื่นใดที่รัฐเข้าไปสนับสนุนบริการด้วย

“การประกันสุขภาพของรัฐ” หมายความว่า การจัดการระบบหลักประกันสุขภาพภาครัฐในด้านชุดสิทธิประโยชน์กลาง การส่งมอบบริการ การสนับสนุนทางการเงิน ระบบข้อมูลเพื่อการบริหารจัดการ และระบบกำกับคุณภาพบริการการประกันสุขภาพ” หมายความว่า การประกันสุขภาพที่รัฐให้บริการ ตามระบบหลักประกันสุขภาพของรัฐ

“สุขภาพ” หมายความว่า ภาวะของมนุษย์ที่สมบูรณ์ทั้งทางกาย ทางจิต ทางปัญญา และทางสังคม เชื่อมโยงกันเป็นองค์รวมอย่างสมดุล

“ชุดสิทธิประโยชน์กลาง” หมายความว่า สิทธิประโยชน์พื้นฐานใด ๆ จากการรับบริการทางด้านสาธารณสุขที่จำเป็นต่อสุขภาพและการดำรงชีวิต ไม่ว่าจะเป็นการวินิจฉัยและรักษาพยาบาล การสร้างเสริมสุขภาพ การป้องกันโรค การฟื้นฟูสมรรถภาพทางร่างกายและจิตใจ การดูแลแบบประคับประคอง ทั้งนี้หน่วยงานผู้รับประกันอาจกำหนดสิทธิประโยชน์ใด ๆ เพิ่มเติมอีกก็ได้

“ผลลัพธ์ทางสุขภาพ” หมายความว่า การประเมินสุขภาพของผู้รับบริการตามพระราชบัญญัตินี้ในช่วงเวลาใดเวลาหนึ่ง ที่เกิดขึ้นจากระบบประกันสุขภาพของรัฐ โดยวัดจากความมีอายุยืนยาว อัตราการตาย อัตราการเจ็บป่วยและพิการ รูปแบบของโรคภัยไข้เจ็บ และคุณภาพชีวิตด้านสุขภาพของผู้รับบริการ

“คณะกรรมการ” หมายความว่า คณะกรรมการ.....

“ประธานกรรมการ” หมายความว่า ประธานคณะกรรมการ.....

“กรรมการ” หมายความว่า กรรมการ.....

“สำนักงาน” หมายความว่า สำนักงานสภาประกันสุขภาพแห่งชาติ

“เลขาธิการ” หมายความว่า เลขาธิการสำนักงานสภาประกันสุขภาพแห่งชาติ

“หน่วยงานผู้รับประกัน” หมายความว่า กรมบัญชีกลาง สำนักงานประกันสังคม และสำนักงานหลักประกันสุขภาพแห่งชาติ

“หน่วยงานผู้ให้บริการประกันสุขภาพ” หมายความว่า สถานพยาบาลทั้งของรัฐ เอกชน และที่เป็นของมหาวิทยาลัยรวมตลอดถึงยานพาหนะซึ่งจัดไว้เพื่อประกอบโรคศิลปะตามกฎหมายว่าด้วยการประกอบโรคศิลปะ การประกอบวิชาชีพเวชกรรมตามกฎหมายว่าด้วยวิชาชีพเวชกรรม การประกอบวิชาชีพการพยาบาลและการผดุงครรภ์ การประกอบวิชาชีพทันตกรรมตามกฎหมายว่าด้วยวิชาชีพทันตกรรม การประกอบวิชาชีพกายภาพบำบัดตามกฎหมายว่าด้วยวิชาชีพกายภาพบำบัด หรือการประกอบวิชาชีพเทคนิคการแพทย์ตามกฎหมายว่าด้วยวิชาชีพเทคนิคการแพทย์ และให้หมายความรวมถึงสถานพยาบาลประเภทที่เป็นมหาวิทยาลัยด้วย

“ผู้รับบริการ” หมายความรวมถึง ข้าราชการ ผู้ประกันตนตามกฎหมายว่าด้วยประกันสังคม และประชาชนผู้มีสิทธิได้รับการรักษาพยาบาลตามกฎหมายว่าด้วยหลักประกันสุขภาพแห่งชาติ

“พนักงานเจ้าหน้าที่” หมายความว่า ผู้ซึ่งนายกรัฐมนตรีแต่งตั้งโดยคำแนะนำของคณะกรรมการ แล้วแต่กรณี ให้ปฏิบัติการตามพระราชบัญญัตินี้

มาตรา ๕ ให้นายกรัฐมนตรี และรัฐมนตรีว่าการกระทรวงการคลังรักษาการตามพระราชบัญญัตินี้

หมวด ๑

คณะกรรมการ.....

มาตรา ๖ ให้มีคณะกรรมการคณะหนึ่ง เรียกว่า “คณะกรรมการ.....ประกอบด้วย

(๑) นายกรัฐมนตรีเป็นประธานกรรมการ

(๒) รัฐมนตรีว่าการกระทรวงการคลัง รัฐมนตรีว่าการกระทรวงสาธารณสุข รัฐมนตรีว่าการกระทรวงแรงงาน

(๓) ผู้แทนหน่วยงานผู้รับประกันจำนวนสามคน แบ่งเป็นผู้แทนกรมบัญชีกลางหนึ่งคน ผู้แทนสำนักงานประกันสังคมหนึ่งคน และผู้แทนสำนักงานหลักประกันสุขภาพแห่งชาติหนึ่งคน

(๔) ผู้แทนผู้ให้บริการจำนวนสามคน แบ่งเป็นผู้แทนกระทรวงสาธารณสุขหนึ่งคน ผู้แทนกระทรวงอื่นนอกจากกระทรวงสาธารณสุขหนึ่งคน และผู้แทนภาคเอกชนหนึ่งคน

(๕) ผู้แทนผู้รับบริการจำนวนสามคน แบ่งเป็นผู้แทนข้าราชการหนึ่งคน ผู้แทนผู้ประกันตนตามกฎหมายว่าประกันสังคมหนึ่งคน และประชาชนผู้ได้รับสิทธิการรักษาพยาบาลตามกฎหมายว่าด้วยหลักประกันสุขภาพแห่งชาติหนึ่งคน

(๖) ผู้อำนวยการสำนักงบประมาณ และ

(๗) ผู้ทรงคุณวุฒิ ซึ่งคณะรัฐมนตรีแต่งตั้งอีกจำนวนสามคน โดยมาจากสาขาการแพทย์และสาธารณสุข สาขาการเงินการคลังและการประกันสุขภาพ และสาขาสังคมศาสตร์และการคุ้มครองผู้บริโภค สาขาละหนึ่งคน เป็นกรรมการ

ให้เลขาธิการเป็นกรรมการและเลขานุการโดยตำแหน่ง และให้เลขาธิการแต่งตั้งข้าราชการจำนวนไม่เกินสองคนเป็นผู้ช่วยเลขานุการ

การแต่งตั้งกรรมการตาม (๔) (๕) และ (๗) ให้คณะรัฐมนตรีพิจารณาสรรหาจากผู้มีส่วนร่วมอย่างกว้างขวางสาขาต่าง ๆ ตามวรรคหนึ่ง จากรายชื่อบุคคลที่จัดให้มีการคัดกรองขั้นต้นเพื่อให้ได้บัญชีรายชื่อกลุ่มที่จะพิจารณาคัดเลือกกันเองต่อไปด้วยหลักเกณฑ์ที่เหมาะสมและชัดเจน โดยมีกระบวนการที่โปร่งใสและเปิดเผย ทั้งนี้ ตามระเบียบที่คณะกรรมการกำหนดโดยความเห็นชอบของคณะรัฐมนตรี

กรรมการตาม (๖) (๗) และเลขานุการ ไม่มีสิทธิในการออกเสียงลงคะแนนใด ๆ แต่ทั้งนี้ไม่เป็นการตัดสิทธิในการที่จะให้ข้อเสนอแนะอันเป็นประโยชน์แก่คณะกรรมการ

มาตรา ๗ กรรมการตามมาตรา ๖ วรรคหนึ่ง (๔) (๕) และ (๗) ต้องมีคุณสมบัติและไม่มีลักษณะต้องห้ามดังต่อไปนี้

(๑) มีสัญชาติไทย

(๒) มีอายุไม่ต่ำกว่ายี่สิบห้าปีบริบูรณ์ และไม่เกินหกสิบปีบริบูรณ์

(๓) ไม่เป็นบุคคลล้มละลาย คนไร้ความสามารถ หรือคนเสมือนไร้ความสามารถ

(๔) ไม่เคยได้รับโทษจำคุกโดยคำพิพากษาถึงที่สุดให้จำคุก เว้นแต่เป็นโทษสำหรับความผิดที่กระทำโดยประมาทหรือความผิดลหุโทษ

(๕) ไม่เป็นผู้ดำรงตำแหน่งทางการเมือง สมาชิกสภาท้องถิ่น หรือผู้บริหารท้องถิ่น กรรมการหรือผู้ดำรงตำแหน่งซึ่งรับผิดชอบการบริหารพรรคการเมือง ที่ปรึกษาพรรคการเมืองหรือเจ้าหน้าที่พรรคการเมือง รวมไปถึงบรรดาเครือญาติของบุคคลดังกล่าว

(๖) ไม่เป็นเจ้าหน้าที่หรือลูกจ้างของสำนักงาน หรือที่ปรึกษาหรือผู้เชี่ยวชาญที่มีสัญญาจ้างกับสำนักงาน รวมไปถึงบรรดาเครือญาติของบุคคลดังกล่าว

กรรมการผู้ทรงคุณวุฒิตามมาตรา ๖ (๗) จะต้องไม่เป็นผู้มีส่วนได้เสียกับกิจการหรือการดำเนินงานหรือประโยชน์ใด ๆ จากการดำเนินการตามพระราชบัญญัตินี้

มาตรา ๘ กรรมการตามมาตรา ๖ มีวาระอยู่ในตำแหน่งคราวละสี่ปี

ในกรณีที่กรรมการตามมาตรา ๖ พ้นจากตำแหน่งก่อนวาระ หรือในกรณีที่คณะรัฐมนตรีแต่งตั้งกรรมการเพิ่มขึ้นในระหว่างที่กรรมการซึ่งแต่งตั้งไว้แล้วยังมีวาระอยู่ในตำแหน่งให้ผู้ได้รับแต่งตั้งแทนตำแหน่งที่ว่างหรือเป็นกรรมการเพิ่มขึ้นอยู่ในตำแหน่งเท่ากับวาระที่เหลืออยู่ของกรรมการซึ่งได้แต่งตั้งไว้แล้ว

เมื่อครบกำหนดตามวาระในวรรคหนึ่ง หากยังไม่มีการแต่งตั้งกรรมการตามมาตรา ๖ ขึ้นใหม่ ให้ประธานกรรมการหรือกรรมการซึ่งพ้นจากตำแหน่งตามวาระนั้นอยู่ในตำแหน่งเพื่อดำเนินการต่อไปจนกว่าประธานกรรมการหรือกรรมการซึ่งได้รับแต่งตั้งใหม่เข้ารับหน้าที่

กรรมการตามมาตรา ๖ ซึ่งพ้นจากตำแหน่งตามวาระอาจได้รับแต่งตั้งอีกได้ แต่จะดำรงตำแหน่งติดต่อกันเกินสองวาระไม่ได้

มาตรา ๙ นอกจากการพ้นตำแหน่งตามวาระ กรรมการตามมาตรา ๖ (๔) (๕) และ (๗) พ้นจากตำแหน่งเมื่อ

(๑) ตาย

(๒) ลาออก

(๓) คณะรัฐมนตรีมีมติให้ออก เพราะบกพร่องต่อหน้าที่ มีความประพฤติความเสื่อมเสีย หรือหย่อนความสามารถ

(๔) ขาดคุณสมบัติหรือมีลักษณะต้องห้ามตามมาตรา ๗

มาตรา ๑๐ การประชุมคณะกรรมการ ต้องมีกรรมการมาประชุมไม่น้อยกว่ากึ่งหนึ่งของจำนวนกรรมการทั้งหมด จึงจะเป็นองค์ประชุม

ให้ประธานกรรมการเป็นประธานในที่ประชุม ถ้าประธานกรรมการไม่มาประชุมหรือไม่อาจปฏิบัติหน้าที่ได้ ให้กรรมการที่มาประชุมเลือกกรรมการคนหนึ่งเป็นประธานในที่ประชุม

การวินิจฉัยชี้ขาดของที่ประชุมให้ถือเสียงข้างมาก กรรมการคนหนึ่งให้มีเสียงหนึ่งในการลงคะแนน ในกรณีที่คะแนนเสียงเท่ากัน ให้ประธานในที่ประชุมออกเสียงเพิ่มอีกเสียงหนึ่งเป็นเสียงชี้ขาด เว้นแต่ในเรื่องใดที่ต้องใช้มติพิเศษ กรรมการต้องลงมติในเรื่องนั้นโดยคะแนนเสียงข้างมากไม่ต่ำกว่าสองในสามส่วนของจำนวนเสียงทั้งหมดของกรรมการตามมาตรา ๖ (๒) และ (๔) และไม่ต่ำกว่าสองในสามส่วนของจำนวนเสียงทั้งหมดของกรรมการตามมาตรา ๖ (๓) และ (๕) รวมกัน

ในการประชุม ถ้ามีการพิจารณาเรื่องที่กรรมการผู้ใดมีส่วนได้เสีย กรรมการผู้นั้นมีหน้าที่แจ้งให้คณะกรรมการทราบและมีสิทธิเข้าชี้แจงข้อเท็จจริงหรือแสดงความคิดเห็นเกี่ยวกับเรื่องนั้นแต่ไม่มีสิทธิเข้าร่วมประชุมและลงคะแนนเสียง

วิธีการประชุม การปฏิบัติงานของคณะกรรมการ และส่วนได้เสียซึ่งกรรมการมีหน้าที่ต้องแจ้งให้ เป็นไปตามระเบียบที่คณะกรรมการกำหนด

ให้คณะกรรมการจัดให้มีการประชุมอย่างน้อยปีละสองครั้ง หรือในทุก ๆ รอบระยะเวลาหกเดือน

ให้นำหลักเกณฑ์ในการลงคะแนนเสียงตามวรรคสาม มาบังคับใช้แก่คณะอนุกรรมการที่ตั้งขึ้นตามมาตรา ๑๑ (๖) โดยอนุโลม

มาตรา ๑๑ ให้คณะกรรมการมีอำนาจหน้าที่ดังต่อไปนี้

(๑) กำหนดนโยบาย หลักเกณฑ์และแนวทางที่จะนำไปสู่ความกลมกลืนของระบบหลักประกันสุขภาพภาครัฐ ไม่ว่าจะเป็นในด้านชุดสิทธิประโยชน์กลาง ด้านระบบบริการ ด้านการสนับสนุนทางการเงิน ด้านระบบข้อมูลเพื่อการบริหารจัดการ และด้านระบบกำกับคุณภาพบริการ เพื่อนำไปสู่ความเป็นธรรม คุณภาพ และประสิทธิภาพ โดยความเห็นชอบของคณะรัฐมนตรี

(๒) กำหนดวงเงินงบประมาณของระบบประกันสุขภาพภาครัฐทั้งหมดในภาพรวม เป็นประจำทุกปี และเสนอคณะรัฐมนตรีให้ความเห็นชอบ

(๓) กำกับติดตามความก้าวหน้า และประเมินผลการดำเนินงานที่นำไปสู่ความกลมกลืนของระบบหลักประกันสุขภาพภาครัฐ พร้อมทั้งจัดทำรายงานเสนอคณะรัฐมนตรีเป็นครั้งคราวอย่างน้อยปีละหนึ่งครั้ง และเผยแพร่ต่อสาธารณชนได้รับรู้

(๔) กำหนดมาตรฐานกลางในการลงโทษหน่วยงานผู้ให้บริการ โดยให้อำนาจในการลงโทษเป็นของหน่วยงานผู้รับประกันแต่ละหน่วยงานตามพระราชบัญญัตินี้

(๕) กำกับ ติดตาม และดูแลการปฏิบัติงานของหน่วยงานผู้รับประกันในการดำเนินงานตามนโยบาย หลักเกณฑ์ แนวทางที่คณะกรรมการกำหนด

(๖) แต่งตั้งคณะอนุกรรมการเพื่อดำเนินการตามที่คณะกรรมการกำหนด

(๗) ดำเนินการเรื่องอื่นตามที่คณะรัฐมนตรี หรือนายกรัฐมนตรีมอบหมาย

ทั้งนี้ การดำเนินการตาม (1) ให้ใช้วิธีการเจรจา โดยให้มีคณะอนุกรรมการที่มีผู้มีส่วนเกี่ยวข้องทุกภาคส่วนอย่างสมดุลเข้าร่วมการเจรจา

สำหรับวิธีการ หลักเกณฑ์ แนวทาง และขั้นตอนในการเจรจา ให้เป็นไปตามที่ประกาศกำหนดในกฎกระทรวง

การวินิจฉัยชี้ขาดของที่ประชุมตาม (1) และ (2) ให้กระทำมติพิเศษ

ข้อกำหนดเกี่ยวกับเรื่องที่ต้องเสนอนโยบาย เพื่อเสนอเข้าคณะรัฐมนตรีให้เป็นไปตามที่คณะกรรมการกำหนด

หมวด ๒

สำนักงานสภาประกันสุขภาพแห่งชาติ

มาตรา ๑๒ ให้จัดตั้งสำนักงานสภาประกันสุขภาพแห่งชาติขึ้น

(ก) ในสังกัดสำนักงานปลัดสำนักนายกรัฐมนตรี มีฐานะเป็นนิติบุคคลตามกฎหมายว่าด้วยระเบียบบริหารราชการแผ่นดิน

(ข) เป็นหน่วยงานของรัฐที่มิใช่ส่วนราชการและรัฐวิสาหกิจ และมีฐานะเป็นนิติบุคคล

(ค) องค์การมหาชน

ให้สำนักงานได้รับการจัดสรรงบประมาณร้อยละศูนย์จุดห้าของงบประมาณรายจ่ายประจำปีด้านการประกันสุขภาพทั้งหมดของปีงบประมาณนั้น ๆ ทั้งนี้ให้อยู่ภายใต้บังคับของกฎหมายว่าด้วยวิธีการงบประมาณ

มาตรา ๑๓ สำนักงานมีวัตถุประสงค์ ดังต่อไปนี้

(๑) บริหารจัดการระบบประกันสุขภาพของรัฐให้เป็นไปในแนวทางที่สอดคล้องกัน

(๒) ดำเนินการบริหารจัดการระบบประกันสุขภาพของรัฐให้เป็นไปตามที่คณะกรรมการกำหนด

(๓) ดำเนินการเพื่อให้กระบวนการเจรจาด้านระบบประกันสุขภาพของรัฐ เป็นไปอย่างสะดวก รวดเร็ว และมีประสิทธิภาพ

มาตรา ๑๔ ให้สำนักงานมีอำนาจหน้าที่ ดังต่อไปนี้

(๑) ดำเนินการตามมติของคณะกรรมการ

(๒) อำนวยความสะดวกแก่คณะกรรมการเพื่อให้การดำเนินงานเป็นไปโดยสะดวก รวดเร็ว และมีประสิทธิภาพ

(๓) อำนวยความสะดวกแก่หน่วยงานผู้ให้บริการประกันสุขภาพและผู้รับบริการในการเลือกผู้แทนและอำนวยความสะดวกในด้านอื่น ๆ เพื่อช่วยให้กระบวนการเจรจาเป็นไปอย่างมีประสิทธิภาพ

(๔) จัดให้มีการเจรจาเพื่อที่จะจัดตั้งและพัฒนาชุดสิทธิประโยชน์ร่วมกัน

(๕) จัดให้มีการเจรจาเพื่อที่จะจัดตั้งและพัฒนาวิธีการชำระค่าบริการและการปรับปรุงระบบบริการสุขภาพของรัฐ (๖) ประสานงานกับหน่วยงานผู้รับประกันในการดำเนินการจัดทำระบบฐานข้อมูลกลางด้านระบบประกันสุขภาพของรัฐ

(๗) ร่วมดำเนินการกับสำนักงานมาตรฐานและการจัดการสารสนเทศระบบบริการสุขภาพแห่งชาติในการวิเคราะห์ข้อมูลด้านสุขภาพของประชาชน และจัดให้มีการประเมินผลระบบประกันสุขภาพของรัฐ

(๘) ดำเนินการวิจัยและสนับสนุนคณะกรรมการเพื่อให้บรรลุภารกิจของคณะกรรมการ

(๙) จัดทำรายงานการประชุมของคณะกรรมการเสนอต่อคณะรัฐมนตรีและรัฐสภาภายในระยะเวลาตามสมควร

มาตรา ๑๕ ให้สำนักงานมีเลขาธิการคนหนึ่ง

คณะกรรมการเป็นผู้มีอำนาจสรรหา แต่งตั้งและถอดถอนเลขาธิการ

หลักเกณฑ์และวิธีการสรรหาเลขาธิการให้เป็นไปตามข้อกำหนดของคณะกรรมการ

ในกรณีที่ไม่มีเลขาธิการหรือเลขาธิการไม่อาจปฏิบัติหน้าที่ได้ ให้รองเลขาธิการที่มีอาวุโสตามลำดับปฏิบัติหน้าที่แทน ถ้าไม่มีรองเลขาธิการ ให้คณะกรรมการแต่งตั้งกรรมการคนหนึ่งเป็นผู้ปฏิบัติหน้าที่แทน

มาตรา ๑๖ เลขาธิการต้องเป็นผู้ที่มีคุณสมบัติและไม่มีลักษณะต้องห้าม ดังต่อไปนี้

(๑) มีสัญชาติไทย

(๒) มีอายุไม่น้อยกว่าสี่สิบห้าปีบริบูรณ์ในวันที่ได้รับแต่งตั้ง

(๓) เป็นผู้ทรงคุณวุฒิซึ่งมีความรู้ ความสามารถ และประสบการณ์เหมาะสมกับภารกิจของสำนักงานตามที่กำหนดไว้ในวัตถุประสงค์และอำนาจหน้าที่ตามมาตรา ๑๓ และมาตรา ๑๔

(๔) ไม่มีลักษณะต้องห้ามอย่างหนึ่งอย่างใดตามตามมาตรา ๗ (๓) (๔) และ (๕)

(๕) ไม่เป็นผู้มีส่วนได้เสียในกิจการของบุคคลธรรมดาหรือของนิติบุคคลที่มีการกระทำกับสำนักงาน

มาตรา ๑๗ เลขาธิการมีวาระอยู่ในตำแหน่งตามที่คณะกรรมการกำหนด แต่ต้องไม่เกินห้าปี และอาจได้รับแต่งตั้งอีกได้ แต่ไม่เกินสองวาระติดต่อกัน

มาตรา ๑๘ นอกจากการพ้นจากตำแหน่งตามวาระ เลขาธิการพ้นจากตำแหน่งเมื่อ

(๑) ตาย

(๒) ลาออก

(๓) ออกตามกรณีที่กำหนดไว้ในข้อตกลงระหว่างคณะกรรมการกับเลขาธิการ

(๔) คณะกรรมการให้ออก เพระบกพร่องต่อหน้าที่ มีความประพฤติเสื่อมเสียหรือหย่อนความสามารถ

(๕) ขาดคุณสมบัติหรือมีลักษณะต้องห้ามอย่างหนึ่งอย่างใดตามมาตรา ๗

มติของคณะกรรมการให้เลขาธิการออกจากตำแหน่งตาม (๔) ต้องประกอบด้วยคะแนนเสียงไม่น้อยกว่าสองในสามของจำนวนกรรมการที่มีอยู่โดยไม่นับรวมตำแหน่งเลขาธิการ

มาตรา ๑๙ เลขาธิการมีหน้าที่ปฏิบัติราชการของสำนักงานให้เป็นไปตามกฎหมาย วัตถุประสงค์ของสำนักงาน ระเบียบ ข้อบังคับ ข้อกำหนด ประกาศ นโยบาย และมติของคณะกรรมการ และเป็นผู้บังคับบัญชาข้าราชการและลูกจ้างทุกตำแหน่ง เว้นแต่จะมีกฎหมายบัญญัติไว้เป็นอย่างอื่น รวมทั้งให้มีอำนาจหน้าที่ดังต่อไปนี้

(๑) บรรจุ แต่งตั้ง เลื่อน ลด ตัดเงินเดือน หรือค่าจ้าง ลงโทษทางวินัยข้าราชการและลูกจ้างของสำนักงาน ตลอดจนให้ข้าราชการและลูกจ้างของสำนักงานออกจากตำแหน่ง ทั้งนี้ตามข้อบังคับที่คณะกรรมการกำหนด

(๒) ออกระเบียบหรือประกาศเกี่ยวกับการดำเนินงานของสำนักงานโดยไม่ขัดหรือแย้งกับระเบียบ ข้อบังคับ ประกาศ ข้อกำหนด นโยบาย หรือมติของคณะกรรมการ

มาตรา ๒๐ ในกิจการที่เกี่ยวกับบุคคลภายนอก ให้เลขาธิการเป็นผู้แทนของสำนักงาน เพื่อการนี้ เลขาธิการจะมอบอำนาจให้บุคคลใดปฏิบัติงานเฉพาะอย่างแทนก็ได้ แต่ต้องเป็นไปตามข้อบังคับที่คณะกรรมการกำหนด

นิติกรรมใดที่เลขาธิการกระทำโดยฝ่าฝืนระเบียบหรือข้อบังคับที่คณะกรรมการกำหนดย่อมไม่ผูกพันสำนักงาน เว้นแต่คณะกรรมการให้สัตยาบัน

หมวด ๓

การบริหารจัดการ

มาตรา ๒๑ ผู้ปฏิบัติงานของสำนักงานมี ๓ ประเภท คือ

(๑) ข้าราชการ ได้แก่ ผู้ซึ่งปฏิบัติราชการโดยรับเงินเดือนจากงบประมาณแผ่นดิน

(๒) พนักงานราชการหรือลูกจ้าง ได้แก่ ผู้ซึ่งปฏิบัติราชการเป็นสัญญาจ้างโดยได้รับค่าตอบแทนจากงบประมาณของส่วนราชการ เพื่อเป็นพนักงานของรัฐในการปฏิบัติงานให้กับส่วนราชการนั้น

(๓) ที่ปรึกษาหรือผู้เชี่ยวชาญ ได้แก่ ผู้ซึ่งสำนักงานให้ปฏิบัติหน้าที่เป็นที่ปรึกษาหรือผู้ทรงคุณวุฒิโดยมีสัญญาจ้างเป็นรายปี

มาตรา ๒๒ การสรรหา บรรจุ และแต่งตั้งข้าราชการของสำนักงานให้เป็นไปตามกฎหมายว่าด้วยระเบียบข้าราชการพลเรือน ทั้งนี้ให้รวมถึงกรณีการกระทำผิดวินัย และกรณีออกจากราชการด้วยโดยอนุโลม

มาตรา ๒๓ การสรรหา เลือกสรร และการจ้างพนักงานราชการให้เป็นไปตามกฎหมายว่าด้วยระเบียบพนักงานราชการ ทั้งนี้ให้รวมถึงกรณีการประเมินผลการปฏิบัติงาน ระเบียบเกี่ยวกับวินัยและการรักษาวินัยด้วยโดยอนุโลม มาตรา ๒๔ การแต่งตั้งที่ปรึกษาหรือผู้เชี่ยวชาญของสำนักงาน ตลอดจนค่าตอบแทนหรือสิทธิประโยชน์ใด ๆ ให้เป็นไปตามระเบียบที่คณะกรรมการกำหนด

หมวด ๔

การบัญชี การตรวจสอบ และการประเมินผลงาน

มาตรา ๒๕ การบัญชีของสำนักงานให้จัดทำตามหลักสากลตามแบบและหลักเกณฑ์ที่คณะกรรมการกำหนด และต้องจัดให้มีการตรวจสอบภายในเกี่ยวกับการเงิน การบัญชี และการพัสดุของสำนักงานตลอดจนรายงานผลการตรวจสอบให้คณะกรรมการทราบอย่างน้อยปีละครั้ง

ให้มีเจ้าหน้าที่ของสำนักงานทำหน้าที่เป็นผู้ตรวจสอบภายในโดยเฉพาะ และให้รับผิดชอบขึ้นตรงต่อคณะกรรมการตามระเบียบที่คณะกรรมการกำหนด

มาตรา ๒๖ ให้สำนักงานจัดทำงบดุล งบการเงิน และบัญชีทำการส่งผู้สอบบัญชีภายในหนึ่งร้อยยี่สิบวันนับตั้งแต่วันสิ้นปีบัญชีทุกปี

ในทุกรอบปี ให้สำนักงานการตรวจเงินแผ่นดินหรือบุคคลภายนอกตามที่คณะกรรมการแต่งตั้งด้วยความเห็นชอบของสำนักงานการตรวจเงินแผ่นดิน เป็นผู้สอบบัญชีและประเมินผลการใช้จ่ายเงินและทรัพย์สินของสำนักงาน โดยให้แสดงความคิดเห็นเป็นข้อวิเคราะห์ว่าการใช้จ่ายดังกล่าวเป็นไปตามวัตถุประสงค์ ประหยัด และได้ผลตามเป้าหมายเพียงใด แล้วทำบันทึกรายงานผลการสอบบัญชีเสนอต่อคณะกรรมการ เพื่อการนี้ ให้ผู้สอบบัญชีมีอำนาจตรวจสอบสรรพสมุดบัญชีและเอกสารหลักฐานต่าง ๆ ของสำนักงาน สอบถามเลขาธิการ ผู้ตรวจสอบภายใน ข้าราชการหรือลูกจ้าง และเรียกให้ส่งสรรพสมุดบัญชีและเอกสารหลักฐานต่าง ๆ ของสำนักงานเป็นการเพิ่มเติมได้ตามความจำเป็น

มาตรา ๒๗ ให้สำนักงานจัดทำรายงานเกี่ยวกับการปฏิบัติตามพระราชบัญญัตินี้ เสนอคณะรัฐมนตรีเป็นครั้งคราวตามความเหมาะสม และให้จัดทำรายงานประจำปีเสนอต่อคณะรัฐมนตรีภายในหกสิบวันนับแต่วันสิ้นปีงบประมาณของแต่ละปีงบประมาณ

รายงานประจำปี ประกอบด้วย

(๑) ผลงานของสำนักงานในปีงบประมาณที่ล่วงมาแล้ว

(๒) ผลการใช้จ่ายสำหรับระบบประกันสุขภาพของรัฐ

(๓) ผลการดำเนินงานด้านระบบประกันสุขภาพของรัฐ

(๔) บัญชีทำการ พร้อมทั้งรายงานของผู้สอบบัญชี

(๕) คำชี้แจงเกี่ยวกับนโยบายของคณะกรรมการ โครงการ และแผนงานที่จะจัดทำในภายหน้า

ผลการดำเนินงานตามวรรคสอง (๓) ให้หมายความรวมถึง ผลลัพธ์ทางสุขภาพและความเป็นธรรมทางสุขภาพ

มาตรา ๒๘ เพื่อประโยชน์ในการส่งเสริมประสิทธิภาพและการตรวจสอบการดำเนินงานของสำนักงานให้เป็นไปตามวัตถุประสงค์ โครงการ และแผนงานที่ได้จัดทำไว้ ให้สำนักงานจัดให้มีการประเมินผล การดำเนินงานตามระยะเวลาที่คณะกรรมการกำหนด แต่ต้องไม่นานกว่าหนึ่งปี

การประเมินผลตามวรรคหนึ่ง ให้จัดทำโดยสำนักงานหรือองค์กรที่เป็นกลางและมีความเชี่ยวชาญในด้านการประเมินผลกิจการของสำนักงาน โดยมีการคัดเลือกตามวิธีการที่คณะกรรมการกำหนด

การประเมินผลการดำเนินงานของสำนักงานจะต้องแสดงข้อเท็จจริงให้ปรากฏในด้านประสิทธิผลในด้านประสิทธิภาพ และในด้านการพัฒนาองค์กร และในรายละเอียดอื่นตามที่คณะกรรมการจะได้กำหนดเพิ่มเติมขึ้น

ในกรณีที่มีเหตุจำเป็นเป็นการเฉพาะกาล จะจัดให้มีการประเมินเป็นครั้งคราวตามมาตรานี้ด้วยก็ได้

หมวด ๕

พนักงานเจ้าหน้าที่

มาตรา ๒๙ ในการปฏิบัติหน้าที่ตามพระราชบัญญัตินี้ ให้พนักงานเจ้าหน้าที่มีอำนาจเรียก เอกสาร หลักฐาน ทรัพย์สินหรือสิ่งของจากหน่วยงานผู้รับประกันหรือหน่วยงานผู้ให้บริการ รวมทั้งให้มีอำนาจเข้าไปในหน่วยงานผู้ให้บริการในระหว่างเวลาทำการ เพื่อให้ได้ข้อเท็จจริงอันที่จะปฏิบัติการให้ เป็นไปตามพระราชบัญญัตินี้

ให้พนักงานเจ้าหน้าที่ตามพระราชบัญญัตินี้ เป็นเจ้าพนักงานตามประมวลกฎหมายอาญา

ในการปฏิบัติหน้าที่ของพนักงานเจ้าหน้าที่ ให้บุคคลซึ่งเกี่ยวข้องอำนวยความสะดวกตามสมควร

หมวด ๖

มาตรการบังคับทางปกครอง

มาตรา ๓๐ หน่วยงานผู้ให้บริการประกันสุขภาพที่เป็นของเอกชนหรือของมหาวิทยาลัยเอกชนรายใด ดำเนินการหรือไม่ดำเนินการใด ๆ อันเป็นการขัดต่อมติของคณะกรรมการ ให้หน่วยงานผู้รับประกัน แล้วแต่กรณี ทำคำเตือนเป็นหนังสือแจ้งให้หน่วยงานผู้ให้บริการประกันสุขภาพที่เป็นของเอกชนหรือมหาวิทยาลัยเอกชนรายนั้น ละเว้นกระทำการหรือกระทำการตามมติของคณะกรรมการ ภายในระยะเวลาตามที่คณะกรรมการเห็นสมควร

มาตรา ๓๑ ภายใต้บังคับแห่งมาตราก่อน เมื่อได้มีการแจ้งเตือนโดยชอบด้วยกฎหมายแล้ว แต่หน่วยงานผู้ให้บริการประกันสุขภาพที่เป็นของเอกชนหรือของมหาวิทยาลัยเอกชนรายใดยังคงเพิกเฉยหรือละเลยไม่ดำเนินการตามหนังสือแจ้งเตือน ให้หน่วยงานผู้รับประกัน แล้วแต่กรณีมีคำสั่งปรับในอัตราไม่เกินสองหมื่นบาทต่อวัน

หากคณะกรรมการเห็นว่า การดำเนินการตามวรรคหนึ่งยังไม่เป็นผล หน่วยงานผู้รับประกัน แล้วแต่กรณี อาจมีคำสั่งระงับใบอนุญาตประกอบสถานพยาบาลของหน่วยงานผู้ให้บริการประกันสุขภาพที่เป็นของเอกชนหรือของมหาวิทยาลัยเอกชนรายนั้นเป็นเวลาไม่เกินยี่สิบวันนับแต่วันที่ได้มีคำสั่งดังกล่าว

หากคณะกรรมการเห็นว่า การดำเนินการตามวรรคสองยังไม่เป็นผล หน่วยงานผู้รับประกัน แล้วแต่กรณี อาจมีคำสั่งเพิกถอนใบอนุญาตประกอบสถานพยาบาลของ หน่วยงานผู้ให้บริการประกันสุขภาพที่เป็นของเอกชนหรือของมหาวิทยาลัยเอกชนรายนั้น หรือเข้าดำเนินการอย่างใดอย่างหนึ่งแทน

มาตรา ๓๒ หน่วยงานผู้ให้บริการประกันสุขภาพที่เป็นของรัฐหรือของมหาวิทยาลัยของรัฐรายใด ดำเนินการหรือไม่ดำเนินการใด ๆ อันเป็นการขัดต่อมติของคณะกรรมการเป็นเหตุให้เกิดความเสียหายอย่างร้ายแรงแก่ทางราชการ ให้ผู้บังคับบัญชาที่อยู่เหนือขึ้นไปของหน่วยงานผู้ให้บริการประกันสุขภาพที่เป็นของรัฐหรือของมหาวิทยาลัยของรัฐรายนั้น ดำเนินการต่อผู้บริหารของหน่วยงานผู้ให้บริการประกันสุขภาพที่เป็นของรัฐหรือของมหาวิทยาลัยของรัฐรายนั้น ตามกฎหมายว่าด้วยความรับผิดทางละเมิดของเจ้าหน้าที่และดำเนินการตามกฎหมายว่าด้วยระเบียบข้าราชการพลเรือน

หมวด ๗

บทกำหนดโทษ

มาตรา ๓๓ ผู้ใดขัดขวางหรือไม่อำนวยความสะดวกตามสมควรแก่พนักงานเจ้าหน้าที่ในการปฏิบัติ หน้าที่ตามมาตรา ๒๙ วรรคสาม ต้องระวางโทษจำคุกไม่เกินหกเดือน หรือปรับไม่เกินหนึ่งหมื่นบาทหรือทั้งจาทั้งปรับ

มาตรา ๓๔ ผู้ใดฝ่าฝืนไม่ปฏิบัติตามมาตรา ๒๖ วรรคสาม ต้องระวางโทษปรับไม่เกินหนึ่งพันบาท

หมวด ๘

คณะกรรมการวินิจฉัยอุทธรณ์

มาตรา ๓๕ ให้มีคณะกรรมการคณะหนึ่งเรียกว่า “คณะกรรมการวินิจฉัยอุทธรณ์” ซึ่งคณะรัฐมนตรีแต่งตั้งประกอบด้วยประธานกรรมการหนึ่งคนและกรรมการอื่นซึ่งเป็นผู้ทรงคุณวุฒิทางกฎหมาย ผู้ทรงคุณวุฒิทางวิชาชีพด้านสาธารณสุข ผู้ทรงคุณวุฒิทางการเงินการคลังไม่เกินหกคน และ ผู้แทนสภาประกันสุขภาพแห่งชาติ เป็นกรรมการและเลขานุการ

ให้นามาตรา ๗ มาตรา ๘ มาตรา ๙ และมาตรา ๑๐ มาใช้บังคับกับกรรมการผู้ทรงคุณวุฒิตาม วรรคหนึ่งโดยอนุโลม

มาตรา ๓๖ ให้คณะกรรมการวินิจฉัยอุทธรณ์ มีอำนาจหน้าที่ดังต่อไปนี้

(๑) พิจารณาวินิจฉัยอุทธรณ์กรณีตามมาตรา ๙(๓) หรือมาตรา ๑๘(๔) หรือมาตรา ๑๙

(๒) พิจารณาวินิจฉัยอุทธรณ์คำสั่งตามมาตรา ๓๑ หรือมาตรา ๓๒

(๓) มีหนังสือเรียกบุคคลที่เกี่ยวข้องมาให้ถ้อยคำ หรือสั่งให้บุคคลดังกล่าวส่งเอกสารหรือหลักฐานอื่นที่เกี่ยวข้องเพื่อประกอบการพิจารณาวินิจฉัยอุทธรณ์

(๔) สอบถามข้อเท็จจริงหรือกระทำการใด ๆ เท่าที่จำเป็นเพื่อประกอบการพิจารณาวินิจฉัยอุทธรณ์

มาตรา ๓๗ ผู้ใดได้รับการปฏิบัติโดยไม่เป็นธรรมตามมาตรา ๙(๓) หรือมาตรา ๑๘(๔) หรือมาตรา ๑๙ หรือไม่พอใจคำสั่งตามมาตรา ๓๑ หรือมาตรา ๓๒ ให้ทำเป็นหนังสือยื่นอุทธรณ์ต่อคณะกรรมการวินิจฉัย

อุทธรณ์ภายในสิบห้าวันนับแต่วันที่ได้รับการปฏิบัติโดยไม่เป็นธรรมหรือวันที่ได้รับแจ้งคำสั่งดังกล่าว แล้วแต่กรณี ทั้งนี้ตามหลักเกณฑ์และวิธีการที่คณะกรรมการประกาศกำหนด

การอุทธรณ์ตามวรรคหนึ่ง ไม่เป็นเหตุทุเลาการปฏิบัติตามมติหรือคำสั่งของคณะกรรมการ แล้วแต่กรณี เว้นแต่คณะกรรมการวินิจฉัยอุทธรณ์จะมีมติเอกฉันท์เป็นอย่างอื่น

คำวินิจฉัยของคณะกรรมการวินิจฉัยอุทธรณ์ให้เป็นที่สุด

บทเฉพาะกาล

มาตรา ๓๘ เพื่อประโยชน์ในการบริหารงานระบบประกันสุขภาพของรัฐตามพระราชบัญญัตินี้ ให้โอนอำนาจหน้าที่ของกรมบัญชีกลาง สำนักงานประกันสังคม และสำนักงานหลักประกันสุขภาพแห่งชาติในส่วนที่เกี่ยวกับระบบสวัสดิการรักษาพยาบาลข้าราชการ กองทุนประกันสังคม และกองทุนหลักประกันสุขภาพแห่งชาติ แล้วแต่กรณี มาขึ้นกับสำนักงานนับแต่วันที่พระราชบัญญัตินี้ใช้บังคับ

มาตรา ๓๙ ให้โอนอำนาจหน้าที่ของคณะกรรมการประกันสังคมตามมาตรา ๙ ประกอบมาตรา ๘ แห่งพระราชบัญญัติประกันสังคม พ.ศ.๒๕๓๓ เฉพาะแต่อำนาจหน้าที่ตามมาตรา ๙ (๓) และ (๔) แห่งพระราชบัญญัติดังกล่าวมาอยู่ภายใต้อำนาจหน้าที่ของคณะกรรมการตามพระราชบัญญัตินี้ภายในหกสิบวันนับแต่วันที่พระราชบัญญัตินี้ใช้บังคับ

มาตรา ๔๐ ให้โอนอำนาจหน้าที่ของคณะกรรมการหลักประกันสุขภาพตามมาตรา ๑๘ ประกอบ มาตรา ๑๓ แห่งพระราชบัญญัติหลักประกันสุขภาพแห่งชาติ พ.ศ.๒๕๔๕ เฉพาะแต่อำนาจหน้าที่ตามมาตรา ๑๘ (๑) (๔) และ (๖) แห่งพระราชบัญญัติดังกล่าวมาอยู่ภายใต้อำนาจหน้าที่ของคณะกรรมการตามพระราชบัญญัตินี้ ภายในหกสิบวันนับแต่วันที่พระราชบัญญัตินี้ใช้บังคับ

ผู้รับสนองพระบรมราชโองการ

นายกรัฐมนตรี

หมายเหตุ:-เหตุผลในการประกาศใช้พระราชบัญญัติฉบับนี้ คือ เนื่องจากระบบบริการสุขภาพของไทยในปัจจุบันนั้น มีแนวทางและวิธีการปฏิบัติที่แตกต่างกัน ก่อให้เกิดปัญหาความเหลื่อมล้ำในการเข้าถึงบริการสุขภาพและระบบประกันสุขภาพของรัฐ ความแตกต่างของระบบหลักประกันสุขภาพที่มีอยู่ อันได้แก่ ระบบสวัสดิการรักษาพยาบาลข้าราชการ ระบบประกันสังคม และระบบหลักประกันสุขภาพถ้วนหน้า มีส่วนทำให้ปัญหาดังกล่าวเพิ่มมากขึ้น เนื่องจากอยู่ภายใต้การบริหารจัดการหลายหน่วยงาน ที่มีวัตถุประสงค์ รูปแบบกลไกการบริหารจัดการ และแนวทางปฏิบัติที่แตกต่างกัน ทำให้ขาดความเป็นเอกภาพ โดยที่เป็นการสมควรส่งเสริมให้มีหน่วยงานกลางที่อยู่ในความกำกับดูแลของภาครัฐ เพื่อให้การบริหารจัดการระบบประกันสุขภาพของรัฐอยู่ภายใต้หน่วยงานเดียวกัน อันจะทำให้เกิดให้เกิดความเท่าเทียมกันการได้รับบริการสุขภาพและระบบประกันสุขภาพของรัฐ ทำให้เกิดประสิทธิภาพต่อการบริหารจัดการระบบประกันสุขภาพของรัฐดังกล่าว ในการนี้ สมควรจัดตั้งสำนักงานสภาประกันสุขภาพแห่งชาติขึ้นเป็นส่วนราชการที่เรียกชื่ออย่างอื่น ที่มีฐานะเทียบเท่ากรม สังกัดสำนักงานปลัดสำนักนายกรัฐมนตรี เพื่อให้เป็นหน่วยงานที่ทำหน้าที่บริหารจัดการระบบประกันสุขภาพของรัฐทั้งสามระบบอย่างกลมกลืนและดำเนินการอย่างสอดคล้องกันตามนโยบายของรัฐบาลที่เกี่ยวข้องกับการบริหารระบบบริการสุขภาพ จึงจำเป็นต้องตราพระราชบัญญัตินี้

BIOGRAPHY

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