รายงานฉบับสมบูรณ์
ฉบับภาษาอังกฤษ

จากนโยบายสู่การปฏิบัติ: เหตุการณ์สำคัญในช่วงการดำเนินการหลักประกันสุขภาพถ้วนหน้าในประเทศไทย

From Policy to Implementation: Historical events during 2001-2004 of Universal Coverage in Thailand

จัดทำโดย
สำนักงานพัฒนานโยบายสุขภาพระหว่างประเทศ

ได้รับการสนับสนุนจากสถาบันวิจัยระบบสาธารณสุข
และ
สำนักงานหลักประกันสุขภาพแห่งชาติ

Contents

Lists of Abbreviations

APB	Area Purchaser Board
BOB	Bureau of the Budget
BHCN	Bureau of Health Care Network
BHPP	Bureau of Health Policy and Planning
BMA	Bangkok Metropolitan Administration
CSMBS	Civil Servant Medical Benefit Scheme
CUP	Contracting Unit for Primary Care
DRG	Diagnostic Related Group
EU	Commission of the European Union
HIO	Health Insurance Office, Ministry of Public Health
HIV/AIDS patients	Human immunodeficiency virus / Acquired Immune Deficiency Syndrome patients
HSRI	Health Systems Research Institute
HCRO	Health Care Reform Office
LSHTM	London School of Hygiene and Tropical Medicine
MWS	Medical Welfare Scheme
MoPH	Ministry of Public Health
NGO	Non-Government Organisation
NESDB	National Economics and Social Development Board
NHSB	National Health Security Board
NHSO	National Health Security Office
OPD	Outpatient Department
PCMO	Provincial Chief Medical Officer
PCU	Primary Care Unit
PHO	Provincial Health Office
SHI	Social Health Insurance
SIP	Social Investment Project
SSO	Social Security Office
SSS	Social Security Scheme
TDRI	Thailand Development Research Institute
TRTP	Thai Rak Thai Party
UC	Universal Coverage of Health Care or Universal Coverage
VHCS	Voluntary Health Card Scheme
WB	World Bank
WCS	Workmen Compensation Scheme
WHO	World Health Organization

Acknowledgements

The editors would like to express their gratitude to, the National Health Security Office for providing financial support through the Health Systems Research Institute, the contributors of the chapters for their dedications, the International Health Policy Program, Thailand, for their coordination, and Ms. Somsong Patarapanich, Managing Director of Trisak Business-Link, for her assistance with the English editing.

IHPP is jointly funded by Thailand Research Fund and Health Systems Research Institute.

Prologue

After two decades of government efforts to expand health insurance coverage and to improve access to basic health services to, the poor, children under 12, and senior citizens, formal sector employees, and members of the voluntary health insurance scheme, about 20% of the population was still not insured by any public health insurance schemes in 2000.

In 2001, the government successfully implemented nationwide, the universal healthcare coverage (UC) policy with a big-bang approach, within the same year. The enactment of the National Health Security Act 2002 (2545 BE) came a year later.

The legislation process was first initiated by several civic groups and was later taken over by the leading political party, Thai Rak Thai (TRT) Party, which won the general election on January 6th, 2001. Thailand, as a lower-middle income country, had a GDP per capita of US$ 2,040 in 2001.

Achieving the UC policy implementation at the time when the economy had not yet fully recovered from the 1997 economic crisis, is quite an interesting case study in itself, as most countries seem to have achieved their universal coverage in a favourable economic and fiscal environment.

The contributors, who have been involved in the UC scheme, describe impartially the, historical events of the policy making processes, results and impacts of the UC policy implementation on the national healthcare system and Thai households, based on the available evidence.

This book is divided into four sections as follows:

Section I: In Chapter 1, Pitayarangsarit explains why and how the UC was put on the political agenda by the TRT party, and later became one of the TRT government's top priority policies in 2001. This chapter also describes the history of Thailand's health insurance schemes and healthcare services. In Chapter 2, Pitayarangsarit, Jongudomsuk and Sakulpanich et al, based on their direct observations, interviews and official documents, explains how the designs of the UC scheme and the National Health Security Act were formulated, with emphasis on different actors' interactions in shaping the policy contents.

Section II: In Chapter 3, Thammathat-aree and Jongudomsuk describe the restructuring of the organizations and their management as preparation for the UC implementation, which is dealt with in Chapter 4, by Pitayarangsarit with the emphasis on Saraburi province.

Section III: Srithamrongsawat and Torwatanakitkul give a review of the impacts of the UC scheme on the national healthcare system in Chapter 5, with special focus on the reform of hospital financing systems and the strengthening of primary care services. In chapter 6, Vasavid, Tisayaticom, and Patcharanarumol et al. analyze the achievement of the policy in, population coverage, service utilization, equity in receiving government subsidies, using benefit incidence approach, and two opinion polls of consumers and healthcare providers on the UC scheme.

Section IV: The final chapter, Chapter 7, by Tangcharoensathien and Jongudomsuk, address some future challenges and provides policy recommendations.

It is hoped that this book will give better insights into the achievement of UC scheme, highlight the unfinished agenda as well as sharing healthcare reform lessons with other reformists worldwide.

Viroj Tangcharoensathien MD, Ph.D.
Pongpisut Jongudomsuk, MD, MPH.
7 February 2005

Chapter I

Agenda setting process

Siriwan Pitayarangsarit

Introduction

Based on the information obtained from interviews with key informants and documents studied during 2001-2 (1), this chapter examines the events and factors contributing to the making of the universal coverage of healthcare (UC) policy, and its agenda setting process, as instigated by Thai Rak Thai Party (TRTP), which officially became a political party in July 1998. A policy analysis framework is used to explain the UC policy process in terms of interactions of four main factors: content, context, actors, and processes (2).

The term "universal coverage" may be defined "as a situation where the whole population of a country has access to a good quality services (core health services) according to needs and preference, regardless of income level, social status or residency" (Nitayarumphong, 1998: 4) (3).

With the support from stakeholders, such as bureaucrats, NGOs, and other civil organizations, in 2001, Thailand introduced the UC policy shortly after the Thai Rak Thai Party (TRTP) government came into power, with the aim to entitle all Thai citizens to healthcare access by reforming the health care system to achieve equity, efficiency, quality and accountability. The government's policy was to establish a subsidized healthcare scheme or better known as the '30 baht Scheme' or the 'Universal Coverage (UC) Scheme' to replace the two existing schemes, the Medical Welfare Scheme (MWS) and the Voluntary Health Card Scheme (VHCS), and expanded coverage to the uninsured. The 30 baht Scheme would be financed largely from tax revenue, with a minimal co-payment of 30 baht per medical visit, and would provide a comprehensive benefit package for active treatment of illnesses and preventive medicine, whose main aim is the prevention of disease. The scheme was already covering about 80% of the population, excluding only those in the formal sector, who were covered by the Social Security Scheme (SSS) and the Civil Servant Medical Benefit Scheme (CSMBS). At the same time, the government would have to reform the country's healthcare-financing and healthcare service systems. The UC policy would also mobilize resources to primary health care, through contracting and collaborating with the private sector providers. It was a "big bang" reform in the Thai healthcare system.

Overview of the universal coverage policy (UC)

The Thai Rak Thai Party (TRTP) won its landslide victory in the 2001 general election because of the party's promise to implement its policies (4, 5). The Party leader, Thaksin Shinawatra, on becoming the Prime Minister of Thailand, announced at a press conference on 6 January 2001, (Election Day), that his Party was committed to implement its policies as promised. Furthermore, since his party was entrusted by the people to set up the government, the party's policies were the government's policies, and therefore: "If the party cannot keep its promise, it would betray the electorate's trust [1] " (6). As the UC policy had been part of the TRT party's manifesto since 26 March 2000 and was promoted during the political campaign under the slogan of 'sam sib baht rak sa thuk rok' ("30 baht treats all diseases"), the '30 baht' policy became one of the government's top priority policies to be implemented after the election.

The government's policy declarations on healthcare financing and healthcare service delivery systems are presented in Box 1.1. The first was one of nine government priority policies: the universal coverage of

[1] Translated from the Thairatch Newspaper, 7 January 2001, page 1.

healthcare (UC) Policy. The second was health system reform under the social sector policy: declaring the intention to legislate for the National Health Security Act.

Box.1 Policy declaration to the parliament by the Thaksin Shinawatra government on 26 February 2001

The universal coverage of healthcare policy was one of nine high priority policies. The universal coverage of healthcare policy aims to 'reduce the national health expenditures and household health expenditures with 30 baht out-of-pocket per episode and provide accessible and equitable quality health services'.

Health policy under social sector policy aims to implement the health system reform by establishing a National Health Security Fund through the legislation of the National Health Security Act.

Source: Policy declaration to the parliament by the Thaksin Shinawatra government on 26 February 2001. http://www.thaigov.go.th/index-eng.htm

The provision of healthcare financing and healthcare services as stated in February 2001 can be summarized as follows.

- All Thai residents are entitled to accessible and equitable health services.
- The policy aims to reduce national health expenditure and household expenditure by establishment of a collective tax-based financing system and paying providers according to the number of registered population under a new health scheme for people outside formal employment. Under this scheme, households pay only a nominal contribution of 30 baht per visit to a medical service.
- The 30 baht Scheme will provide the choice for people to register with a health care provider from either public or private sector.
- The government will guarantee a quality of health services which can be accessible geographically.
- The government intends to reform the health financing system by establishing the National Health Security Fund through legislation. The Fund is expected to harmonize benefits, costs and management between several existing schemes that will lead to an equitable healthcare system.

Thus, Thailand chose to establish, a largely subsidized healthcare service scheme, which separated the purchaser role from that of the Ministry of Public Health (MoPH), and a cost control with the closed-end payment method. The system was expected to have dual funding within a single system in the future. However, the policy was implemented rather quickly in 2001 by the MoPH, but in four progressive stages to expand the healthcare coverage. Table 1.1 shows the chronological events leading from the UC policy formulation to its implementation during 2001-2002. Under the 30 baht Scheme, health registration was supposed to cover the whole country by April 2002, and was meant to be before the legislation of the National Health Security Act (November 2002). This meant the country having wide insurance coverage under three different management schemes; the Social Security Scheme (SSS), the Civil Servant Medical Benefit Scheme (CSMBS), and the 30 baht Scheme (UC). However, in 2004, the health insurance reform was in a transitional stage, with the development of the 30 baht Scheme still in its infancy in regard to the resource allocation, strengthening of primary health care, and choice of providers.

Table 1.1 Chronological events culminating in the policy formulation, implementation of the 30 baht scheme, and enactment of the National Health Security Act

Periods	Events of Thailand regarding the universal coverage policy
January 2001	Election of the Thaksin government
February 2001	Policy declaration in the parliament on 26-27 February 2001: official announcement of the UC policy – 'the 30 baht Scheme'
March 2001	Consultation meeting chaired by the PM
April 2001	Implementation of the first phase of the UC in 6 provinces: extension of the Medical Welfare Scheme to cover uninsured
May 2001	Guidelines for implementation published
June-October 2001	Phase II. Private collaboration: expansion to 15 provinces with the collaboration of private providers and university hospitals
October 2001	Phase III. Nationwide implementation: expansion of coverage to all provinces except the inner Bangkok districts started from January 2002
April 2002	Phase IV. Achieving universal coverage: expanding coverage to the whole country including the inner Bangkok districts and achieved universal coverage
November 2001 - 2002	Parliamentary process of the National Health Security Act

Thai healthcare system and context before the introduction of the 30 baht Scheme

In Thailand, universal healthcare coverage had long been a concern among academics and researchers particularly in the Ministry of Public Health (MoPH). The vision to achieve universal healthcare coverage was discussed at the Health Financing Conference in 1993, organised by the MoPH and the World Bank (7). By that time, 50% of population had insurance coverage and the proportion of population with health insurance protection has been gradually increased since then. Many insurance schemes have been developed independently at different times. However, until 2000, the healthcare system was far from ensuring universal access of healthcare to all Thai citizens. Although the new Constitution promulgated on 11 October 1997, made equity in healthcare mandatory, as it is the right of Thai citizens, and UC was also one of the goals in the 8th National Social and Economic Development Plan (1997) (8), there was insufficient interest among policy-makers to implement the UC policy.

Healthcare delivery and financing system

In Thailand, the MoPH was responsible for healthcare service delivery and financing management. The MoPH invested in the infrastructure of healthcare units in every district and sub-district, and hospitals and health centres were gradually built up in all areas of the country during 1981-1991. The 'Decade of Health Centre Development' policy (1986 to 1996) was aimed at establishing health centres in all sub-districts (Tambons) in rural areas. Consequently, by 2000 there were few geographic areas where people could not access to healthcare services.

Alongside with the infrastructure development, there was also expansion of the health-financing system. Before the health insurance reform, there were four main public health insurance schemes, covering four major population groups. They were the Medical Welfare Scheme (MWS), Civil Servant Medical Benefit Scheme (CSMBS), Voluntary Health Card Scheme (VHCS), and Social Security Scheme (SSS), and founded in 1975, 1978, 1983, and 1991, respectively. The first Social Security Act was promulgated in 1954, but

was not implemented because of resistance from insurance companies, private enterprises and state enterprises (9). Although the government managed the four schemes, administration of these schemes was fragmented, and they could not cover the total population. In 2000, only 69% of the total population was insured: 37% by the MWS for the poor, senior citizens, children under 12 and the disabled; 11% by the CSMBS for civil servants and their families; 9% by SSS for private sector employees; and 12% by the VHCS for the general population, especially in rural areas (10). Thirty-one percent of the population was excluded.

Problems of access to healthcare

Many Thai people could not afford healthcare services. Siamwala et al (2001) reviewed the problems of healthcare accessibility and found that although these problems were prevalent, their severity varied from case to case. A survey by ABAC-KSC International Poll (2000) found 43.8% of the sample population experienced high healthcare costs or unaffordable costs. 62.5% of the sample population was in debt and 16.6% asked for exemption. Another study on catastrophic payment in healthcare in Songkhla Province (11) found many factors related to unaffordable healthcare costs. These factors were education, occupation and income levels of the households' heads or the income-earners. Households with low level of education, occupation or income were likely to be unable to pay healthcare costs when their family members became ill. In some cases, people were denied treatment because they were not insured and in most cases, they reported, there were health complications and physical disabilities caused by delayed medical treatment (10).

In 1997, Pannarunothai and Mills reported, for the first time, inequity in Thai healthcare financing system, and observed that poor people were more likely to pay for their own medical fees than the rich (12). They also reported an inequitable pattern of household health expenditure by income quintile and per capita. For the underprivileged, the costs of their healthcare services were high proportion relatively to their household incomes, when compared to privileged. This phenomenon was supported by other studies of regressive healthcare financing system[2] by income quintile group (14), and Kakwani index[3] (16). Pannarunothai et al (2000) found that out-of-pocket payment by household was the most regressive system, followed by indirect tax financing system; i.e. Value Added Tax (15). Hence, the regressive financing system was a problem, and it was concluded that a more desirable financing system would be payment according to ability to pay (15). Household healthcare expenditure was a major source of health finance in Thailand. It was 44% of the total healthcare expenditure in 1994, but decreased to 41% and then 33% of the total healthcare expenditure in 1996 and 1998, respectively (17). The reduction of household "out-of-pocket" payment due to substitution of other progressive sources, thus, reflected the less regressive nature of the total health financing system (16).

The use of healthcare services was affected by insurance coverage. Tangcharoensathien et al (2001) described utilisation and characteristics of the uninsured (18). Hospital admission rates of the uninsured were lower than those of the insured, no matter what their health insurance schemes were (see Table 1.2). The privately insured used hospital inpatient care services (1.5 times per year), more frequently, three times more frequent than the uninsured (0.04 times per year), followed by those insured under other health insurance schemes (19).

---

[2] The regressive healthcare financing system refers to the extent to which payments for healthcare fall as a proportion of a person's income, as his or her income rises (13).

[3] Kakwani index is based on the extent to which a tax system departs from proportionality (15).

Table 1.2 Annual Hospital Admission Rate per Capita with Insurance Coverage, 1996

	Admission rate
Uninsured	0.04
Medical Welfare Scheme (MWS)	0.10
Civil Servant Medical Benefit Scheme (CSMBS)	0.08
State enterprise	0.06
Social Security Scheme (SSS)	0.05
Voluntary Health Card Scheme (VHCS)	0.08
Private insurance	0.15
Total	0.06

Source: National Statistic Office 1996. Health and Welfare Survey

Under-utilization of hospital services was a problem with the uninsured and poor. One study found that the poor had inadequate access to antenatal care, which was more common in urban areas than in rural areas (20). The Provincial Health Survey (1996) provided characteristics of the uninsured by income, education and occupation. Twenty-eight percent of the poorest households (monthly household income less than 2,000 baht), who should have been covered by the Medical Welfare Scheme, were actually not insured. The uninsured rates were highest among taxi drivers and traders (21).

Pannarunothai and Renburge (1998), in their analysis of Thai data from the 1986 Health and Welfare Survey, measured equality in access to healthcare, using concentration index[4] from the point of view of horizontal equity (equal medical care received on equal health need). They found that when adjusting for the same level of illness, the rich used the healthcare services more than the poor. Another study using the data from the 1991 Health and Welfare Survey (22) confirmed that the percentage of those attending hospital for healthcare services, was higher in the rich quintile than the poor quintiles (14).

As discussed above the problems concerning access to healthcare services for the insured and the uninsured (e.g., unaffordable medical bills, inequitable financing of healthcare services), therefore, justified the strong demand for healthcare reform in Thailand. However, problems aside, were Thailand socio-economically, and most important of all politically ready to tackle the much-needed healthcare reform?

Social, economical and political context

As a democratised country, with a constitutional monarchy, Thailand was never colonized. Its population was estimated in 2001 at 62 millions, of which 35% lived in urban areas (23). In recent years Thai economy has been growing at an average of 7.8% annually, making Thailand a lower-middle-income country (8). Changes in its political system and its economy have always had great influence on the policy-makers. Two noteworthy examples were the promulgation of the 1997 Constitution and the 1997 economic crisis.

The Thai political system was transformed from absolute monarchy to constitutional monarchy in 1932, but democratization of the country came after the demise of military dictatorship during the 1970s and 1980s. Three main groups had dominated the policy elite, namely the aristocrat, bureaucrat and the

[4] Concentration index for illness rate (or healthcare utilisation) is twice the area between a curve which plots the cumulative proportion of illness rate (or utilisation of health care) against a curve which plots the cumulative proportion of population (Pannarunothai et al., 2000).

army, and they relied on businessmen for their financial support. After the fall of the military in 1973, business-based politicians gained more political prominence and increased their political clout, thanks to the parliamentary system (24). The early part of this period was aptly described as 'bureaucratic polity' (25) where power fluctuated between the elected government and the military, and the lack of democratic control allowed the bureaucrats to hold the balance of power in policy decision-making (26). The later part of the period, however, witnessed the rise of 'business politics', during which corporate elites were interested in having both financial and political power (24).

The close relationship between politicians and self-interest has led to vote-buying and electoral corruption (Callahan and Mccargo, 1996 quoted in Green, 2000). Problems, such as power abuse for personal gains, corruption among politicians, devoid of ethical or moral principles, were good enough reasons for the political reform movement during the 1990s (8). Corruption scandals were rife, and in 1991 the military, with backing from the middle class, took over government in order to clean up the regime. However, the middle class soon realized that their prosperity depended on the modern economy, which was adversely affected by the coup. As their support for the military government waned the middle class protested in street demonstrations, which came to a climate known as 'Bloody May' (27). They were successful in overthrowing the military regime in May 1992 (28), which was then followed by the political reform movement for democratization the country.

The government in 1995 appointed a committee to consider the political reform, and this sparked off the process of constitution drafting, a series of public hearings, and the promulgation of the 1997 Constitution, which was accelerated by the economic crisis in July 1997. The 1997 Constitution, or the 'People's Constitution': reduced the King's parliamentary control over the appointment of the senate; created direct election of members of the senate; and increased the political parties' power over the parliament by election of members of the parliament or MPs on a party-list basis. The electoral rules were also changed to prevent "vote buying" and other irregularities. Moreover, the duty of inspecting political parties was transferred from the Ministry of the Interior to an independent election commission (8).

By doing away with the bureaucratic monopoly of policy-making, the 1997 Constitution also increased civilian power or public participation in decision-making in matters relating to human rights. The Constitution therefore encouraged a subsequent movement within the civil society to propose new health laws.

Although the 1991 Constitution addressed the right of citizens to access healthcare and of the poor to free healthcare services, the 1997 Constitution affirmed the right by adding the principle of equity in healthcare access together with defining the role of both private and public sectors in providing healthcare services (Section 52 of the Constitution) (29). The access to healthcare services for all was also stated in the 8th National Socio-economic Development Plan (1997-2001), but because of the economic downturn and lack of political support, there was no follow-up with an action plan.

Thailand's economy has developed from an agrarian economy to an industrial-base economy (26). It grew by leaps and bounds after 1985, with Thailand opening its door to welcome foreign investments (30). The economic growth brought with it increased demands for healthcare services, and more private hospitals were built in response to the market support policy of the Bureau of Investment (BOI) (31). However, with the economic burst in 1997, the Thai economy contracted by 10.5% in 1998 (32). The major causes of the economic crisis were attributed to short-term foreign debts, private-sector investments in non-productive businesses (particularly, in the real estate, automobile industries, petrochemical industries and private hospitals, inefficient production structures, foreign-capital dependency, monetary liberalization policy without an effective monitoring and inspection system, and inefficiency of public-sector management (8). To maintain its overall economic stability, Thailand adopted a managed-float-currency-exchange system in 1997, and requested financial and technical assistance from the International Monetary Fund on 14 August 1997 (8). The economic crisis had immense social repercussion on unemployment, under-employment, household income contraction, changing expenditure patterns, and child abandonment. The crisis reduced about one million people to poverty, with 54% of

these people being the ultra-poor[5]. Household health expenditure reduced by 24% in real terms. Self-medication was preferred to institutional healthcare, especially in poorer households. Private hospitals were in debt as their services were obviously not much needed (33).

Following the crisis, Thailand began to implement measures for reform of the financial sector, corporate governance, security of national and international borrowing, and policy to motivate banks and other business firms to move towards their competitive frontiers. The resilience of the Thai economy facilitated its quick economic recovery and its poverty began to improve. After contracting by 10.5% in 1998, Thailand's economy grew by 4.4% in 1999 and 4.6% in 2000 – and remained positive at 1.9% in 2001 (32), in spite of the global economic slowdown (8, 34). As a reaction to the crisis and spurred by the international reform trend, Thailand carried out many reforms in the public sector before 2001, including changes recommended by donor countries.

Coexisting reform policies before 2001

With a neo-liberal approach, Thailand opened its doors to international finance, opened its capital accounts, promoted free market including deregulation, and privatization and liberalization (35). For example, the master plan for state enterprise sector reform programme was approved by the Royal Thai Government Cabinet on September 1, 1998 (36), and as a result several state enterprises were privatized including those in the telecommunication sector. During the Chaun Leekphai administration (1998-2000), many pieces of legislation were introduced for reform of different sectors. The Devolution Act 1999 set the pace for devolution of the MoPH's services, provided by its health centres, district and provincial hospitals, to elected local government by 2004. The MoPH would then play a more diminishing role in direct service provisions, but would retain its role in financing, policy direction, monitoring and evaluation. Within the health sector, there were developmental changes taking place, such as strengthening the National Essential Drug Lists, payment reform in the Civil Servant Medical Benefit Scheme, the introduction of efficient use of drugs and supplies, and transformation of public hospitals into autonomous hospitals.

In 2000, the health sector reform movement, with a three-pronged strategy: generation and management of knowledge, involvement of civil society, and political support, was coordinated by the Office of Health System Reform, and funded by the Health Systems Research Institute under the National Health Systems Research Committee. The movement was meant to have the involvement of the whole society in drafting a knowledge-based national health bill during 2000-2003, aiming to reform the whole healthcare sector. The universal coverage of healthcare was one of the objectives of the bill. Thus these simultaneous reforms partly influenced the readiness for the implementation of the 2001 UC policy.

Political process of the UC adoption

As a preparation for the party's campaign for the 2001 election, a taskforce, consisting of medical and health experts, was set up in mid-1999, to monitor the government's performance. In its effort to come up with a "core health policy" to strengthen its political platform, the party focused on the question of how to effectively utilize the existing healthcare resources, with cooperation from both the public and private sectors, and finally ended up with the universal healthcare coverage policy, suggested by a health reformist. The health reformist, who was asked to carry out a detailed study of "universal healthcare coverage" and how to finance the UC scheme, which the party thought "was a good policy", presented the party a crude estimate of a required budget of 80-100 billion baht. The TRTP's health team believed that the scheme would work with even some token contribution from healthcare service users. The

[5] Ultra poor is defined as those with incomes below 80 percent of the poverty line and the poverty line in Thailand in 1998 was based on food consumption basket which varies according to age and sex (31). By 1998, the average poverty line for Thailand was at Thai baht 878 per month per person equivalent to US 73 cents per day (32).

question was what would be the appropriate amount of contribution, 100 baht, 20 bath? Eventually the party settled for 30 baht, which became one of the party's top national agenda.

The TRT party's decision to scrape the 100 baht contribution was based on various sources of information, suggesting different capitation rates. A report by the Management Sciences for Health and the Health Systems Research Institute, suggested 1,040 baht (37), considering that Ban Phaew Hospital received a budget of 782 baht per capita annually (38), the Social Security Scheme was operating on a rate of 1,400 baht per person per year. With this information about the existing capitation rates, the party's health team came up with a rough budget of 62-84 billion baht for a population of 60 millions. Bearing in mind that the government's health budget in 1999 was 70 billion baht, an extra budget would be required to finance the UC scheme and a reform of the overall health service system would also be anticipated.

In 2001, heartened by the results of the polls, which predicted election victory for the TRT party, the party leader announced that his government would, allow, a moratorium, or a three-years suspension of payment of debts for farmers, a one-million baht "revolving" fund for each village, set up a Citizen Bank, and introduce the "30 baht for treatment of all deceases" scheme. On winning the election, the newly elected Prime Minister (PM), Thaksin Shinawatra made his declaration in the Parliament that "the universal coverage of healthcare policy was one of nine high-priority policies. The universal coverage of healthcare policy aims to reduce the national health expenditures and household health expenditures with 30 baht out-of-pocket per episode and to provide accessible and equitable quality health services (Policy declaration to the parliament by the Thaksin Shinawatra government on 26th of February, 2001). The Permanent Secretary of Health also supported and implemented the UC policy urgently in the next two months, in six provinces, as a pilot study. The more information the TRT party had gathered, the more confident the party became in making the UC policy one of its top priorities for implementation.

The UC agenda setting was triggered by the party leader's foresight and initiative in sourcing and researching relevant healthcare issues, by consulting and involving health experts. Choosing the UC policy for the party's election campaign to attract voters was by no means fortuitous. It was no doubt a calculated manoeuvre, based on its legitimacy, congruency and feasibility. Thai citizens had been granted the constitutional right to healthcare services, and therefore, the UC policy was legitimate in that sense. The UC policy was meant by the party to be the precursor to the intended reform of the healthcare system. So, it was in congruence with the party's policy for overhauling the overall healthcare system. The party also believed that it was feasible to implement the UC policy with the existing government's budget. The UC policy has also found support in Hall's model, which assumes that when an issue (or policy) has "high" legitimacy, congruency, feasibility and support, it is more likely to be on the agenda. In order not to lose any time in implementing the UC scheme, for fear of organized resistance, the Ministry of Public Health (MoPH), with its experienced staff and management, was assigned to oversee the setting up of the new healthcare scheme. The rush in implementing the system meant there were inadequate technical and financial preparations, which probably was resultant of the TRT party's complacency or undue optimism about its ability to finance the UC budget, without realizing that the initial starting cost for financing the UC implementation would be higher than what had been expected. At the same time the amalgamation of the several existing health schemes was lagging behind this rather rapid move toward enlarging the health insurance coverage for all. Moreover, equitable resource allocation would not have been possible without carefully planned measures for resource allocation. This fast track or "big bang" approach brings to mind Taiwan's experience in its healthcare reform in 1995. Its National Health Insurance Scheme was implemented two months after the establishment of its Bureau of National Health Insurance, causing chaos and confusion (*Cheng, 2003*).

UC development and Thai health researchers

Without the UC policy, not all Thai citizens would have been able to access to healthcare services. Although, more and more people in all the sub-districts (tambons) of Thailand had access to health centres' services, not all the Thai citizens were covered by health insurance. In 2000, only 69 % of the

overall population was covered, and to maximize the coverage, a national health scheme or the UC policy was warranted. As far as health insurance was concerned, in the public sector, the civil servants by then had been given compensations for work-related injuries, and illnesses, since 1955, and later were covered for non-work–related accidence as well. In 1978 the Civil Servant Medical Benefit Scheme (CSMBS) was inaugurated by Royal Decree, making medical expenses of the civil servants, their dependants, and pensioners, reimbursable (39-42). In the private sector the attempt to enforce the Social Security Act 1955, was hindered by private insurance companies, and other enterprises. It did not work out because no prior situation analysis was carried out, the Act was too broad, without defining workers' benefits, and no effective and efficient communication system was put in place to inform the public about the Act. Other attempts also ended in fiasco because of the government's indecision. Amidst all the dithering, nevertheless, an amendment was made in the Labour Law 1972, to include Worker Compensation Fund or Worker Compensation Scheme (WCS), which had been operating since 1973. Employers in the private sector were supposed to contribute to the scheme to pay for their employees' medical bills incurred from their work-related injuries or illnesses. By 1988, it was reported (7) that the whole population had been covered by the WCS. Later, with petitions sent to all the political parties' leaders, by students, trade unions, and NGOs, the Social Security Scheme (SSS) was incorporated into the Social Security Act 1990. The SSS was intended to supplement the WCS by providing a more comprehensive healthcare coverage, with financial contribution made on a tripartite basis.

People, who were outside the workforce, were exempted from paying for healthcare services in 1975, during the government of Kuk-lit Pramote. This exemption scheme, administered by the MoPH, and later known as the "Medical Welfare Scheme", extended its coverage to senior citizens, children, handicapped people, veterans and their families, monks, communities' leaders and health volunteers (43). A "National Voluntary Health Project" was also introduced. This project was started by the MoPH as "Mother and Child Health Development Fund", which was developed into the "Health Card Project" with support from the government, as evidenced in the Sixth National Health Development Plan (1987-1991). The Health Card System was intended to be instrumental to achieving the coveted plan for universal health coverage (44). Nonetheless, the Health Card System was never carried out in practice, due to political instability, limited support from the MoPH, and community management problems. However, after several pilot studies between 1984-1993, with support from the German Aid agency, GTZ, the Health Card System was resurrected as the "Voluntary Health Card Scheme", with a national insurance base to include the self-employed (45).

The interest in the UC policy was revived in 1993, in the "Health Financing in Thailand" workshop, held by the National Economics and Social Development Board (NESDB), the MOPH, and the World Bank, in Petchaburi Province, Thailand. The discussion was centered on universal healthcare coverage, but no consensus was reached, because of the participants' diverse views on the subject. For example, some suggested a gradual reform over a 12 years period, to be coordinated by the National Health Security Coordinating Body. The others preferred the National Health Security Purchasing Cooperative as the sole financial manager. In 1996, another international workshop, "Health Care Reform: At the Frontier of Research And Policy Decisions", was orchestrated, in Nakornrajsima Province, by the Commission of the European Union (EU) and the World Health Organization (WHO), during which, the paper on "Thailand at the Crossroad: Challenges for Healthcare Reform", raised the questions of why, how to do it and who should be involved, in reforming the Thai healthcare system. In March 1998, the workshop, "Achieving Universal Coverage of Healthcare: Experiences from the Middle and Upper Income Countries" was organized by the EU, the Institute of Tropical Medicine (Antwerp), the London School of Hygiene and Tropical Medicine, and Edinburgh University. Once again the Thai delegates were unable to come to any agreement on how to achieve universal coverage, and on its timing.

In 1996, although the Health Commission approved the first draft of the National Health Security Act, it failed to reach the Parliament for adoption before the dissolution of the Parliament (46). The draft did not receive full-hearted support from the bureaucrats, as its adoption by the Parliament might put their careers in jeopardy (Interview key persons in the MoPH). However, the UC policy was incorporated in the

1997 Constitution and the 8th National Health Plan (1997-2001). The 1977 Constitution affirmed the right of Thai citizens to healthcare services, while the 8th National Health Plan aimed at attaining universal coverage. With the economic crisis in 1997, and lack of political support, there was further delay for the UC implementation. In spite of its setback, the HSRI's taskforce proposed reform for the CSMBS, entailing development of a provider payment system, which was approved by the Comptroller General's Department for experimenting in the fiscal year of 2001. The HSRI also proposed a universal coverage in March 2001, which was taken on board by the new government as its policy. The HSRI's proposal suggested a set of objectives for the UC policy, including equity, efficiency, choice, and good quality healthcare services. These objectives were also used as guidelines for the UC policy. The HSRI's report also considered three alternatives. They were: expansion of the existing system with several insurance schemes, a single system to harmonise benefit and cost subsidy from government, and a dual system with two separate schemes, one for people employed in the public sector, and the other for the private employment sector, together with management arrangements and plans for each of the proposed alternatives.

Thailand's democratisation: actors as policy allies

Pressure groups, such as, NGOs and civil societies also played quite a significant part in the UC agenda setting process, and in their staunch support for the National Health Security Act. Empowered by the 1997 Constitution, permitting a quota of 50,000 electors to propose bills affecting citizen rights and roles of the state (Process to Propose a Bill by Electors Act, 1999), a united group of eleven NGO networking groups submitted their own draft, and mounted a campaign for universal coverage, which was called, "klong karn ronnarong pur luk pra gun sukkhaparb tuanna", in 2000 (47). Their draft, submitted to the Parliament in March, 2001, proposed, equitable benefits for all the population, increase in people participation in health management, and consumer protection. While the number of electors, who proposed the draft, was being verified, the government's own draft was submitted to the Parliament in November 2001, and a year later, the National Health Security Act was passed on 18th of November, 2002.

Between 1999 and 2001, the press also played an influential role in keeping the general public informed and heightening their awareness of and interest in the UC policy. According to the data gathered from the Matichon Library Database, and judging from the number of articles on health related issues published in the papers, the newspapers gave quite intensive and extensive reporting of the issues pertinent to the UC policy. Public interest in the UC policy was further kindled by the campaign spearheaded by the NGO in October 2000, as mentioned above. A public opinion survey confirmed that the UC policy was gaining wide support and popularity.

Thus, different interest groups acting as policy allies, notably, bureaucratic, academic, health-related professional, etc., had been deliberating on issues concerning the UC policy, long before TRT party acquired its prominence in the political scene. Public participation was encouraged, with NGO, and civil societies representing the grassroots, being "invisible" but active actors in the agenda setting process, as will be discussed below, along with "content, context, and process" within the policy triangle framework (Walt and Gilson 1994).

Explaining policy process by content, actors, and context

Content

The content of the UC policy, underpinned by the equity principle, was appealing to the public, because it identified the existing healthcare access problems, reflected social values and upheld the government's ideology. The UC policy was chosen by the TRT party because it had a potential to win votes and gain popularity. The UC policy content was in line with Thai people's constitutional right to healthcare services and it has brought about two major changes. One of them is, because of it, since 2001, all Thai citizens have been entitled to healthcare services from hospitals receiving a controlled per capita budget. Another change was the establishment of the National Health Security Office to ensure equitable and efficient services. The government, although, advocated that all Thai citizens should receive healthcare services,

regardless of their incomes, was not willing to make households pay for fear of losing its popularity. Instead, the government thought of financing the UC scheme with its budget, while its health team suggested merging the Social Security Scheme and the Civil Servant Medical Benefit Scheme, and naming it the National Health Security Scheme. The costs saved from this merger meant money that could be used to finance the UC scheme. But this was easily said than done, and in the end the government decided, in favour of the public, to let public hospitals shoulder the costs, which were within the government budget of 1,202 per capita. This calculated move allowed the public to reap benefits immediately from the scheme, which further enhanced the government's popularity, which was very much cherished by the government. The bureaucrats, on the other hand, raised their objections, but their opposition could not have stopped the government from having its own way.

Actors

The policy actors in this UC agenda setting process were, the Prime Minister (PM) and his party, health reformists within the MoPH, research institutions, and NGOs. With the PM, as "visible actor", and the rest of the actors, "invisible" (48), stage was set for the UC agenda setting process. The PM, Thaksin Shinawatra, a business magnate, won the 2001 election, with a majority of seats (248) in the Parliament. The reason for his victory was support from the middle-class and the rural people. The middle-class was confident in him in bringing his business acumen to bear in running the country's economy, and his political platform appealed to the rural people with his promise of remedial measures to help farmers and villages. Moreover, he took notes of what the rural people wanted and championed their causes. As "visible" actor, he was also a change-agent, bringing about reforms in the healthcare system with the UC scheme. With his leaning for business-based politicians' power, the decline in bureaucratic power was inevitable.

A few reformist bureaucrats, as actors, took part in researches on universal healthcare coverage, and financed them. For example, in 2001, the Health Systems Research Institute (HSRI), an autonomous research organization, under an executive board of the MoPH chaired by the Health Minister commissioned a number of researchers to investigate and to recommend alternatives. Their findings suggested that universal healthcare coverage would alter the health financial structure and the role of the MoPH should be shared with consumers. The system should be administered by a Health Board participated by provider as well as consumer representatives, which would report either to the Health Minister or to the Prime Minister. The upshot of the UC implementation would be weakening of the bureaucratic power base, since organizations, like NGO and civil society would exercise their constitutional right and participate more actively.

The 1997 Constitution has increased the civilian right, by allowing civil societies to elect their own senators, as their representatives, to take part in policy decision-making. As the result of this 1977 Constitution, many non-governmental organizations' representatives have since been elected, as senators to vote on behalf of the people, and to safeguard their interests. The monopolized power enjoyed by the bureaucracy in formulating public policies, has also been constitutionally curtailed, to make room for public participation in drafting bills and in decision-making concerning human rights. Under the constitution an independent election commission has also been established. In Thailand NGOs were first founded in the 1970s, and since then, with their 300 network groups, their interests have branched off into many areas, including health, human rights, urban and rural development and politics (Thai Fund Foundation and Development Support Consortium, 2003). Their support for the UC policy has been very much in keeping with their mission in improvement of healthcare services and human rights. Apart from these actors and their voices, Kingdon (1995) points out that for an issue (e.g., the UC policy) to reach the decision-making process, three kinds of factors – problem, politics, and policy – must conjoin to make the issue prominent.

Context

Apart from the structural and cultural variables, several contextual or situational factors were crucial to the UC agenda setting to make changes in the healthcare system. The political context in changing the election system, which was created by the Constitution, was favourable to TRT government, whose

policies were geared to relieve sufferings from the aftermath of the economic crisis (e.g., suspension of debt payment for farmers, villages' revolving loans), and opened "a new window of opportunity for any new policy"(49), hence making it possible for the UC policy to be implemented.

The three factors, each developed along the time and met at a point of time to create window of opportunity, were problems of health access, researches for alternative solutions and political changes. Indeed, there were indicators of problems concerning healthcare service equity in financing services. Government institutions also reported problems, such as utilization rates, patterns, and resource distribution (National Bureau of Statistics). These reports tended to present factual matters, without suggesting any remedy, and therefore their influence on the decision-making process was minimal. The healthcare related problems became magnified during the economic crisis in 1997. The TRT party then set about ferreting information from the grassroots about their experiences of healthcare problems. The TRT party's manifesto addressing the problems of poverty, and the universal healthcare coverage, was very much for the good of the public, and needless to say, a "vote-winner". With respect to the political environment at the time, factors like, national mood, organized political forces, change in government, and consensus, were also favourable to change. With an independent election commission created under the 1997 Constitution, all political parties were subject to scrutiny or inspection, causing them to re-examine their conducts, especially with regard to canvassing or soliciting votes. The TRT party's UC policy seemed to capture the national mood for change, with its promise of benefits for all from the healthcare reform. The UC policy was compatible with public expectation and societal values.

Conclusions

The universal healthcare coverage was much talked about, but did not receive enough support for it to reach the political agenda, until the TRT party saw it as an opportunity to seize the idea for its political campaign. The power was vested in the new Prime Minister and bureaucrats to influence the process of UC agenda setting, before and after the general election, which also provided the opportunity for these actors to pool their resources. What really drew the public attention and their astounding support for the UC was the Prime Minister's charismatic leadership. Another situational factor contributing to its successful adoption was the economic crisis, which the party turned it into an opportunity to capitalize on the problems of healthcare services that were very much in need of reform. Although much consultative discussion took place among the policy makers, ultimately the decision rested with the Party leader. The UC was chosen for three reasons: legitimacy, congruence with the Party's principles, and feasibility. It was opportune to promote it as the solution to healthcare problems. However, although the UC was regarded as a "good policy", the MoPH bureaucrats opined that some aspects of UC would be difficult to implement.

Acknowledgements

The author would like to thank: the MoPH's senior officers and other informants from non-government organisations for their assistance in data collection; the World Health Organization for their funding; and Professor Gill Walt for her academic advice. Special thanks go to Dr.Sanguan Nitayarumphong and Dr.Suraphong Seubwonglee for the insights into the policy making process.

References

1. Pitayarangsarit S. The Introduction of the Universal Coverage of Health Care Policy in Thailand: Policy Responses [For the Degree of Doctor of Philosophy]. London: London School of Hygiene and Tropical Medicine; 2004.
2. Walt G, Gilson L. Reforming the Health Sector in Developing-Countries - the Central Role of Policy Analysis. Health Policy and Planning 1994;9(4):353-370.
3. Nitayarumphong S. Universal Coverage of Health Care: Challenges for the Developing Countries. In: Nitayarumphong S, Mills A, editors. Achieving Universal Coverage of Health Care: Experiences

from Middle and Upper Income Countries. Nonthaburi: Office of Health Care Reform, Ministry of Public Health, Thailand; 1998. p. 4.
4. Phongpaichit P, Baker C. Thailand's Thaksin: New Populism or Old Cronuism. In; 2001 27 November 2001; Johns Hopkins University-SAIS, Washington DC; 2001.
5. Siamwalla A. Implementing Universal Health Insurance. In: Pramualratana P, and Wibulpolprasert, S., editor. Health Insurance System in Thailand. Nonthaburi: Health Systems Research Institute; 2002.
6. Shinawatra T. Thaksin emphasised to be the prime minister of the three-party coalition regime in a press conference. Thairatch Newspaper 2001 7 January 2001;Sect. 1.
7. Nitayarumphong S, Pannarunothai, S., Kanchanachittra, C., and Pakpean, W. ed. Health financing in Thailand. In: Workshop on Health financing in Thailand, 11-13 November 1993; 1993; Dusit Resort and Polo Club Hotel, Petchaburi Province; 1993.
8. Wibulpolprasert S, editor. Thailand Health Profile 1999-2000. Bangkok: the Express Transportation Organization Press; 2002.
9. Chantaravitul N. Social Security: 30 years of wait. 2 ed. Bangkok: Komol Keemthong Foundation; 1985.
10. Siamwalla A. Proposal to Achieve the Universal Coverage of Health Care. Nonthaburi: Health Systems Research Institute; 2001.
11. Sujariyakul A, Chongsuwiwatwong V. Ability to pay and catastrophic illness of inpatient in Songkla Province. Research report. Nonthaburi: Health Systems Research Institute; 1999.
12. Pannarunothai S, and Mills, A. The poor pay more: Health-related inequality in Thailand. Social Science & Medicine 1997;44(12):1781-1790.
13. Van Doorslaer E, and Wagstaff, A. Equity in the finance of health care: methods and findings. In: Van Doorslaer E, Wagstaff, A., and Rutten, F., editor. Chapter three in the Equity in the finance and delivery of health care: an international perspective. London: Oxford University Press; 1993.
14. Makinen M, Waters H., Rauch, M., Almagambetova, N., Bitran, R., Gilson, L., McIntyre, D., Pannarunothai, S., Prieto, A.L., Ubilla, G., and Ram, S. Inequalities in health care use and expenditures: empirical data from eight developing countries and countries in transition. Bull World Health Organ 2000;78(1):55-65.
15. Wagstaff A, and Van Doorslaer, E. Equity in the finance and delivery of health care: concepts and definitions. In: Van Doorslaer E, Wagstaff, A., and Rutten, F., editor. Chapter two in the Equity in the finance and delivery of health care: an international perspective. London: Oxford University Press; 1993.
16. Pannarunothai S. Equity in health. Bangkok: Health Systems Research Institute; 2000.
17. Pongpanich Sea. National Health Account 1996-1998. Nonthaburi: Health Systems Reseach Institute; 2001.
18. Tangcharoensathien V, Pitayarangsarit, S., and Srithamrongswad, S. Overview of Health Insurance Systems. In: Pramualratana P, and Wibulpolprasert, S., editor. Health Insurance Systems in Thailand. Bangkok: Desire; 2001. p. 28-40.
19. National Statistics Office. The Health and Welfare Survey. Bangkok: National Statistics Office, Priminister Office; 1996.
20. Wongkongkathep S. Impact of Economic Crisis on Prenatal Care and Child Delivery in Ministry of Public Health Hospitals. Health Policy and Planning Journal (Thailand) 1999;13(3):66-77.
21. Ministry of Public Health. Provincial health survey 1996. Bangkok: Bureau of Health Policy and Plan, MoPH; 1997.
22. National Statistics Office. The Health and Welfare Survey. Bangkok: National Statistics Office, Priminister Office; 1991.
23. Department of Local Administration. Administrative data. In: Department of Local Administration, Ministry of Interior; 2000.
24. Phongpaichit P, Baker C. Thailand: Economy and Politics. New York: Oxford University Press; 1995.
25. Bowornwathana B. Governance Reform in Thailand: Questionable Assumptions, Uncertain Outcomes. Governance: An International Journal of Policyand Administration 2000;13(3):393-408.

26. Green A. Reforming the health sector in Thailand: The role of policy actors on the policy stage. International Journal of Health Planning and Management 2000;15(1):39-59.
27. Nelson MH. A Decade after Bloody May 1992: The Events and their Consequences. In: M.H. N, editor. Thailand's New Politics - KPI Yearbook 2001. Bangkok: White Lotus Co.; 2001. p. 492-509.
28. Phongpaichit P, Baker C. Democracy, Capitalism and Crisis: Examining Recent Political Tranitions in Thailand. In; 2001 15 November 2001; Princeton University; 2001.
29. Council of State of Thailand. Comparisons of the 1991 and 1997 Thai Constitutions. In: Office of Council of State, Thailand; 2003.
30. Phongpaichit P, Baker C. Thailand's Boom and Bust. Bangkok: Silkworm Books; 1998.
31. Pitayarangsarit S, Wibulpolprasert S, Tangcharoensathien V. Policy framework towards private health sector in Thailand. Unpublished. Nonthaburi: Health Systems Research Institute; 2000.
32. National Economic and Social Development Board. National Income accounts of Thailand 1994 - 2001constant at 1988 price. In: NESDB; 2002.
33. Tangcharoensathien V, Harnvoravongchai P, Pitayarangsarit S, Kasemsup V. Health Impacts of Rapid Economic Changes in Thailand. Soc. Sci. Med. 2000;51(6):789-807.
34. The World Bank. The World Bank and Thailand. In: The World Bank; 2003.
35. Phongpaichit P, Baker C. The Politics of Economic Reform: Thailand. In: Carnegie Endowment for International Peace; 2000.
36. The Royal Thai Government. Master Plan for State Enterprise Sector Reform. In: Office of State Enterprises and Government Porfolio; 1998.
37. Donaldson D, Pannarunothai S, Tangcharoensathien V. Health Financing in Thailand. Technical Report. Bangkok: Management Sciences for Health and Health Systems Research Institute; 1999 May 1999. Report No.: ADB#2997-THA.
38. Pitayarangsarit S, Tangcharoensathien V, Kasemsup V, Sahapattana P. Block Grant for The First Autonomous Hospital in Thailand: Why 782 Baht Per Capita? Health Policy and Planning Journal (Thailand) 2000;3(1):4-19.
39. Royal Decree for Civil Servant Medical Benefit Scheme. B.E.2523. In; 1980.
40. Process to Propose a Bill by Electors Act. In; 1999.
41. Rojvanit A. The Civil Servant Medical Benefit Scheme. In: Nitayarumphong S, Pannarunothai S, Karnjanajitra C, Parkpean W, editors. Health Financing in Thailand: Proceeding of A National Workshop "Health Financing in Thailand" 11-13 November 1993 at Dusit Resort and Polo Club, Petchaburi province, Thailand. Petchaburi: Veteran Welfare Organization Press; 1993. p. 37-50.
42. Supachutikul A. Situation Analysis on Health Insurance and Future Development. Bangkok: Health Systems Research Institute; 1996.
43. Nitayarumphong S, Pannarunothai, S., and Srithamrongsawat, S. Towards universal coverage of health care. Nonthaburi: Superia Printing; 2000.
44. Boonyuen D, Singhkaew S, editors. Health Insurance System in Thailand. A workshop on 10-12 June 1986 at Grand Palace Hotel, Pattaya, Chonburi Province. Bangkok: National Health Planning Committee; 1986.
45. Keeranund T. Voluntary Health Insurance in Thailand. In Health Financing in Thailand. In: Nitayarumphong S, Pannarunothai, S., Kanchanachittra, C., and Pakpean, W., editor. Workshop on Health financing in Thailand, 11-13 November 1993; 1993; Dusit Resort and Polo Club Hotel, Petchaburi Province; 1993.
46. Jongudomsuk P. Achieving Universal Coverage of Health Care in Thailand through 30 Baht Scheme. In: SEAMIC Conference 2001 FY; 2002 14-17 January 2002; Westin Riverside Plaza Hotel, Chiang Mai, Thailand: Health Care Reform Office, Ministry of Public Health; 2002.
47. NanUdon T. Rakawin Leechanawanichpon: Flighting for Universal Coverage. Chalard Sur (Smart Purchasing) 2002 Apr-May 2002:42-4.
48. Kingdon J. Agendas, alternatives, and public policies. 2 ed. Boston: Little, Brown & Co; 1995.
49. Gilson L, Doherty J, Lake S, McIntyre D, Mwikisa C, Thomas S. The SAZA study: implementing health financing reform in South Africa and Zambia. Health Policy Plan 2003;18(1):31-46.

Chapter II
Policy formulation process

Siriwan Pitayaransarit
Pongpisut Jongudomsuk
Thaworn Sakulpanich
Salinla Singhapan
Prommin Homhual

Introduction

This chapter is composed of two parts; The first part of this chapter, based mostly on the information from a 2001-2002 study (1) deals with the factors, either human or institutional, forces or events, driving the process of formulating the UC policy, and shaping the designed features of the 30 baht Scheme. The second part describes the legislative process of the 2002 National Health Security Act, and is based on direct experiences of the staffs of the National Health Security Office. The chapter also focuses on how knowledge was used to inform policy-makers, on support from politicians and stakeholders, and technical difficulties to be overcome.

The system design of the 30 baht Scheme was important for its successful implementation to achieve universal healthcare service coverage. Legislation was also needed to legitimate the policy and to ensure its sustainability in the long run

Objectives of the UC policy

"The goal of the universal coverage of healthcare policy is to equally entitle Thai citizens to quality healthcare according to their needs, regardless of their socio-economic status" (2).

The three main objectives of the UC policy declared by the MoPH in March 2001 were: universal coverage; single standard for benefits and healthcare; and sustainability in terms of finance, institution and policy. To realize these objectives, the policy-makers decided on:

- General tax-based finance with a user fee of 30 baht/visit, for population outside the SSS and the CSMBS;
- Promotion of the use of primary health care to create equity by having a single system, with improvement of the quality of healthcare services of primary care units;
- A single standard benefit package and payment method by merging the existing health insurance schemes;
- A purchaser-provider split within the contracted model involving relationship between providers and fund holders, based on commitment to provide services and agreed payment;
- Decentralization of fund management to the provinces and administration by each province's Area Purchaser Board, to increase accountability;
- Quality assurance by the use of hospital accreditation;

- A close-ended provider payment method, for financial sustainability, "which involves several payment methods, with budget ceilings, that is capitation and case-mix weight payment under a ceiling budget"; and
- Collaboration with private health providers.

Promotion of the use of primary health care is a main feature of the UC policy. Evidence in Ayutthaya province in 1992 (3) showed a quite successful primary health care model (4). The concept of primary medical care management gradually diffused to other provinces with the introduction of Primary Care Units (PCUs), under the Office of Health Care Reform. During a national conference on medical education in April 2001, the Consortium of the Deans of Medical Schools was unanimous on changing the medical curriculum to support the development of primary health care (4). This seemed to be in line with the objective of the UC policy.

Another main feature of the UC policy is the close-ended provider payment method. A contracted capitation model had been used to launch the Social Health Insurance Scheme. The data on healthcare financing systems in Thailand showed the advantages of using a capitation model that it would contain costs and provide an acceptable quality of services, as opposed to the cost escalation and inefficiency, found in some fee-for-service reimbursement models, such as the one used to provide medical benefits to civil servants (5).

Intended design of organization and management

During the transitional period, the formal sector employees would be under one management system, while those in the informal sector by another management system. As a policy-making body, the National Health Security Board (NHSB), once set up, would have to, keep the design of the UC scheme moving, give policy directions to the UC scheme managers, and ensure a consistent single standard of healthcare for all. The National Health Security Office (NHSO) would act as a secretariat of the NHSB and at the same time would manage the 30 baht scheme for people in the informal sector. The Social Security Office (SSO), Ministry of Labour and Social Welfare, would administer the SSS and CSMBS, which eventually would be integrated with SSS. More details of the organization and management are presented in chapter 3, (by Thammathat-Aree and Jongudomsuk) of this book.

<u>The Health service and financing system in design (March 2001)</u>

According to Kutzin (1998) (6), a financing system involves: 1) institutional arrangement, including source of finance, allocation institution and methods, provider payment mechanisms, and providers; 2) health-support system including quality assurance; and benefit packages and rules of healthcare service access. Within Kutzin's perspective, the features of the financing system for achieving universal coverage might have been formulated as follows:

1. Many existing schemes would be restructured into, Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS), and Universal Coverage Scheme (30baht), which could then be merged with the Medical Welfare Scheme (MWS), and the Voluntary Health Card Scheme (VHCS).

2. The Universal Coverage Scheme (30 baht) would be financed by the government's allocated budget from general tax revenue, to provide preventive medical care and health promotion, excluding renal dialysis for care of terminal cases, and anti-retroviral drug treatment for HIV/AIDS patients.

3. A major reform in the provider payment system would be a shift from the historically-based budget to per capita budget, with two payment options: inclusive capitation paid directly to contracted primary health care networks; and an inpatient care budget, separate from the capitation to be allocated by Diagnostic Related Group weight (DRG weight).

4. The 30 baht Scheme would also bring in primary care units as gatekeepers and the primary care services would be provided by both public and private facilities.

Actors in policy formulation stage at the national level

The complexity and highly technical nature of the policy details involved actors, such as "policy elites" and their interactions in the policy formulation process. Policy elites, as decision-makers, are "formally charged with making authoritative decisions in government" (Grindle & Thomas, 1991, p. 19). The policy elites in the UC policy formulation process were the elected politicians, the Prime Minister (PM), the Health Ministers, the Minister of Finance, the Minister of Labour and Social Welfare, the Minister of Commerce, the Minister of Interior, and the Minister of Education. The top civil servants participated in the formulation process were, the Permanent Secretary of the MoPH, the Secretary General of the National Economic and Social Development Board, the Director General of the Comptroller General Department, the Secretary General of the Civil Service Commission. However, the Minister and top civil servants only in the MoPH were actively in the process. More specifically the PM was the agenda setter, the Health Minister as a policy ambassador, carried out public relations in promoting the work and policy of the MoPH, and his deputy, as a health expert, selected appropriate policy issues for inclusion in the agenda. The top civil servants were said to influence the decision on timing, and sequencing the stages in implementation.

Widen participation and consultation

The TRT government was in the position to manipulate, content, timing sequence of reform, and was able to acquire necessary information (7). The key players in this process were the PM, the Health Minister, and the deputy Health Minister. These three politicians shared similar business background, with tested skills, experience in management and they were advocators of market economy. They together represented the private sector's cooperation in the 30 baht Scheme. Among the top civil servants, the Permanent Secretary (PS) played a decisive role in the 30 baht Scheme in 2001. However, in order to increase stakeholders' participation, the MoPH established steering committees, notably the MoPH Operational Centre Committee, the Executive Committee, and the National Policy Committees, assisted by a team of taskforces with their members possessing specific expertise in each issue. They were from the bureaucracy, academia, health professions, and consumers. Together these taskforces tackled the following issues and developed guidelines for:

- Benefits package and financial management;
- Quality of health services;
- Registration system for beneficiaries based on the use of information technology (IT);
- Public relations and handling of grievances;
- Management of providers relationship and public opinions;
- Healthcare service infrastructure and organizational reform;
- Regulations for purchasing system development;

- Human resource development;
- Knowledge for system development; and
- Drafting the National Health Insurance Bill and public hearings.

Policy networks and styles

Policy networks are interactions among different groups, inside and/or outside government (8, 9), while issue networks involves loose relationship between members, and policy communities have close relationship (8).

Richardson (1982) suggests that there is a variation of four styles: 1) plan and consult with policy community, 2) fire-fighting, 3) planning and rationality, and 4) reaction to problems when necessary. The government, for consultation for its policy formulation, set up several issue networks and policy communities, for example the Operational Centre Committee (War Room) with its membership being limited to managers and health professionals. Their different policy styles had significant impact on the formulation process. Any of these styles could be adopted at different stages of the policy formulation. During the "experimentation" phase, the Permanent Secretary with support from the Health Minister, ordered a nation-wide implementation of the UC policy, and then coped with the problems as they emerged. The policy elites adopted a "think-and-do" and then "do-and-correct" approach, as they were running out of time – with their six months for system trial (10). The "War Room" or Operational Centre Committee preferred a "fire-fighting" style, while the Executive Committee coordinated its works with other ministries and the private sector (National Policy on the Universal Coverage of Healthcare Policy, 2001b). The change in policy style from "plan-and consult" (with advice from other technical committees) to "fire-fighting" approach amounted to very little as far as the progress of the UC policy formulation was concerned.

Process of policy shaping: case studies

Case 1: Issues of sources of finance: actors and power / uncertainty of evidence

Although during TRT party's campaign on "30 baht treats all diseases", it was decided that the scheme would mostly be financed from the general tax revenue, the different policy committees had other ideas how it should be financed. The academic community thought that monthly contribution on the basis of households' ability to pay might work, but the Medical Welfare Scheme had already experienced failure with such a system. The only way for the government to finance the scheme was either by direct income tax or indirect tax, e.g., value-added tax (VAT).

The objection raised by the bureaucrats to using tax revenue as a source of finance, was that it would be a strain on the government budget, since the cost of financing it was estimated between 48 billion baht in 2002, and 52 billion baht in 2003. Any increase in budget would also mean increase in public debts. This was then about 56 % of GDP (11). The Director of the Bureau of Budget also disagreed with the proposed increase in government budget, he, and other politicians seemed powerless in influencing the government's decision. The Deputy Leader of the Democrat Party also joined in the protest against the proposed "welfare system" financed by the tax revenue, which would not be sufficient for the purpose (12). The question of equity was also mooted by the Democrat Party, but to no avail. Much time was spent on the appropriate use of the term, "welfare system", and whether "social safety net", might not be more appropriate, when their immediate concern was how to make the rich pay more, which should have been the center of their debate. Anyhow while the issues still being debated, it seemed a foregone conclusion, especially with public support as shown by the SuanDusit polls

(13-16), that the government would commit itself to the idea of financing the UC scheme from tax revenue, provided that resources could be raised by merging other insurance systems to save costs, and to avoid service duplication once the UC system started operating.

But first, how much would be required for the UC budget? Two proposed figures of the rate of 900 baht per capita (17, 18), and 1,500 baht (19) were not accepted as being too low and too high estimation, respectively. Finally, the government accepted the rate of 1,202 baht as proposed by the MoPH for the fiscal year 2000 (20). However, the figure was criticized that its estimation overlooked the cost of age/sex-adjusted illness, and the cost of teaching hospitals (21). It was underestimated also because of the use of the utilization rate in 1996 without any adjustment. For the fiscal year 2003, a working group of stakeholders came up with the figure of 1,414 baht with technical support from a group of researchers (22), while the MoPH offered a lower rate, arguing that users of the 30baht scheme had so far only a coverage rate of 85%, referred to a study (23), which meant that the rest, 15%, of those under the 30baht scheme, were not insured and chose to pay for their own healthcare services.

What did all these differences mean? It meant that the government could not merge the existing healthcare schemes because of, obstruction of those who had more to lose than gain from the proposed amalgamation; the decision making process was hindered by actors who tried to safeguard their own interests; and technical information and evidence proffered for debates sometimes seemed to have created confusion and uncertainty, rather than reassurance and consensus.

Case 2: Budget allocation methods: bureaucrats' resistance and lack of adequate information for decision-making

Amidst all the "voices" of disagreements, the Permanent Secretary of the MoPH decided to implement the flat rate of budget per capita to allocate money to the provinces in the 2002 fiscal year. His decision was thwarted because it would put the providers at risk. The previous proposal on the adjusted per capita rate by researchers was thought to be too complicated to explain to the public for acceptance in the transition phase, consequently the flat rate capitation was chosen. There was also concern about salary inclusion in the 30 baht scheme, or addition of the material budget per capita on top of the salary budget. The Health Minister and the Health Permanent Secretary all agreed to inclusion of salary costs in the budget, while the civil servants working in provinces, who would be losers, disagreed, because their salaries would be depended on hospital management's efficiency, over which they would have any control. To boost the morale of these people, the MoPH decided that their salaries would be guaranteed (24) by allocation of additional budget from the Contingency Fund, which ceased to operate after the budget allocation system was changed by the MoPH to the capitation on top of the salary budget in 2003. It was also suggested by the Permanent Secretary in 2003 that secondary and tertiary care sections would be financed separately from the capitation budget, in other words the system would be reversed back to the supply-based system. This would be contradictory to the TRT party's promise of putting the healthcare services in the control of the people, by reforming the whole healthcare system, in terms of its financing, health personnel, infrastructure, and service delivery. But luckily, it never happened. The Rural Doctors Society supported the reform (25). Thus strong political leadership and policy legitimacy were the main driving force.

This case suggests that the reform suffered from much dithering among the decision-makers with inadequate information to make them make up their mind once and for all about budget allocation. The reform might have also been affected by the lack of technical skills among researchers, or the impatience of the decision-makers to implement the UC policy without proper information. The bureaucrats had shown quite a strong resistance, for fear of losing their incomes or financial benefits.

Case 3: Inclusive capitation or exclusive capitation payment system: *inadequate information to support decision-making* – learning by doing approach

The MoPH had to choose either inclusive capitation or exclusive capitation payment system in the fiscal year 2002.

The inclusive capitation system would cover the cost of preventive medicine, health promotion, curative services including primary, secondary and tertiary care. The supporters for the inclusive capitation of payment were senior health officers, private hospitals, community hospitals, and some academics. The reasons for their support of the system were: low administration cost, assured revenue, cost saving in treatment via health promotion. The people who opposed the system pointed out the downsides of it as being: disincentive to providers to pay for high-cost treatment, delay in patient referral, and unsustainable.

The exclusive capitation system would cover the cost for preventive medicine, health promotion, and primary health care. It would also entail collection of fund to be managed by provinces, paying hospitals for treatment of inpatients in secondary and tertiary healthcares, by weighted allocations under a national budget. This system was supported because of its case-by-case payment, which would induce hospitals to admit more patients, but as pointed out by the Health Insurance Office, the data of the Diagnostic Related Group weights (DRG weights) was not yet ready, and this might cause errors in budget allocation. The inclusive capitation of payment would require well-trained computer officers, and some of the pilot provinces had not yet had well-trained staff with the expertise or skills to use software to operate the system in allocating money for patient healthcare services.

Since there was no general consensus on either of the two systems, decision was held back and the provinces were left to decide for themselves until the issues had been further debated in the 2003 fiscal year. Finally, a single system of the exclusive capitation was chosen for all the provinces by a consensus among the people in high positions of the MoPH and health researchers amid complaints from small hospitals.

Case 4: Delivery by primary care units and hospitals: ideal design but inadequate preparation for change

The Primary Care Unit (PCU) was to be introduced, by the MoPH's order, in all the areas with a population of 10,000 people, as gatekeepers. These gatekeepers would supervise registration, with the view of improvement of the health service delivery system to become more cost-effective. PCUs were expected to provide continuity and comprehensive care with a holistic approach to people in catchment areas. Several new primary care models would have to be tried out in the provinces, designed to be the main contracted units, holding funds for primary care services to registered members, and as gatekeepers, to refer patients to hospitals. Public and private hospitals were also allowed to become contracted units, if they could provide primary care at the same standards as those demanded by the MoPH for PCUs. Private hospitals resented the gatekeeper regulation because it would restrict the number of patients admitted. Some front line health officers saw the health promotion aspect of the policy in more positive light. Public hospitals' pressure could be relieved by their referral of patients to PCUs. The problem of allocating enough doctors to PCUs and of limitation of resources became quite acute.

Hospitals would be forced to upgrade to become more capital or technology intensive, and "centres of excellence". The capitation payment system was to encourage hospitals to improve their quality of healthcare services. The accreditation procedure has been implemented since 2002 for that purpose. The UC policy altered hospital income, expenditure and their financing methods. Hospitals, as CUPs received their budgets according to their number of registered population, with responsibility for financing their network PCUs and referral cases. Their incomes derived directly patients' payments would be replaced by the 30 baht Scheme budget. It was anticipated that 24 % of the community hospitals, and 46% of the general hospitals would experience financial hardships (26).

Case 5: Private providers' collaboration: power of interest groups

Private collaboration would encourage improvement in quality services by health competition, but would be delay, because the quality assurance system had not yet been developed (27). Private collaboration would have to wait until the registration system was put in place and people had been registered. The private providers were insistent on joining the 30baht scheme, believing that their incomes would be augmented (28). As it happened, the MoPH relented and allowed them to join in early June 2001, but in its effort to protect its hospitals' financial status, the MoPH put a limit on the number of registered population for private providers. In addition, in order to prevent opportunists cashing in on the scheme, no more new private providers were allowed to join the scheme (29). Although the Rural Doctors Society did not agree, it was the PM's wish to incorporate the private sector, and it must be respected.

Legislative process

The first attempt to develop a health security law for all Thai citizens was "The Health Insurance and Standard Medical Service Bill", which was drafted by the Ministry of Public Health and the Standing Committee on Health, House of Representative during 1995 – 1996. This bill proposed a compulsory health insurance model, which would receive financial contributions from the people and the government to a public health insurance fund, but the indigent would be allowed free medical treatments. Those, who were already covered by the public health insurance under other laws, would be excluded. The beneficiaries of juristic persons, whose health insurance benefits were considered equal to or better than the benefits stipulated in this bill, would also be excluded (30). This bill was not deliberated further until after the political reform and the enactment of a new Constitution of the Kingdom of Thailand B.E. 2540 in October 1997. Section 52 of the Constitution stated that all Thai citizens "shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from public health centers of the state, as provided by law". Section 82 decreed that "the state shall thoroughly provide and promote standard and efficient public health service".

Protection of the right of the Thai people to healthcare services by the Constitution, motivated civil societies, non-for-profit organizations and other interest groups to joined together to develop the National Health Security Act using the drafted Health Insurance and Standard Medical Service Bill as its model. The drafting started in 2000 and finished in 2001 with many amendments made in the bill. Although the concepts of using primary health care units as gatekeepers for referral services were similar to those of the bill, general tax revenue was used instead of insurance contribution; consumer protection was introduced with no fault liability system. One of the significant changes was to establish universal coverage for all Thai citizens under one single fund management. Copies of this modified bill were distributed nationwide to ask for people's signatures to support the bill in 2000. According to Section 170 of the Constitution, a quorum of fifty thousand people with the right to vote, was needed for submission of the bill to the President of the National Assembly for consideration. More than sixty thousand people voted for it.

Political parties were also interested in the UC policy, and one of them was Thai Rak Thai party which announced its intention to have all the Thai citizens covered by its proposed healthcare insurance scheme. The Thai Rak Thai party's leader, Thaksin Shinawatra who was the Prime Minister of Thailand at the time of this study, initiated the UC policy, using the slogan "30 baht treating all diseases" as one of his key campaign promises, in April 2001. At the same time the Ministry of Public Health was ordered to develop a National Health Security Act. This act was conceptually approved by the Council of Ministers on July 31, 2001 and sent to the office of the Council of State for review by the Ministry of Public Health and other related agencies. This bill was duly returned to the Council of Ministers for final approval, before its submission to the National Assembly[1].

The House of Representatives had the first reading of National Health Security Act on November 21, 2001. There were six National Health Security Acts to read: one from the cabinet, four from the political parties and the last one from civil societies, which planned to petition using Section 170 of the Constitution. But the process of verifying 60,000 names of people was not finished on time of the first reading of the House of Representatives. The members of the House of Representatives, chose to ignore Section 170 of the Constitution, and submitted this bill for the first reading. The House passed the bill at its first reading on November 22nd, 2001 and appointed an ad hoc committee of 35 members, to scrutinize, to revise the bill, and to report its findings to the House. The committee convened 23 meetings from the 3rd of December 2001 onward. During the review, the committee together with the Ministry of Public Health held four public hearings in the North-east province (Khon Kaen) on February 19th , 2002, in Cheing Mai on February 22nd , 2002 , in Bangkok on March 1st , 2002 and Songkla on March 5th , 2002. The ad hoc committee finished the revision on April 4th, 2002 and reported to the House. The House of Representative passed the bill at its second and third readings on May 15th, 2002 with a majority of 376 votes, and the bill sent the revised National Health Security Act to the Senate on May 17, 2002.

The Senate passed the bill at its first reading on May 30th, 2002, with a majority vote of 111 members. Although this bill was considered as a financial bill which the Senate should have given the result to the House of Representative within 30 days. But the House of Senate had extended the consideration time to 60 days using Section 174 of the Constitution. The Senate appointed an ad hoc committee with 34 members to review the bill. The committee held its first meeting on June 21st, 2002 to review and modified the bill. During this period, the content of the National Health Security Act was earnestly debated in the in newspapers, at healthcare professional meetings and in the Senate. Labour union representatives negotiated for modification or removal of certain clauses of the bill. Medical doctors' representatives, and other health care personnel showed their support for the concept of the UC policy, voiced their concerns about the power of the National Health Security Office, and the liability issues in the bill, e.g., liability for misdeeds that were not of their own doings, and they might have to appear in court. The ad hoc committee addressed these concerns at their subsequent meetings, and the bill was amended, accordingly. The Senate passed the bill at its second and third readings on August 31, 2002, with a majority vote of 88 members. [2] Eventually, the National Health Security Act was submitted by the Prime Minister to His Majesty the King on November 11th, 2002, was published in the Royal Gazette on November 18th, 2002, and was enacted on November 19th, 2002 (31).

---

[1] The National Assembly of Thailand is a bicameral institution consisting of the House of Representatives and the Senate, any bill has to pass three readings in the House of Representative and has to pass three readings in the Senate

[2] According to the Constitution, the amended bill will be returned to the House of Representatives. If the House of Representatives approved such amendment, the Senate returns the revised bill to the House of Representatives, who will accept or not accept the final bill of National Health Security Bill of the Senate.

Table 3.1 shows the significant issues of the bill and its amendments throughout the legislative process.

At that moment, there were at least three groups of people who disagreed with the establishment of the UC system on different issues.

Physicians

The Physicians' movements opposed the establishment of the no-fault liability system under the UC (Section 41&42 in the bill), which would threaten their profession. This was a result of Section 42, which clearly stated that after providing preliminary financial assistance to patients, who suffered as a consequence of doctors' malpractice or negligence, the NHSO could have recourse to the law to prosecute the alleged physicians. Their movements were led by physicians working in public hospitals, by holding meetings to inform physicians and to express their opinions to the public (32); organizing a nationwide protest by wearing black clothes on August 28th , 2002 (33); declaring their intention to resign from public health services (34); deliberately prolonging the time taken for medical examination of patients (35) and etc. Later they formed a group, called "Association of Physician for Medical Profession" and their majority won the election for the Medical Council (36) in 2003.

Leaders of labor unions

The labour union leaders were worried about the merging of the Social Security Fund and the Workmen Compensation Fund with the UC fund (Section 10, 11 in the bill), which could affect their benefits, a few of them led a movement to oppose the merger. With reference to Section 13 (4) of the National Health Security Act, attempt by these labour union leaders to be elected members of the National Health Security Board as representatives of non-for-profit organizations failed.

Civil Servants

Although the civil servants were not happy about the merging of the Civil Servant Medical Benefit Scheme with the UC Scheme (Section 9), which would affect their benefits, they couldn't openly criticize it, since the 30baht scheme was the government's policy.

Table 3.1 Significant issues of the National Health Security Act and its amendment during the legislative process

	Council of Ministers' Bill	House of Representative's Bill	Senate' Bill
Definition of Health Services	Medical and public healthcare services for: health promotion, prevention of illness, treatment of diseases, diagnosis, and rehabilitation.	Inclusion of Thai traditional and alternative medicine services in the definition	Addition of the Thai traditional and alternative medicine service in the Act, pursuant to Medical Registration law
Entitlement for health service	Entitling the Thai population to public healthcare services with standards and efficiency as prescribed in this Act according to financial status of government.	Deleting the phase "according to financial status of government"	Same as the House of Representative's Bill
Personal Health Care Unit	Using primary health care facilities as contracted unit and gatekeeper to refer beneficiaries for more comprehensive treatments.	Same as Council of Ministers' Bill	Same as Council of Ministers' Bill
Special measures to specific existing health insurance / welfare schemes in Thailand	Special measures for: Scheme for civil servants, state enterprises and other government agencies including their dependent (only health service benefits) Social Security Scheme (only health service benefits) Worker Compensation Scheme (only health service benefits) Protection for Motor Vehicle Accident Victims Scheme (only health service benefits) Private health insurance companies	Same as Council of Ministers' Bill	Deleting measure for private health insurance company from the Bill

Table 3.1 Significant issues of the National Health Security Act and its amendment during the legislative process (Continue)

National Health Security Board Chairman	Minister of Public Health	Minister of Public Health	Minister of Public Health
Composition of members	Central government: 8 Local government: 4 NGO: 4 Health personnel 1 Expert 5	Central government: 8 Local government: 4 NGO: 5 Health personnel 1 Expert 6	Central government: 8 Local government: 4 NGO: 5 Health personnel 5 Expert 7
National Health Security Office	State agency as a juristic person under control and supervision of the Minister of Public Health Secretary General is appointed by National Health Security Board	Same as Council of Ministers' Bill	Same as Council of Ministers' Bill
National Health Security Fund Source of Fund	1.Central government budget 2.Providing public health service 3.Administrative fine 4.Donated money & property 5.Interest or benefit 6.Other money or property earned by affairs of the Fund	Add 2 sources of Fund: 1. Local government organization as prescribed by law 2.Bill can be submitted for collect contribution to National Health Security Fund from person or-juristic person	Modifying the 2 new sources of Fund from the House of Representative's Bill: 1. Local government organization as prescribed by law 2.Other contribution as prescribed by law
Budget for administration	-Does not mention	Not more than 5 percent of annual budget of National Health Security Fund to be used for administrative activities. - Same as Council of Ministers' Bill	From annual government budget which separate from National Health Security Fund.
Budget for no-fault liability	- Not exceeding 1 percent of annual budget for health service to be paid for liability from health care services		- Same as Council of Ministers' Bill

Table 3.1 Significant issues of the National Health Security Act and its amendment during the legislative process (Continue)

	Council of Ministers' Bill	House of Representative's Bill	Senate' Bill
Health Service Standard and Quality Control Board Chairman	Permanent secretary of Ministry of Public Health	Permanent secretary of Ministry of Public Health	Elect a member among themselves to be a chairman
Composition of Board Members	Central government (MOPH): 2 Local government: 2 Health care professional councils: 4 Health personnel: 2 NGO: 5 Expert: 4 Other: 3	Central government (MOPH): 2 Local government: 2 Health care professional councils: 4 Health personnel: 2 NGO: 5 Expert: 4 Other: 3	Central government (MOPH): 3 Local government: 4 Health care professional councils: 4 Health personnel: 11 NGO: 5 Expert: 6 Other: 2
Health care facilities and standard of services - Enrollment - Payment	Enrollment of health care units networks of health care units, and public relations to be organized by the office	Same as Council of Ministers' Bill	Same as Council of Ministers' Bill Payment to Health care unit in pursuance to the following conditions; (1) to be based on the Standard Prices of all diseases (2) to cover personnel salaries ; (3) to consider the differences of health care units' missions (4) to consider the differences of beneficiaries and the differences of the sizes of health care units' responsible areas

Table 3.1 Significant issues of the National Health Security Act and its amendment during the legislative process (Continue)

	Council of Ministers' Bill	House of Representative's Bill	Senate' Bill
Health care unit standard control	Investigation Committee conducting investigation and its comments to Secretary General to issue an order advice, fine and notification to relevant agencies.	Same as Council of Ministers' Bill	Investigation Committee conducting investigation and its comments to Standard and Quality Control Board to issue an order advising, fine and notify relevant agencies
Transitory Provision			For healthcare units under Ministry of Public Health, the Office paying service expenses for Ministry of Public Health for three years from the starting date of public health service pursuant to this Act.

Sources:

1. Minutes of meetings of ad hoc committee of the House of Representatives
2. Reports of ad hoc committee to the House of Representatives
3. Minutes of meetings of ad hoc committee of the Senate
4. Reports of ad hoc committee to the Senate

Analysis

Institutional factors, values, and ideology in the decision making process

Needless to say that all the actors mentioned so far tried in their own ways and within their positional power to bring their influence to bear on the formulation of the UC policy, but ultimately, and of course understandably, to protect their own interests. As participants in the process, their own decisions were informed by technical advice / consultation (based on either primary and/or secondary data. They were also affected by "the impact of their choice on bureaucratic interactions, the meaning of change for political stability and support, and their relationship with international actors" (Grindle & Thomas, 1989. p. 223). Apart from these actors, structural or institutional factors are said to have acted in synergy to drive the process. Structural factor were, health structure, economic, value and ideology. The health system including its infrastructure, the on-going development of the health insurance coverage which had covered about 69% of the population, and human resources in the public health sector, made it contextually, financially and technically feasible for the policy to work. The distribution of health infrastructure with health personnel, to the provincial and rural areas, also encouraged their local people to use the primary care services.

Figuratively speaking, the road to universal healthcare coverage, especially in its formulation stage, needed knowledge gathered from research studies to achieve its end. The following are some examples of researches brought to bear on the policy formulation:

- R&D on models of health care financing and primary care system (The Health Care Reform Office)
- Health equity and equity index (The Center for Health Equity Monitoring, Naresuan University)
- CSMBS financing and reform strategy, and the UC reform proposal (HSRI)
- Capacity building of researchers in health financing and economics (IHPP)
- The research community (academics, civil servants and advocacy groups such as the Rural Doctor Society).

These studies and researches on the UC policy, were possible with a robust economic system. How did the economic system then facilitate the UC policy movement, in its policy formulation?

Economic system

The Thai economy was in bloom before the economic burst in 1997. The health economy then allowed development of the health delivery system and increase in capital investment in the private sector, stimulated by, the Broad of Investment (BOI), low interest capital, improvement in urban incomes. Thus, the private health sector grew rapidly between 1988-1997, but its-supply exceeded demand, and as a result its resources were underutilized, and its system badly needed reform. What was needed to steer this restructuring or reform was values and ideology to guide it along.

Ideology: public and private

The ideology behind the UC policy may be said to be egalitarianism or equal access to healthcare for all Thai citizens whose right is enshrined in the 1997 Constitution. The government therefore would resort to the general tax revenue to finance the UC scheme, which would also admit healthy competition within a "new" public management by both public and private contracted health providers. Because of Thailand's liberalization policy, private profit-making hospitals were also allowed to operate within the so-called free market.

As a developing country, Thailand must look for guidance and learn from the developed countries (middle and high-income countries), although it has been reported that international agencies were not involved in the policy formulation stage. However, the World Bank did help via its Social Investment Project Loans, and indirectly influence the design of the policy.

Legislation

Thus all in all, the actors, institutional structures, both internal and external, were the prime movers of the UC policy formulation, regardless of all the squabbling, fluctuation, and delays. In certain instances, the legislative process had to be set in motion to legitimize new structures or changes in the existing structure, for the sake of smoothing the way for the UC policy formulation and implementation. The National Health Security Office (NHSO) was established after the National Health Security Act was put into effect in May 2002. The Act decrees: NHSO's autonomy, a distinct entity from the MoPH; the rights of the entire Thai population to access healthcare services, to choose their healthcare providers for health coverage; registration of both public and private providers. The legislative process was therefore lending its helping hand to the UC formulation and implementation, which was carried out by the MoPH.

The Government's influence

The House of Representatives and the Senate decided on the enactment of the National Health Security Act under the government's pressure. The government realized it was opportune to have the law endorsing its UC policy. The public support of the policy also heightened the public regard for the Prime Minister. Another high-profile figure and a strong supporter of the policy was the Health Minister, Sudarat Kayuraphan, also a key member of the TRTP's administrative committee, but with no technical knowledge in health sciences. Indeed health and medical knowledge and know-how were needed, and it was a medical doctor, Dr. Suraphong Suebwonglee, who assisted in the formulation of the UC policy, and later became the deputy Health Minister. He steered the changes during the transition period, making sure that the reform of the health system was progressing along the charted path. He successfully brought about the increase, in 2002, in per capita allocation, including the salary budget. His becoming the Minister of Information and Technology, in 2002, meant a setback for the change in the "per capita allocations, excluding salary budget". As a preparation to the UC implementation, the Permanent Secretary of the MoPH successfully merged the Rural Hospital and the Rural Health Division, to form the Bureau of Health Care Network, which had close relationship with providers in the provinces in resources distribution. The Bureau, which later became the Department of Health Care Promotion, was responsible for allocation of human resources, capital investment, and contingency fund. The Provincial Health Offices, as passive purchasers, asked to have more flexibility, and to let province select their own systems. The MoPH's medical doctors had mixed feelings about the reform system; those from the communities were for the reform system, while doctors from the provincial hospitals resisted the idea. The UC scheme also included

public hospitals run by universities, the Ministry of Defense, and local administrations. They would indeed be better off, since the UC system would grant them a budget on top of their own budget.

Non-governmental and the private sectors, the public and international agencies

When the National Health Security Act was debated in Parliament, some private practitioners and hospital owners joined forces to oppose the Bill, especially the section concerning liability. Their concern was assuaged by the Health Minister's promise to modify the liability section, and the bill was duly passed. The Medical Council disagreed with the National Health Security Act on the issue of the NHSO's control on consumer protection, which in itself would undermine its own authority. Consumer representatives were on the health commission of the House of Representatives and the Senate, to comment on the content of the bill, but had nothing to do with the UC policy implementation. Apart from the general public views on the UC policy being usually reported in the press, some groups of beneficiaries campaigned for "Health rights for all, not only for the poor". The solidarity of the Thai people as manifested in the slogan "the health help the sick and the rich help the poor" was evident.

Apart from taking part in health seminars, the international agents, such as WHO, ILO, and the World Bank, did not have any direct involvement in the actual implementation of the Policy, although their ideas, concepts and comments in these seminars must have somehow input into the system.

Conclusions

The analysis in this chapter clearly shows how the actors influenced the policy formulation, and how their decisions were guided by their own considerations of the pros and cons of the policy, how and to what extent, the political context in particular enhanced the opportunity for reform of the healthcare system.

The state and policy elites took the dominant roles in policy formulation. Many different actors formed different networks to influence policy at the formulation stages. It was dynamic as policy networks changed and influential factors changed according to the technical issues involved. The approach (policy style) to decision-making also shifted during policy formulation, depending on stages of the processes.

The policy networks involved in the UC policy formulation were tightly knit and can be described as policy communities - they played negotiation and bargaining roles in policy formulation. However, the participants were limited to health managers and health professionals (providers) and excluded consumers. The health policy research communities played significant roles in providing technical advice. The health policy research community in Thailand had strengthened considerably during the last decade (1992-2002), and played an important role as policy entrepreneurs in this reform. The development of several independent research institutions had created competition and complementarities, which provided evidence for policy-makers and acted as a catalyst for a rich discourse on different solutions. However, the uncertainty surrounding the technical evidence created policy debate and the extent to which research was used for making decisions still depended considerably on its quality, clarity, timing, and the responsiveness to policy-makers' concerns.

The contextual factors clearly influenced the direction of decision-making. These included the health infrastructural system, knowledge building in the health system, economic base, ideology of the public sector, and external factors.

Though the decision to rely on tax-based finance was based on an anticipation of the financial feasibility, it would result in complications regarding sustainability. Immediate consequences were apparent in hospitals – as financial constraints – and in the low utilisation rate of the newly registered population. More consequences and challenges will be discussed in the implementation chapter.

Acknowledgements

The authors would like to express their gratitude to: the MoPH and the Committee on Public Health for their assistance in data collection; the World Health Organization for their funding; and Professor Gill Walt for her academic advice.

References

1. Pitayarangsarit S. The Introduction of the Universal Coverage of Health Care Policy in Thailand: Policy Responses [For the Degree of Doctor of Philosophy]. London: London School of Hygiene and Tropical Medicine; 2004.
2. Ministry of Public Health, editor. Guideline for the Management of the Universal Coverage Policy during the Transitional Period. Nonthaburi: Ministry of Public Health; 2002.
3. Pongsuparb Y. Development of Family Practice in Thailand: Ayutthaya Case Study. Research report. Nonthaburi: Health Care Reform Office; 1996.
4. Jongudomsuk P. Achieving Universal Coverage of Health Care in Thailand through 30 Baht Scheme. In: SEAMIC Conference 2001 FY; 2002 14-17 January 2002; Westin Riverside Plaza Hotel, Chiang Mai, Thailand: Health Care Reform Office, Ministry of Public Health; 2002.
5. Tangcharoensathien V, Wibulpolprasert S, Nitayarumphong S. Knowledge-based changes to health systems: the Thai experience in policy development. Bulletin of the World Health Organization 2004;82(10):1-10.
6. Kutzin J. Enhancing the insurance function of the health systems: a proposal conceptual framework. In: Nitayarumphong S, and Mills, A., editor. Achieving universal coverage of health care: experiences from middle and upper income countries. Nonthaburi: Office of Health Care Reform, Ministry of Public Health, Thailand; 1998. p. 27-101.
7. Grindle M, Thomas J. Public Choices and Policy Change: The Political Economy of Reform in Developing Countries. Baltimore and London: The Johns Hopkins University Press; 1991.
8. Marsh D. The Development of the Policy Network Approach. In: Marsh D, editor. Comparing Policy Networks. Buckingham: Open University Press; 1998.
9. Hill M. The Policy Process in the Modern State. 3rd ed. London: Prentice Hall; 1997.
10. Siamwalla A. Personal interview by a journalist cited in Bangkok Post: 1 April 2002 "No-one knows if providers can cope on 1,202 baht a head". In: Assavanonda A, editor. Bangkok: Bangkok Post; 2002. p. 2.
11. Thairat Newspaper. The Director of the Bureau of the Budget pointed the 30 Baht project led to negative balance of the government budget. Thairat 2001 1 April 2001.
12. Democrat Party. Aphisit pointed 2 projects caused problems of the budget allocation in the fiscal year 2003. In: Democrat Party; 2002.
13. SuanDusit Polls. Three months polls on the Taksin government performance. In. Bangkok: SuanDusit Teaching Institution; 2001.
14. SuanDusit Polls. Six months polls on the Taksin government performance. In. Bangkok: SuanDusit Teaching Institution; 2001.
15. SuanDusit Polls. A year polls on the Taksin government performance. In. Bangkok: SuanDusit Teaching Institution; 2001.
16. Manager Newspaper. Thaksin's Polls pointed that the "30 Baht" is the most favourite. Manager 2002.
17. Pitayarangsarit S, Tangcharoensathien V, Kasemsup V, Sahapattana P. Block Grant for the First Autonomous Hospital in Thailand: Why 782 Baht Per Capita? Health Policy and Planning Journal (Thailand) 2000;3(1):4-19.

18. Pitayarangsarit S, Kantamara T, Tangcharoensathien V. Operating Costs of Health Centers in Samut Sakorn, Fiscal Year 1999 (in Thai). Health Policy and Planning Journal (Thailand) 2001;4(1):5-23.

19. Pannarunothai S, Patamasiriwat, D., and Srithamrongsawat, S. Universal health coverage in Thailand: Options and feasibility. Nonthaburi: Office of Health Care Reform, MoPH; 2000.

20. Tangcharoensathien V, Teerawattananon, Y., Prakongsai, P. Universal Health Care Coverage: how the 1,202 Baht capitation rate comes from? Journal of Health Science 2001;10(3).

21. Pannarunothai S. Universal Health Care Coverage Budget: limitations of the calculation of the 1,202 Baht capitation rate? Journal of Health Science 2001;11(1):121-126.

22. Prakongsai P, Patcharanarumol W, Tisayaticom K, Tangcharoensathien V. Capitation Rate of the Universal Health Care Coverage for the Fiscal Year 2546 (2003AD) (in Thai). Journal of Health Science 2002;11(5):599-613.

23. Pannarunothai S, Patmasiriwat D, Kongsawat S, Srithamrongsawat S, Suttayakorn W, Rodsawaeng P. Sustainable Universal Health Coverage: Household Met Need. Research report. Phitsanulok: Center of Health Equity Monitoring; 2002.

24. Ministry of Public Health, editor. Guideline for the Management of the Universal Coverage Policy during the Transitional Period. Nonthaburi: Ministry of Public Health; 2001.

25. Botaphiboon V. Doctor Vachira Botphiboon. In: editor TN, editor. Bangkok: Thaipost Newspaper; 2001. p. 4-5.

26. Na Ranong V, Na Ranong A. The Evaluation of the Ministry of Public Health Implementation of the Universal Coverage Policy. Research report. Nonthaburi: Thailand Development Research Institute; 2002.

27. Director of Food and Drug Administration. Health Minister announced the 30 baht scheme will start on the first of April. In: reporter n, editor. Bangkok: Bangkok Business Newspaper; 2001. p. 13 and 16.

28. Prachachart Thurakij Newspaper. Private hospitals won't let 80 Billion Baht of the '30 Baht' go to only public hospitals. Prachachart Thurakij Newspaper 2001 22 March 2001;Sect. 21, 24.

29. The first taskforce of the Universal Coverage of Health Care Scheme. Third Meeting Minute of the first taskforce of the Universal Coverage of Health Care Scheme at 13.30-16.30 Room 6, 3rd Floor, 1st Permanent Secretary Office Building. Meeting minute. Nonthaburi: Ministry of Public Health; 2001 16 March 2001.

30. The Health Insurance and Standard Medical Service Bill 1995. In; 1995.

31. National Health Security Act B.E.2545. In; 2002.

32. Krungthep Thurakij Newspaper. Public physicians move against the National Health Security Act. Krungthep Thurakij 2002 11 August 2002.

33. Thai Post Newspaper. Physicians wear black in August, 28 to protest 30 Baht Scheme. Thai Post 2002 26 August 2002.

34. Matichon Newspaper. Physicians announce to resign from the government in protest at the unfair National Health Security Act. Matichon 2002 20 September 2002.

35. Krungthep Thurakij Newspaper. Physicians use "detail examination" to protect their

profession. Krungthep Thurakij 2002 23 September 2002.

36. Krungthep Thurakij Newspaper. Opposition physicians apply for medical council candidate. Krungthep Thurakij 2002 17 October 2002.

Chapter 3
Organization and management

Jadej Thammatach-aree
Pongpisut Jongudomsuk

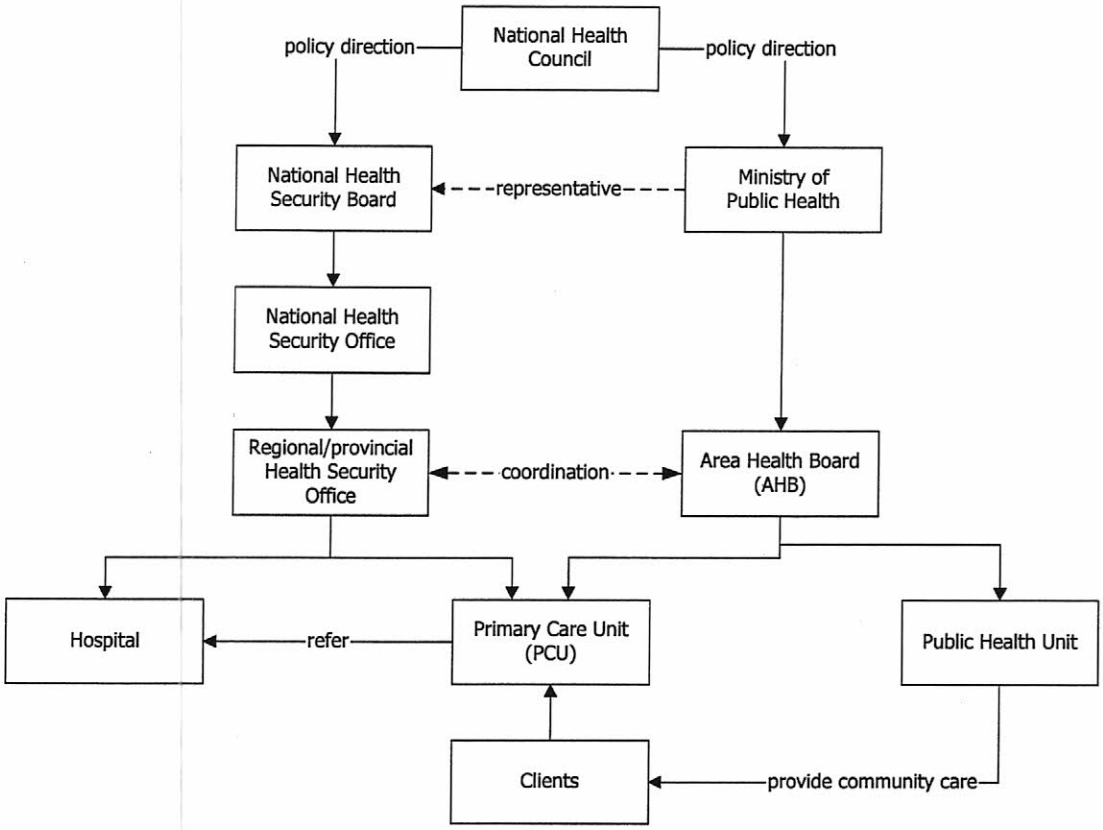
Introduction

During the period of the UC policy implementation, the organization structure and management of healthcare system in each level changed dramatically for three reasons. 1) Guided by the Public Sector Reform Act B.E. 2545, the government had to increase the number of ministries from fourteen to twenty ministries, and the MoPH was restructured into three clusters. 2) According to the Decentralization B.E. 2542, at least 35% of the total government revenue was for allocation to local governments, which was scheduled to be completed by 2006. 3) The National Health Security Act was passed in 2002 to reform the healthcare system in Thailand. After the Thai Rak Thai party government came to power, the UC policy was one of nine government priority policies. The UC policy implementation process was characterized by rapid, radical and top-down change (1). This rapid implementation encouraged a "do and correct" approach, which provided some flexibility into what otherwise appeared to be top-down process. One of main changes in the implementation process was in organization design and management of healthcare system.

Proposed structure prior the implementation of universal coverage scheme

Prior to the implementation of the universal coverage scheme, the Health Systems Research Institute (HSRI) set up a working committee to propose an implementation plan for the UC policy (2), in September 2000. The committee completed its feasibility study and system design in March 2001, two months after the Thai Rak Thai government came to power (3). The committee proposed to establish a new system which purchaser was spited from provider, a purchaser-provider spit approach. In addition, health care budgeting should be separated between budget for personal healthcare and public health services. The MoPH was expected to be a national policy body and policy regulator. Most of public health services were expected to be managed by local governments. In addition, the Area Health Board (AHB) would be established as a devolved structure to manage healthcare providers under the local government. However, because of the delay of health care devolution according to the Decentralization Act B.E. 2542, funding and management of public health services remain the responsibility of the MoPH. The conceptual framework of system organization is demonstrated in figure 1.

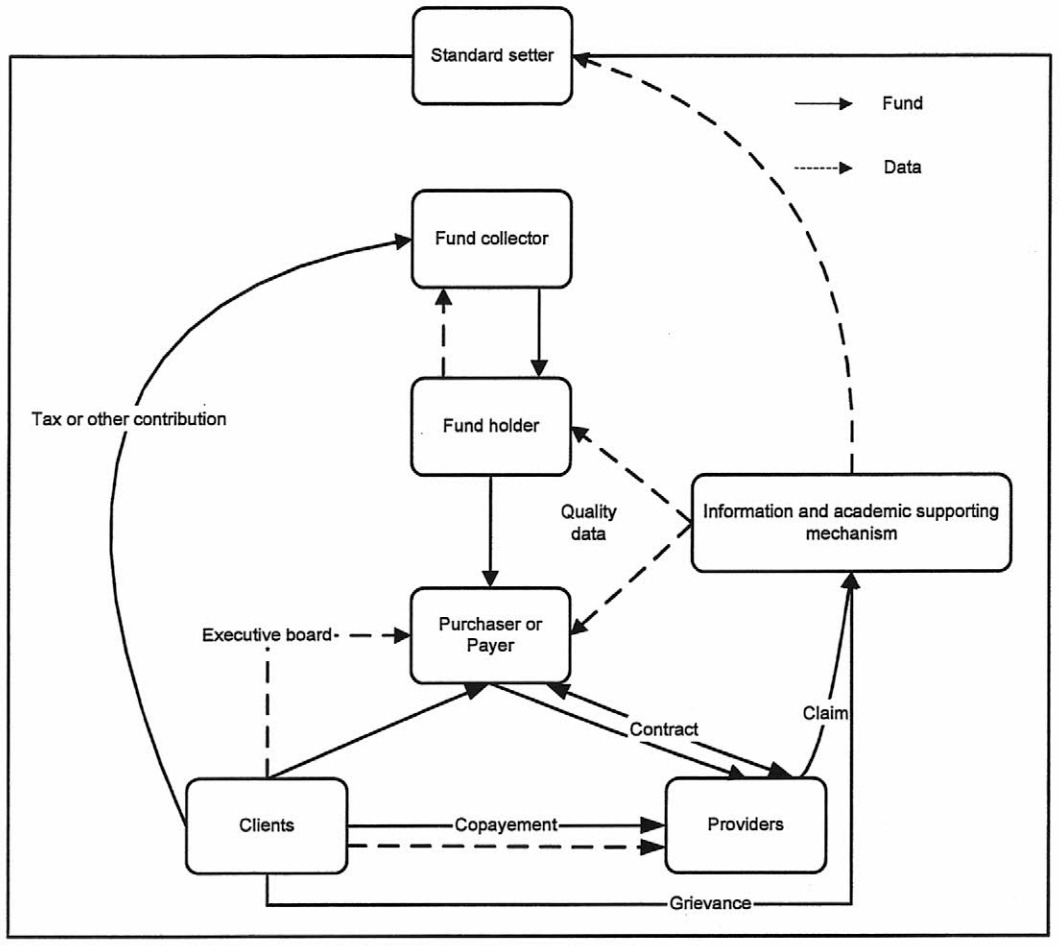
Figure 1 Proposed relationship between universal coverage and healthcare systems



The committee's proposed details of the system components and management system with flow of data and fund are shown in figure 2. Figure 2 delineates their crucial roles played by the stakeholders in the system: standard setter or unifier, fund holder, purchaser or payer, fund collector, information and academic supporting mechanisms. Their roles and functions can be described as follow;

1. The standard setter or unifier was a policy setting body, which made decisions on essential benefit packages, any estimate of budget needed, formulation of rules and regulations.
2. The fund holder was a fund manager responsible for budget allocation to meet the objective of universal coverage scheme.
3. The purchaser or payer was a unit managing the fund allocated from the fund holder in order to get essential services needed for their beneficiaries. Its management role also included identifying and contracting health care providers to provide services to beneficiaries.
4. The fund collector collected financial contribution or tax to fund the system by transfer to fund holder.
5. The information and academic supporting mechanism was part of the system to support system management. It provided information and technical support for the process such as budget estimation, development of payment mechanism, and etc.

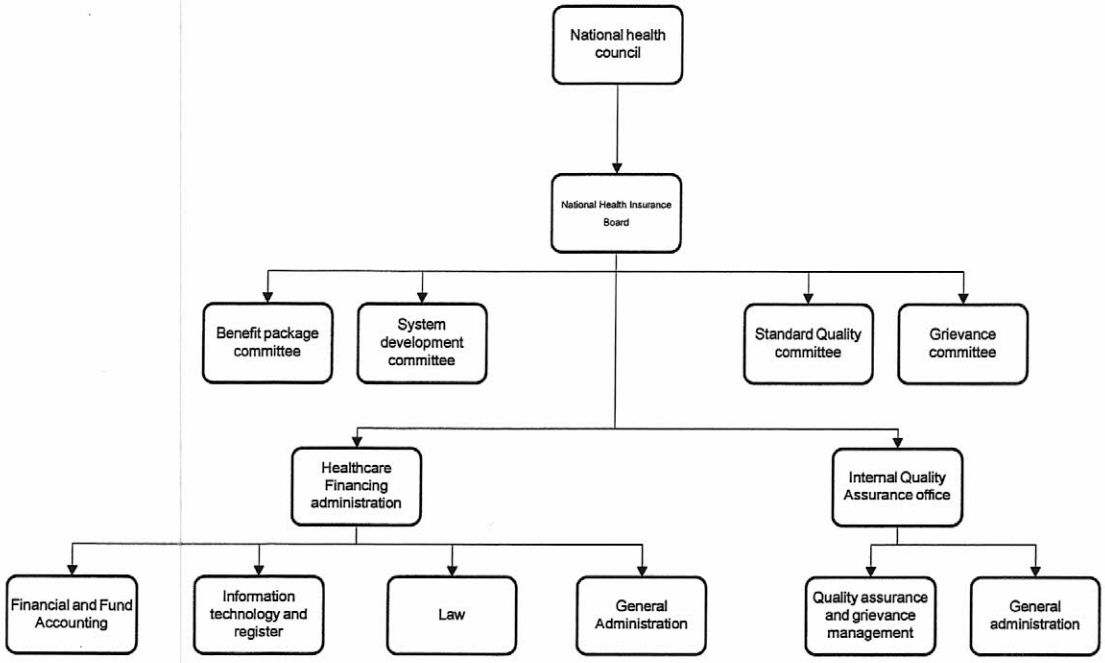
Figure 2 Proposed system component and mechanism of management system



The new system should be established by law within which four main structures were also proposed, as summarized in Figure 3. The **National Health Insurance Board** (NHIB), an independent organization under the National Health Security Act, was responsible for setting up benefit packages, standards of services and provider payment. Within the NHIB there were: subcommittee for benefit packages, subcommittee for system development, subcommittee for standards and quality, and subcommittee for grievance handling. The **Health Care Financing Administration**, a secretariat of the NHIB, was responsible for implementing the universal coverage policy. The **Internal Quality Assurance Office** was responsible for quality assurance, grievance processing and acted as a secretariat of the subcommittee for standards, quality and grievances. The **Area Purchaser Board** was a local purchaser who managed the fund for purchasing healthcare from the providers.

The proposal had been used as inputs for drafting the National Health Security Bill. The proposal of the HSRI research team was also the main document used as a milestone of the implementation stage, with recommendations being considered during the execution process.

Figure 3 Proposed organization of Healthcare Financing Administration and Internal Quality Assurance office



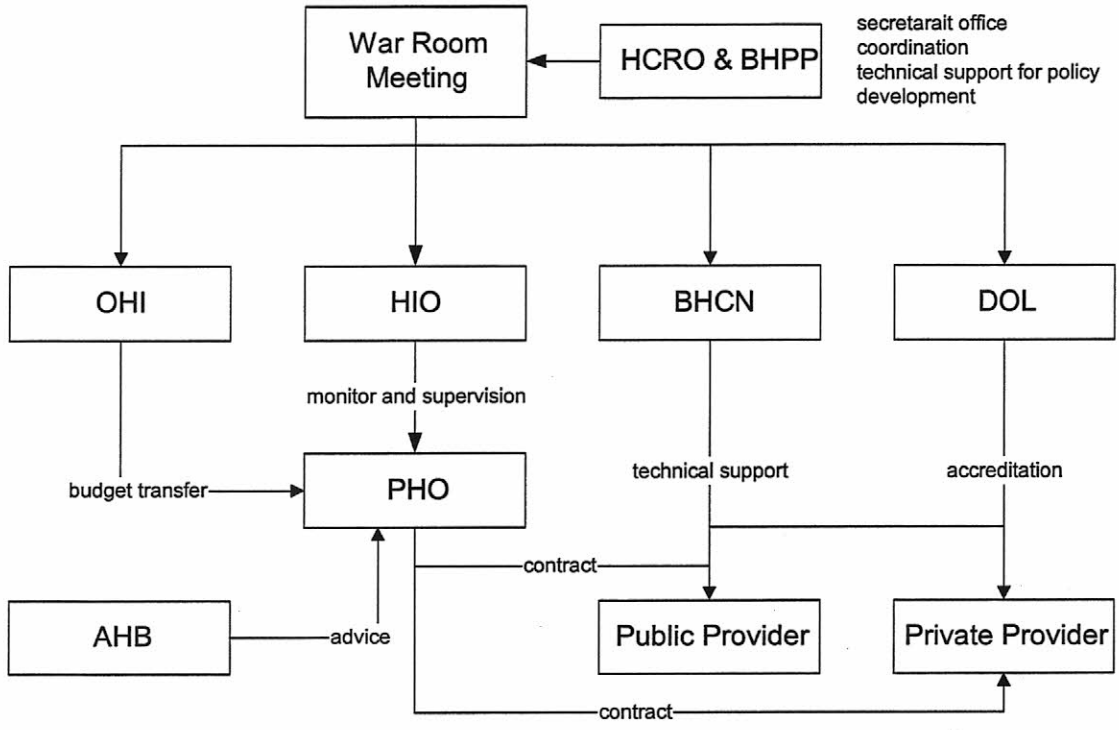
Management structure under the MoPH for implementing universal coverage scheme

With the advent of the new government in January 2001, the implementation process went on an experimental spree. The first six provinces were selected as pilot study in April 2001, because of their well prepared infrastructures as a result of their participation in many development and research programmes in the past.

Before the promulgation of the Health Security Bill, the MoPH, set up a temporary functional structure, to be responsible for the UC policy implementation. A core team for policy development was formed by a small group of technical people from the Health Care Reform Office (HCRO) and the Bureau of Health Policy and Planning (BHPP). The team's proposal was debated at a workshop held in the Government House on March 17th, 2001 and was adopted as a framework for further policy development. Following the workshop, the MoPH set up 10 more working groups, comprising representatives from various sectors, consumer groups, and private health care providers, to develop detailed policy contents, which was used as guidelines for policy implementation (3). The other MoPH organizations responsible for putting the policy into practice were: the Health Insurance Office (HIO), the Bureau of Health Care Network (BHCN), the Inspector General Office (IGO), and the Division of Medical Registration (DMR). The roles and responsibilities of each of these organizations are summarized in Figure 4. Notwithstanding these many organizations shouldering the responsibility of implementing the UC policy, the MoPH, set up a committee, known as "War Room"[1], to coordinate and monitor activities pertaining to the policy implementation, and to solve problems as obstacles to realizing the UC policy.

[1] The War Room committee was chaired by the deputy Minister of Health and had a regular meeting on Monday morning.

Figure 4 Internal structure of the MoPH for the implementation of the UC policy



In April 2001, the UC policy was first implemented in six pilot provinces, whose healthcare services were provided only by the MoPH's providers, and later, in June 2001, in 15 more provinces, with participation from both public and private healthcare services providers. By October 2001, 75 provinces and some areas of the Bangkok Metropolitan Administration (BMA) began their implementations. The BMA had to delay its implementation because of its system complexity, thus, people living in some areas of the Bangkok Metropolis were not covered by the policy until April 2002.

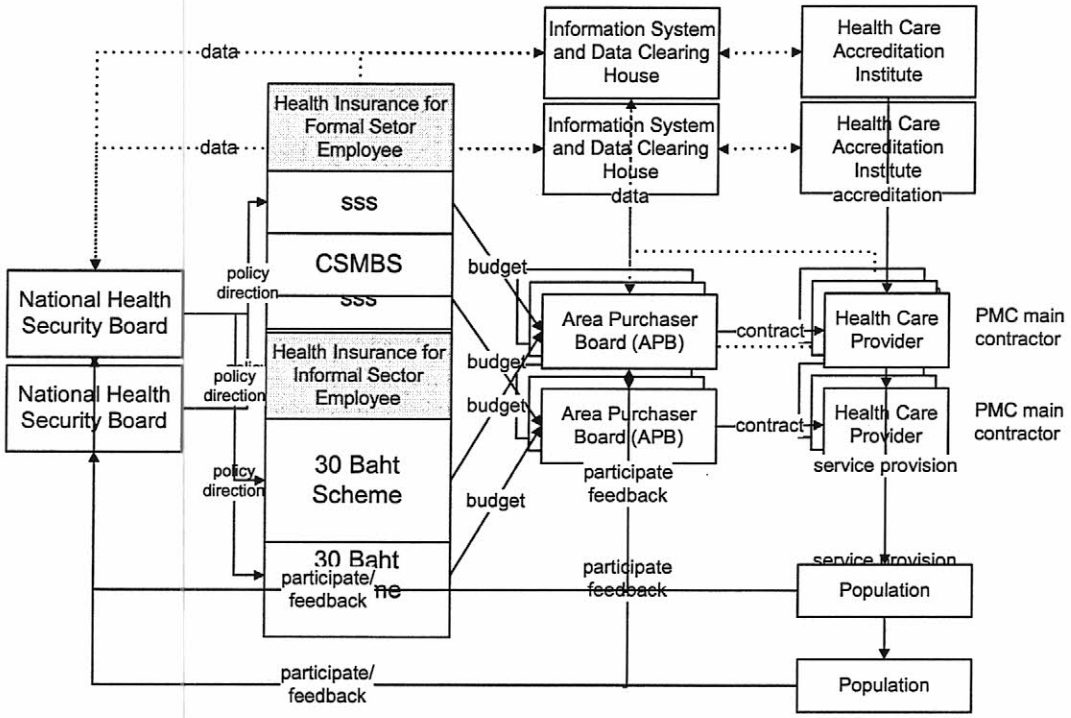
Since the MoPH realized that the MoPH implementing structure might limit participation of other stakeholders, a new temporary structure, the National Health Security Board (NHSB) and the National Health Security Office (NHSO), therefore, came into being by order of the Prime Minister. The deputy Prime Minister chaired the temporary NHSB and the main responsibility of the NHSB was to prepare the establishment of the universal coverage system. The temporary NHSB set up six subcommittees to develop specific proposals for specific subsystems. These subsystems included health insurance information system, financial and budgeting system, system for consumer protection, benefit package, system for quality improvement and accreditation, organization and management structure.

The subcommittee for development of organization and management structure proposed that the NHSB should be the UC system manager. Since there were two other major schemes in Thailand; the Social Security Scheme (SSS) and the Civil Servant Medical Benefit Scheme (CSMBS), the NHSB, then, should coordinate other schemes in both vertically to align the structure of implementation, and horizontally, for policy congruency in implementation, and to chart its direction. The UC system should be organized based on six principles; purchaser provider split, linking funding agency, good governance, stakeholder participation, clear line of authority and flexibility.

At the national level, the NHSB would provide policy direction for all public health financing schemes, mainly were the UC, the SSS and the CSMBS. The central office would act as a fund holder.

There were still debates about the appropriate size of population, taken care of by each local purchaser. The academics purposed that such a decentralized structure, or an Area Purchaser Board (APB), should be located in areas with more than three million population to ensure adequate risk-sharing and economy of scale. Accordingly, 21 APBs would be established nationwide (4). The proposed system for the transitional period is described in Figure 5. The MoPH proposed to assign the Area Health Board (AHB), a devolved structure established according to the Decentralization Act B.E. 2542, to perform as a provincial purchaser, to promote the integration of personal health care and public health programmes. Finally it was decided to decentralize the fund management to the Provincial Health Office (PHO), which, at the same time, became a provincial branch office of the NHSO and the AHB was just an advisory board.

Figure 5 Proposed systems under UC policy during the transitional period



The proposed system, which was modeled on the existing MoPH structure, was criticized for causing possible conflict of interests, since the MoPH also owned a majority of public health care providers in the country. The MoPH, acted as a purchaser and provider at the same time and it would be difficult for it to be an effective healthcare purchaser without compromising its role as provider and vise versa. However, because of the delay in establishing the National Health Security Board (NHSB), and the National Health Security Office (NHSO) was under pressure to expedite the implementation of the UC policy, the MOPH, was then the only choice, and the most capable agency suited to task of orchestrating the implementation of the UC policy in the early stage.

Management structure under the National Health Security Act

a. Organization by law

Regarding the National Health Security Act B.E. 2545, there are three main structures responsible for the law enforcement: the National Health Security Board, the Standard of Service and Quality Control Board and the National Health Security Office. They are supposed to support one another in providing good quality and easy access to healthcare services (figure 6).

The National Health Security Board was established on May 19th, 2003, made up of thirty one members, with half of its member being elected, and the other half by appointment. During the period of representative election, according to Section 67 of the National Health Security Act, the representatives of the Board were elected within 180 days after the proclamation of the Act. The members of the National Health Security Board were the: Minister of Health, permanent secretary of the MoPH, permanent secretary of the Ministry of Defense, permanent secretary of the Ministry of Finance, permanent secretary of the Ministry of Commerce, permanent secretary of the Ministry of Interior, permanent secretary of the Ministry of Labor and Welfare, permanent secretary of the Ministry of Education, Director of the Bureau of Budget, and five qualified senior persons, four of whom were consumer representative. The Minister of Health was the board chairman.

Figure 6 Organization structure of universal coverage system

The National Health Security Board (4) is responsible for setting: benefit package, standard of healthcare services, criteria for fund management and payment of no-fault liability[2], and for encouraging local governments and NGOs to join the management of the UC system. Furthermore, the board is a body providing regulations for contracting providers.

The Standard of Service and Quality Control Board is composed of thirty six members, who are appointed and elected like the members of the National Health Security Board, The role of this board is to, control, monitor and support standards and quality of healthcare units, propose standard fees for treatments of diseases, process of grievances, pay for no-fault liability, and to support the development of information for decision-making of service quality for people.

The NHSO is a secretariat office of both national committees. It is an autonomous organization reporting to the Minister of Health. The NHSO would work as a system manager in ensuring the attainment of universal healthcare coverage for all beneficiaries. Apart from

[2] No-fault liability means a system of compensation for persons who have been injured or adversely affected, without the need to prove fault or wrong doing.

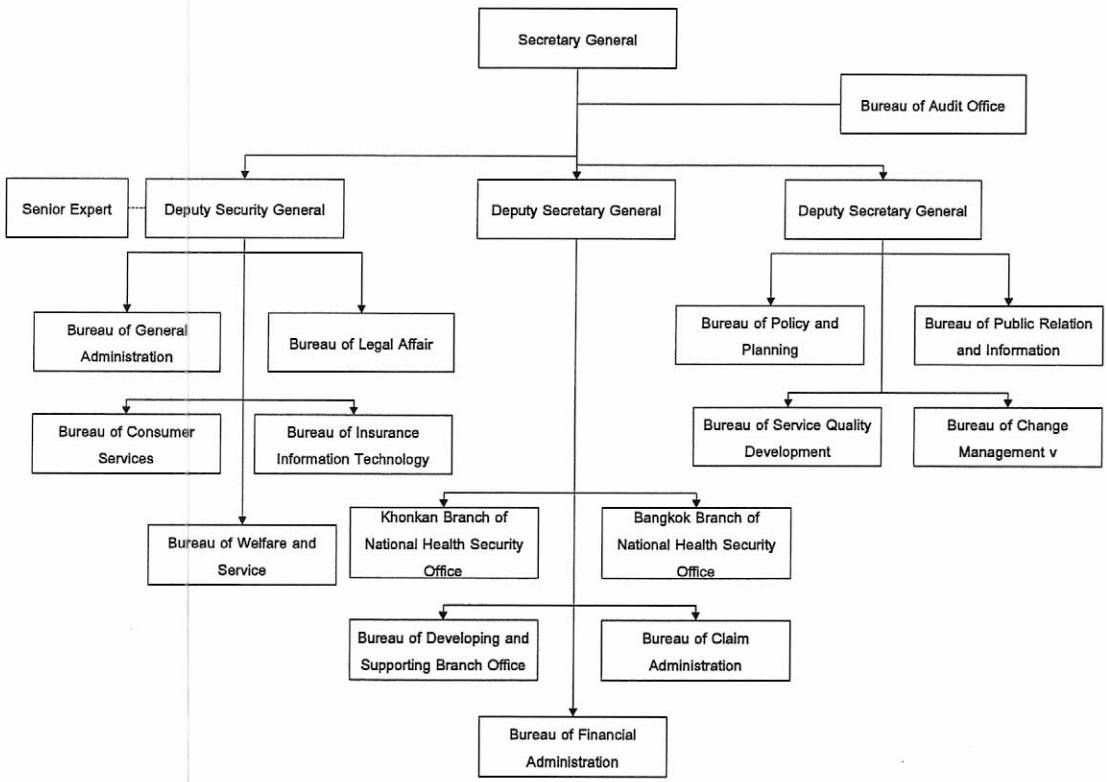
its responsibility for the board secretariat, the NHSO's duties include, collection and analysis of implementation data, registration of beneficiaries, registration of healthcare providers and their networks, management of fund, claim processing and reimbursement, monitoring healthcare providers to ensure good quality of care, and facilitation of the process grievance handling.

b. Organization of the NHSO

The NHSO's structure can be divided into supportive and functional parts by form of fifteen Bureaus, as summarized in figure 7.

The NHSO's 14 Bureaus are in the central office, and one regional office in Khon Kaen province. All Bureaus are grouped into three clusters according to their tasks and responsibilities. The grouping process was done continuously to achieve better internal coordination and collaboration. Each cluster reports directly to the deputy Secretary General. Senior experts will help the deputy Secretary General in specific tasks. Management system of the NHSO is designed to be transparent and accountable in all administrative process. For instance, all budget and action plans of the NHSO have to be approved by the NHSB. The NHSO also has to report annually to the cabinet for performance appraisal.

Figure 7 Organization structure of the National Health Security Office



Conclusion and recommendation

This chapter describes principles and practices used in organization and management of the UC system. It was found that although organization and management models proposed by technical people seemed to be sound for implementation, they would not be totally adopted. Experiences in the UC policy implementation showed the evolution of management structure to cope with unexpected and emerging obstacles. This evolution process, in fact, was based on the existing healthcare management infrastructure, interaction of stakeholders including technical people, availability of resources, management skills, and etc. The availability of technical inputs, therefore, could facilitate the evolution process to the right direction.

Some principles have already been accepted for designing organization and management of the UC system. These include; purchaser provider split, decentralization, transparency and accountability, and participation of all stakeholders in management system. It is anticipated that the management structure of the UC system will continue its evolution although the National Health Security Office has already put in place some basic infrastructures.

Reference

1 Pitayarangsarit S. The Introduction of the Universal Coverage of Health Care Policy in Thailand: Policy responses (For the Degree of Doctor of Philosophy). London: London School of Hygiene and Tropical Medicine; 2004.

2 Universal Coverage development team of Health Systems Research Institute. The proposal of Universal Coverage System. 1st edition. Nonthaburi: Design; 2001

3 Siamwalla, A. Implementing Universal Health Insurance. In: Phromporn Pramualratana, Suwit Wibulpolprasert, editors. Health Insurance System in Thailand.1st ed. Nonthaburi: Health System Research Institute; 2002.p. 224-228

4 National Health Security Act. B.E. 2545.

Chapter 4
Implementation process: learning before doing and learning by doing

Siriwan Pitayarangsarit

Introduction

As a result of pressure from the government, the UC scheme was initially implemented in the selected provinces, using "tools and techniques" best suited to their own situations. Systematic trial and evaluation of these provinces would lead to some conclusions as to whether the UC scheme was a success and should seek wider application / implementation; or was a limited success and should be developed further.

It seems appropriate to first give an overall view of the UC implementation process, as a backdrop against which Saraburi as a selected province for more specific implementation can then be described in details. Information in this chapter is derived from a thesis conducted by Pitayarangsarit (2004). The 30 baht Scheme was meant to bring about changes in the organization and management of healthcare services by: 1) creating Contracted Units for Primary Care (CUPs), 2) allocating providers' budgets based on their sizes of population, 3) extending services provided by hospitals and health centers, and 4) by restructuring their referral systems.

Implementation in transition

The UC scheme was implemented in **four phases** between 2001 and 2002. In the **first phase** (April 2001), the scheme was modeled on the Medical Welfare Scheme (MWS), which allocated budgets to different provinces in accordance with their number of registered people, who could also benefit from treatments, and medicines on the National Essential Drugs List. A budget of 399.8 million baht was allocated to six pilot provinces, of which 10% was to pay for change in management, and 5 % for healthcare network development. The rest of budget was for financing healthcare services, with a capitation rate of 477 baht per annum. 2.5 % and 1.25% of the 477 baht went to the Central MoPH for "high-cost-care" patients and administration, respectively. 10% of the 477 baht was for administration of provincial health office, including a small amount, less than 1%, for healthcare promotion and preventive measures. 45% of the budget was allocated to outpatient care, while 55% went to inpatient care. Providers of healthcare received their allocations in proportion to their numbers of registered population.

With a budget 1,510 million baht, of which 1,100 million baht came from the Revolving Fund of VHCS, the **second phase** (June 2001) was able to operate with a capitation rate of 1,202 baht annually, covering, medical treatments (574 baht or 61.5%), preventive medicine and health promotion (175 baht), and capital replacement (93.4 baht, 10% of which for medical treatments) (1). The budget for registration of the newly insured was based on 262 baht per capita 4 monthly. Fund allocation to providers for outpatient care, promotion and preventive care, was in accordance to their number of registered people, plus incentives. Payment to providers could be either by inclusive or exclusive capitation. In the former, patient care was part and parcel of the capitation budget, as per outpatient, promotion and medical treatments. In the latter, the budget for inpatient care, not from the capitation budget, was pooled at the PHOs and reallocated according to case-mix loads. Eight provinces elected the exclusive capitation method, and seven provinces opted for the other. Altogether 18 provinces were involved in this transition stage, in the 2nd phase (2). During this period problems encountered in the provinces were to do with availability of computers, lack of computing skills, etc.

In this **third phase** (October 2001), the MWS was emerged with the 30 bath Scheme which extended to every province. The CSMBS introduced a central information system for medical records and provider payment with weighting, and the SSS extended its coverage to all firms employing at least one person.

With a budget of 47,000 million baht for a population of 45 million, and a capitation rate of 1,202 baht, as in the **2nd phase**, the system was supposed to pay for capital replacement, high-cost care, and accident and emergency costs by pooling budget for these items to the central unit. The providers received about 1,052 baht per capita per year. For the public providers, the population–based budget, inclusive of salaries, was allocated to the PHOs, which authorized the provincial insurance committee to decide on the provider payment methods. The public providers received a budget for outpatient care, promotion and preventive medicine, according to the size of their registered population, on top of which there were other incentives. 40 provinces chose the exclusive capitation method, while 28 provinces selected the inclusive capitation, and the rest of the provinces preferred the mixed-system. 36 provinces had their salaries deducted at the provincial level, and 34 provinces chose to have their salaries subtracted at the CUP, other provinces were happy with the mixed-method (3). Any public health unit with a ratio of one doctor per 10,000 population, in primary care, was qualified to become a PCU or CUP. People were advised to have their first contact with PCU within the registered provider network, and for referral to hospital care.

In the **fourth phase** (April 2002), for the purpose of completing the 30 baht scheme in the metropolis, Bangkok was divided into 14 zones of provider networks, depending on hospitals' locations. It was somewhat complicated because of different "classifications" and numbers of hospitals: four BMA hospitals, one police hospital, three Ministry of Defense hospitals, and three MoPH hospitals. In 2002, there were 128 CUPs, consisting of 92 public CUPs and 36 private CUPs.

The budget of the 30 baht scheme for public hospitals outside the MoPH (contracted-providers) supplemented by government salaries and capital budgets as in the previous system, was based on 578.6 baht per capita per year for a comprehensive care including caring for inpatients, ambulatory patients, sickness prevention, health promotion, and authorized medicines. The public contracted service-providers reimbursed the health centers for services to 30 baht cardholders, at a rate of 100 and 150 baht per patient's visit, for public health centers and private clinic, respectively. The public hospitals outside the MoPH were hardly affected by the UC policy implementation, and did not appear to have mobilized any money from the Contingency Fund.

In April 2002, the Medical Services Department was assigned the task of coordination and implementation of the 30baht Scheme in Bangkok, with participation from the providers, but not from the consumers. The Committee for Implementation was also set up by the National Health Security Policy Committee, in 2001, which in turn appointed: a provider-network-development committee, chaired by the Deputy Governor of Bangkok; and an implementation-coordination committee, later nicknamed as "Bangkok War Room" committee, headed by the Director General of the Medical Services Department.

It seems from the above discussion, that the implementation as shown in these four stages had been progressive in moving towards universal coverage per se, but how successful had the implementation phases been in terms of number of people covered? The 30 baht Scheme widened its coverage from 1.4 million people in its first phase (April, 2001), to 4.9 million people (in 15 provinces), in the second phase (June, 2001). The figure 21.3 million people of newly insured in phases 3 and 4, was moved to the target of 45 million people covered by the 30 baht scheme. Thus, about 91.9% of the Thai population was covered by health insurance under public schemes in 2002. Those who were not insured during these periods, probably due to some technicality problems (e.g., incomplete population database), included senior citizens, handicapped people, prisoners, hill tribes, beggars, orphans, and migrant workers.

The public health insurance schemes, ever since the commencement of the SSS, their shares of the health service users, only rose higher than those enjoyed by the public providers, with the introduction of the UC policy. The lack of adequate information was one reason why only 96 private hospitals joined the 30 baht Scheme in 2002. The number of public hospitals joining the SSS was 132. The private healthcare providers only had 3% of the registered population, and there were only 9% of CUPs in the private sector.

Implementation in Saraburi province: a case study

Saraburi was singled out for the study of the implementation of the UC policy because: 1) both the private and public providers in the province had already joined the UC programme, 2) the province, despite its budget constraint, was able to get started with extra finance from the Contingency Fund, and 3) the province had the necessary data and health personnel.

Saraburi is about 107 kilometres from Bangkok. Within its 13 districts, there were 168,979 households with a total population of 607,600 in 2000. Its Gross Provincial Product was 115,539 millions baht (4). In 1999 the province had more health resources per person than the national average, with the exception of dentists. Saraburi, as the centre for the patient referral system, had, one general hospital (400 beds) in Phabudhabaht District, one regional hospital (634 beds) in its city, two private hospital (200 beds each), three small private hospitals on its outskirt, and a college of nursing. The average illness rate of Saraburi residents was 3.975 episodes per capita per year in 1996 similar to the average figure of the whole provinces (5), but its hospital admission rate in the same year was 0.05 admissions per capita per year, rather low by comparison with the other 75 provinces. The share of hospital admission in regional and general hospitals, private hospital and community hospitals were 46%, 38% and 17% respectively. Pannarunnothai (2002), reported that 2,564 patients from Saraburi were admitted to hospitals in other provinces, while 13,596 patients from other provinces were in Saraburi's hospitals (6). It seems therefore, that the population-based budget could work against the interest of the province's providers, as the allocated budget would be less than their historical incremental budget and the revenue from reimbursable referred cases might be uncertain.

Saraburi was one of the 15 provinces that implemented the UC policy in the second phase. Its Provincial Health Office was responsible for registration of beneficiaries, finance and accounting, development of information and technology system, regulating provider, network development, handling grievances, public relations and evaluation. There were Advisory Committee, Steering Committee, Administrative Committee, Service Delivery Committee, and Public Relations Committee. With an Area Health Board, acting as advisor, the Administrative Committee was responsible for decision-making and management, with help from the Provincial Health Planning and Function Committee, and from the sections within PHO, responsible for monitoring and evaluating the programme. Members of these committees included MPs, and volunteer villagers, and they had different roles as follows.

- The Advisory Committee with two senators and four MPs, advising other committees on matters concerning implementation of the UC policy.
- The Steering Committee, chaired by the Saraburi Governor, with the PCMO as secretary, and 29 members.
- The Administrative Committee with members from the health professions, coordinating works and providing technical support to the Steering Committee.
- The Service Delivery Committee responsible for providing services to and keeping the public and communities informed, and
- The Public Relations Committee for disseminating information to consumers.

The Provincial Health Committee for Planning and Evaluation

This committee was responsible for regular management of healthcare in the province. With its composition of heads of staff of PHO's sections, directors of community hospitals, and other big hospitals, and district health officers, this committee coordinated health plan and monitored its outcomes.

The Saraburi Provincial Health Insurance Office and other sections within PHO.

The Saraburi Health Insurance Office, responsible for health insurance scheme of the province, was operated by, one director, who had experience in the management of the SSS fund, and two officers from

the Public Relations Section of the PHO. The rest of 10 staff had years of experience in 'clearing insurance bills'. Under the Bureaucratic Structure Act, B.E 2545, in 2002 the PHO was restructured into five different sections: General Administration, Strategy Development, Technical Support, Consumer Protection and Health Insurance. In 2002, during the transition period, the Human Development and Primary Health Care Development Section was responsible for healthcare network development and primary care unit development. With time, and adjustment to the UC implementation process, the PHO assumed more and more responsibility of the UC policy implementation. Thanks to the strong leadership of the PCMO, and experiences of the people involved, the scheme was implemented with certain flexibility to allow changes as where and when possible. An effective communication system was also at work, within which there were three communication pathways: communication to the PCMO, communication with the PHO and communication between the PHO and "operational implementers".

Policy communication

The central government communicated to the provinces the policy content, through official communications or meetings with provincial representatives. Information sent from the central MoPH, to the provinces was conveyed by each province's inspector general, for example, decision on the salary subtraction. The inspector general had also to allay anxieties among the residents of Saraburi concerning the policy, and its implementation. A more formal source of communication was the book of guidelines for implementing the policy. The revised version was published in January 2002 (Ministry of Public Health 2002a). Underlined by the principles of solidarity, equity, and sustainability, the book addressed specifically the priority issues of people's participation, building up the strength of primary care, decentralization, provider-purchaser split, cost containment, performance-based payment, consumer protection and choice. Changing the funding system left out less urgent issues, such as hospital accreditation, provider networks, public-private mix for service delivery, and gatekeepers. The War Room kept the province(s) informed of its decisions on the UC matters by releasing its resolutions twice a month. These published resolutions were useful in problem solving. Messages received by the province from different authorized sources, meant absence of coordination among them, and lack of cohesion, perhaps in the policy and hence in implementation. However the Permanent Secretary was the one to give the green light to the province to start the ball rolling. The communication within Saraburi's PHO was via the Health Insurance Section which was the main source of the UC information. Apart from circular letters, meetings were convened, twice monthly, by the section heads, and once a month by the Health Planning and Monitoring Committee, within the PHO. The PHO stayed in contact with the "operational implementers" by official circular letters, implementation guidelines, documents, meetings, and supervision. However, in the province health volunteers acted as "messengers" conveying information about health services and activities to their communities, and carried out household surveys for registration purposes. Bill boards and posters were also used. Health providers registered their users based on their records with assistance from their health volunteers.

While top-down communication from the central power to the province(s) might have been deemed appropriate as information received was perceived more like "command or order" to be carried out by the province's PHO, information transmitted within the province was stamped with the "it is a policy, we must do it!" So order had to be obeyed.

Users and providers of the health system in Saraburi

Any resident with proof or evidence of having their domicile in Saraburi was qualified to register with a healthcare service provider in the province. At the initial stage, the Administrative Committee chose to set two big healthcare networks, following the SSS system, which operated with a concept different from that of the UC policy in terms of the promotion of the use of primary care. The UC policy, which wanted to reinforce the primary care system, allowed any provider or hospital (no limit on the number of beds) to become a Contracted Unit for Primary Care. Later, provider networks were divided into 12 networks. The change of the provider-network system was a result of changing the payment method from "capitation

excluding budget for inpatient care" to "capitation including budget for inpatient care". Later, the payment method turned back in the next fiscal year after the MoPH decided to chose a single method for the whole provinces. It was proposed that a pilot study of choices of registered providers in municipalities would start in 2003. Meanwhile people had to be registered with their allocated primary care providers in their districts, that is people in a tambon could go to the health care centre in their tambon and the community hospital in their district to benefit from the 30 baht scheme, with the exception of people from the villages on the border between two districts, who could choose to register with the nearest hospital.

The Contracted Units provided primary care through their PCUs, which should have a doctor/population ratio of one doctor to 10,000 people. By 2002, Saraburi Province developed 20 CUPs, and there was a five-year plan to upgrade health centers to PCUs in the province. As it turned out, the increase in number of CUPs depended more on their hospitals' locations and capacities, rather than on the size of population. The CUPs were also responsible for both personal and community-care, disease prevention or preventive medicine, and health promotion, as a means for cost-saving in treatment, and as the saying goes "prevention is better than cure".

Salary subtraction

In 2002, the total budget calculated on the cost of per capita health care multiplied by the number of registered population (e.g., 1,052 X 403,000 people = 424 million baht). Since the province received its budget for salaries directly from the Ministry of Finance, the 30baht scheme would pay only for the difference between the salary budget and the total cost for health care. Sadly the salary budget was about 463.4 million baht, much higher than the estimated capitation. This meant that the province might not, possibly, receive any budget from the 30 baht scheme. This understanding caused the staff's distress, and necessitated a request for extra money from the Contingency Fund. The request was justified on the ground that the estimated hospital revenue in 2002 was 1.5 times less than the labour cost. The average hospital revenue of the province was 1.4, which was close to the cut-off point. An extra 215.3 million baht for six CUPs from the MoPH, was therefore warranted. However, the Contingency Fund Committee approved an additional budget of only 85.5 million. Only 40% of the province's budget was allocated to the community hospitals, and 60% was for salaries. The decision was then made to subtract salaries at CUPs, which was the reason why it was change to inclusive capitation payment method.

The private providers were paid by inclusive capitation, directly by the Provincial Insurance Office (PIO) within the PHO. However as it turned out Saraburi had four different payment systems. The first was for the providers as previously agreed in 2001. The second system was a suggestion from the central administration, changing from the exclusive capitation payment of two public networks to inclusive capitation payment of the 12 MoPH's CUPs. The third method of payment was a method used in 2002, similar to the second system, as the payment system continued from 2001. The fourth was the inclusive capitation back to the two-a method proposed for a pilot study in late 2002, which changed the inclusive capitation back to the two-network exclusive capitation. Basically there were two choices, exclusive and inclusive, with some variations in each, as shown in the four different ways of payment. This switching from one payment method to the other might have been a reflection of indecision, or perhaps an indication of "do and correct "approach".

Impact of the policy on implementation

Hospital Finance

The UC policy affected hospital revenues and expenditures, as it intended to replace hospitals' incomes from the uninsured patients' payments with the tax revenues. The MoPH used the proportion of the total budget spent on salaries as a criterion for asking extra money from the Contingency Fund Committee. The financial data of the public provider networks suggested that ten out of twelve of them in Saraburi

needed a budget of more than 1,052 baht per capita. Only six networks were granted extra money from the Contingency Fund. In Saraburi, provider networks were grouped as follows:

Group 1 had networks with small population, less than 20,000. These hospitals had an average fixed cost of 7.4 millions baht, and an average marginal cost of 843.3 baht per capita. With a flat rate capitation, they could not possibly operate effectively. Hospitals under financial stress were not always granted extra by the Contingency Fund Committee. In 2002, the Committee changed its ruling to grant extra money to hospitals in remote areas, with a population coverage of under 25,000. Small hospitals, which were in close proximity, should be incorporated into one big hospital. Hospitals in the provinces, which either failed to qualify for extra funding or to join forces as one big hospital, had to find other solutions. For example Sao Hai Hospital, with its coverage of civil servants and public sector's employees, had to seek more revenues from the Civil Servant Medical Benefit Scheme, and the Social Security Scheme.

The hospitals in Group 2, which had the required number of population and were efficient performers, could share their fixed costs. Gaeng Khoy Hospital network, for example, earned a great deal of revenue from the UC scheme with its coverage of 50 thousand people. Insufficient funding was not necessary the only reason hospital networks could not implement the UC policy satisfactorily. For instance, the Ban Mo Hospital network experienced a shortage of doctors, and doctors from Phabudhabaht had to be rotated to help out. Its performance worsened, and the hospital had to refer patients to other hospitals Eventually, the Contingency Fund came to its rescue, and the network got itself demoted to Group 3, which was classified as inefficient in capacity and hence performance.

A high referral rate in the networks in Group 3 was a sure sign of their low capacity and poor performance. Wihandaaeng Hospital and the Nong Khae Hospital networks, incurred 53% and 31%, respectively, of their in-house expenses, for referral costs. The former had a ratio of 9.5 nurses per doctor, and the latter 9.3 nurses per doctor, whereas the province's average nurse/doctor ratio was 5.7. Saraburi Hospital itself was better off with a doctor/nurse ratio of 4.6 nurses to one doctor. Hospitals in the province had to help each other in terms of medical staff, as in the case of the Saraburi Hospital, having four medical specialists working, in roster at Gaeng Khoy Hospital.

Group 4 was labeled as "inefficiency due to higher supply over demand". Phabudhabaht Hospital was said to have a registered population of about 76,000, and 400 hospital beds, but there was low demand for its services. It was supposed to increase its income from referrals from its community hospitals, but patients could also be referred to Saraburi Regional Hospital, with more sophisticated services, or to private hospitals. Without enough patients, to offset its mounting costs, it was not performing efficiently as stipulated by the UC policy. Phabudhabaht Hospital was not alone in this situation of "inefficiency due to higher supply over demand". Hospitals in the same network had similar problem. What was needed was for the MoPH to draw up some long-term plan, but no offer of the kind was forthcoming.

Surely if hospitals had "rich resources and capacity to import patients" as in Group 5, they must have been doing well by the UC policy. This was not so as shown in the case of Saraburi Hospital, which had a budget deficit. Its revenue was 1.4 times of its salary cost, and therefore it required an extra 117.6 million bath for its operation within the UC policy. The Contingency Fund Committee approved only 56.4 million baht. The hospital should have received about 105 million baht from its "imported" or referral patients, between 2001 and 2002, but there were few reimbursements.

It may be assumed from the discussions of the five groups of networks that the provinces were left to their own to juggle with their allocated budgets, and other related problems. Of course they could have recourse to the Contingency Fund. The MoPH mobilized the Contingency Fund to help those hospitals experiencing financial difficulty to stay solvent, and by redistribution of resources, some hospitals had budget surpluses. However poor distribution of human resources, especially medical doctors, made it harder for some hospitals to cope than others. In 2002, there was a shift in the policy to include salaries in the budget, and by 2003 this change in the policy was endorsed. Perhaps the MoPH could have offered

more solutions to their problems, e.g., problem with provider networks, and the referral system in the province.

Provider network and referral system

At the beginning in response to the UC policy, all district hospitals acted as Contracted Units for Primary Care (CUPs), and managed their capitation budgets as they pleased. Due to financial and capacity constraints, these hospitals had to reconsider their situations, and reacted differently. Ban Mo Hospital, like other community hospitals, had a high turnover of physicians, and had to refer their patients to other big hospitals, thus increasing its expenditure. The overall quality of services at the Ban Mo Hospital had been fast improving, as it was in the process of being accredited, and with help from Phabudhabaht Hospital, it was able to sustain its development as a primary care unit. In the midst of all these happenings, what role did the PCU system play?

Impact on PCUs management, human resources, and financing system

According to the UC policy, health service providers must have a PCU for every 10,000 residents, and this concept was experimented with gradual expansion in every province as well as in Saraburi. In 2002 the Saraburi Provincial Health Office proposed that each district to have a PCU in a hospital and one in a health centre. Gaeng Khoy District started with two health centers as Primary Care Units (PCU), with other districts also developing their own PCUs at their health centers and /or at hospitals. The health centers with their staff of nurses, midwives and health personnel, in these districts provided mother and child care, antenatal and post-natal cares, including health promotion, and health education as parts of their community programmes. The nurses at PCUs provided holistic care services, while doctors on standby in Outpatient Department, came to PCUs on request. Services at PCUs included routine medical check-ups, dispensing medications and home visits. Each PCU had on average, five permanent staff, assisted by a team of five people, including one doctor and one pharmacist from a hospital, who came once a week. Patients' appointments at these centers could be as many as 80 a day. Health centers and hospitals developed their own "models" of PCU to suit their budgets and capacity. For example, one PCU in Wihandaeng district carried out Pap smear screening for cancer, hygiene education in communities and schools, prevention of dengue fever with control of mosquito larvae, rehabilitation for the disabled, and so on.

Since there was no plan of any kind for human resource employment, reshuffling, relocation and recruitment of human capital, took place in a haphazard fashion, due mainly to, 1) no clear written policy for implementation, 2) no clear authority, leading to confusion, fragmentation and lack of coordination, and 3) inter-faction fighting. Doctors' salary payment method, which was not defined by the 30 bath policy, seemed chaotic. Private hospitals could only offered low salaries, which attracted only young and inexperienced graduates, driving away the experienced practitioners to OPD, thus the system seemed to create a two-tier standard services.

Villagers' evaluation of the UC scheme

The implementation of the 30 baht scheme which affected the implementers and villagers in Sarabui was meant to: 1) increase accountability and responsibility of healthcare service providers, 2) increase equity in access to services, 3) expand the range of services in primary care, and 4) fortify provider networks and the referral system. The villagers interviewed in April 2002 believed that the UC policy was useful, especially for the poor, but not for those with chronic illnesses. Confusion about the rules of the UC scheme with those of the VHCS and the MWS among the villagers was inevitable. The "under-privileged" or those with no fixed abode were not registered. No one among the villagers seemed to notice any change in healthcare service quality as a result of the UC scheme. The interviewed villagers however did appreciate home visits by staff from health centers and having doctors seeing patients at these centers.

On the whole only 20% of the population, who was covered by the public employment insurance scheme, did not benefit from the 30 baht scheme.

With the exception of senior citizens and children, the beneficiaries of the 30 baht scheme were farmers, unskilled labours, shopkeepers, who were the majority recipients in the rural areas but were the minority in the municipal areas. The 30 baht scheme help mostly the people who could not even pay the initial 500 bath for the Voluntary Health Card, and yet not poor enough to qualify for the MWS means test. Villagers suggested that with a minimum wage of 140 baht a day, anybody could afford the 30 baht health cost. However, transport costs were problems for some, and old age pension of 300 baht per month did not make a pensioner's life any easier.

Conclusions

In a hierarchical society like Thailand, decisions made at the top level become orders to be obeyed by the subordinates. Such was the case with the top-down and quick approach of the MoPH implementation, and perhaps it was intended not to allow the opposition to get sufficient time to protest. It also created administrative problems, which had to be dealt with reactively rather than proactively. The bureaucrats or political elites, and other actors often failed to reach a consensus on almost of the issues concerning the policy, because of their own self-serving interests, and therefore not acting out of public interest. However when conflict of interests seemed to stand in the way of good decision making or there was pressure on them to get on with their tasks of implementing the UC policy, they somehow worked out some sort of compromise. So this 'do and correct' approach did allow some flexibility, but with the bureaucrats tipping the balance.

The 30 baht Scheme, as one of several other proposed health reforms, induced a radical change in the healthcare financing system. In October 2001, the scheme shifted from the historically based financing system to a population-based financing system. The main support for the reforms was from people outside the MoPH, within which different factions contested on the ground that these reforms would directly affect all the personnel in the health sector. On the whole the changes were non-linear, and without any specific guidelines, the reform directions were either pushed or pulled by different stakeholders. The important factors (push factors) facilitating implementation of the UC policy were, clear policy goals with strong political leadership, strong institutional capacity and skilful implementers, and flexibility and discretion on the part of the implementers. These "push" factors had to work against the "pull" of resistance of the bureaucrats, medical professionals, and budgetary constraints.

The financing reform had no doubt affected hospitals' finances and their staff morale, despite their positive attitude towards and responses to the concept of universal healthcare coverage and its goals. However, their concern for financial insecurity was allayed by the Contingency Fund which guaranteed their staff's salaries. With certain degree of autonomy for the provincial authorities, the Provincial Chief Medical Officer of Saraburi, was able to integrate all the reforms, as dictated by the UC policy and other aspects of the government sector reform, into the PHO plan. This province was able to achieve some degree of success in its UC implementation, because it had the managerial skills to cope with changes as well as technical capacity to operate the IT system. Its successful operation could also be attributed to the social capital investment in the rural development plan, which involved relocation of medical doctors to all the provinces, with capacity development of the healthcare systems in each province.

Acknowledgements

The author would like to thank: the Saraburi Provincial Health Office and its staff for their assistance in data collection, Professor Gill Walt for her academic advice, and the World Health Organization for their funding.

References

1. Tangcharoensathien V, Teerawattananon, Y., Prakongsai, P. Universal Health Care Coverage: how the 1,202 Baht capitation rate comes from? Journal of Health Science 2001;10(3).
2. The evaluation committee of the UC implementation in the transition period in fifteen provinces. Recommendations for the UC Countrywide Implementation in October 2001. Memogram. Nonthaburi: Health Policy and Planning Bureau; 2001 15 August 2001.
3. Na Ranong V, Na Ranong A. The Evaluation of the Ministry of Public Health Implementation of the Universal Coverage Policy. Research report. Nonthaburi: Thailand Development Research Institute; 2002.
4. National Economic and Social Development Board. Gross Provincial Product of Thailand 1999 edition. In: National Economic and Social Development Board; 2000.
5. National Statistics Office. The Health and Welfare Survey. Bangkok: National Statistics Office, Priminister Office; 1996.
6. Pannarunothai S. Evaluation and Monitoring the Universal Coverage Program: Situation Analysis Focusing on Information System in Seven Provinces in 2001. Interim report. Phisanulok: Center of Health Equity Monitoring; 2002 January 2002.

Chapter 5
Implications of the Universal Coverage Scheme on health service delivery system in Thailand

Samrit Srithamrongsawat
Sinchai Torwatanakitkul

Introduction

The UC scheme aims to achieve equity, efficiency and strengthening primary care. A close-ended payment had been adopted to pay providers: a per capita budget was allocated to provinces. The abrupt shift from a historical supply-based allocation to a need or demand-based allocation had enormous financial implication on health facilities. Although the policy aimed to achieve equitable allocation of budgets to meet the needs of the population in each province, unfortunately, the existing inequitable distribution of health professionals is a major problem to achieve equity. The situation was compounded by the problem of the scheme being under-financed with the low per capita budgets. All CUPs were required to set up primary care units (PCUs), which embodied the concept of family medicine, for every 10,000-15,000 registered beneficiaries.

This chapter first gives a brief review of the financial reform and strengthening primary care, then followed by an analysis and discussion of the impacts of the new financial arrangements, of increasing workload and development of primary care, on the providers. The analysis was limited to MoPH hospitals outside Bangkok, where 90% of the population has been covered, based on information culled from MoPH hospitals' financial and activity reports, and other secondary data, such as the Health and Welfare Surveys and opinion polls. This chapter then ends with some conclusions.

Reform components of the UC scheme

To make the policy more sustainable and improve the current health care systems, the UC scheme incorporated financial reforms and strengthening primary care, the details of which are given in the following sections.

Financial reform

An annual per capita budget, inclusive of salary, non-salary operating and capital replacement, was proposed and negotiated among major stakeholders, such as the MoPH, the NHSO and the Bureau of Budget. The annual per capita budget for each category of care in fiscal year 2002-2005 is presented in Table 1. The 2002 capitation rate was proposed by the technocrats in the MoPH and was accepted by the government without any negotiation. It was estimated by using the 1996 service utilization rate with 100% compliance with the UC scheme and unit cost of service in 2000 (1). A new capitation rate of 1,414 Baht, was calculated for 2003 fiscal year by employing the 2001 service utilization rate from the 2001 Health and Welfare Survey, and unit costs of service provision in the same year (2), however, it was not negotiated down by the government, on the ground that compliance with the UC scheme was not 100%. The annual capitation rate was subject to annual negotiation between the MoPH, NHSO, and the Bureau of Budget.

Table 1 Per capita budget for the UC scheme in 2002 – 2005

Category	2002	2003	2004	2005
1. Outpatient care (OP)[1/]	574	574	488.2	533.01
2. Inpatient care (IP)[1/]	303	303	418.3	435.01
3. Prevention and promotion services (P&P)[1/]	175	175	206	210
4. Accidence and Emergency care (AE)[2/]	25	25	19.7	24.73
5. High cost care[2/]	32	32	66.3	99.48
6. Ambulance system[3/]	-	10	10	10
7. Capital replacement[4/]	93.4	83.4	85	76.8
8. Remote area[5/]	-	-	10	7
9. No fault liability[6/]	-	-	5	0.2
Total	1,202.4	1,202.4	1,308.5	1,396.3

Source: NHSO

Note: [1/] allocated to provinces according to the number of beneficiaries registered
[2/] reserved at the NHSO to pay hospitals providing high cost care to UC beneficiaries and emergency care in case of services used outside their registered hospital.
[3/] allocated to the MoPH for setting up ambulance system
[4/] allocated to private hospitals and the MoPH according to capital investment plans
[5/] allocated to hospitals in remote areas
[6/] reserved at the NHSO to pay patients suffered from treatment received

In 2002 a single capitation rate was allocated to provinces. It achieved perfect equity as each province has the same capitation rate. Based on the existing imbalance of human resource distribution and a single capitation rate for all, created financial disruption in affluent provinces having higher staff population ratio. Financial surplus was observed in provinces having lower staff population ratio.

This problem was solved by a temporary solution, by using a contingency fund (CF) of 5,000 million baht, to support hospitals with financial difficulty, on condition that they proposed an efficiency improvement plan prior to CF approvals. Single capitation rate was strongly opposed by hospitals with financial difficulties. It became a major conflict between the conservatives and reformists in the MoPH. The reformists who supported single capitation saw an opportunity to achieve equitable human resources allocation through gradual systems adjustment. The conservatives felt there were too much noise and conflicts, and that reallocation of staffs cannot be achieved through this avenue.

The MoPH earmarked staff cost out of the capitation rate for 2003 onward, staff cost was allocated according to the actual number of staffs in each province. This meant provinces having higher staff intensity got more resources. Then, the non-staff capitation rate was allocated on a flat rate. As a result, there was a large discrepancy in total capitation rate (staff and non-staff cost), in favour of the affluence provinces and discriminated against the others. At this juncture, there was no other mechanisms to address the imbalance of manpower, such as slow down the inflow of new graduates and specialists in the affluence provinces and vice versa.

The noise from less affluence provinces in 2003 was heard. In 2004, after salary was deducted from the capitation, the non-staff capitation rate was then allocated to provinces using a differential rate adjusted for hospital type, 300 baht per capita for regional hospital (RH), 390 baht for general hospital (GH), and 490 baht for district hospital (DH) [1]. There is again no mechanisms to address imbalance of human resource allocations.

[1] This was based on the principle that larger hospitals had full salaries supports while they have a greater capability to generate revenue from other sources i.e. CSMBS and SSS than district hospitals.

In 2002, provinces were flexible to choose either inclusive[2] or exclusive[3] capitation to pay CUPs. However, they have been ordered by the MoPH to adopt an exclusive capitation model, to pay CUPs since 2003 due to the fear of negative implications of the inclusive capitation payment (3)[4]. The CUPs had flexibility to adjust payment rate and payment method for hospitals and healthcare centers. However, the MoPH required all MoPH CUPs to adequately allocate budgets to health centres for operating services.

In conclusion, financing reform did not fully achieve the equity goal of reform, due to the existing imbalance of human resource allocation. At the same time no other effective mechanism to address this imbalance.

Establishment of primary care units (PCUs)

Primary care units have been chosen as main providers under the UC scheme for two main reasons (4). Firstly, primary care is better suited to provide quality care based on a holistic approach and better access by rural population. Secondly, it is expected that a system with a primary care gatekeeper will lower overall healthcare costs and improve the efficiency of resources used. The policy was meant to shift service delivery from technology-based hospital care to a more comprehensive and holistic approach of primary care.

Due to lack of effective primary care units in the transition phase, hospitals were chosen as CUPs, and the UC scheme required all CUPs to have at least one PCU for every 10,000-15,000 healthcare service beneficiaries. In the first year, all MoPH hospitals were required to set up at least two PCUs, one within and outside a municipality. Most PCUs within municipalities have been set up in hospitals as separate units, but some of them are in town centres, outside the hospital. Most district hospitals have employed professional nurses to provide care in PCUs, while specialists have been employed by provincial hospitals.

Health centres have been chosen to be upgraded to PCUs in rural areas, instead of setting up new ones. Variations of service provision have been identified in PCUs outside municipal areas. Most provincial hospitals send a medical team of one specialist, and few nurses working either full-time or few days a week, to PCUs. Nurses are rotated to work in PCUs of some district hospitals on working days, but with supervision from a doctor once a week. Some PCUs had full-time nurses providing care. Most hospitals referred uncomplicated chronic cases such as diabetes and hypertension to PCUs and health centres.

Impacts of the UC scheme on providers

Financial impacts

The financial impacts of the UC scheme on healthcare providers were caused by, (a) the low per capita budget, especially for inpatient care and, (b) problems related to budget allocation.

---

[2] Inclusive capitation refers to paying CUPs a capitation fee for outpatient and inpatient care. CUPs act as fund-holders paying for referral OP and IP cases.

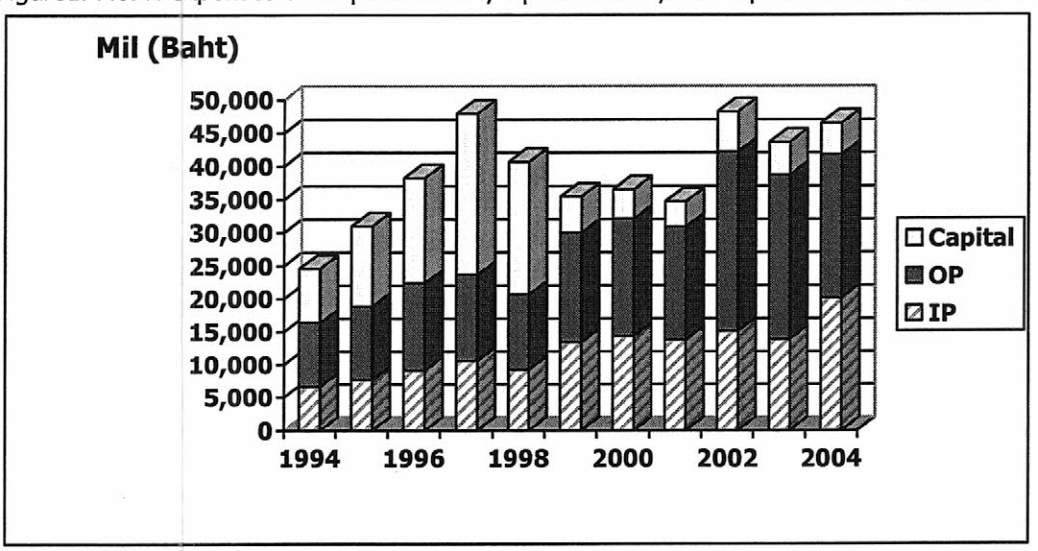
[3] Exclusive capitation refers to paying CUPs a capitation fee for outpatient care only, CUPs act as fund-holders paying referral OP cases. The rest forms a global budget at provincial level to pay inpatient care by DRG.

[4] Pannarunothai (2002) found that increase in mortality rate of acute myocardial infarction patients in inclusive capitation payment hospitals was greater than that in exclusive capitation payment hospitals and there was slightly higher referral rate in the latter

The UC scheme was criticized for being under financed, particularly for inpatient care (5) since it was based on the 1996 service utilization rate without taking into account the aging population and increase in admissions between 1996-2001. Using the 2001 services utilization rate and unit cost of services provided in the same year suggested that the 2002 per capita budgets was under-estimated by 212 baht (2).

Figure 1 shows the trends of MoPH spending on outpatient care (OP), inpatient care (IP), and capital replacement, for the year 1994-2002. The 2002 outpatient budgets increased remarkably, 59%, from 17,077 million Baht in 2001 to 27,111 million Baht in 2002. The inpatient budgets increased slightly, 9%, from 13,814 to 15,090 million baht. A decline in the MoPH total spending was observed in 2003, due to a drastic reduction of the contingency fund from 5,000 million baht in 2002 to only 500 million baht in 2003. An increase in the IP budgets was evident in 2004 due to the increase in the per capita budgets for IP as shown in Table1. Shrinkage of capital investment budget from 1999 onwards was also observed.

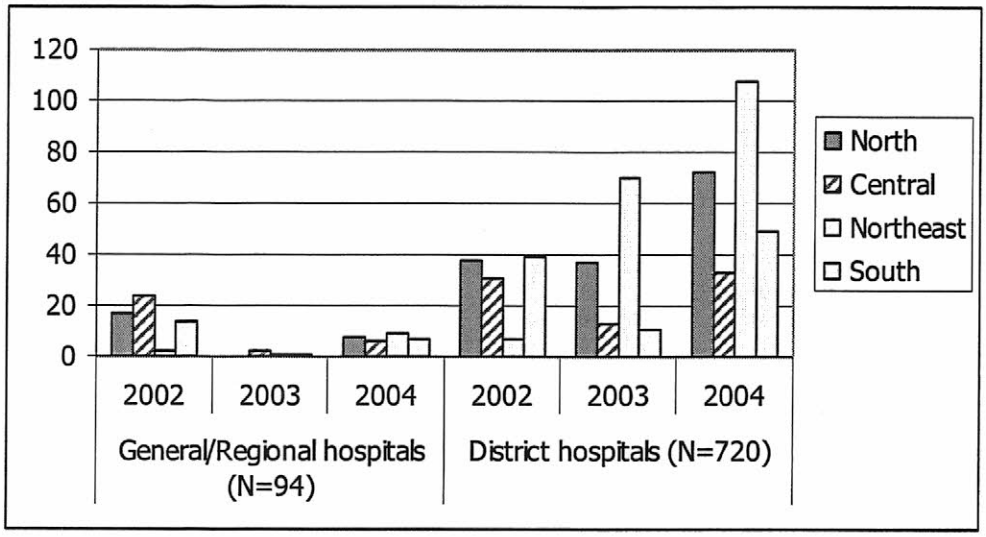
Figure1. MoPH expenses of outpatient care, inpatient care, and capital investment 1994 - 2004



Source: NHA 1994 – 2001 (6): MoPH spending on OP, IP, and Capital investment
The 2002 – 2004 figures are calculated from the per capita budgets and budget plan

The sudden change in the allocation from supply-based to demand-based allocation, using a single capitation rate in 2002 resulted in conflicts. The affluence provinces and provincial hospitals with relatively high number of health personnel in relation to their population received less budgets, while the provinces in the northeast and district hospitals with relatively low number of health personnel in relation to their population, had more budgets. However, the situation reversed once salaries were excluded from the capitation rate in 2003 (Figure 2), but result in gap of inequity of capitation rate when salary was taken into account. In 2003, capitation rate favoured the affluence provinces and provincial hospital, as against the poorer provinces and district hospitals.

Figure 2 Number of hospitals with financial constraints and receiving financial support from the contingency fund during 2002-2004 by type of hospital and region.



Source: MoPH, 2002-4

On average 60% of the provincial hospitals experienced in 2002 financial constraint. Only 10% of the provincial hospitals in the Northeast, shared the same problem. On average, 16% of the district hospitals experienced the same problem in 2002, with only an extremely low number of 3% of district hospitals in the Northeast.

Only few provincial hospitals continued to be affected by the financial constraints after salaries being excluded from the per capita budget in 2003. In 2003, there was a decline in number of district hospitals experiencing financial constraint in the Central and Southern regions, but there was still a sharp increase in the number of district hospitals with financial constraint in the Northeast region.

The percentage of district hospitals with financial constraints in the Northeast increased from 3% in 2002 to 27% in 2003. The costs incurred from the rapid expansion of PCUs according to revenues gained in the first year might partially explain the problem of district hospitals in the Northeast when they received fewer budgets in the following years. Adjustment for the capability to generate revenue from other sources, did not appear to have solved the problem, since the magnitude of problem increased in both the provincial and district hospitals.

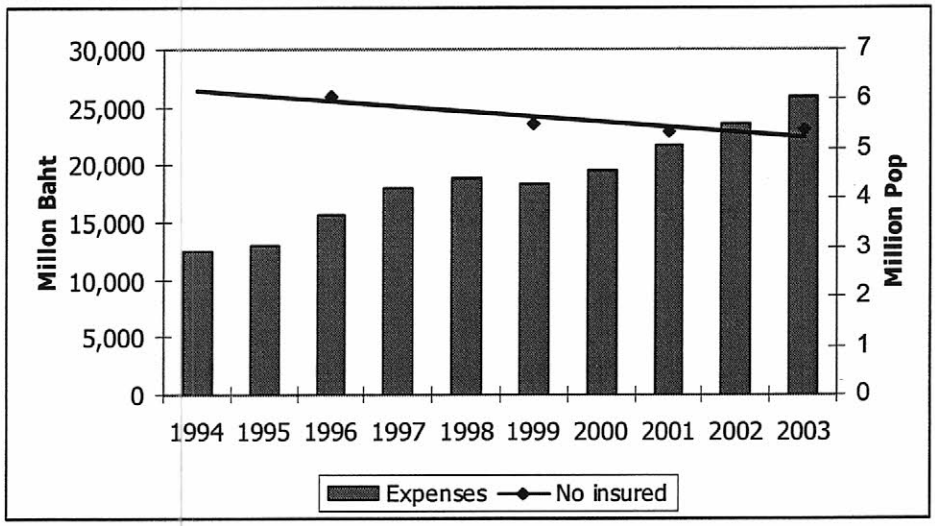
Generating more revenues from other sources was one means to mitigate the financial constraints. The Civil Servant Medical Benefit Scheme (CSMBS) was the most common source employed by most public hospitals to generate more revenues due to its unregulated retrospective fee-for-service payment system. The escalating cost of the CSMBS was apparent as shown in Figure 3. The average annual increase in CSMBS expenditure was 13% during 1994-8 and 10% during 1999-2003, in contrast with the 1.6% annual decrease in the number of CSMBS beneficiaries during 1996-2003, as a result of public sector reform towards a lean government.

The Social Security Scheme (SSS) was another potential source for generating more revenues even though it was less attractive than the CSMBS, due to the capitation payment of the SSS. However, the capitation rate of the SSS was more attractive than that of the UC due to its relatively low service utilization rate. The immigrant labor insurance was another potential source similar to that of the SSS, but it was usually available only in provinces requiring immigrant labors. In general, big hospitals with specialists and state-of-the-art technology equipment were

bound to have a greater intake of patients, with their greater capabilities in generating additional revenues from other sources, i.e. CSMBS and SSS, than district hospitals. This was taken into account in adjusting the per capita budget for the 2003 allocation.

Some hospitals allowed payment in arrear, and deployed their cost-saving strategies, such as control of drug prescription for UC beneficiaries with strict adherence to the National Essential Drug List, use of generic names and locally manufactured drugs, instead of imported brand name drugs, adjusting the number of staff working overtime, cutting down non-medical care expenses, or postponing some investments, e.g., in medical equipment, construction, and training (7, 8).

Figure 3 CSMBS expenditure during 1994 – 2003 (million baht in current year price) and number of its beneficiaries (in million people)



Source: Expenditure: NHA 1994-2001; ILO & IHPP (2004);
Number of CSMBS beneficiaries: HWS 1996, 2001, 2003; Social survey 1999

Service delivery system impact

Improvement in services provision at primary level

With the establishment of PCUs, which were "upgraded" health centers, PCUs have more qualified doctors and nurses. The flat rate capitation payment system has been working well for the primary care services because of their relatively low costs. With more budgets they are able to have more available drugs, equipment, and to extend their service hours in the evening and weekend. Hence the policy has been providing good quality services which have also been made available to people near their home (9, 10).

Increase in workload

The UC Scheme has increased the demand for health services, particularly by those who were previously uninsured, as it has reduced the financial barrier to access to healthcare services covered by the UC scheme. This increase in demand has had implications for healthcare personnel's workload. More than 70% of healthcare workforce claimed that their workload increased as a result the UC policy (11). Comparing service utilization rates between 2001 (before the UC) and 2003 (after the UC) revealed that use of healthcare facilities increased by

25% for outpatient care in contrast to use of non-institutional care (Table 2). The hospital admission rate was increased by 9%. There was a decline in the use of outpatient and inpatient care in private hospitals, especially for hospital admissions as shown in Table 2.

Table 2 Use of health facilities by UC beneficiaries between 2001 and 2003

	Outpatient visits			Hospital admissions		
	2001	2003	% Change	2001	2003	% Change
Utilization rate, visit/person/yr.	2.846	3.547	24.6	0.076	0.083	8.8
Use of UC card in getting care,%		56.6			80.9	
Pattern of service used,%						
Non-institution care	30.6	28.0	-8.5			
Health centre/PCU	22.2	26.2	**18.0**			
District hospital	14.2	22.0	**54.9**	30.0	54.4	**81.0**
Provincial/tertiary hospital	18.3	8.9	**-51.6**	59.0	35.9	-39.1
Private clinic	12.0	12.3	2.8			
Private hospital	2.6	2.5	-3.0	11.0	9.7	-11.9

Source: The 2001 and 2003 Health and Welfare surveys (12, 13)
Note: Those previously uninsured and those covered by the MWS and the HC are grouped as UC beneficiaries in 2001.

Shift of use of services towards primary care level

There was a shift from using services of out-patient care in hospitals to using services in health centres and district hospitals, between 2001 and 2003, which could be explained by the improvement in primary care services provided by PCUs, and the capitation payment. The increase in out-patient visits in district hospitals might be best explained by the capitation payment since these hospitals acted as primary care gatekeepers. The increase in the number of admissions, with more admissions in district hospitals than in provincial hospitals, might be due to a greater financial incentive provided by the flat rate DRG weight global budget payment for district hospitals to admit more patients, and their relatively low unit cost of service provision (14, 15).

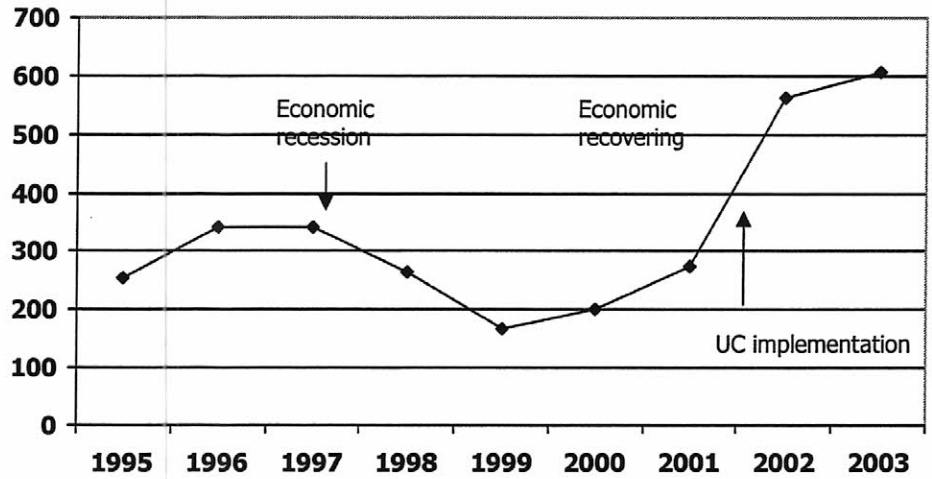
Shortage of physicians and health personnel with appropriate skills to provide care in PCUs

Shortage of doctors, particularly in district hospitals and in the northeast region, was a main constraint in policy implementation, especially when there was an increase in demand for healthcare services, not to mention the resultant increase in workload. The situation worsened when the number of MoPH doctors resigned from the public sector in 2002 doubled in 2001 (Figure 4). The reason for their resignation was overwork and low payment in the public (11, 16). It was not just the overwork, created by the UC policy implementation; another contributory factor to their quitting the public sector might have been improvement in the country's economy, which made it possible for private hospitals to attract more medical doctors with better pay offers.

The shortage of medical doctors and healthcare personnel with the prerequisite skills for primary care also restricted the operations of PCUs. This problem stemmed from the fact that, due to lack of general practitioners or family medical doctors, most medical specialists in provincial hospitals

were deployed to PCUs to provide primary care services to patients. This underutilization of their skills and knowledge, understandably led to their resentment of and opposition to the UC policy (8, 17). The problem was also dealt with by employment of more professional nurses by most of the district hospitals, to work in PCUs or communities, for which they were not trained.

Figure 4 Number of MoPH doctors resigned from public sector during 1995 - 2003



Source: MoPH

Quality of care and discrimination in service provision

Table 3 shows the healthcare professionals' ratings of the quality of services provided to patients covered by different insurance schemes in 2003 and 2004. In general, the majority of providers rated the quality of services provided to all patients as "good" or "very good". They also evaluated the improvement in quality of services provided to all groups, for 2003-2004. However, the quality of services provided to the UC beneficiaries were at the bottom rank, followed by that provided to Social Security Scheme (SSS) beneficiaries, while the quality provided to CSMBS beneficiaries was considered the best.

Table 3 Quality of services provided to patients covered by different insurance schemes and payment status rated by health professionals in 2003 and 2004

Type of payment	2003 (N = 3,006)		2004 (N = 4,417)	
	Good/very good	Poor/very poor	Good/very good	Poor/very poor
CSMBS	79.6	2.3	81.4	1.2
Out-of-pocket payment	75.9	3.3	80.0	2.1
SSS	73.1	2.8	77.7	3.1
UC	62.8	4.9	73.5	4.0

Sources: ABAC poll (11) and Suan Dusit Poll (16)

Conclusions

The financial constraints, allocation in favour of affluence provinces and provincial hospitals and increased workload at district health systems raised concerns about efficiency, equity and quality of care. The current inequitable human resource allocation is a primary problem that was yet to be solved, impeding achievement of equity goal.

The financial deficit in implementing the UC scheme reflected the need for adequate financing, or more subsidies from other schemes, such as the CSMBS, SSS, reserved revenue, or other sources. Cross subsidy is possible only if hospitals have capacity to generate these resources. For some district hospitals with limited capability to generate revenue from other sources or limited reserved revenue, there may be negative impacts on their services. A huge reduction in capital budgets since the economic crisis is also cause for concern. The limitation of new technology investment may also have some negative impacts on the quality of care provided by hospitals. The UC scheme should be more pre-emptive by putting aside adequate funding and some finance for new investments by the government in state-of-the-art technologies, for good quality services.

The expectation that with more budgets the provinces might be able to recruit more medical staff, especially for more physicians, was not realized, due to the MoPH being the major employer, without any explicit policy guidelines for redeployment of human resources, hence the provinces or hospitals were not in any position to acquire more doctors or other medical professionals. However, it would have been politically feasible for hospitals to hire more non-medical and paramedical staff, and for the government to restrain from closing down any public facilities, had the MoPH then come up with an explicit policy on redeployment, and attractive pay packages for physicians in rural areas, plus other incentives for providers.

The capitation payment is an incentive for providers to give limited services to those needing expensive care services, like senior citizens, and patients with chronic conditions. Age and other risk factors should be taken into account in calculating the capitation rate, to prevent selecting low risk beneficiaries for hospital registration, and their bias in service provision. In addition, keeping and close monitoring of their quality of care must be diligently enforced.

Establishment of PCUs has brought better quality of services to people near to their home, increased physical access, and also reduced costs of healthcare services, particularly for those living in the rural areas, those with chronic conditions, the poor, and senior citizens. Quality of services provided in health centres could have been improved by having professional nurses in these health centres. Indeed, orientation training, development of primary care curriculum, and other training programmes for staff, together with an MoPH explicit policy for the development of PCUs, would also be needed.

References

1. Tangcharoensathien V, Tirawattananon Y, Prakongsai P. Budget for Universal Health Care Coverage: How was the 1,202 Baht Capitation Rate Derived? Journal of Health Science 2001;10(3):381-390.
2. Prakongsai P, Pacharanarumol W, Tisayaticom K, Tangcharoensathien V. Capitation Rate of the Universal Health Care Coverage for the Fiscal Year 2546BE. Journal of Health Science 2002;11(599-613).
3. Pannarunothai S. Evaluation of the Universal Coverage Scheme in 21 Provinces: Analysis of hospital admissions within provinces and cross-boundary cases. Bangkok: Thailand Development and Research Institute; 2002.
4. Jongudoumsuk P. Achieving Universal Coverage of Health Care in Thailand Through 30 Baht Scheme. Nonthaburi: Health Care Reform Office, Ministry of Public Health; 2002.
5. Pannarunothai S, Patmasiriwat D, Srithamrongsawat S. Letter to Editor, Budget for implementing the Universal Coverage Policy: Weakness of the 1,202 Baht Per Capita. Journal of Health Science 2002;11(1):123-128.
6. Tangcharoensathien V, Vasavid C, Mek-Krajang C, Tatiyanonpong S. National Health Accounts in Thailand 1994-2001. Nonthaburi: International Health Policy Program; 2003.
7. Srithamrongsawat S, Lapying P. Financial Management of the Universal Health Care Coverage Project in the First-year Implementation: A Case Study in Four Provinces. Journal of Health Science 2003;12(6):889-906.
8. Srithamrongsawat S, Lapying P. Evaluation of the Universal Health Coverage Policy Implementation: A case study in Samut Sakorn, Phuket, Sukhothai, and Ubon Ratchathani province. Pitsanulok (in Thai): Center for Health Equity Monitoring (CHEM), Naresuan University; 2002.
9. Lapying P, Srithamrongsawat S. The First-year Implementation of Primary care Unit of the Universal health Care Coverage Project : A Case Study in Four Provinces. Journal of Health Science 2003;12(6):923-936.
10. Srithamrongsawat S. Financial protection and enabling access to care for Thai elderly: the role of public insurance. London: University of London (PhD thesis); 2004.
11. ABAC Poll. Providers' Opinion towards the Universal Coverage Policy: A Case Study in Contract Heatlh Facilities in 13 Provinces. Bangkok: ABAC-KSC Internet Technology and Training Institute, Assumption University; 2003.
12. NSO. The 2001 Health and Welfare Survey. Bangkok: National Statistics Office, The Office of Prime Minister, Thailand; 2001.
13. NSO. The 2003 Health and Welfare Survey. Bangkok: National Statistic Office, The Office of Prime Minister; 2003.
14. Pannarunothai S, Kongsawat S. Cost per DRG Relative Weight for Regional, General, and Community Hospitals. Journal of Health Science 2001;3(3):391-399.
15. Upakdee N, Mahaboonpachai V, Pannarunothai S. Cost per Relative Weight by Diagnosis Related Group of Public and Private Hospitals under Contract with the National Health Security Office. Journal of Health Science 2003;13(4):619-631.
16. Suan Dusit Poll. Medical and Health Personnel's Opinion towards the Universal Coverage Policy. Bangkok: Rachapat Suan Dusit University; 2004.
17. HSRI. The First Evaluation of the Universal Health Coverage Policy. Nonthaburi: Health System Research Institute; 2003.

Chapter 6
Impact of Universal Healthcare Coverage on the Thai Households

Chitpranee Vasavid
Kanjana Tisayaticom
Walaiporn Patcharanarumol
Viroj Tangcharoensathien

Introduction

Several efforts by the previous governments for extension of healthcare coverage, for example Social Security Scheme for the formal sector to all size of establishments, the Low Income Scheme which later covered the elderly, children under 12 and the social disadvantaged group, as well as the voluntary health card, a public subsidized voluntary insurance scheme. It failed to achieve healthcare insurance courage for all Thai citizens. 30% of the total population were still not covered by any health insurance scheme (1) (Table 1), before October 2001.

Table 1 Insurance coverage prior to October 2001

Health insurance schemes	Coverage
Social Welfare Scheme	38%
Voluntary Health Card Scheme	12%
Civil Servant Medical Benefit Scheme	11%
Social Security Scheme	9%
Private Insurance	~ 10%
The uninsured	~ 30%
Population	61.46

Source A Challenge from targeting to Universality (1)

A year after the UC policy implementation, the UC scheme was assessed. This chapter describes, in its first section major achievement of UC, the impacts on coverage, health care service utilization, compliance with the regulations of the scheme, equity in public healthcare financing, and households' health expenditures. This section analyses the findings, statistical data, from the Household Socio-economic Survey (SES) and the Health and Welfare Survey (HWS, two nation-wide surveys conducted by the National Statistical Office

The second section of the chapter analyses the findings of the research survey, "The Opinion Survey of the Members and Healthcare Providers under the UC Scheme", conducted by the National Health Security Office and ABAC-KSC Internet Poll research Centre, Assumption University, in 2003.

Part one: major achievements

The coverage of population

In 2003, the result of the 2003 HWS indicated that the UC scheme covered 47.7 million people out of the total 63.9 million populations (74.7% of the total population). 76% of these 47.7 million people were in the rural areas. The CSMBS and the SSS covered 9.6 and 9.0 % of the total population respectively. However, 3.25 million people (5.1% of the total population) were still uninsured (Figure 1 and Table 2).

Figure 1 Population by health insurance scheme, 2003

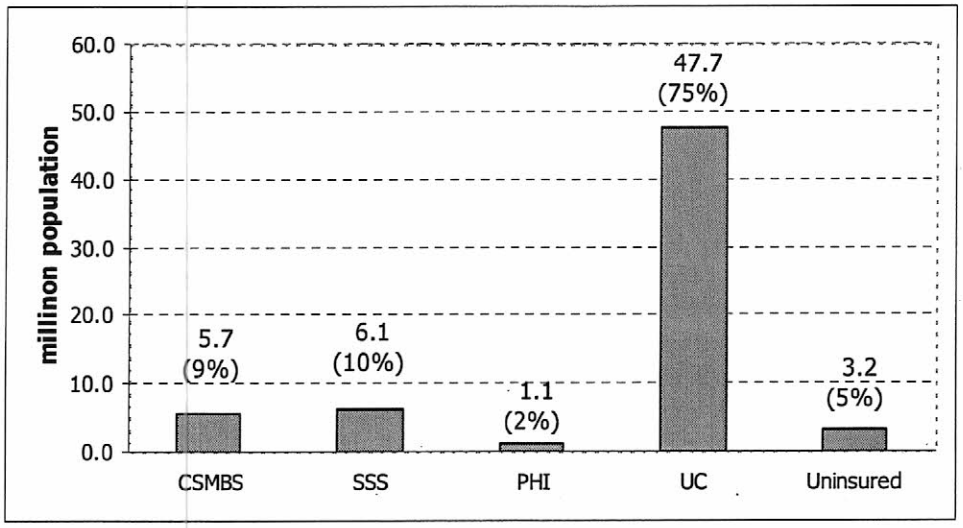


Table 2 Number and percentage of population by insurance scheme and area, 2003

Health Insurance Scheme	Population			%		
	Total	Municipal Area	Non-municipal Area	Total	Municipal Area	Non-municipal Area
Total	**63,884,553**	**20,925,797**	**42,958,756**	**100.0**	**32.8**	**67.2**
Civil Servant Medical Benefit Scheme	5,721,048	3,052,284	2,668,764	9.0	14.6	6.2
Social Security Scheme	6,109,735	3,713,873	2,395,862	9.6	17.7	5.6
Universal Coverage	47,751,864	11,633,746	36,118,118	**74.7**	**55.6**	**84.1**
Private Insurance	1,055,021	614,637	440,384	1.7	2.9	1.0
The Uninsured	3,246,885	1,911,257	1,335,628	5.1	9.1	3.1
Total	63,884,553	20,925,797	42,958,756	100.0	100.0	100.0

Source The 2003 Health and Welfare Survey, National Statistical Office (2)

The Northeastern region (86.5%) was found to have the highest ratio of population covered by the UC scheme. The Northern and the Southern regions covered 80.2 % and 79.4% of the total regional population, respectively. While the central region had 65.7% and Bangkok covered only 47.1%, which was less than half of the total population in the area. In contrast, Bangkok had the highest percentage of population covered by the SSS (25.5%).

Among the uninsured 3.2 million people, about 1.1 million people resided in Bangkok (34% of the total uninsured), and 0.9 million people lived in Central region (Table 3).

Considering income quintile, 34% of the UC members were in the poorest income quintile while 26% were in the poor income quintile. These figures reveal that the UC scheme covered 60% of the low-income households (Figure 2).

Table 3 Number and percentage of population by insurance scheme and region, 2003

Health Insurance Scheme	Bangkok	Central	North	Northeast	South
Civil Servant Medical Benefit Scheme	810,242	1,348,315	1,015,344	1,634,753	912,394
	(10.1)	(9.3)	(9.0)	(7.6)	(10.6)
Social Security Scheme	2,047,728	2,400,697	540,810	670,364	450,135
	(25.5)	(16.5)	(4.8)	(3.1)	(5.3)
Universal Coverage	3,782,442	9,541,640	9,090,172	18,534,831	6,802,779
	(47.1)	(65.7)	(80.2)	**(86.5)**	(79.4)
Private Insurance	284,715	346,316	212,754	144,279	66,958
	(3.5)	(2.4)	(1.9)	(0.7)	(0.8)
The Uninsured	1,104,363	891,128	471,880	441,064	338,450
	(13.8)	(6.1)	(4.2)	(2.1)	(3.9)
Total	8,029,490	14,528,096	11,330,960	21,425,291	8,570,716

Note: percentage in bracket.

Figure 2 Ratio of population by health insurance scheme and income quintile group (Quintile 1-the poorest and Quintile 5-the richest)

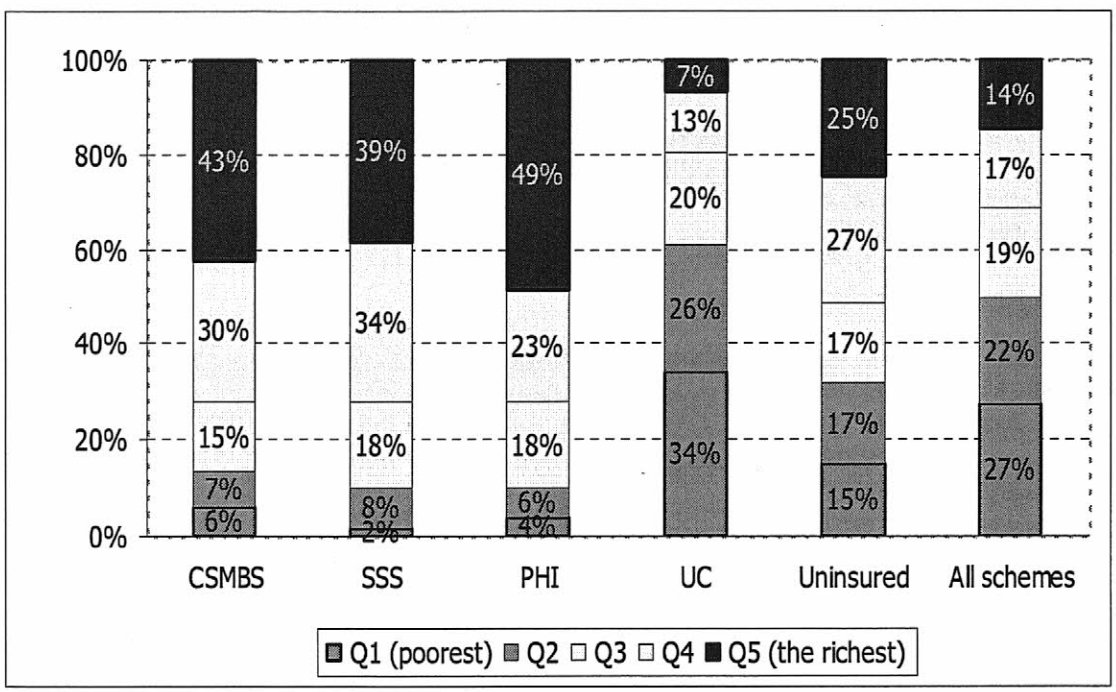


Table 4 shows the uninsured population by income quintile, in 2003. More than half of the whole country's population had high income (54.1% rich and richest groups). Bangkok had the highest percentage in the richest quintile, while the Central and the Southern regions were in the rich quintile. On the other hand, the highest percentages of the people in the Northern and the Northeastern regions were in the poorest quintile, future surveys should investigate why these people still have not obtained the UC card. They should have covered by the Scheme.

Table 4 Percentage of the uninsured by region and income quintile, 2003

Income quintile	Total	Bangkok	Central	North	Northeast	South
Poorest	13.0	1.0	6.4	40.1	30.8	11.4
Poor	15.1	3.3	12.1	30.7	29.3	22.3
Middle	17.9	12.8	23.2	17.4	15.3	23.8
Rich	27.2	36.0	31.2	7.7	13.2	30.7
Richest	26.9	46.9	27.0	4.1	11.3	11.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

Healthcare service utilization and compliance of the UC beneficiaries

To understand the UC beneficiaries' behaviours in choosing their healthcare service providers, the report relied on information about morbidity and healthcare service utilization of the UC patients.

Outpatient care

The UC members had a high morbidity rate, which increased from 4.101 episode/person/year in 2001, to 4.926 episodes/person/year in 2003, an increase of 20%. The use of institutional healthcare increased from 69.4% to 72.0% (an increase of 3.7%). The public institutional healthcare utilization increased from 54.8% to 57.2% (an increase of 4.4%).

Inpatient care

The admission rate of the UC members increased from 0.076 admission/person/year in 2001 to 0.083 admission/person/year in 2003 (an increase of 8.8%). The use of public healthcare sector increased from 89.0% in 2001 to 90.3% in 2003 (an increase of 1.5%). The use of private healthcare services decreased from 11.0% in 2001 to 9.7% in 2003 (a decrease of 11.8%) (see Table 5).

Table 5 Comparison of morbidity rate and utilization rate of UC beneficiaries between, 2001 and 2003

	Outpatient care			Inpatient care		
	2001	2003	% Change	2001	2003	% Change
Morbidity Rate (episode/person/year)	4.101	4.926	20.1%	0.076	0.083	8.8%
Utilization Rate						
Non-Institution Care,%	30.6	28.0	-8.5%			
Institution Care	69.4	72.0	3.7%	100.0	100.0	
Public	54.8	57.2	4.4%	89.0	90.3	1.5%
Private	14.6	14.8	1.4%	11.0	9.7	-11.9%

The information from the survey showed that the percentage of outpatients in the health centres and district hospitals, increased by 18% and 54.9%, respectively. In contrast, services in the provincial hospitals decreased by 51.6%. This indicated a shift of utilization pattern towards district health systems, an intended impact of the UC Scheme.

The increase in healthcare services for inpatients in the district hospitals was accompanied by a sharp increase in workload, which went up to about 81%, while the provincial public hospitals had lighter workloads, about 39.1% less than before, as shown in Table 6.

Table 6 Comparison of choice of care of UC members 2001 to 2003

	2001	2003	% Change
Out-patient	100.0	100.0	100.0
Non-institution care	30.6	28.0	-8.5
Institution care	69.4	72.0	3.8
Health Center	22.2	26.2	**18.0**
district hospital	14.2	22.0	**54.9**
Provincial Hospital/Tertiary Care	18.3	8.9	**-51.6**
Private Clinic	12.0	12.3	2.8
Private Hospital	2.6	2.5	-3.0
In-patient	100.00	100.00	100.00
District Hospital	30.0	54.4	**81.0**
Provincial Hospital	59.0	35.9	- 39.1
Private Hospital	11.0	9.7	- 11.9

Not all UC members exercised their right to free care, only 56.6% of the UC members used their UC cards for OP healthcare services, and 80.9% for IP healthcare services. The OP compliance rate in the rural areas was 60.5% higher than that of the urban areas, where compliance was 41.2%. The IP compliance rate was 85.1% of the rural UC members, and 65.3% of the urban UC members.

The result also shows that the compliance rates among the exempted UC members[1] were higher than that of the non-exempted UC members[2], regardless of type of services and locations (Table 7).

[1] Exempted UC members are waived from a nominal pay of 30 Baht per visit or admission.
[2] Non=exempted UC members are liable to pay a nominal fee of 30 Baht per visit or admission

Table 7 Compliance rate of UC members, 2003

	Outpatient care			Inpatient care		
	Total	MA	Non-MA	Total	MA	Non-MA
Not exercise right	43.4	58.8	39.5	19.1	34.7	14.9
Exercise right	56.6	41.2	60.5	80.9	65.3	85.1
Total	100	100	100	100	100	100
• Exempted UC members exercised right	62.6	50	65.1	84.8	72.7	87
• Non-exempted UC members exercised right	49.2	34.3	54.3	77.3	60.8	83.1

Note: MA-Municipal Area, Non MA-Non Municipal Area

Equity in public healthcare financing

To determine whether the rich or the poor UC members gained from the UC budgets, the data of the 2002 Household Socio-economic Survey (SES) were analyzed, using the utilization rate for outpatient (OP) and inpatient (IP) at several levels of public health providers, unit cost of OP and IP at each level, and expenditure paid by households to analyze benefits incidence. All UC members were classified into deciles by their per capita expenditure, the first deciles is the poorest, and the tenth deciles is the richest.

The 4th quarter of the 2002 SES was used to estimate Benefit Incidence Analysis as it had the full effects of UC scheme. Household expenditure for IP in the 4th quarter was asked for the past year, during the period of October 2001 to 2002 which had a full effect of UC scheme.

The results in Table 8 indicated a pro-poor financing of UC Scheme. UC members in lower deciles get larger proportion of benefit from the Scheme, especially from OP services provided by district health systems (including health centre and district hospitals) due to better access to services. OP and IP services at provincial hospitals are less pro-poor. Services provided by district health system were in favour of the poor than by provincial hospitals.

Table 8: Benefit incidence analysis (BIA) by per capita expenditure decile households, 2002

per capita expenditure decile households	Outpatient care			Inpatient care			Total
	Health Center	District Hospital	Provincial Hospital	District hospital	Provincial hospital	Public hospital outside province	
10% Poorest	12.2%	11.5%	3.5%	11.7%	6.7%	**21.1%**	8.90%
2	13.1%	13.6%	6.5%	10.5%	7.0%	4.3%	9.29%
3	10.8%	14.1%	8.7%	8.6%	9.2%	3.2%	9.98%
4	15.4%	11.5%	10.7%	14.2%	9.8%	10.1%	11.53%
5	13.7%	13.2%	8.5%	10.4%	10.8%	13.7%	11.03%
6	11.7%	11.8%	15.6%	7.4%	14.2%	4.7%	12.12%
7	13.9%	10.2%	10.6%	24.9%	6.7%	6.6%	12.38%
8	5.6%	8.2%	17.0%	6.5%	13.8%	**26.4%**	11.77%
9	2.9%	3.3%	7.8%	2.8%	14.0%	5.3%	7.13%
10% Richest	0.7%	2.5%	11.1%	3.0%	7.8%	4.6%	5.87%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
CI	-0.272	-0.247	0.052	-0.189	-0.008	-0.154	-0.110
Robust SE of CI	0.043	0.038	0.043	0.054	0.042	0.186	0.023
Kakwani Index; KI	-0.689	-0.663	-0.334	-0.599	-0.399	-0.560	-0.511
Robust SE of KI	0.048	0.044	0.048	0.060	0.047	0.205	0.027

Source: The 2002 Household Socio-economic Survey, National Statistical Office (3). Analyzed by IHPP using data collected in the 4th quarter of the survey

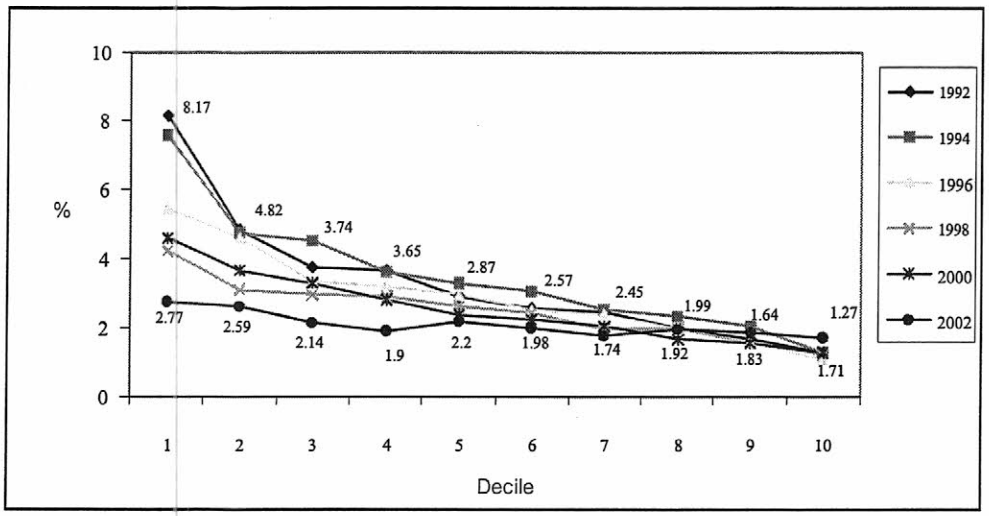
Household expenditures on health pre and post UC era

Gap of household health expenditure

Pitayarangsarit demonstrated the gap of household health expenditures by household incomes deciles. In Figure 3, the 1st decile group represents the poorest group and the 10th decile represents the richest. She founded that the poorest deciles spent 8.17% of their monthly income in 1992 in health services, while the richest deciles spent only 1.27% of their monthly income. The discrepancy index of household spending on health between the poorest and the richest deciles was 6.4 times in 1992.

However, the situation had improved consistently with the efforts of previous governments to provide social safety nets, such as the Low-income Card Scheme for the poor, the Voluntary Health Card Scheme, and the Social Security Scheme. In 2002, a year after the UC scheme implementation, this difference was narrowed to 1.6 times. The impact of UC Scheme was very significant among the poor, as seen by a large gap of achievement between 2000 and 2002 among Deciles one to four. See Figure 3.

Figure 3 Ratio of household health expenditure to income, by income deciles, 1992-2002



Source: The 1992-2000 data are quoted from the 1999-2000 Thailand Health Profile4, the 2002 data are analyzed from the 2002 Socio-economic Survey, National Statistical Office[3]

Household financial risks from medical bills

This section describes experiences of Thai households with risk of bankruptcy due to unaffordable medical bills, in the past decade. The ratio of household health expenditure and the household ability to pay was considered, i.e., the total household expenditures other than food expenditures (5).

If 25% of non-food expenditure on health was a benchmark for catastrophic illness of household, the data in Table 9, indicated that 4.9% of households suffered from catastrophic illness[3] in 1996, but this incidence gradually reduced to 4.4, 3.8 and 3% in 1998, 2000 and 2002, respectively (see Table 9). This confirmed findings in Figure 3 of successive government efforts to extend financial protection in health care.

Table 9 percentage of households by ability to pay on health

% of non-food expenditure on health	1996	1998	2000	2002
0-0.5%	31.9	33.2	34.5	41.2
0.5-10%	51.3	51.5	50.8	48.1
10-25%	11.9	10.9	11	7.6
25-50%	3.5	3.6	3.1	2.5
>50%	1.4	0.8	0.7	0.5
total	100	100	100	100

Source[1]

Household saving on health after UC scheme

This section describes the impact of UC on households' savings. The Household SES conducted by the National Statistical Office in the year 2000 and 2002 which was before and

[3] Catastrophic illness can be defined as unaffordable medical bills incurred from illness that can result in household bankruptcy.

during the UC implementation, provided information of household health expenditures. The 4th quarter of each set of data was used to reflect the full-blown effects of UC Scheme.

The study found that the overall household health expenditures decreased in all deciles except deciles 8th and 10th. The 1st and the 9th deciles had the first and second most decreased expenditure 45% and 46%, respectively, though health expenditure of the richest deciles increased.

Not only the total expenditures of household decreased but the behavior of household also changed. The household expenditures on self- prescribed drugs and OP service in all deciles decreased, except the 10th deciles. Changes in IP expenditure had no consistent pattern among ten deciles. This confirmed that the barrier to access to public healthcare services had been removed (Table 10).

Table10 Average monthly household health expenditure by per capita consumption expenditure deciles, pre and post UC, 4th Quarter of 2000 and 2002 (Unit: Baht)

House hold Deciles	2000				2002				% Change
	Self-pres cribed drug	OP	IP	Total	Self-pres cribed drug	OP	IP	Total	
1	22.03	46.48	18.45	86.96	14.63	24.22	8.61	47.46	-45%
2	25.32	50.52	14.92	90.76	18.96	29.98	15.82	64.75	-29%
3	30.89	75.27	12.39	118.55	22.99	44.37	18.74	86.10	-27%
4	34.18	110.41	25.36	169.94	28.12	50.40	27.37	105.89	-38%
5	39.22	126.60	39.94	205.76	33.83	73.05	24.31	131.18	-36%
6	53.07	163.53	60.63	277.23	31.46	103.58	36.64	171.68	-38%
7	57.14	173.51	64.61	295.26	42.74	119.26	56.32	218.33	-26%
8	50.71	179.85	60.11	290.67	50.33	177.63	88.78	316.75	9%
9	98.43	404.85	89.54	592.82	38.80	201.51	78.76	319.07	-46%
10	76.94	570.96	188.40	836.30	111.24	727.81	350.43	1,189.48	42%

Source: The 2000 and 2002 Household Socio-economic Survey, National Statistical Office[3,6]. Analyzed by IHPP using data collected in the 4th quarter of the survey

The overall household expenditure on healthcare services of the whole country in 2002 was approximately 49,594 million baht, a decrease of **9,649.3** million baht (16.3%) from 59,243 million baht in 2000. This reduction meant more purchasing power of households or more savings (Table 11).

Table 11 Household health expenditure for the whole country in 2000 and 2002 (Unit: Million Baht)

Household Deciles	Monthly household health expenditure		Changes (Calculated based on No. of households in 2002)
	2000	2002	
1	149.8	88.1	- 61.7
2	170.1	108.1	- 62.0
3	168.2	144.2	- 24.1
4	250.2	156.2	- 94.0
5	403.7	224.9	- 178.7
6	366.3	258.3	- 108.0
7	555.2	292.8	- 262.4
8	498.8	559.4	60.6
9	770.7	549.8	- 220.9
10	1,603.9	1,751.1	147.1
Total/Month	4,936.9	4,132.8	- 804.1
Total/Year	59,243.1	49,593.8	**- 9,649.3**

Source: The 2000 and 2002 Household Socio-economic Survey, National Statistical Office (3,6). Analyzed by IHPP using data collected in the 4th quarter of the survey

Another set of data from the 2003 Health and Welfare Survey conducted by the national Statistical Office during April 2003 was used for imputation of household savings on healthcare services. The idea was to compare household health expenditures in public healthcare services, between the current uninsured and the current UC members, who were both previously uninsured. The 2001 and 2003 HWS indicated that there were approximately 18 and 3.25 million people uninsured in 2001 and 2003 respectively. This study referred to 15 million populations who were previously uninsured but currently insured by the UC scheme.

Thus, **Group 1** was defined as the previously uninsured people and currently still uninsured. This group consisted of approximately 3.25 million populations, with an average spending of about 916.7 baht/capita/year.

Group 2 was defined as the previously uninsured people, but currently insured in the UC scheme. This group consisted of approximately 15 million populations, with an average spending of 206.3 baht/capita/year. However some of them exercised their right to public healthcare services, but some did not.

Group 3 a subset of Group 2, the previously uninsured people and currently insured in the UC, and was selected only those who used their right to the public health care services whenever they were ill or hospitalized. This group spent on average about 66.5 baht/capita/year on health services.

Group 1 had health expenditure, 710.5 baht/capita/year higher than Group 2. The total 15 millions who were previously uninsured but currently insured, could therefore have saved **10,634** million baht /year.

Group 3 spent 850.2 baht/capita/year on healthcare services less than Group 1. The total saving by this group would be **12,726** million baht /year.

It can be interpreted that the UC implementation had saved about **10,634-12,726** million baht in 2003 on household health expenditure.

	Group 1 Uninsured pre and post UC	Group 2 Previous uninsured, current UC member (All members)	Group 3 Previous uninsured, current UC member (Only complied right)
Out-of-pocket (Baht/person/year)	916.72	206.26	66.48
Saving (Baht/person/year)		710.46	850.24
Total Saving (Million Baht/year)		10,633.9 (710.46*15 Million Pop)	12,726.1 (850.24*15 Million Pop)

This study was not concerned with the decease in population of each year which could have caused different expenses as well as changes in consumer behaviors among the uninsured people, some of whom were in the high income category and tended to consume a high level of healthcare services. Thus, the imputation for savings may be higher than has been vouched for by the existing evidence.

Summary notes on achievement of UC Scheme

Three major findings emerged from our analysis.

In 2003, the UC scheme covered 47.7 million people, most of whom were from low-income households and resided in rural areas, and 5% of the population were still uninsured.

The 2003 utilization rate of the UC members in 2001, increased in the public sector by 25% for OP, and 11% for IP, especially in the districts. The compliance by UC members was not a 100%, but the UC compliance rate was higher in rural areas and in IP than OP services. Financing UC scheme indicates a pro-poor nature, especially services provided by district health systems.

The Thai households had lesser health expenditure during the UC implementation than before its implementation. In 2002, the household saving on healthcare services was approximately 9,649.3 million baht. In 2003, the saving was between 10,634 -12,726 million baht among the previous uninsured and currently insured by the Scheme. The maximum saving was a result of full compliance of UC members.

Recommendations

The hospital revenue from the out of pocket payment by the previously uninsured people was depleted, and was more so in the years after. The UC scheme probably exerted heavy pressure on the public hospital financing system and on the workloads of their personnel. Thus, there is an urgent need to ensure adequate budget to sustain good quality services to UC members.

There is also a need for a further opinion survey of public perceptions of quality of healthcare as well as healthcare service system. The National Health Security Office should put together appropriate measures or effort to extend UC coverage to the uninsured people.

Part two: perception of UC members

The National Health Security Office and ABAC-KSC Internet Poll Research Center, and Assumption University conducted the Survey on perspectives of the scheme among UC members. A survey of 15 years old and over who are UC members in 13 provinces aimed to evaluate their perspectives on UC program performance, problem in access to health services as well as their satisfaction with the programme. The sample size was 6,087 UC members residing in 13 provinces i.e., Bangkok, Nonthaburi, Kanjanaburi, Chainat, Chacheongsao, Chiangrai, Lumpang, Pitsanulok, Khon-Khan, Mahasarakam, Nakhonratchasima, Nakhonsrithamarat, and Trang Province, and was carried out during 21st May-30th June 2003 (7).

Key findings

The knowledge and perception of UC members

Of the total sample, 91.8% knew the names of their healthcare providers as appeared on their UC cards. Their primary sources of information about the UC services (e.g., procedure, and method) were, village health volunteers, public health officials and the community leaders were their secondary sources.

In case of dissatisfactory services, 28.6% of the sample would complain first to the MoPH, hospitals, and their final resort the community leaders, 22% would not complain, while 49.4% could not decide or were not sure what they would do.

Most samples agreed that their designated healthcare providers could continuously follow up their health status, with 35.6% fully agreed, 50.6% agreed, 9.0% disagreed, 2.3% completely disagreed, and the rest 2.5% offered no opinion.

The decisions to choose the designated healthcare providers were, by order of importance, based on quality of healthcare providers and network, convenience in access, being public providers, time of service, and being private providers.

Of the total sample, 55.8% said, given opportunity they would not change their designated healthcare providers, 34.4% would like to, and the rest 9.8% was unsure. They wanted to change because of inconvenient transportation, and they would like better services. Those who did not want to change because they were satisfied with their designated providers, convenient access and good services, 51.8% chose "private clinics" as their second choice instead of the designated one. 37.0% insisted on keeping their existing providers, whereas, 11.2% was indecisive. Of the total sample, 63.6% would like their families to use the same service providers. 35.8% depended on families' preferences, and only 0.6% did not give any opinion.

On co-payment, 60.7% reported they could afford more than UC co-payment (30 Baht), on average, 77.8 Baht.

The opinions on healthcare services

The survey found that 91.9% of the sample used their UC cards for health services, and 8.1% did not do so. 75.5% of those who used the UC cards did not find any difference in the time taken to have their services, compared to those who were in different benefit schemes. 19.7% said it took longer time of services, and 4.8% reported it was quicker than before .

Satisfaction with the UC healthcare services

The following records their various degrees of satisfaction with different aspects of the services

Satisfaction with

- ***Physicians***: 69.7% were "satisfied", 23.2% "rather satisfied", 4.3% "not quite satisfied" and 1.5% "not satisfied at all", while 1.3% did not express any opinion.
- ***Nurses***: 62.7% expressed satisfaction, 26.7% "rather satisfied", 7.5% "not quite satisfied", and 1.8% "not satisfied", with 1.3% having no opinion.
- ***Other Healthcare officials***: 62.0 % were "satisfied", 27.5 "rather satisfied", 7.4% "not quite satisfied", 1.5% "not satisfied", and 1.6% "no comment".
- ***Prescribed drugs:*** 55.0% were "satisfied", 28.3% "rather satisfied", 10.9% "not quite satisfied" and 4.5% "not satisfied", with 1.3% "no idea".
- ***Medical equipment***: 60.1% were "satisfied", 25.7% "rather satisfied", 6.3% "not quite satisfied" and 1.9% "not satisfied", with 6.0% "no comment".

Satisfaction with healthcare service expenditures for: 79.3% were "satisfied", 17.2% "rather satisfied", 1.9% "not quite satisfied", 0.7% "not satisfied", 0.9% "no comment".

Time taken for services, 59.5% were "satisfied", 26.6% "rather satisfied", 9.4% "not quite satisfied", and 3.9% "not satisfied', with 0.6% "no comment".

Convenience in traveling to healthcare providers: 71.3% were "satisfied", 20.7% "rather satisfied", 5.8% "not quite satisfied", and 1.6% "not satisfied, with 0.6% "no comment"

Equity in healthcare services, 63.8% indicated "satisfied", 25.2% "rather satisfied", 6.9% "not quite satisfied" and 2.9% "not satisfied", with 1.2% "no comment".

Outcomes of treatments, 62.3% were "satisfied, 27.9% "rather satisfy
ed" 6.5% "not quite satisfied', and 2.3% "not satisfied", with 1.0% "no comment".

The opinion on overall UC scheme performance

When requested to assess the UC scheme performance, out of 10 marks, 66.8% rated the UC scheme between 8 and 10, 29.9% ranked it 5-7, and 3.3% rated it less than 5 marks. The average mark was 8.01 with a standard deviation of 1.99.

The sample was asked to appraise the strengths and to suggest improvements of the UC scheme, as follows:

The strengths of the Scheme were identified, for example an increase in benefits with reduced health expenditures to the households, the scheme benefits to the poor, good services were provided, it is convenient to access the designated providers and the Scheme ensure equity of access to healthcare by all.

However, improvements were also suggested, for example, the manners of the staffs, quality of services and drugs, choices for designated providers, and increase the number of providers.

Acknowledgements

The authors would like to express their gratitude to: the Thailand Research Fund (TRF) and the Health Systems Research Institute (HSRI) for their grant to the Senior Scholar Program for Health Policy and System Research; the National Statistical Office (NSO) for providing us with information from their database for our analysis; and the National Health Security Office (NHSO) for the financial support to International Health Policy Program, Thailand.

Reference

1 Tangcharoensathien V, Teokul W, and Chantrawongpaisal L. Social Welfare System in Thailand: A Challenge from targeting to Universality. Paper presented at the UNRISD Workshop on Social Policy in a Development Context; Transforming the Development Welfare State in East Asia, Novotel Hotel on Siam Square, Bangkok, 30 June-1 July 2003.

2 National Statistical Office. The 2003 Report on Health and Welfare Survey, Whole Kingdom. Bangkok, Office of the Prime Minister. 2003.

3 National Statistical Office. The 2002 Report on Household Socio-economic Survey, Whole Kingdom. Bangkok, Office of the Prime Minister. 2003.

4 Wibulpholprasert, S. Editor. The 1999-2000 Thailand Health Profile, Nonthaburi, Printing Press, Express Transportation Organization. 2002.

5 Wagstaff, A. Measuring equity in health care financing: Reflections on and alternatives to the World Health Organization's Fairness of Financing Index. Development Research Group and Human Development Network, World Bank. 2001.

6 National Statistical Office. The 2000 Report on Household Socio-economic Survey, Whole Kingdom. Bangkok, Office of the Prime Minister. 2001.

7 National Health Security Office and ABAC-KSC Internet Poll Research Center. The Perspectives of UC Members and Healthcare Providers to UC Program. Nonthaburi, 2004.

Chapter 7
Future Challenge

Viroj Tangcharoensathien
Pongpisut Jongudomsuk

This chapter identifies current challenges for future research and evidence based-policy decisions to improve the performance of the UC scheme.

Governing Board –its vision and directions

According to the National Health Security Act B.E. 2545, the National Health Security Board (NHSB) has been set up as a governing body of the whole UC system. The Board comprised 30 members, chaired by the Minister of Health. There were eight *ex-officio* board members representing their ministries, five health professions representatives, four local government representatives, five representatives from non-profit organizations, and seven senior experts in various areas. The Board members were appointed by the Cabinet to serve a term of four years, which was renewable once.

Many interest groups intervened in the election of representatives of non-profit organizations and nomination of senior experts, with the intention to influence the Board's directions.

Although members of the network of NGOs, which campaigned for the UC policy, won the election to represent them, the NGO's attempts to nominate names of senior experts failed. In the first nomination of the interim National Health Security Board, most of the academicians previously participated in the policy development of UC were nominated.

However, with the first nomination being turned down because the Board meeting did not form a quorum (1), there was then a need for second nomination, which was heavily manipulated by the high officials of the MoPH (2). As a result, four former high officials of the MoPH together with other three senior experts, who were less critical of the government policy, were nominated.

The NHSB was expected to be a national policy body who oversees consistency and convergence among the three public health insurance schemes (the Civil Servant Medical Benefit Scheme, the Social Security Scheme and the 30 Baht Scheme). However, since the beginning of its establishment the role of NHSB has been limited only to the implementation of the 30 baht scheme. The NHSB, in the first few years of office, was overwhelmed with all the administrative issues related to the establishment of the NHSO and with addressing UC implementation problems.

The other factors limiting the NHSB's performance are discussed below.

Role Ambiguity

As a national policy body, the NHSB had to set all the standards and procedures for purchasing healthcare services for the beneficiaries. Although purchasing healthcare was not a new activity, it was an additional task of the public organization, and was emerging as a new healthcare management discipline. Purchasing healthcare services was more than just paying bills submitted by providers, but it was ensuring maximum healthcare benefit from a rather limited budget (3). As it was also a new discipline in Thailand, the NHSB had a very limited understanding of its purchasing role.

In addition to the NHSB's task in setting up benefit package and standard of care, its function was still mostly concentrated on budget allocation. Budget allocation by the NHSB was also interfered by the MoPH representatives and its allies, who demanded that the payment for providers under the jurisdiction of MoPH had to be transferred through the MoPH, instead of

transferring directly from NHSO to the providers, especially during the three years transitional period. This interference is interpreted as a power struggle between the MoPH's and the NHSB, because the MoPH resented having its purchasing role transferred to the NHSB by the Law.

In conclusion, the NHSB was in the early stage had to learn how to be an effective healthcare purchaser.

The involvement of the NHSB and NHSO in the quality improvement of healthcare contractors especially the public one, was ambiguous. During the first two years (2002-2003) the NHSO spent a substantial amount of its administrative budget on quality improvement of primary care units and referral centres. This became a big issue for debate in the NHSB. Although some board members agreed that it was useful for the system development, but most of the board members including representatives of the Bureau of Budget argued that it was the responsibility of the MoPH.

Lack of long-term vision

At the beginning, because its lack of clear understanding of its role and administrative responsibility, the NHSB ended up having to make decisions related to the policy implementation.

The NHSB discussed its long-term vision in its first workshop in August 2003, and a roadmap to realize its vision in the second workshop in March 2004. After the second workshop, the NHSB appointed a subcommittee to develop and finalize the roadmap with a consensus from all the stakeholders. However, the scope of the proposed roadmap was still limited only the UC scheme, instead of an inclusion of all the other public health insurance schemes as decreed by the Law. There was no activity to harmonize the other three public schemes.

The review of the minutes and observations of the Board's meetings revealed that the managerial work of the board was of a small nature, with no provision for broad strategic directions for management and for monitoring its outcome.

Conflict of interests

Since the NHSB comprised all the stakeholders and the majority of its members was representatives of healthcare providers and health professionals, there was a tendency to postpone or not to support decisions that could put pressure on providers to improve efficiency, quality and responsiveness, especially on the healthcare providers under the jurisdiction of the MoPH.

The power struggles between NGO representatives, the government ex-officio representatives, and health professionals were evident in the NHSB meetings.

The NHSB's board member composition should be revised for it to become an effective governing body of the overall health insurance schemes in the future. A smaller number of people from other institutions, with no conflicting interests may make better board members. In addition, it must develop new concepts and tools for healthcare management. The NHSO will have to strengthen its capacity to be an effective secretariat office of the NHSB and an efficient healthcare purchaser in the future.

Harmonization of Three Public Health Insurance Schemes – a real contentious issue

After the establishment of the UC system, Thai citizens have now been covered with three main public health financing schemes, SSS for the formal private sector employees, CSMBS for the government

employees and their dependants (including state enterprises), and the UC for the rest of the population.

The original intention of the National Health Security Act was also aimed at harmonizing all the existing public health financing schemes. Harmonization is by means of convergence of budget subsidies, benefit packages, payment mechanisms, to ensure quality and overall efficiency of the health systems.

As stated in Sections 9, 10 and 11, it was expected that beneficiaries of SSS and CSMBS would utilize health services, according to benefit packages specified by their own schemes, under the system managed and supervised by the NHSB/NHSO. This can happen when there is mutual agreement between the three concerned parties, NHSB, SSO and the Ministry of Finance who is responsible for CSMBS.

There have been movements against this change from labor unions leaders and civil servants as they were afraid that this would curtail their benefits (4). The government tried to stop the opposition movements by agreeing to amend the law, to postpone the change. In addition, because of this conflict, the NHSB also tried to avoid discussion or make decision on issues related to the SSS and CSMBS. Development of long term vision and a roadmap to achieve its vision was an example of NHSB delaying tactics, as the roadmap did not directly address the fundamental issues of inequity.

Instead of enforcing the Law, the NHSO attempted to create a collaborative atmosphere among financing agencies who were responsible for the implementation of three main public health financing schemes. A memorandum of understanding (MOU) among the NHSO, the SSO and the Comptroller General Department of the Finance Ministry was signed on January 17, 2004 to set up a committee and subcommittees to collaborate and coordinate the development of each health care financing scheme.

The developments of management information system, standard of health services and health facilities, claim and audit system were the main areas of collaboration. Two workshops of high officials from the three agencies were organized in March and November 2004 to develop detail of collaboration. During the last workshop, it was proposed that a national long-term plan to achieve universal coverage of healthcare should be developed by a concerted effort of people from the three health financing schemes (5) to complement the roadmap developed by the NHSB. The high officials of the NHSO expected that, eventually, this collaboration would lead to a more harmonization of the existing schemes.

In fact, a system harmonization has already started in the management of budget for providing health promotion and disease prevention (P&P). This happened unintentionally because the budget preparation for the provision of P&P in the UC system in 2003 also included budget for those who were in the SSS and CSMBS (6) and it continued in 2004 with the acceptance of representatives from the SSO and Comptroller General Department (7). Management of P&P budget was also an issue discussed in the collaborative committee, which led to a single financial management system to cover the entire population.

No-Fault Liability System – distortion from intention to implementation

A system to support patients who were adversely affected by medical errors had been operating informally well before the establishment of the UC system. Some hospitals created their own funds and used the funds to assist patients when needed. Health personnel in other hospitals had to pay patients financial compensation by themselves.

In 1996, the Act on Liability for Wrongful Acts of Officials B.E. 2539 was enacted to protect health personnel in public hospitals. According to the Law, patients who are damaged from medical errors by public health personnel cannot, by the law, sue the personnel directly but have to sue their government offices instead, i.e., the Ministry of Public Health. However, since its proclamation, the law has never been used by patients to claim financial compensation (8).

The National Health Security Act B.E. 2545 has opened an opportunity to re-establish an effective mechanism to compensate patients for adverse events and negligence, as stated in Section 41 of the Law that up to 1 percent of the UC fund should be used for this purpose. The original intention of this Section was that this financial assistance would be provided without any proof of guilt. However, since the regulation related to Section 41 states that no financial compensation should be in order, until investigation has been carried out to prove that the damage has not been caused by natural history of disease or that health services delivered has been according to professional standard. This created a major resistance among medical professionals and movement to abolish Section 41.

In 2004 when the Section 41 was fully implemented, there were 85 cases of patients who claimed for financial assistances, and 62 cases were approved. The total financial assistance was 4.53 million baht (9). Since an investigation process was needed, this would create social stigma and significant tension to healthcare providers especially for medical professionals who were implicated. It should be noted that some doctors resigned from the public services after the process completed (10).

The Law enforcement (through the promulgation of related regulation), then distorted the original intention of Section 41 and created more confrontation between medical professionals and patients. Therefore, there is a need to revise the regulation related to Section 41 so that the system can function properly according to its original intention.

In addition, impact of this no-fault liability system should be assessed systematically to get sufficient feedback for the system adjustment so that it can totally replace the existing informal compensation for medical negligence, in the future.

Role of Local Government – tension with MOPH

According to the Decentralization Act B.E. 2542 and Health Care Decentralization Action Plan, all public health facilities would be transferred to be managed under the newly established Area Health Board (AHB). AHB was also expected to be a provincial purchaser responsible for the management of budget for the implementation of UC system (11). In addition, the general government revenue had to be increasingly allocated to LG, starting from 20% in 1999 to not less than 35% in 2006 (12). Unfortunately, this had been postponed when Thai Rak Thai Party took over the administration in 2001.

The National Health Security Act B.E. 2545, states in Section 47 that the NHSB should create supportive conditions for LG to manage the universal coverage system for people in their localities. Despite pressure from the representatives of LG in the NHSB to comply with this Section, the NHSB carried out a study to explore possible roles or functions for LG. Since the Province Health Office (PHO) had already been appointed a provincial purchaser, the LG, could therefore appropriately take on the functions of health service provision, and financial contribution, for the health system development.

However, these proposed functions did not satisfy the LG, who had its heart set on the purchasing role, by replacing PHO. The final decision on the composition of the provincial subcommittee overseeing the function of the provincial purchaser was its attempt to get better of the situation. It was proposed by the representatives of LG in the NHSB that the sub-committee should be chaired by one of the LG representatives. The argument used by a representative of the MoPH to counter the proposal that the LG was not ready for this role, and therefore the Provincial Chief Medical Officer (PCMO) should chair the subcommittee for the two years transitional period.

The LG accepted to have its financial contribution used as an alternative source to finance the UC scheme, as mandated by Section 39 of the Act, provided that they could involve more in the management of UC budget, either by chairing the provincial subcommittee or replacing PHO as a local purchaser. It was unclear how financial contribution of LG would be spent. The initial response of the LG representatives was that they would prefer to spend their budgets to improve healthcare services in their localities, rather than using them to boost the overall budget (13).

Long-term Financing – the neglected key sustainable issue

The UC scheme has been a success. It is rapidly covering an increasing number of people who previously had limited access to healthcare services due to financial barriers. The scheme has adopted capitation as a provider payment mechanism and as a resource allocation mechanism. The capitation contract model has been widely accepted as an effective long-term cost containment strategy, and should therefore encourage better efficiency in, resource allocation, and overall health systems. The adoption of the use of primary care provider network has resulted in overall systems efficiency, as normally primary care can produce services at a lower cost than tertiary care, and is more accessible by rural population.

However, its long-term financial sustainability is as yet uncertain. This uncertainty was due to the public fiscal constraint, and to the fact the government approved the capitation rate according to calculation based on available evidences of utilization and unit cost of health services only for the first year of the UC implementation or for the fiscal year 2002, and not for the fiscal years from 2003 to 2005. Any approved capitation rate, below the real cost, would result in the UC system being chronically under-financed, and this in turn would put the whole Thai healthcare systems in jeopardy.

Evidence indicates that as long as the UC scheme depends entirely on general revenue financing through annual budgeting process, which in the past the Bureau of Budget did not use adequate evidence on its budget allocation, the UC scheme remains vulnerable to budgetary competition and political manipulation, rather than relying on evidence of utilization and costs of services – even if it has effective built-in cost containment mechanisms.

The way for the country to set aside resources for personal healthcare, to buffer against budgetary pressures and competition is to set up a Universal Coverage Fund (UC Fund) as stipulated in Section 39 of the National Health Security Act 2003. These earmarked resources should be used to replace the annual budget from general tax revenue.

In partnership, for example with National Economic and Social Development Board, the Bureau of Budget, Ministry of Finance, ILO and IHPP, a groundwork study on long-term financing were conducted by IHPP (14). This study has forecast the total budgetary requirement for the next 20 years for the UC Scheme, based on the capitation projection and total number of beneficiaries, and showed that the UC Fund can probably be self-sustainable if the following recommendations are accepted.

Recommendation 1

Revenue should be generated for the UC Fund by earmarking two thirds of the 100% additional tobacco tax revenues in the country, and half of the 50 % of the additional excise tax on alcohol and beer.

It is argued here that an increase in the tobacco tax and excise tax on alcohol and beer means higher price of tobacco, alcohol and beer beverage, resulting in decrease in consumption and perhaps smuggling which is an adverse outcome. Another argument showed that it would probably more than compensate the government for the income it would "pay" to the UC Fund. The discussion with experts of the MOF showed that financing UC from tobacco and alcohol excise tax can have the best positive impact. For example, increasing Value Added Tax on general goods should have a negative impact on the consumers especially the poor, while an increase in retail prices of tobacco and alcohol should have more popular support, while reduction in consumptions should improve health of the population.

Recommendation 2

By reducing expenditure of the UC Fund by expansion of coverage of Social Security Scheme to non-working spouses and dependants (estimated at 6 million beneficiaries who have been currently covered by UC scheme) without raising the contribution rate, by 2005, the UC Fund will save the

budget at least 9 billion baht. The International Labour Office (ILO) has recommended this same option to Thai Social Security Office in several occasions.

Recommendation 3

The Traffic Accident Protection Act should be amended to cover all traffic victims in car accidents caused by both the insured and uninsured cars, and a proper scheme administrative cost. The current Scheme has an unacceptable administrative cost, as high as 41% of the total premium collected in 2002. A major reform is to mandate the Department of Land Transport as sub-contractor to collect insurance premium as a mandatory requirement when the car owners have their car licenses renewed.

A large amount of the premium should be transferred to the National Health Security Office (NHSO) to cover all the victims' medical care expenses, and death and invalidity compensations. Medical health expenditure covers for traffic victims should supplement the current UC expenditure on traffic injuries Although this amendment to the Act is badly needed, it is easily said than done, not to mention objection from private insurance companies.

To achieve a maximum result, the NHSO should seriously consider adopting all these recommendations. It is imperative to have a timeframe for promotion and introduction of the UC Fund. The UC Fund should be effective by the fiscal year 2009.

Dedicating fund for the UC Scheme requires strong political backup. An initial discussion with the Ministry of Finance should be a positive step forward using taxes from sales of from tobacco, beer and spirit, for further funding the UC scheme.

Traffic Victim Protection Act -- what are the reform options?

The Traffic Victim Protection Act was implemented since 2535 BE. Though it is a mandatory scheme, instead of public sector, the for-profit private insurance companies are the carriers of the scheme. The Scheme compensates healthcare insurers, based on fee for services and maximum liability, a lump sum for death and disability. The financial report in 2545 indicated a net premium of 7,003 million baht collected, with very high administrative cost (41%) and low loss ratio (52%), and an inadequate coverage of all traffic victims. There is a need for a major reform to the Traffic Victim Protection Act. In the context of UC, this Act creates duplication of services already provided by other schemes; hence, allowing private insurance companies to take advantage the situation by not paying medical bills for traffic injuries. Currently, the UC Scheme, SHI and CSMBS have to subsidize patients injured in traffic accidents, instead of the private insurance companies paying them.

A study was conducted by IHPP in 2004 (15) to estimate, a total resource requirement (for medical care, death and disability compensation) for all traffic accident victims, and how much from the additional gasoline tax would the government use to cover all traffic victims, and to provide policy choices for reform.

Based on secondary sources of information, it was estimated that the total resource requirement for all traffic accident victims would be 7,158 million baht in 2545, of which 63% for inpatient care, 16% for pre-hospital care, 15% for death compensation, 5% for outpatient care and 1% for disability rehabilitation.

Household consumption of gasoline from the 2545 household socio-economic survey conducted by National Statistical Office was used to compute the total litre of different types of gasoline consumed by households, categorized by income deciles. To generate the total 7,158 million baht to cover all traffic victims, the government has to raise 0.32 baht to a litre of gasoline, given no price elasticity of demand by all household deciles. Several scenario of raising gasoline tax was proposed. We recommend the least regressive option, 0.26bBaht per litre for all type of gasoline except Octane 95, and 0.55 baht per litre of Octane 95.

The goal for reform is to cover all traffic victims (both caused by the insured and non-insured cars), and any appropriate Scheme administrative cost.

Three reform options have been proposed, based on sources of finance, option one should generate revenue from premium contribution by car owners, option two from general tax and option three from dedicated gasoline tax. An analysis of the three options indicates that option two and three are neither politically feasible nor socially acceptable. There is no other choice, but using premium as sources to pay for the cost of traffic injuries, as increase in gasoline tax, or from general tax can affect not only the car owners, but also all the gasoline consumers and tax payers in general.

The study recommends a major reform, by mandating the Department of Land Transport as sub-contractor, to collect insurance premium, while the car owners having their car licenses renewed. A large amount of the premium should be transferred to the National Health Security Office (NHSO) to cover all victims for their medical treatments, death and invalidity compensations. The second preferred choice should be a minor reform, by sub-contracting private insurance companies to collect premium, with a large amount of premium transferred to the NHSO.

Whatever reform options are adopted, serious resistance from the insurance industry is inevitable. A strong public education and public consensus is required to support the reforms.

References

1 National Health Security Office. 2003. The meeting minute of the National Health Security Board on May 14, 2003, at 09.00-12.00 am. at Room 1, 2nd floor, Office of Permanent Secretary Building, Ministry of Public Health, Nonthaburi.

2 Dr Yupadee Sirisinsuk personal communication

3 Ovretveit J. 1995. Purchasing for health. Open University Press. Buckingham and Bristol.

4 Panat Thailuant. 2004. Expectation of Thai people to the National Health Security System. A speech in the workshop of three public health insurance funds on November 4th, 2004 at 10.30-12.00 am. Blue Marine Room, Puremas Beach Hotel, Rayong.

5 National Health Security Office. 2004. The meeting minute of collaborative committee among three public health insurance funds on November 4th, 2004 at 13.00-16.00 pm. at Blue Marine Room, Puremas Beach Hotel, Rayong.

6 Patcharanarumol W, Prakongsai P, Tisayatikom K, Tangcharoensathien V. 2002. Capitation rate for promotion and prevention package for the fiscal year 2546 B.E. (2003 AD). Journal of Health Science 11: 582-98.

7 National Health Security Office. 2004. The meeting minute of subcommittee to prepare integrated budget for the fiscal year 2004 on March 3rd, 2004, at 09.00-12.00 am. at Narakorn Room, 14th floor, Jusmine International Building, Nonthaburi.

8 Jongudomsuk P. 2000. Summary report of subcommittee on the development of guideline to help assisting patients who get damage from clinical practice. A report submitted to the Medical Council, Nonthaburi.

9 National Health Security Office. 2004. Progress report of the National Health Security Office on the fourth quarter. National Health Security Office, Nonthaburi.

10 Sringernyouang L et. al. 2004. Preliminary report on evaluation of no fault liability system under the UC system. National Health Security Office, Nonthaburi.

11 Office of Decentralization. 2002. Decentralization Action Plan. In: Operational manual for decentralization. Office of Decentralization, Office of Prime Minister.

12 Office of Decentralization. 2002. Decentralization Act B.E. 1999. In: Operational manual for decentralization. Office of Decentralization, Office of Prime Minister.

13 Pinyo Tunwisaids personal communication.

14 Patcharanarumol W., Tangcharoensathien V., Cichon M., Vasavid C., Tisayaticom K., Prakongsai P. 2004. Financing Universal Healthcare in Thailand. Nonthaburi, International Health Policy Program.

15 Tangcharoensathien V., Lertiendumrong J., Patcharanarumol W., 2004. Traffic Victim Protection Act in the context of Universal Coverage: what are the reform options?. Nonthaburi, International Health Policy Program.

Lists of Contributors

Chitpranee Vasavid:
Chitpranee Vasavid is a researcher at International Health Policy Program, Thailand. She graduated in Bachelor's degree of Statistics (2nd Honor) from Chulalongkorn University and earned Master of Applied Statistics from Macquarie University, Australia. Her research areas include: the National Health Accounts in Thailand, phase I (NHA1:1994) , phase II (NHA2:1996-1998) & phase III (NHA3:1994-2001); the Analysis of Household Income and Income Distributions, 1988–1992; the Analysis of Socio-Economic Characteristics of Poor Households in Thailand, 1988–1992; a Study on the Impact of Economic Crisis on Households, 1999; the Post Enumeration Survey of the 2002 Socio-Economic Survey; the Post Enumeration Survey of the 2003 Health and Welfare Survey; and Achievement of Universal Health Care coverage Scheme in Thailand.

Jadej Thammathat-aree:

Jadej Thammatach-aree is the director of Bureau of General Administration at the National Health Security Office. He graduated in Doctor of Medicine at Faculty of Medicine, Chulalongkorn university and earned Master of Business Administration from Thammasat university. He worked as a physician and also as a director of district hospital in rural area and perimeter of Bangkok for thirteen years. He changed his career into health insurance field. His interested research areas include; quality management and indicator, hospital management, healthcare financing.

Kanjana Tisayaticom:
Kanjana Tisayaticom is a researcher at International Health Policy Program on secondment from Trang Hospital. She graduated in Nursing and Midwifery, health Administration and Master of Health System Research and Development at Prince of Songkhla University. Now she is studying on Master of Social Protection Financing from Maastricht University, the Netherlands. Her interested research areas include:
Healthcare financing, such as Healthcare cost both household sides and hospital sides, including National Health Account; moreover she paying attention in catastrophe illness such as end stage of renal disease and equity in health care allocation.

Pongpisut Jongudomsuk:

Pongpisut Jongudomsuk is the director of Bureau of Policy and Planning at the National Health Security Office of Thailand. He graduated in Doctor of Medicine at Faculty of Medicine, Ramathibodi Hospital, Mahidol University and earned Master of Public Health from Institute of Tropical Medicine, Antwerpen, Belgium. He worked as a physician and also as a director of district hospital in rural area for ten years. He changed his career to be a research manager in the Office of Health Care Reform Project, a project supported by the European Union, in the Ministry of Public Health. His previous position was the Deputy Director of Bureau of Policy and Strategy, Ministry of Public Health. His interested research areas include; design of health care system to support primary care, resource allocation and provider payment, health care devolution and equity in health and health care financing.

Prommin Homhual:
Prommin Homhual is a legal officer in National Health Security Office. He had worked in health insurance legal administration for many years as deputy chief of Legal Affair section in Health Insurance Office, Ministry of Public Health before and during the preparation of National Health Security Bill. He graduated in Nursing Science from Baromrajonani collage of Nursing, Ubon Rajathani, and Bachelor of Art in Law from Ram Kham Haeng University and Master of Science (Public Health): Public Health law Administration from Mahidol University. His interest research areas include: Legal liability related to Medical service activities and comparative study for medical service entitlement in each group of Thai citizens.

Salinla Singhapan:
Salinla Singhapan is a legal officer in National Health Security Office. She had worked in health insurance legal administration for many years as chief of Legal Affair section in Health Insurance Office, Ministry of Public Health before and during the preparation of National Health Security Bill. She graduated in Nursing Science from Baromrajonani collage of Nursing, Ratchaburi and Master of Science (Public Health): Public Health law Administration from Mahidol University.

Samrit Srithamrongsawat:

Samrit Srithamrongsawat is a senior technical advisor in the Health Insurance Division, Ministry of Public Health of Thailand. He got his medical degree from Chulalongkorn University, and had 6 years of experiences as the director of two community hospitals, and 6 years as deputy provincial chief medical officer and head of communicable diseases control section at Phuket Provincial Health Office. He has been working in the Health Insurance Office, Ministry of Public Health of Thailand, after completion of MSc Health Service Management from the LSHTM since 1995. He is currently a PhD candidate in Health Policy and Health Care Financing at London School of Hygiene and Tropical Medicine. His issues of interest include health insurance, health care financing, resource allocation, and equity.

Sinchai Torwatanakitkul:
Sinchai Torwatanakitkul is the director of the Bureau of Information Technology and Communication, Ministry of Public Health of Thailand. He got his medical degree from Chulalongkorn University and a certification of Family Medicine from the Medical Council. He had 12 years experiences as the director of community hospitals, 1 year experiences in one Provincial Health Office, and another one year in the Health Insurance Division, Ministry of Public Health. His issue of interest is financial management.

Siriwan Pitayarangsarit:
Siriwan Pitayarangsarit is a researcher at International Health Policy Program, Thailand on secondment from the Khon Kaen Provincial Health Office. She graduated in Doctor of Dentistry and Master of Public Health at Chulalongkorn University and earned PhD in Health Policy Analysis from the London School of Hygiene and Tropical Medicine. Her interested research areas include: the policy process of public health policies such as resource allocation policy; household health expenditures and public health financing including demand and supply of the high cost care such as HIV/AIDS prevention and treatment, and the care for terminal illness; the private sector roles in health service system including private providers, private health insurance companies, and NGOs; and the impact of the international regulations and reform trends on the national health system.

Thaworn Sakunphanit:
Thaworn Sakunphanit is a senior expert at National Health Insurance Office. He graduated in Doctor of Medicine and Certificate of Internal Medicine from Faculty of Medicine Ramathibodi Hospital and Bachelor of Art in Economics from Sukhothai Thammathirat University. His interest research area include: health insurance management and actuarial model development; health service management such as case management / disease management in chronic care; payment mechanism especially case-mixed management, hospital management, and medical informatics.

Viroj Tangcharoensathien:
Dr. Viroj Tangcharoensathien is Director of International Health Policy Program at the Ministry of Public Health of Thailand. The Program aims for capacity strengthening in health systems and policy research. He got a six year institutional grant from Thailand Research Fund for Senior Research Scholar Program in 1998-2004. IHPP is one of the core partners of Health Economic and Financing Program at the London School of Hygiene and Tropical Medicine headed by Professor Anne Mills. His research interest includes financing healthcare, HIV/AIDS, public private mix.

He is the pioneer for the development of National Health Account, National AIDS Account. He also provides technical supports to ILO project in Lao PDR on social health insurance extension, reform of the government health insurance scheme, and financial protection for the poor. After medical

graduation from Mahidol University in 1979, he worked as a medical officer and administrator in several remote district hospitals in Ubon Ratchatani Province from 1980 through 1987. Professor Prawase Vasi supported him through a Rockefeller Foundation Grant to pursue his PhD in health economics and financing at the London School of Hygiene and Tropical Medicine in 1987-90. Upon returning from the UK, he worked in the Health Planning Division of the Ministry of Public Health (1991-94) before being seconded by the Ministry of Public Health to work as a full-time health policy researcher at the Health Systems Research Institute and now heads the IHPP.

Walaiporn Patcharanarumol:
Walaiporn Patcharanarumol is a researcher at International Health Policy Program on secondment from Maharat Nakorn Ratchaisima Hospital. She graduated in Pharmaceutical Science from Khon Kaen University, Master of Health Development at Medical Faculty, Chulalongkorn University and Master of Social Protection Financing from Maastricht University, the Netherlands. Now she is doing PhD in Health Care Financing for the Poor at the London School of Hygiene and Tropical Medicine. Her experiences were much more concentrated on healthcare financing for example; National Health Account (NHA), capitation rate computation based on actuarial method, long term projection of health care expenditure and revenue for Fund of Universal Health Care Coverage. Moreover, her interested research areas include equity and efficiency of resource allocation and pro-poor healthcare financing.