THE POLITICAL ECONOMY OF THAILAND'S '30 BAHT' UNIVERSAL HEALTHCARE COVERAGE SCHEME: 2001-07

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Declaration

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Abstract

Shortly after winning a landslide victory in 2001, the Thai Rak Thai Party introduced the 30 baht Healthcare System, also known as the Universal Healthcare (UC) Scheme. For the first time, this made modern health services available to every Thai citizen for a nominal fee of 30 baht (well under one US dollar). Unsurprisingly, there were immediate improvements in healthcare outcomes in Thailand, and the programme was one of a number that consolidated the hold of the Thai Rak Thai Party in Thai politics, a hold that it and its successor parties continue to have. This research argues that these political motivations had a significant impact on the programme's design, and on the problems that emerged with its financial viability.

This dissertation examines the background of the UC System (the 30 baht Healthcare System), and assesses its efficiency in the management of resources, equity of access, and service quality, and the long term viability of the UC scheme in terms of financing and the continued participation of private sector service providers. It finds that secondary data is very hard to access and provides neither a comprehensive picture nor satisfactory answers to these questions. The research used a qualitative case study approach to shed light on important aspects of the performance of the scheme, without aiming at comprehensiveness given the limitations of time and resources. The researcher faced significant reluctance from hospitals to reveal internal management strategies and costs and the initial goal of six case study hospitals was reduced to two. Nevertheless, these two provide very useful insights into important aspects of the scheme. The first is B-Care, a private hospital that joined the scheme in its very early days but then opted out when the financial arrangements proved to be unviable. The second was Baanpaew Hospital, a public hospital. Public hospitals are obliged to participate in the scheme but Baanpaew was exceptional in that it devised changes in management and specialisation that enabled it to remain financially viable, unlike many other public hospitals which face ongoing financial problems. The two case studies therefore shed light on the financial stresses to which the scheme led, and the types of responses that may be required to ensure the survival of the scheme in the future.

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Collecting data for this dissertation proved to be much more difficult than was envisaged and the number of case studies had to be reduced as a consequence. Even the secondary data was a challenge and I must thank all my colleagues at the National Health Security office (NHSO) and the Ministry of Public Health. Without their support, the secondary statistical data which is internal to these organisations and on which I also heavily relied could never have been accessed for a research project.

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1.3 List of abbreviations

BOB	Bureau of Budget
CSMBS	Civil Servant Medical Benefit Scheme
CUP	Contracting Unit for Primary Care
DRG	Diagnostic Related Group
MoPH	Ministry of Public Health
MWS	Medical Welfare Scheme
NGO	Non-Government Organisation
NESDB	National Economics and Social Development Board
NHSB	National Health Security Board
NHSO	National Health Security Office
OPD	Outpatient Department
SSO	Social Security Office
SSS	Social Security Scheme
TDRI	Thailand Development Research Institute
TRTP	Thai Rak Thai Party
UC	Universal Healthcare Coverage
UCS	Universal Healthcare Coverage Scheme
UHC	Universal Health Coverage
VHCS	Voluntary Health Card Scheme
WHO	World Health Organisation

Chapter 1. Thailand's political economy of 30 baht Universal Healthcare Coverage Scheme

1.1 Introduction

Thailand's economic development was rapid in the 1980s and 1990s with high economic growth and the development of new industrial sectors. The size of its manufacturing sector grew rapidly, and agriculture performed well with the country enjoying relatively high growth in agricultural exports. Nevertheless, large pockets of relative poverty remained and this was regionally concentrated in some areas like the North-East of the country and the extreme South (Chamarik, 1999). The simple economic theory that growth will eventually trickle down to all has not been effective anywhere and was not effective in Thailand. Thai policy-makers historically did not pay a lot of attention to anti-poverty programmes or distributive issues (Wibulpolprasert, 2000). Although there were a number of programmes aimed at welfare, this was not a priority for Thai policy-makers and the regional poverty issues persisted. Perhaps it was understandable given that Thailand was still a relatively poor country in the 1980s and 1990s. Politicians and policy-makers focused on growth and investment, apparently believing that poverty would decline or would at least be easier to tackle as the country became more prosperous. Greater prosperity would indeed in principle provide more resources to enable the poor to access a larger portion of the country's economic success and this would lead to a reduction in poverty (Siamwalla & Jitsuchon, 2007).

The economic crisis of 1997 dealt a serious blow to the gradualist approach supported by the ruling establishment in Thailand. People-oriented policies, which were branded as populist by critics, began to emerge in the political arena and soon began to dominate. The crisis was attributed by many citizens, particularly in the poorer areas, to the liberal laissez-faire policies the country had been following. These resulted in speculative investments and asset bubbles that contributed to the financial crisis of 1997. The crisis was a turning point in Thailand's politics because the policies that had apparently contributed to the crisis had also primarily benefited the rich. This popular

dissatisfaction contributed to the political rise and electoral success of the Thai Rak Thai Party led by Thaksin Shinawatra, a process that began in the 2001 general elections. The party's populist platform and the subsequent implementation of large parts of this programme marked a transition in Thailand's economic and political development (Siamwalla, 2007).

This was the political context in which the 30 baht Health Scheme, also known as the Universal Healthcare (UC) Scheme, was introduced. This was a radical extension of access in the accessible healthcare coverage available in Thailand at that time. The message to the poor was very compelling: a visit to a healthcare clinic or hospital would incur a charge of 30 baht (one US dollar was around 50 baht in 1998) and this would be the only charge for the full course of treatment regardless of the type or cost of treatment required. Given the very high market cost of medical treatments for serious health problems, it is easy to see why such a policy would be immediately very popular with a large segment of the population that had previously had limited or no access to modern medical services (Phongpaichit, 2004). According to a study on households' financial and social status conducted by the National Statistics Office, the 30 baht scheme was the scheme most accessible to the poor, compared to other populist schemes promised or introduced by the Thai Ruk Thai Party (TDRI, 2009).

The 30 baht Universal Healthcare Scheme represented huge progress in its motivation and in the improved access to modern healthcare that it provided to the excluded sections of the population. Undoubtedly there was a significant improvement in healthcare access as a result of the initiative, and not surprisingly this had positive effects on healthcare outcomes in Thailand. On the other hand, the scheme had some significant limitations that affected its financial viability and that may well affect its future unless policy-makers take steps to address some of the questions about financial viability. The fiscal allocations and the rules for allocating funds across hospitals and treatments did not reflect the real cost of different types of treatments, and the rules for hospitals for deciding between treatments and trade-offs were not clear (TDRI, 2009).

1.2 The health insurance programme 'Just 30 baht for the treatment of all illnesses'

Thailand adopted the United Nation's (UN) objective of good health for all, and so health insurance for all was introduced with a view to improving public health. Health insurance for all represents the guarantee of the accessibility of healthcare services to everyone in accordance with his or her needs, and healthcare services are provided to everyone on the basis of equality and individual dignity. Access to such healthcare services is considered each citizen's basic right, not a form of patronage given by the state to its citizens. This right is derived from the 1997 constitution, which states in Article 52 that each person has a right to receive standardised healthcare services and the poor have a right to receive medical services free of charge from state-run healthcare service units. In addition, Article 82 stipulates that the state has to provide standardised and effective healthcare services for the people (Sunthorndham, 2012).

As illness affects everyone at some time or other, a politician who can offer a strategy for making treatment free or cheap in a country with a lot of poverty will immediately acquire a lot of support and loyalty. Thaksin, with his skills and experience as a marketing strategist, understood this fact well. Not surprisingly, Thaksin recognised that a programme for providing healthcare insurance for all would be an important platform for consolidating his power base after winning the 2001 election with a majority of parliamentary seats. The scheme Thaksin introduced was a healthcare insurance programme called in Thai 'Just 30 baht for the treatment of all illnesses', also often referred to as the Universal Healthcare Scheme. Analysts were immediately doubtful about the viability of such a programme because it aimed to provide universal coverage for all types of healthcare problems virtually for free, implying very large funding requirements. However, Thaksin was entirely serious and as soon as his government was formed the Ministry of Public Health (MoPH) was instructed to implement this programme (Pitayarangsarit, 2004).

Thaksin's populism was consistent with the poor's needs and it provided a solution to the problem of insecurity which plagued those outside the formal sector of economic activities. The immediate and widespread appeal of the Universal Healthcare Scheme can be attributed to three factors (Phongpaichit, 2005). Firstly, a universal healthcare

system was to be introduced in Thailand for the first time, providing an unspecified level of coverage to everyone. Initially, this set of policies appealed to all, not just one specific group of people. The ‘just 30 baht for the treatment of all illnesses’ programme could in principle also appeal to the middle and lower middle classes because not all the people in these higher income groups were adequately covered by existing schemes. The healthcare programme complemented other universal programmes that were part of the Thaksin strategy of delivering to his constituency of the excluded. For instance, there were other programmes aimed at providing one million baht for every village, with the declared intention of freeing every peasant from their debt burden. Whilst these programmes were universal, their target was clearly the poor and previously excluded. These groups were therefore the most enthusiastic about the introduction of these programmes.

Secondly, Thaksin presented his image to the general public as the people’s friend and as one of them, although he was actually one of the richest businessmen in Thailand. His gift was his ability to engage in informal conversations with people using local dialects and even joke and chat about his sex life. The image of him as an accessible leader contributed to his immense popularity as an accessible and progressive leader.

Thirdly, Thaksin managed to convince the masses that he could turn their wishes into effective state policies. He tried to make it appear to the public that the old-fashioned politics, which was marked by politicians making promises but failing to deliver, was now history. In fact, he did deliver all the promises adopted by his party prior to the election and this set him apart from the previous politicians, though the nature of the implementation and its viability remains questionable to this day and is one of the subjects of this dissertation. However, Thaksin disregarded democratic principles concerning legal procedures, the rule of law, and civil rights. He disregarded these democratic principles by arguing that his mandate to rule was given to him by a very large number of people, which he regarded as approval of his exercising his power in an authoritarian manner for the benefit of his supporters. However, exercising his power in such a manner led to confrontations with parliamentary members, opposition parties, civil society, academics, non-governmental organisations, and agencies created by the constitution to deter the abuse of power by authority. Thaksin and his men

viewed his authoritarianism as comparable to that of the popular strongman in Thai history, Sarit Thanarat (1957-63), who was widely admired for his decisiveness and firm actions to achieve his goals.

Thaksin initially had multiple objectives but circumstances made him turn more strongly to the populist part of his policy portfolio. Thaksin originally intended to assume the responsibility for the revival of Thai capitalism after its collapse in 1997, which would involve working closely with a broad base of Thai capitalists and entrepreneurs to work out a programme of economic regeneration. However, he soon came under fire from the middle classes for his personal tax and other irregularities including the charge of not fully declaring his stockholdings. At this stage, shortly after coming to power, Thaksin realised the power of the masses to protect him from these criticisms. They came out in force to defend Thaksin from the charge of 'covering up his stockholding'. An embattled Thaksin soon realised that he needed to consolidate his power base by delivering to the constituencies that most strongly supported him. In summary, Thaksin's populism and his pro-poor leadership arose out of a political strategy based on delivering to the needs of those outside the formal and recognised domain of economic activities, but his commitment to these strategies became progressively stronger as he realised that this constituency was the only one he could rely on to stay in power. These political considerations affected the speed with which the Universal Healthcare Coverage Scheme was rolled out, and this in turn had significant implications for the limited preparations made to ensure the viability of the financing for the programme and the limited attention given to the details of what was to be covered, for whom, and how.

1.3 The significance of the research

Like other big schemes, the 30 baht scheme is prone to political intervention both in its motivation and in its design. This is only relevant if the political motivations affect the sustainability of the programme, or the quality or allocation of services, either intentionally or unintentionally. Generally, politicians exert their influence over the decision making relating to the operation of the scheme through the appointment of a politician to the chairmanship of the National Health Security Committee. Similarly, local politicians become involved in the local management of the scheme in a variety of

ways. The involvement of politicians in the scheme can be regarded as their attempt at rent-seeking, not unlike their involvement in other populist schemes in order to gain popularity, the practice adopted by the Tai Ruk Thai party whilst in power. After the party came to power they introduced a number of populist projects which were given titles that sounded appealing, had a clear message, and were easy to remember. Soon these project names became household names. Such phrases included 'one tambon, one product', 'one fund for each village', 'Thailand as the world's centre of fashion', 'Thailand as the world's kitchen', and 'Thailand as Asia's Detroit', and were highly appealing to the general public (Ruangsakul, 2011).

Such projects was often perceived by critics as serving the purpose of a political agenda at the cost of the misuse of public funds that might have an adverse effect on the country's budget. An insufficient supply of finance for the implementation of such schemes was likely to result in growing budget deficits that would eventually impose all the costs of a debt burden on the general public or result in inflation. In reality, the unsuccessful implementation of certain projects was allowed to continue as their presence satisfied the poorer classes who were the largest proportion of voters and crucial for Thaksin's hold on power.

The Universal Healthcare Coverage Scheme, adopted as the country's most important policy, was aimed at achieving three main objectives: 1) institutionalising equality in terms of access to healthcare services and sharing the financial responsibility for the costs of these services; 2) providing standardised healthcare services at a minimum level which could keep the majority of the people satisfied; and 3) maintaining operational efficiency such that the minimum of resources resulted in the maximum benefits in terms of healthcare promotion (Jongudomsuk, 2002). Achieving these three objectives involved upgrading the budgetary allocation, financial management, accountancy, and service delivery systems in the healthcare system in very quick order.

As Thailand is a middle income country with a large middle class which would be critical of any wasteful use of tax resources, it was necessary for policy makers to arrange the allocation of resources in the most efficient way, and equality had to be achieved in ways that minimised conflict with the significantly powerful taxpaying middle class. It is not unusual during the implementation of a scheme which is very

large in scale, such as the Universal Healthcare Coverage Scheme, for it to be subject to questions, criticism and protests as such a policy affects a large number of people and can induce profound changes in a country's healthcare system at the personal and organisational level. Those affected by the policy included those standing to benefit from it and those who would be deprived of their current advantageous position in terms of access to healthcare on a privileged basis or in terms of a low tax burden. The question concerning the implementation of such a policy with such a large financial requirement relates to the extent of the poor's access to healthcare service, the source and the amount of funds required for implementing the policy, and the mechanism for facilitating its efficient operation and resource management.

1.4 Objectives of the study

1. To study the political economy of the Universal Healthcare Coverage Scheme and the impact on policy implementation;
2. To study the access to the Universal Healthcare Coverage Scheme in Thailand;
3. To study the financial management of the Universal Healthcare Coverage Scheme in Thailand;
4. To study the implementation of the Universal Healthcare Coverage Scheme through case studies of particular hospitals.

The next chapter presents the framework of analysis, elaborated from a literature review of political economics and policy analysis. Thereafter the methods of data collection will be described.

Chapter 2. Research framework and methods

This chapter develops a policy analysis framework through a review of different disciplines relating to political economics and policy, to help explain the Universal Healthcare Coverage (UC) Scheme analysis. Thereafter, the study objectives and research questions are specified, and finally, it explains the study methods used.

2.1 Framework of political economy

The political economy of Thailand's 30 baht Universal Healthcare Coverage Scheme from 2001-2007 refers to a body of analysis and a perspective on UC policy which seeks to understand the conditions which shape population health and healthcare within the wider macro-economic and political context. The relationships between political economic and universal healthcare are complex and can be analysed in terms of a range of different linkages. In this chapter, the literature is reviewed to obtain appropriate ideas or theories helpful to the formation of research methodology.

According to Crane and Amawi (1997), 'political economy' suggests a focus on phenomena that lie at the crossroads of the fields of politics and economics. It seeks to explain how political power shapes economic outcomes and how economic forces influence political action. Although divergent beliefs are held as to the direction and strength of the relationship of politics and economics, exploring their interconnection is the basis of political economy. But political economy is not simply an amalgam of the two traditional fields; rather, it attempts a new synthesis. Implicit in the endeavour of political economy is a critique of the scope and methods of both economic and political sciences. To the political economist, *ceteris paribus* assumptions and numerous 'exogenous' variables rob neoclassical economics of explanatory power. Likewise, much of political science pays insufficient attention to how economic processes and structures might influence the play of power. By contrast, a theory of political economy should be judged precisely by how well it captures the interaction between politics and economics (Crane & Amawi, 1997). A political economy approach offers multidisciplinary tools for understanding the interrelationships between political and economic institutions and process, including the ways the government manages the allocation of resources and the economic system, and the behaviour of people affects

the form of government and the kind of laws and policies that get made (Drazen, 2001; Johnson, 2000). According to Piampongsan (1995), political economy is the study of social phenomena with the attention directed to:

1. The interrelatedness of social, economic, and political structures of society that require a holistic approach to study;
2. The conflict of interests between groups in society;
3. The dynamics of social phenomena; and
4. The unrelenting use of a critical approach to probe into social phenomena.

2.1.1 Political economy of healthcare

According to Foucault (1982), the political economy of healthcare has its roots in the original meaning of political economy of the 18th century, that is, a meaning which disengaged the economy from the family and refocused it on the problems of the broader population on the assumption that the latter has its own regularities (e.g. mortality and morbidity rates, cycle of scarcity, etc.) which statistics demonstrate to be not reducible to the family. Moreover, the ultimate purpose of government is pastoral concern for the welfare of the population through the increase of its wealth, longevity, and health. Herein lies the origin of public healthcare, that is 'the emergence of the health and well-being of the population in general as one of the essential objectives of political power'. For the first time 'health and sickness, as characteristics of a group, a population, are problematised…' including efforts to organise a global, quantifiable knowledge of morbidity phenomena. (Foucault, 1982, cited in Cohen, 1989)

2.2 Politics

Politics concerns the exercise of power in society or in specific decisions over public policy. So politics is about power and influence in society as well as in the processes of policymaking within government. It concerns who participates in and who influences the decisions that government make and who gains and who lose (Kraft and Furlong, 2013).

According to Lindblom (1980), politics can be described as the interactions of groups or individuals in their effort to gain legitimacy in controlling the mechanism of resource allocation. The interaction may be characterised either by competition or

compromise or the combination of both that result in the formation of policy directing the way resources are allocated. The implementation of policy is conducted through the administrative process and structure. Politics involves any activity or action aimed at policy making to achieve a desired allocation of values and resources to the general public. Such allocations of values and resources are made through policy, laws and orders, and regulation (Lindblom, 1980). When a government has legitimacy, it means that its citizens are predisposed to accept the actions of the government, not only when they happen to agree with those actions, but also when they disagree. Legitimacy is more than a sense of resignation that the government can do whatever it wants. It is a sense that the actions of the government, at least most of the time, serves the public interest (Bickers and William, 2001).

2.2.1 The politicians

Politicians hold their position in the executive and the legislative branch; politicians wield influence in shaping policies. Their roles determine budgetary allocations as regards the purpose and timing of allocation (Thiratayakinan, 1990).

Budgetary allocation reflects power relations in society, as it results from the interaction of politicians and rested interests. Those with vested interests with greater bargaining power stand to reap more benefits from particular allocations. In addition, the politicians' success in achieving budgetary allocations serving their own purposes reflects their influence over their fellow politicians.

Generally speaking, the politicians who exercise their direct influence over budgetary allocation are key figures in government and the legislative branch, usually in charge of big and important ministries. They work with bureaucrats in analysing budgets and resolving conflict in budgetary allocation.

- **The role of the politician**

The conduct of policy making in Thailand is required to go through legislative processes resulting in acts, royal decrees, and ministerial rules (Acts, Royal Decrees, Royal Enactments, 2009). Acts concern the laws made by the king with the advice and consent of the parliament, such as the Anti Money Laundering Act 1999, the National Education Act 1999, and the Ministerial Improvement Act 2002. Royal enactments

describe the laws made by the king based on administrative power, such as the royal enactment on national and public safety, economic security, and disaster prevention, as well as the royal enactments on the reform of financial institutions 1997, and the royal enactment on the administration of the state under emergency 2005.

Royal decrees describe the laws made by the king based on constitutional law, acts, or royal enactments. Royal decrees are lower in status than acts and are not allowed to contradict acts, such as the royal decree on land management 2003, or the royal decree on election date 2007. Ministerial rules are determined by ministries to accelerate problem resolution such as the ministerial rules on service fees to be shared by medical doctors 2002, and the ministerial rules on the opening and closure of entertainment outlets 2004.

Generally, political actors appointed to ministerial positions in ministries assume the roles of directing and monitoring policy implementation to achieve the purpose of policies. For example, the minister of public health is responsible for directing and monitoring the implementation of 30 baht scheme. He or she has to be briefed of the performance of policy implementation, appointment of senior officials to the posts, and if those officials fail to implement policies, political actors are authorised to remove those officials from their posts.

In the political market, the interaction of people and politicians produces the policy 'cycle of the political market' characterised by four phases (Limmanee, 2002): 1) parties formulate campaign strategies for forthcoming elections; 2) the winning party or parties constitute the government and formulate and implement policies that serve the interests of its supporters; 3) the government, capitalising on being in power, makes adjustment in its policies to draw more votes; 4) the people vote for political parties with the hope of being satisfied with their needs.

2.2.2 Interested groups

- **The role of vested interest**

Vested interests describe mainly business interests comprising business persons and the associations of entrepreneurs, but they can also refer to well-organised professional groups like doctors, lawyers and so on. These groups have the organisational capability

and resources to occasionally pressure the government to grant them privileges in terms of financial allocations. Their success depends on their organisational capabilities and financial resources, which together give them bargaining power. Their moves may either be open and direct or secretive (Anderson, 1970). In democratic countries, vested interests operate by influencing politicians and political parties, either openly or secretly.

With the diversity of vested interests in industrial societies, no particular vested interests can dominate the policy-making process. However, the government is still likely to concede to arguments for resources and privilege to business interests and professional groups in order to win their co-operation for solving economic and service delivery problems.

In countries with a limited number of vested interests and weak political parties, a few well-organised groups can wield more significant influence over policy making, and it is more likely that checks and balances may not operate to ensure that these privileges do not hurt the public interest. In contrast, in more developed countries with diverse and powerful vested interests co-existing with strong political parties, the influence of vested interested over policy making is still strong, but the chance of damaging outcomes is reduced by the competition between them.

- **The role of bureaucrats**

Although bureaucrats implement policies and act generally as regulators, they too can play a role in the initial phase of policy making by providing decision makers with information which might shape the views of policy makers, and the way they implement policies in line with their own interests can have a significant effect on outcomes. These interests can make bureaucrats compete for power within their own organisations and to exclude the general public from the process of policy making. To be effective, bureaucrats often work closely with the interests of politicians and can be rewarded with promotions to higher positions

- **The role of civic groups**

In theory, civic groups also participate in policy making through the parliamentary system, but in practice their impact can be limited in many contexts. They can be

constrained by the absence of adequate information provided by bureaucrats, not to mention the difficulty of evaluating the impact of policies due to the complexity of most situations.

However, democratic regimes need to be responsive to ordinary citizens as their power is based on being elected by the general public. These considerations set up a complex set of forces and interests which collectively affect the policy formulation and implementation process. This process will not be described in detail in this thesis, but the analysis of the implementation and effects of the 30 baht healthcare scheme is based on our reading of the broader political economy of Thailand, which helps to put the discussion of the healthcare policy in its social and political context.

2.2.3 Stakeholders involved in policy making in Thailand

Based on the discussion earlier, the key stakeholders involved in the policy process in Thailand include the following:

Politicians who win the mandate to rule the country through elections. As they are authorised to conduct state affairs, they are in positions of power to affect the formation of policies and decide on resource allocation. Politicians wield direct influence over budgetary allocations. Opposition politicians also have an influence by organising counter mobilisations and groups, and this sets constraints on how a ruling party can drive the policy process.

Bureaucrats mainly act as enforcers of laws, rules and regulations, and are engaged in the task of policy implementation. Moreover, in the initial phases of policy formulation, they also supply decision makers with information. They can thus shape the views of decision makers in critical ways and this gives them considerable strategic power. They can serve politicians loyally, or even collude with them against the general interest or in violation of the law in a developing country context, and they may be rewarded with higher positions and promotions as a result. This is why bureaucrats in the police department and armed forces can demand extra funds from the government, often without clear accountability, because their support is often critical for the government in power.

Business interests provide financial support to political parties in exchange for policies favourable to their interests. There are many examples in Thai politics of close associations between businesses and political parties, For instance, Chartthai party's connection with many industrialists including Boonsong Srifuangfong, the founder of Thai Asahi Co. Ltd. is well known, and this resulted in the appointment of Mr. Dej Boonlong, Mr. Boonsong's right hand man, to the position of the deputy secretary to the prime minister from 2001 to 2005.

The **general public** is very often a passive consumer of policies coming from political parties, except in moments of crisis. Political parties produce public goods and services for the general public, but do not directly participate in the policy formulation and implementation process. Their influence is usually limited to an ex post response to the outcomes of these policies, because they have an opportunity to vote a party out of power if they are unhappy with particular policy outcomes.

Thus, the stake holders who play the most active role in policy making are politicians, bureaucrats, and business and professional interests, with the general public usually being passive customers of political parties, except through the indirect mechanism of elections. Professional interests are relatively underdeveloped in Thailand in terms of their organisation, so that business interests still play a dominant role in politics.

2.3 Public policy

Public policy is a course of government action or inaction in response to public problems. It is associated with formally approved policy goals and means, as well as the regulations and practices of agencies that implement programmes. Looking at public policy this way emphasises the actual behaviour of implementing agencies and officials, not merely the formal statement of policy goals and means found in laws and other expressions of government policy (Kraft and Furlong, 2013).

The policy process can be further divided into three stages. The first phase is policy formulation, the second is policy implementation, and finally policy evaluation. Policy formulation involves submitting problems to cabinet meetings in which the problems are considered and their importance and prioritisation determined. This stage involves setting a policy agenda. We can expect policy makers to select the problems that most

affect their own political interests to be high up on the agenda. Thus those outside politics who are pressing for the resolution of particular problem need get their timing right in submitting proposals to political policy makers. They have to negotiate with other vested interests if they want to influence agenda setting. They also need to keep in mind the scope of the agenda, which should not be so large that it impacts on other vested interests.

In Thailand, the problems that impact on the political fortunes of policy makers are mainly responses to crises that need to be addressed such as drought problems, problems that have a demoralising effect on people like student suicides or pollution problems in cities, and problems affecting the state's territorial integrity like the secessionist movement in the deep south. Sometimes, however, a more concerted policy formulation processes can be triggered, as in the case of healthcare policy, where a number of stakeholders pushed for reform, and it coincides with the political interests of key politicians at a particular time (Sajjapunroj, 2007).

Generally, the policy process of selecting an agenda can be triggered in two different ways. Important stakeholders may raise problems and submit them to the government, and these problems may either be local or national, or the government may internally raise certain reform agendas in pursuit of its own interests. The internal agendas are more familiar to policy makers in the government compared to problems raised by other stakeholders. The latter therefore requires more compelling reasons to appear on the priority list (Anderson, 1970).

However, external situations can provide opportunities for some problems to be selected as part of the agenda. This depends on stakeholders using an opportunity presented by a moment of political change or a crisis to bring issues to the table that may otherwise not have succeeded in making it onto the agenda. Once on the agenda, the political system converts priorities into policies. The policies in turn may prove to be effective or may fail. If the policies prove to be failures, the government, the legislative branch, and the bureaucracy can make adjustments in order to improve policy making and implementation, or the general public can punish the politicians at the next election (Easton, 1965).

2.3.1 Policy making

The so-called ‘Process Model’ of policy making spells out the policy-making process into five stages (Dye, 1984). The first stage is about the identification of the problems or agenda setting. This stage involves determining what the public thinks are problems and, if they are politically relevant problems, the category to which the problem belongs. Problems such as unemployment or the falling prices of agricultural products can be identified as politically relevant and then analysed to determine their causes and the level of their severity. The identification of viable responses is also critical, because some important problems may have no viable solutions. The problems are then subjected to prioritisation. Financial constraints make it necessary to prioritise problems, though they seem equally urgent and severe, and prioritisation of problems involves politics.

The second stage concerns a discussion of policy alternatives. After problem identification, alternative mechanisms of resolving these problems are identified and analysed in terms of political feasibility, cost and benefits, and the effect of each alternative on the political objectives of the government.

The third stage involves policy adoption or approval. This stage is characterised by the selection of policy alternatives as suggested by the policy analysis. The selection of proper alternatives involves taking into consideration factors such as the feasibility of implementation, and support from well-organised interests and the general public. This selection clearly involves politics and political judgements.

The fourth stage involves policy implementation. This involves the assignment of the task of policy implementation to selected organisations or agencies. These organisations or agencies may be existing ones or be newly set up. The criteria for the selection of organisations involves considering their structure, finance, personnel (in particular, numbers), locations, and equipment, ultimately to determine financial feasibility and effectiveness in delivery.

The fifth stage involves the ongoing task of policy evaluation. This stage involves the conduct of studies to find out whether or not policy implementation is successful. The success of policy implementation results in the continuation of policies or in the extension of the scope of policies, whilst failure should lead to the improvement or

termination of the policy. An important challenge is to ensure that political actors do not interfere with policy evaluation to get positive results.

Policy evaluation can help to identify mistakes. The mistakes may have to do with analysis not being thoroughly done, the use of the wrong techniques for data analysis, or the absence of components of successful policy implementation. In particular, the effectiveness of agencies and the cost of delivering services can often be miscalculated, and we will see that this was an important dimension of the problem in the healthcare sector reforms studied in this thesis. The correct identification of mistakes is essential for their correction as shown in figure 2.1.

Table 2-1 – The policy process model

Stage of the Process	Means
Agenda setting	How problems are perceived and defined, command attention, and get on to the political agenda of governments
Policy formulation	The design and drafting of policy goals and strategies for achieving them
Policy legitimation	The mobilisation of political support for the formal enactment of policies, including justification or rationales for the policy action
Policy implementation	Provision of institutional resources for putting the programmes into effect within a bureaucracy
Policy evaluation	Measurement and assessment of policy and program effects, including success or failure

Source: adapted from Kraft M.E. and Furlong S.R. Public policy, Politics, Analysis, and Alternatives, 2012

2.3.2 UC policy in Thailand

In 2001, Thailand introduced the UC policy very rapidly after the new Thai Rak Thai Part (TRTP) government came to power (Pitayarangsarit, 2004). The 30 baht scheme or UCS was initiated by the Thaksin administration, largely for political purposes to provide a payoff to his core constituency. Its principle was consistent with the right of access to standardised healthcare services and the poor enjoyed healthcare services provided free of charge by the state. The introduction of the scheme directly addressed the high costs of medical treatment borne by the poor, which the previous welfare programmes targeting healthcare for the poor failed to achieve. The finance for the 30 baht scheme soon accounted for 60% of the total public healthcare expenditure as the people covered by the scheme were required to only pay 30 baht for their treatment and the rest had to be covered by government subsidies.

The basic principle of the scheme was to ensure public participation at all levels to guarantee access to quality services for all. Participants in the scheme were allowed to choose the primary unit with which they wished to register. The participating service units, especially primary care gatekeepers, were subject to quality accreditation. Patients were managed across care providers through networking links between hospitals even though these were not centrally administered. Relatively effective connections were rapidly established between service units in the public and the private sectors so that cost containment was actually achieved to a reasonable extent without reducing the level of services and without significantly adverse effects on quality and accessibility. This is because a professional healthcare system with good management infrastructure already existed even if these resources were rapidly overstretched by the demands of the additional patients who joined the healthcare system on a formal basis.

2.3.3 Healthcare policy and politics in other countries

The decisive factors regarding the success of universal coverage programmes always relate to the direct intervention of the governments in the initiation of healthcare security programmes for all, the role of healthcare related NGOs, the stability of althcare-related bureaucracy, and the efficient way in which the bureaucrats perform their duty.

However, the presence of certain conditions providing fertile ground for the success of the implementation of healthcare related programme is required. It relates to peace and political stability within countries that helps foster economic development leading to improved quality of life in terms of higher income and education, as in Tamil Nadu (India), Kerala (India) and Costa Rica (Palafox, 2011). In Costa Rica, steady economic growth enabled the country to invest continuously in social welfare and establish the Costa Rica Social Security Fund. In Tamil Nadu (India), the improved transportation infrastructures greatly helped support the operation of the network of healthcare related service units in the countryside (Muraleedharan, Dash, Gilson, 2011).

In Sri Lanka, the steady growth of the GDP since 1985, together with the government’s commitment to social welfare, resulted in massive investment in hospital infrastructure contributing to the fact that most Sri Lankans live within three kilometres of a public facility (Palafox, 2011).

As important as peace is, political stability and economic development are the decisive factors contributing to an improvement in the standard of healthcare to the general public, as long as this still remains the role of governments, bureaucrats, and the non-governmental sector.

In Tamil Nadu, the considerable achievement in maternal and neonatal healthcare compared with many of its neighbours in India and elsewhere in Southeast Asia has been attributed both to a political commitment to healthcare, and to the fact that the successive administration adhered to such commitment (Balabanova, Conteh, Mckee, 2011).

Successful interventions regarding healthcare issues in Tamil Nadu have also been attributed to the competence of the public healthcare management at the district level (which is unique in India) that was granted with sufficient autonomy to perform their duties. A large proportion of patients (80% of outpatients and 60% of inpatients in Tamil Nadu) used the services provided by the private sector. However, core, maternal and child healthcare services are still provided in the public sector. This is indication of the prominent role in healthcare of the non-government sector.

Political vision is the decisive factor in the development of a comprehensive reform programme (*Manas*) that paved the way for subsequent coherent reforms in Kyrgyzstan. Furthermore, the reforms retained support from successive Kyrgyz governments (Balabanova, Conteh, McKee, 2011).

In Ethiopia, the government entered into international and regional partnerships regarding healthcare issues, due to their political vision and leadership. In November 2009, it became the first country in the region to sign a national agreement, or pact with development partners, based on a comprehensive health sector development programme. In Bangladesh the importance of healthcare was established in the 1972 constitution.

The capability, flexibility, and autonomy of bureaucrats is also evident. In Tamil Nadu, the Medical Service Corporation, an autonomous body managing drug procurement, has been able to bypass bureaucratic procedure to introduce innovative measures that improve the availability of essential drugs and promote rational drug use.

In Kyrgyzstan, a donor representative report showed a culture of pragmatism in deciding whether to reform works or not and taking action where needed. In Ethiopia, regional healthcare offices were set up after the country embarked on healthcare reforms in the wake of civil war. In Bangladesh, authorities at the district level were instrumental in implementing government formulated policies and programmes in the delivery of emergency obstetric care (which is the same through sub-districts, or '*upazilas'*). Participation of the non-governmental sector, be they private firms or healthcare related NGOs, may enhance the efficiency of healthcare services or increase out-of-pocket payments that lead to bankruptcy from illness. In Bangladesh, NGOs play a major role in healthcare services. One of the world largest NGOs, BRAL, estimates that it reaches 110 million people by means of 64,000 village healthcare works. These NGOs are autonomous and flexible enough to play an important role in improving health, for example by preventing diarrheal deaths in children and by reaching out to the marginalised population living in isolated areas or suffering from stigma or a lack of resources (Balabanova, Conteh, McKee, 2011).

However, the negative consequence of the growth of the private sector has grown more apparent. In Sri Lanka, the rapidly expanding private sector is attracting healthcare workers from the public sectors (Palafox, 2011). Thus, the private and public sector being in balance with each other leading to the optimum efficiency of healthcare service is lost.

Among the more developed countries, the United States is the least committed to universal healthcare whilst Great Britain and Sweden have completed the establishment of genuine universal healthcare. As for Germany and Japan, universal healthcare coverage has also been achieved but through the covering of fees by national insurance rather than by government subsidy (Theodoulou, 2002).

The state possesses a large degree of control in Germany, Sweden and Japan, with the healthcare infrastructure overseen by a government agency. In Sweden and Japan the governments have the power to dictate and enforce all policies. In Germany, Great Britain, and the United States, where the policy making process is by a committed parliament, no governmental sectors such as medical professionals, hospitals professionals, insurance companies, pharmaceutical companies, advisory groups and

unions are allowed to participate in policy making. In the United States, the national government delegates a great deal of authority to individual states and entrusts responsibility to private companies. The difficulty in raising funds and maintaining costs, however, puts pressure on those countries to let non-governmental and the private sector share the healthcare burden. All of the above have incorporated private insurance into the system.

2.4 Criteria of policy evaluation

Evaluative criteria are the specific dimensions of policy objectives (what policy proposals seek to achieve) that can be used to weight policy options or judge the merits of existing policies or programmes. Evaluative criteria can also be regarded as justifications or rationales for a policy or government action. It makes sense to choose the criteria that fit a given policy and set of circumstances (Kraft and Furlong, 2013). The criteria of project evaluation refer to *what* is being evaluated and *how* as opposed to the process of evaluation. According to Dunn (1981) a number of criteria are relevant, but common ones are based on efficiency, effectiveness, adequacy, equity and satisfaction. DAC evaluation criteria are based on three different criteria; relevance, impact, and sustainability (OECD, 2016). The details will depend on the type of sector and policy being evaluated, but the general principles are useful to keep in mind.

2.4.1 Efficiency

Efficiency involves maximising outputs whilst using minimal inputs, or in other words the ability to extract maximum profits or social benefits from one unit of investment of resources. Thus, the measurement of efficiency involves using cost-benefit analysis as efficiency implies maximising net benefits, defined in some way. Generally, policies where the objectives include improving tangible benefits can be evaluated using efficiency-based criteria, such as the policies related to the construction of dams for generating electricity, airports, express ways, or aspects of the universal healthcare coverage policy.

2.4.2 Effectiveness

Effectiveness involves the level of attainment of objectives. Effectiveness thus concerns the attainment of objectives of policies. Effectiveness is judged by the degree

to which objectives have been attained, not from an estimate of net benefits obtained. In some cases, policies can best be judged in terms of effectiveness, for instance social policies having nothing to do with the delivery of services or infrastructure, such as crime reduction, narcotics policy, corruption suppression policies, and some healthcare policies like AIDS prevention policy.

2.4.3 Adequacy

Adequacy is measured by the ratio of policy outcomes to the needs of the whole society. Adequacy can be judged by contrasting the volume of policy outcomes with the needs of the whole society. If the volume of outcomes fail to meet the demand of the whole society, adequacy is not achieved. For example, during the second Anand Panyarachun administration in Thailand, telephones were in great demand, but the government could only provide a very limited number. Similarly, if 100,000 peasants need plots of land, and the government can only provide plots of land to 5,000, the policy responses can be judged as being inadequate.

2.4.4 Equity

Equity refers to the equal distribution of benefits of policy outcomes, particularly to the underprivileged in society. The equity-based evaluation involves determining whether the underprivileged in society, be they the poor, the disabled, children, the elderly, or people in different geographical areas, enjoy the benefits of policy outcomes. The policies aimed at promoting equity include land reform policy, public bank policy, and universal healthcare coverage policy.

The definition of equity given above is complemented and elaborated by Culyer's idea of healthcare equity which points out the two aspects of healthcare equity: 1) horizontal equity which refers to equal treatment of those with equal initial healthcare, equal need and equal expected final healthcare; 2) vertical equity which refers to more favourable treatment for those with worse initial healthcare, with greater need and worse expected final healthcare (Culyer, 1991).

2.4.5 Sustainability

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable. When evaluating the sustainability of a programme or projects, it is useful to consider the following questions: To what extent did the benefits of a programme or project continue after donor funding ceased? What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project? (OECD, 2016).

2.4.6 Satisfaction

Satisfaction refers to the contrast between what is expected from policy implementation and what policy implementation actually yields. For instance, if 100 units of outcome from policy implementation are expected but actually more than 100 units are delivered after the implementation of policies, the policy can be said to be satisfactory, and vice versa. In 2002, rubber planters in southern Thailand were satisfied with the price guarantee policy of the government when they got 40 baht/kilogram for their raw rubber, which was higher than they expected.

It should be noted that efficiency and equity can go hand in hand, lending themselves to being achieved simultaneously. Efficiency and equity are achieved simultaneously in the way that resource allocation benefits the underprivileged in societies whilst those in an already more advantageous position are unaffected by the measure to achieve equity. Technically, this can be referred to as achieving a 'Pareto improvement'. (Tinkeerhadhit, 2002).

A process model of policy analysis is used to identify separate sets of questions relevant to analysing the universal healthcare policy in Thailand. The analysis looks at five stages, although equal importance is not given to all stages.

The application of policy evaluation to the UC (30 baht Healthcare) scheme is particularly important because the UC scheme involved: significant political considerations of the politicians driving its formulation and implementation; significant financing that was initially, at least, not forthcoming; great changes in the country's healthcare security system; a series of conflicts between politicians, bureaucrats and

healthcare managers; frequent changes to the scheme; and a large number of diverse stakeholders. The criteria used in different parts of our evaluation involved looking at considerations of equity, efficiency, and viability.

2.5 Resource allocation

Resource allocation is concerned with the extent to which the mechanisms of resource allocation achieve efficiency, equity and viability, and helps to pose the research questions as well as helping to reform the analysis of research objectives and methodology.

2.5.1 Efficiency

Efficiency refers to the allocation of limited economic resources to meet the healthcare needs of a society and can be categorised into three variants:

1. Technical efficiency, achieving a specified healthcare gain with the minimum expenditure of inputs;
2. Economic efficiency, achieving a specified healthcare gain at the least cost; and
3. Allocative efficiency, maximising the healthcare gain from a specified level of resources by allocating the available resources in the best way across patients, regions, treatments, hospitals and so on.

The fragmentation of healthcare insurance in Thailand gave rise to inadequacies in coverage and efficiency, thereby undermining the equality of opportunity in accessing healthcare services. Inefficiency stemmed from a lack of bargaining power on the part of the user and the fact that healthcare providers' performance was not subject to public scrutiny. The practice of a 'fee for service' resulted in a higher healthcare expenditure growth rate compared to the GDP, even during the economic recession (Sri-anan, 2002).

Thai citizens are entitled to different benefits offered by different healthcare schemes, the Civil Servant Medical Benefit Scheme (CSMBS), the Social Security Scheme (SSS), and the Universal Healthcare Coverage Scheme (UCS) (Tangcharoensathien, 2004). However, these three schemes are under the supervision of three different agencies. The CSMBS comes under the comptroller general, whilst the SSS and the UC

are supervised by the Social Security Office of the Ministry of Labour Affairs and the NHSO. The supervision of these schemes by different agencies has resulted in fragmentation of their management and has led to high costs due to overlaps. Moreover, there are differences in the benefits offered to participants and the procedure for monitoring disbursement, not to mention the systems for complaints which contribute further to the complicated management of these schemes (Tangcharoensathien, 2004).

2.5.2 Equity

Achieving horizontal or vertical equity may involve the re-organisation of services and the redistribution of resources. But it is unlikely that allocative efficiency or equity will be achieved in a fragmented healthcare system where comparisons cannot be easily made between different segments of the healthcare system providing similar services to different groups of people, or different services to people with similar healthcare needs (Pannarunothai, 2000a).

In addition to the high management costs of identifying efficient and equitable ways of delivering healthcare outcomes, the healthcare system in Thailand is also plagued by the problem of inadequate coverage and large variations in the entitlement of benefits offered by the various healthcare insurance schemes. The amount of money available to cover the costs of treating the same disease varies between the different healthcare schemes. Other variations exist in relation to the benefits offered. For example CSMBS participants are entitled to be provided with services in all participating hospitals throughout the country, whilst the SSS and UC participants can only use the services of registered hospitals under these schemes. The SSS participants are required to make a monthly payment of 200 baht in order to retain their right to access medical treatment, whilst participants of the CSMBS and UC scheme are entitled to receive medical treatment without being required to make any payment (Pitayarangsarit, 2004).

The participants in the SSS and the UC scheme felt that they were provided with services of a lower standard, as the cost of their treatments had to be covered by the per capita allocation. Hospitals participating in the SSS and UC scheme were thus motivated to cut costs. In contrast, the disbursement of money to cover the cost of medical treatment as practised in the CSMBS was based on a fee for services and the

hospitals joining the CSMBS had free rein in determining the treatments required by a particular patient. An attempt was made to eliminate this discrepancy which discriminated against patients in the other two schemes by allocating funds to them for the treatment of severe and chronic diseases. As a result, the idea of centralising the administration of the three schemes in order to reduce the discrepancy in accessibility to high quality services and the variation in entitlements was proposed. The efficiency of the healthcare system in Thailand would have been improved if it was administered by a single agency or ministry. On the one hand, such a merger is likely to be resisted by hospitals who prefer to offer expensive treatments if they are unconstrained and also by patients in the more generously funded public schemes (Tangcharoensathien, 2004; Pitayarangsarit, 2004).

2.5.3 Viability

Any healthcare scheme also has to pass the test of viability. The viability of a programme can depend on a variety of political economy considerations that determine whether the demands made on a programme can be financed given the political economy of a society. Thus, viability depends on the political feasibility of sustaining the financing for a project, which depends on: local political conditions and the willingness to pay of different categories of patients and taxpayers; the existing management systems, cost structures, and specialisations of different types of healthcare providers into which the new system has to fit; the demands that are likely to be made on a particular programme given the healthcare requirements and conditions of a particular country; and the broader political acceptability of the programme in the particular historical context (Pitayarangsarit, 2004).

The main objective of the UC scheme in Thailand was to guarantee equal access to decent healthcare services. The scheme was built on three principles: 1) financing based on general taxation, rendering it a free scheme at the point of service delivery; 2) the availability of all types of healthcare services and benefits with an emphasis on primary services; and 3) close-end budgeting to particular healthcare providers with the provision of predetermined payments to control costs. Mechanism for the protection of the rights of patients and healthcare providers, the dissemination of information, dealing with complaints, and awarding compensation when mistakes happen were not

available at the outset and many of these systems are yet to be created at the time of writing. More importantly, a system of hospital accreditation has not yet emerged and all hospitals are not required to participate in the UC scheme (Pitayarangsarit, 2004).

In informal discussions, healthcare professionals recognised a number of critical issues that need to be addressed in order to improve the efficiency and effectiveness of the healthcare system in Thailand. These include: 1) an effective separation of buyers of services in the public authorities and the service providers who are often public hospitals; 2) an enhancement of research and development capabilities based on a network of research units involved in research and development to improve the quality of services over time; 3) systems for dealing effectively with political pressure and insulating hospitals from these pressures; 4) the development of effective systems for public participation in discussions of healthcare priorities and the quality of service; and 5) systems to control the risk of uncontrolled expenditures (Jongudomsuk, 2002; Sunthorndham, 2012)

A consideration of the problems affecting the healthcare system in Thailand led to the formulation of the research questions concerning the UC scheme, to determine some of the answers related to the efficiency, equity, and viability of this scheme. These can be categorised as follows:

1. Efficiency:
    a. Was the new scheme properly costed and did the government make appropriate plans for providing adequate funding for sustaining the scheme?
    b. Does the scheme achieve a specified health gain via a minimum number of inputs and at the lowest cost?
    c. Does the scheme maximise a specific healthcare gain from a specified level of resources?
2. Equity
    a. Did the 30 baht scheme achieve a sustained improvement in accessing healthcare services for previously excluded groups in Thailand?
    b. Did people receive medical treatment under the UC scheme without discrimination?

c. Did the treatment arrangements satisfy the needs of all groups of people?
d. Did the UC scheme achieve the objective of keeping people in good healthcare?

3. Viability
    a. What were the sources of problems for maintaining the financial viability of the system?
    b. Did the healthcare system have an adequate mechanism for identifying care priorities?
    c. What were the problems preventing the identification of healthcare priorities?
    d. What were the political drivers behind the adoption of the 30 baht scheme, and how did these affect the design and implementation of the scheme?
    e. Did the UC scheme achieve sustainably?

It was not envisaged that a single research project would find comprehensive answers to all these questions. However, as these questions are closely interrelated, the answers to those questions that were examined more closely provide insights into a range of related questions. The research was then organised around a limited range of research objectives that were explored in greater detail.

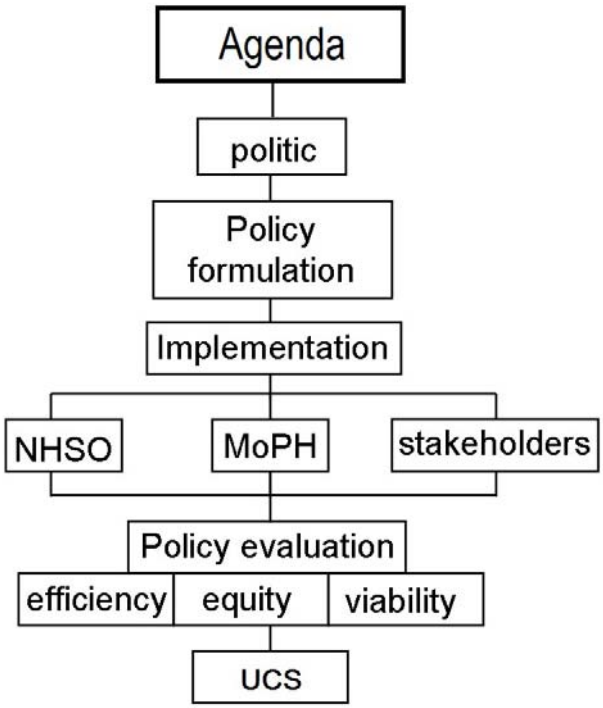
2.6 Research objectives

The study had a number of objectives. It does not aim to provide a full evaluation of the scheme and its viability, but to provide insights into a number of aspects that may contribute to a fuller understanding of the project. The UC project is important enough for it to survive in some form or other in Thailand, despite having been subject to significant criticism and having made some backward steps, particularly with the opting out of most of the private hospitals that initially engaged in the scheme. The insights that this research offers at the ground level may be useful for contributing to a thorough evaluation of the programme and the directions in which it needs to be reformed to enable it to become fully sustainable and contribute to a viable healthcare system in the country. The study objectives included:

1. To study the political economy of the Universal Health Coverage Scheme and the impact on policy implementation;
2. To study the access to the Universal Health Coverage Scheme in Thailand;
3. To study the financial management of the Universal Healthcare Coverage Scheme in Thailand;
4. To study the implementation of the Universal Healthcare Coverage Scheme through case studies of particular hospitals.

To organise several theories and ideas into a lens to investigate UC policy, the study uses a framework of policy analysis because it provides a useful device to explore the interrelationship of political economy and public policy. It is composed of political drive and policy outcome.

Figure 2-1 – Conceptual framework of the political economy of Thailand's '30 baht' UC scheme



Note: 1. NHSO: National Health Security Office 2. MoPH: Ministry of Public Health 3. UC: Universal Healthcare Coverage

2.7 Scope of the research

The aim of the research was *not* to provide a comprehensive answer to these questions as that would require a scale of data collection and investigation across regions that would be beyond the scope of a single research dissertation. However, as the next chapter explains, the aim was to use available data and new data based on case studies to shed light on these questions and to inform a more comprehensive debate on the healthcare sector reforms in Thailand. These limited objectives were difficult enough to achieve. The initial objective was to engage in detailed case studies of six hospitals of different types across Thailand. However, it was found that hospitals were very reluctant to share financially and politically sensitive data and information on their participation in the healthcare programme and the internal responses and cost-saving and service delivery mechanisms they adopted in response to the emerging financial limitations of the scheme. As a result, though much time was initially spent on all six hospitals and trying to collect information on their responses, the study narrowed down the case study section to two hospitals. Fortunately, the two hospitals were significant in representing two different types of responses.

The first was a private hospital that was one of the first to opt into the Universal Healthcare Coverage Scheme. It tried to adapt its service delivery and financial management to the requirements of the healthcare scheme. However, as the financial implications of the scheme became more obvious this hospital found that its continuing participation in the scheme was resulting in a two-tier healthcare delivery system within the hospital that was detrimental to the satisfaction levels perceived both by the 30-baht patients as well as the private patients who were paying much higher fees for services. As a result, this hospital eventually opted out of the system. As this pattern of opting in and eventually opting out was a common feature of many private sector hospitals, this example is significant in identifying some of the internal management problems of dealing with the financial allocations and expectations of the Universal Healthcare Coverage Scheme.

The second hospital was a public hospital that made great strides in adapting to the 30-baht programme. Unlike many public hospitals that were put under great strain by the programme and struggled to manage workloads on staff and growing financial deficits,

our second hospital was one of the few that did rather well but by specialising in particular types of treatments and by innovating new internal management routines that were particularly good at delivering these specialised services. The second hospital therefore represents the types of public sector responses that were viable and that are increasingly being adopted by other public sector hospitals.

The study is limited to an investigation of the UC scheme from 2002-2010. The topics of study range from efficiency and sustainability, to the politics of programme initiation, the enactment of the National Health Insurance Act, and programme operation. It also looks at the different interest groups which stand to gain or lose from the existence of the scheme, such as politicians, civil servants, healthcare-related professionals, hospitals, patients and NGOs. Within this broad remit, the study limits itself to particular aspects of these problems that emerge from discussions with our target respondents without aiming at achieving a comprehensive assessment of the scheme as a whole in terms of these criteria.

2.8 Research methodology

2.8.1 The research process

The research methodology is largely qualitative, based on an analysis of political economy and based on extensive discussions with service providers, administrators and politicians. These discussions took place after the researcher conducted his preliminary study on the UC scheme and related topics, such as the enactment of the relevant laws, the policy making process, the evidence of political pressures and priorities, and the problems and difficulties related to policy implementation. The researcher then studied the theories available and selected the appropriate ones to be used as a guideline and frameworks for conducting the study and data collection process, as shown in Appendix 1. The checklist questionnaires are shown in Appendix 2. Data collection was performed at the national and provincial levels. Data from the national level mostly concerns policies, working procedures, executive decisions, and policy implementation at the national level, whilst data from the provincial level is mostly concerned with policy implementation and the related problems and difficulties. Other data on the UC scheme includes opinions about the scheme and satisfaction with the services offered by the scheme, as well as its impact based on questionnaires distributed to case study

hospitals. The findings and their interpretation were then subjected to re-evaluation, verification, and comparison with the data previously collected. As the UC scheme is notable for its sheer size and complexity, its assessment cannot be based on a simple set of parameters and measurements. The researcher thus opted for an inductive approach characterised by the collection of data in order to propose different hypotheses that provide partial assessments and explanations.

2.8.2 Research ethics

The data collection and interviews followed the requirements of research ethics recommended by SOAS, University of London. At the time the research project commenced, there was no requirement from the university to get formal ethical approval from the relevant authorities in the country being researched, but there were guidelines on the conduct of the research and measures to be followed to protect all individuals being interviewed and organizations providing information. These guidelines were fully complied with. In particular, the researcher fully informed all research participants of the purpose of the research, the methods to be used, the possible uses of the research, including public presentation and publication. All names of individuals and hospitals that are referred to in the text have the express approval of the individuals or responsible officers of the hospitals. Harm to any participant was also avoided by making sure that any comments or criticisms that could be attributed to interviewees that may have consequences for their welfare or their future access to services (however unlikely that may be) were not used, or were used in an anonymised form. Moreover, any documents that contained confidential or sensitive information, or names or details of patients, were not used. When the researcher accessed and used quantitative or qualitative information from parts of such documents, he ensured that these documents remained in the custody of hospitals or other responsible agencies at all times.

Preparation for the interviews consisted of the following steps and at each stage ethical guidelines were strictly adhered to:

1. Interview planning: this step was marked by the researcher thoroughly reviewing the available empirical and theoretical literature, and formulating questions. The questions relevant to the objective of the research fell into four categories.

a) Questions about policymaking and financial management. This part of the interview questions were concerned with:

- The steps in policy formulation regarding treatment, as well as the identities of those pushing for and against the policy formulation;
- The legal framework of policy and regulation regarding treatments;
- The factors contributing to the effectiveness of the policy.

b) Questions about the problems and difficulties in implementing the UC scheme.

c) Questions about efficiency, equity and sustainability:

- How was the efficiency of the management of the scheme measured?
- Did the scheme result in equity and complete coverage?
- Is the scheme sustainable and what are the factors contributing to its sustainability?

d) Questions about the appropriate model for the national healthcare system which incorporates the principles of efficiency, equity and viability.

At each stage both the analytical questions and the ethical implications of interviewing particular categories of respondents was considered to determined the feasibility of particular lines of enquiry.

2. Arranging the interviews: This step involved the researcher identifying the most likely sources, who were both well-informed and most likely to give extensive answers to sensitive questions. The interviewees included:
   - National politicians who were members of the House of Representatives and local politicians who were representatives of municipalities, administrative organisations of the provinces, and the administrative organisation of Tambons or sub-districts.
   - The executive committee of the National Health Security commission.
   - Managers of state-run and private hospitals.
   - Users of the services provided by state-run and private hospitals.

2.8.3 Research tools

- In-depth interviews consisting of questions formulated to obtain data from key informants, including the executives of the NHSO, the managers of private hospitals, and personnel involved in the provision of services. These included questions on the background of the scheme, risks involved, guidelines for service provision, efficiency, equity, viability, regulations on cost control, the results of the implementation of the UC scheme, and an appropriate model for the scheme.
- Reliability and validity assurance.

The questions used in the in-depth interview were examined by experts from a number of agencies, including:

- The National Health Security commission.
- Thailand Development Research Institute (TDRI).
- National Economic and Social Development Board (NESDB).
- The Ministry of Public Health (MoPH).
- The National Health Security Office (NHSO).

Duration of study:

The fieldwork was carried out from 1 October 2011 to 31 March 2012.

2.8.4 Selection of hospitals for the case studies

The core of the research used a case study approach, which has a number of advantages and disadvantages depending on three conditions: the type of research questions; the control an investigator has over the design of the questions and following them up with further investigations; and whether the phenomenon is so contemporary that statistical evidence may be unavailable (Yin, 1994). The case study approach also has the ability to answer ‘how and why’ questions concerning a contemporary set of events over which the investigator has little control (Yin, 1994).

The hospitals selected by the researcher initially included six hospitals but it was expected that not all of them would proceed to a full case study. The research was

finally focused on two in-depth case studies. These were a state-run hospital and a private hospital, where the objective was to study the provision of services, policy implementation, budgetary allocation, project management, problems and difficulties in provision of the service, and the impact of the scheme. The hospitals were selected because apart from their obvious differences, they were also similar in that they joined the UC scheme at a very early stage of the introduction of the scheme. They were also different in that the public sector hospital innovated arrangements that allowed it to stay within the scheme whilst the private sector hospital dropped out eventually. The case studies were conducted to investigate the responses of the hospitals to the scheme. All six hospitals that were initially approached were selected following suggestions from three or more qualified personnel who identified the appropriateness of the hospitals in terms of relevance for the research questions of the research. The two hospitals that were finally selected for the case study are:

1. Baanpaew Hospital in the province of Samutsakorn – a state run hospital which continues to participate in the UC scheme.
2. B-Care Hospital in the province of Pathumthani in the Greater Bangkok area – a private hospital which initially opted in but then opted out of the UC scheme.

2.8.5 Selection of key informants

The selection of specific informants to interview was achieved on the basis of purposive sampling, and targeting key informants was consistent with the objectives of the study. These included academics, experts, and the director of the Office of Policy and Planning for the NHSO.

Key informants were selected for in-depth interviews, and they were divided into two groups. The first group included those involved in policy making, such as heads of public sector organisations, politicians involved in healthcare related issues, members of the National Health Security commission, and executives of the National Health Security office. The second group comprised of service providers and patients involved in the UC scheme, including the managers of state run and private hospitals and patients benefitting from the scheme.

For the first group of interviewees, the researcher focused on politicians, members of the National Health Security commission, and academics as shown in table 2.2.

Table 2-2 -Members of the National Health commission

Type of interviewee	**Number of interviewees**
National politicians and local politicians	6
Civil servants	3
NGOs	3
Academics	4

For the second group of interviewees, the researcher opted for purposive sampling in order to select key informants that clearly represented this group, as shown in table 2.3.

Table 2-3 - Group 2 interviewees

Interviewees	**Hospital Size**			**Number of Interviewees**	**Total**
	Large	**Medium**	**Small**		
Management of the state-run hospital	2	2	2	6	**6**
Management of the private hospital	**2**	**2**	**2**	**6**	**6**
Patients	2	2	2	6	6
Total					**1**8

The researcher conducted in-depth interviews on topics related to the research questions discussed above. The interviews involved introductions, breaking the ice and cultivating trust, and recording answers to questions. The times and locations, as well as language used, were taken into consideration in the preparation for the interviews. Thai professional culture requires an elaborate process of introductions and discussions before questions can be asked on specific topics. The researcher is a doctor who has been involved in the healthcare system for a long time, and had the advantage of having a high level of credibility in asking questions on a research basis. The researcher also had considerable prior inside knowledge of the way the Thai medical system works. These advantages were critical in procuring credible information from the informants. Nevertheless, as has been explained earlier, despite these advantages, many hospitals were reluctant to disclose information beyond the general, and the final case studies had to be limited to two cases.

2.8.6 Textual analysis

Textual investigations of secondary literature of different types was used extensively, including documents, publications, records, minutes, and official proceedings relevant for understanding the different ways in which organisations carried out their activities. Public opinion polls were also informative to understand whether the public supported the policy or not. The text was first treated as a description, as telling the story of what has happened. However, a parallel analysis using an inductive approach was also carried out to analyse the complex data and documents as it was not unusual for the official texts to be overoptimistic in their assessments (Thomas, 2003).

To fulfil objectives 2 and 3, the methods of data collection and data analysis were as follows:

Data collection at the national level:

1. Data from the Ministry of Public Health (MoPH).
2. Data from NGOs.
3. Data from political parties.
4. Data from the Countryside Doctor Society.

Data collection at the provincial level.

Data from targeted provinces.

Primary data: obtained from those involved in policymaking, workers, directors of state-run and private hospitals, and those affected by the UC scheme. In-depth interviews were conducted with those involved in the scheme and those standing to gain or lose from the existence of the scheme.

Secondary data: obtained from annual reports, research, articles written in Thai and in foreign languages that pertain to the UC scheme, cabinet resolutions concerning the scheme, media coverage from 1997 up to the present time, data from the National Statistics Office, Thailand Development Research Institute (TDRI), National Economic and Social Development Board (NESDB), the MoPH, project evaluation of the UC scheme conducted by various institution, and reports on the operation of the NHSO.

2.8.7 Data analysis and verification

Verification of published data and analysis was based upon data triangulation across sources and using our own fieldwork and experiences in the healthcare sector to check whether particular sets of data or particular responses were credible or likely to be erroneous. With regard to the time factor of verification, the researcher conducted the interviews with those involved in the scheme's operation at different times. Different individuals from different agencies involved in the implementation of the UC scheme were also interviewed to enable triangulation. After data collection, the researcher checked whether the data content was different from that of other interviewees and the cause of such discrepancies was investigated and determined as much as possible.

To ensure that the interviews were conducted smoothly and were not bothersome to the interviewees, the researcher extensively reviewed the questions before commencing the interviews. Moreover, an informal and open-ended style was used that was appropriate in the Thai context, as explained above, with the written questions providing a background guide to long conversations. Interviewees were also asked for their permission to record the interview and the recorded material was subjected to detailed content analysis later on to ensure that nuances were not misinterpreted or overlooked.

2.9 Limitations of the research

Direct enquiries on an issue that is highly politicised in Thailand are very difficult due to cultural and political sensitivities. Data relating to such matters had to be obtained from various sources so that the consistency of the data could be checked as far as possible.

In-depth investigations about what the data means require a great deal of collaboration and co-operation on the part of the interviewees. Healthcare professionals are very busy and time given to this kind of digging is inevitably very limited. If the respondents were able to give much more time possibly the results would have been more nuanced. However, the broad results were not significantly distorted by the time limitations facing the respondents.

Thai has a discursive style of presenting political and economic ideas. Some distortion of meaning may arise during the translation from Thai into English. The fact that the researcher was also Thai mitigated these problems.

Certain types of data are kept hidden and sources cannot be identified, especially those involving political interests, and some of the internal hospital information about economic viability was commercially sensitive. It took a considerable amount of time to check data, identify its source, and then access the source. Once again, whilst it was not always possible to get hard statistics, the author is very confident about the qualitative results.

The hospital selection is thus by no means fully representative. The sample ignores many other important types of hospitals, like large public teaching hospitals or small private sector clinics. However, the two hospitals represent some important types of responses and can help to identify some of the important implications of the types of financing and management systems that are associated with the national financing policy that was gradually implemented in association with the universal healthcare system.

2.10 Conclusions

The methodology of the research on the efficiency, equity, and viability of the UC scheme is largely qualitative, based on secondary documents, and primary research based on in-depth interviews with selected critical respondents selected in accordance with the objectives of the research. Those selected as interviewees within the healthcare system were experienced healthcare personnel who had been involved in the healthcare insurance system for a long time and consequently they could provide useful data that helped to fulfil the research objectives. Politicians and bureaucrats were also interviewed to provide other perspectives on the design and implementation of the policy.

Data analysis and verification was based upon triangulation and comparison of particular responses and data with the broader data set and overall performance of the system. Inductive reasoning was applied to interpret the data obtained from the

interviewees and from published sources. The interpretation of this information is the substantive contribution of this research.

Chapter 3. The development of healthcare in Thailand: a historical background

The UC scheme with its overarching goal of equal entitlement to healthcare among all Thais has three defining features: a tax-financed scheme free at the point of service; a comprehensive benefits package with a primary care focus; and a fixed budget and a cap on provider payments in order to control costs. Prevention and healthcare promotion were included in the benefits package, and a number of mechanisms were set up to protect UC scheme beneficiaries, such as an information hotline, a patient complaints service, a no-fault compensation fund, and tougher hospital accreditation requirements (HSRI, 2012).

3.1 Background to health insurance in Thailand

Health insurance in Thailand has steadily evolved; before the great healthcare reform was initiated in 2001, the state had provided healthcare insurance programmes which can be grouped into five main categories:

1. Social welfare for the low income earners and those deemed deserving of help from the state;
2. Voluntary healthcare programmes;
3. Social welfare in the form of medical services provided to bureaucrats, retired bureaucrats living on pension, and employees of state enterprises;
4. Compulsory healthcare insurance as dictated by the Social Security Act; and
5. Contingency healthcare insurance, exemplified by the law concerning danger from automobiles.

In addition to the healthcare insurance programmes supported and initiated by the state, there were also healthcare insurance services provided by insurance companies. Due to the existence of these varied healthcare insurance programmes there was a disparity in the benefits. The expenses for the healthcare insurance programme for bureaucrats and employees of state enterprises dramatically increased, as the programme offered move benefits to those covered by the programme. However, the healthcare insurance

programme for bureaucrats and employees of state enterprises was in total subsidised eight times more than the healthcare insurance programme for low income earners (Tangchareonsathien, 2004). This fragmented healthcare insurance system gave rise to an inadequacy in coverage and efficiency, and undermined the equality of opportunity in accessing healthcare services. Inefficiency stemmed from a lack of bargaining power on the part of the user and the fact that healthcare providers' performances were not subject to public scrutiny. The practice of a 'fee for service' resulted in the expenditure on healthcare increasing at a greater rate than that of the GDP, even in during the economic recession (Sri-anan, 2002).

The UC scheme or 30 baht scheme was aimed at creating a healthcare insurance system marked by proper quality control which was made possible through the separation of users and service providers. Previously, the MoPH allocated funds to its subsidiaries via supply side financing, which did not reflect the demand of users. However, when the focus was shifted to the role and performance of the service providing units affiliated to the ministry, as well as their relationships with the users, the allocation of funds became responsive to the demands of the units and in fact reflected the demands of the users. Budgetary allocation then occurred through demand-side financing. Consequently, the MoPH was thus deprived of its power to a certain extent in determining the budgetary allocation (HSRI, 2012).

The state was assigned the duty of lowering healthcare and financial risks through the provision of subsidies. In addition, the UC scheme also featured a mechanism which was designed control costs through payments in accordance with a closed agreement made in advance with the healthcare units, thus limiting the financing in order to prevent excess spending (Pitayarangsarit, 2004).

The stated goal of the UC scheme is to 'equally entitle all Thai citizens to quality healthcare according to their needs, regardless of their socio-economic status.' This goal is based on the universality principle, and the scheme was conceived as a scheme for everybody, and not one that targets only the poor, vulnerable, and disadvantaged (HSRI, 2012). The strategic objectives of the UC scheme are:

- To focus on healthcare promotion and prevention as well as curative care.

- To emphasise the role of lower-cost primary healthcare and the rational use of effective and efficient integrated services.
- To foster proper referral to hospitals.
- To ensure subsidies on public healthcare spending are pro-poor, at the same time ensuring that all citizens are protected against the financial risks of obtaining healthcare.

The National Health Security Act was enacted in 2002; however, the MoPH initiated the 30 baht scheme prior to its enactment. The pilot projects were implemented in two stages in 21 provinces: during the first stage, projects were implemented in the six provinces of Payao, Yasothorn, Nakorn Suwan, Patumtani, Samutsakorn and Yula from 1 April – 30 September 2001; the second stage saw project implementation in fifteen provinces of Nontaburi, Saraburi, Srakaew, Petchburi, Nakornratchasima, Surin, Nongbualumpoo, Ubonratchathani, Amnajcharoen, Sukhothai, Prae, Chiangmai, Phuket and Narathiwat from 1 June – 30 September 2001; and finally, the scheme became nationwide on 1 April 2002, with Bangkok being the last province covered.

3.2 Evolution of health insurance in Thailand

The healthcare insurance system in Thailand has evolved since the establishment of the MoPH in 1942. Before this time people had to share the cost of treatment in state-run hospitals, but in 1945 a measure to protect people from the financial risk attributed to costly treatment was taken for the first time. The poor were informally made exempt from paying service fees by the government officials in charge of social welfare, who exercised their discretion regarding this matter. The practice of informal exemption from the payment of service fees evolved into the practice of granting the right for free medical services based upon a consideration of the level of household income through a means testing scheme. Cards have been issued every three years since 1981 to those households whose income is below the poverty line (Tangcharoensathien, 2002).

Bureaucrats and employees of the state, whether they were retired or not, were eligible for free medical treatment, together with their parents, their spouses, and up to three offspring yet to come of age. Workers in the private sector were eligible to claim compensation for the cost of medical treatment from the social security fund to which

employers and employees paid into through the SSS. The middle income earners who were neither bureaucrats nor workers in the private sector could opt for the VHCS through the purchase of cards for 500 baht, and this voluntary scheme was subsidised by the state. The wealthy who could afford healthcare insurance policies bought these from insurance companies. Table 3.1 chronicles the milestones of healthcare insurance in Thailand, which include the introduction of healthcare insurance policies by insurance companies in 1929, the enactment of the first Social Security Law in 1954, and finally the enactment of the National Health Security Act in 2002.

Table3-1 - The history of healthcare insurance in Thailand

Year	Event	SW	FB	CI	VI
1929	Health insurance policies offered by insurance companies				✓
1954	The first social security law (no enforcement)			✓	
1974	Compensation fund for labourers			✓	
1975	Free medical services for the poor	✓			
1978	The first private firm specialising in healthcare insurance				✓
1980	The medical welfare programme for civil servants		✓		
1981	The issuance of cards for the poor	✓			
1983	Phase 1 of healthcare card scheme : Fund for mother and child healthcare				✓
1984	Phase 2 of healthcare card scheme : Fund for mother and child healthcare				✓
1990	Social security law imposed on firms with 20 employees or more			✓	
1991	Phase 3 of healthcare card scheme marked by the adoption of insurance policy and premium				✓
1992	Free medical services for the elderly	✓			
1993	Law protecting the rights of persons involved in road accidents			✓	
1994	The extension of the scope of the social security law to include firms with ten employees or more			✓	
1994	Phase 4 of the healthcare card scheme marked by the state's contribution to the scheme and allowing for the use of cards issued in other zones				✓
1994	The inclusion of community leaders and healthcare volunteers in the healthcare card scheme and the full contribution to the scheme by the state		✓		
1994	Medical welfare programme for earners of low incomes and the needy	✓			
1998	New regulations linking budgetary allocation to the welfare programme for low-income earners to provincial population. (the next two sentences are not clear) The introduction of reinsurance for costly treatment through the reimbursement method based on DRG (Diagnostic Related Groups). Adoption of global budget applied to the case of costly treatment	✓			
1998	Change in the method of reimbursement in the welfare scheme for civil servants marked by the introduction of co-payment. The privilege given to civil servants becoming restricted to the acquisition of essential drug free of charge. Limitation in a person's use of special room imposed on civil servants		✓		
2000	Inclusion of pensioners and youths in the Social Security Scheme			✓	

Year	Event	SW	FB	CI	VI
2001	Pilots projects as part of the introduction of the UC Scheme were carried out in six provinces	✓			
2002	Nationwide implementation of the Gold Card Scheme. Enactment of the National Health Insurance Act	✓			

Source: Adapted from Tangchareonsathein, 2002, cited in Supachutikul

SW = Social Welfare, FB = Fringe Benefit, CI = Compulsory Insurance, VI= Voluntary Insurance

3.3 The different forms of health insurance

Prior to the introduction of the UC scheme, six forms of healthcare insurance existed targeting six different groups of people as shown in Table 4.2 follows.

Table3-2 -The different healthcare insurance schemes prior to the introduction of the UC scheme

Scheme	Number (million)	Percentage
Health Insurance Scheme for the poor	16.821	27
Voluntary healthcare scheme subsidised by the state (500 baht card)	11.214	18
CSMBS	7.787	12.5
SSS	5.295	8.5
Voluntary healthcare insurance scheme	1.246	2
The uninsured	19.936	32
Total	62.299	100

Source: Adapted from MoPH, 2010 (Thai Public Health, 2008-2009) cited in NSO

The healthcare insurance scheme for the poor was initiated in 1975 and evolved from the social welfare scheme for the poor. The scheme was extended to cover the elderly in 1989, children up to 12 years old, the disabled, veterans and their families in 1992, and community leaders and healthcare volunteers and their families in 1994. Since 1979 the issuing of cards, formerly at the discretion of the commission, has been based on information relating to incomes. However, the scheme only covered 30% of the poor in 2001 and its main issue was its inaccessibility for a large number of the poor as a result of the failure to achieve a fair distribution of the cards. As a result, the majority of the card holders were not actually poor.

The VHCS, which was supported by the state, was initiated in 1953 for workers outside the public and private sectors, such as peasants, freelancers, vendors, and shop owners. This scheme evolved from the community healthcare insurance funds set up by the MoPH, which promoted the access to basic healthcare services for rural people. Cards were sold at a subsidised price, and between 1993 and 2001 a card that was worth 1,000

baht was actually sold at 500 baht, and when the value of a card increased to 1,500 baht, the state bore the increase. These cards were informally referred to as the 500 baht card, and treatment was limited to no more than five familial members within the period of one year. The benefits offered by the scheme were nearly the same as those offered by the MWS for the poor. The scheme covered 23.4% of the population and was popular among rural people until its termination in 2001.

The CSMBS was initiated in 1980 and the entitlement to the benefits offered was also granted to spouses, offspring and parents. Individuals covered by the scheme could use the healthcare services at state-run hospitals throughout the country, but the use of private hospitals was permitted only in the case of accidents with the limit for allowable expenses for central and provincial bureaucrats being set by the comptroller general's department. These allowable expenses for local bureaucrats and employees of state enterprises were determined by the organisation to which they belonged. Outpatients were required to pay the service fee before they were eligible for reimbursement, and inpatients were required to present a document signifying the acknowledgement of their illness from the organisation to which they belonged. Hospitals then used these documents to obtain reimbursement from the comptroller general's department. In 2005 people covered by the scheme who suffered from chronic illnesses and who were pensioners could have their names registered as prospective users of the services provided by hospitals and hospitals were reimbursed by the comptroller general's department on the basis of these lists with patients not being required to pay any service fees. This practice was later applied to other bureaucrats who were not suffering from chronic illness. As the state provided reimbursement for the actual service fees the expenses of the scheme were high.

The compulsory healthcare insurance scheme initiated by the state was comprised of two funds which were managed by the Office of Social Security of the Ministry of Labour and the Social Security commission:

1. The compensation fund for illnesses attributed to working conditions, which was set up in 1974; and
2. The social security fund, which was set up in 1990.

These two funds were set up for employees within the private sector. Employers were obliged to assume the sole responsibility for contributing to the compensation fund, whilst workers, employers, and the state made equal contributions to the social security fund. The benefits offered by this scheme were nearly the same as those offered by the other healthcare insurance schemes.

A compulsory healthcare insurance scheme for road accidents was initiated in 1993 and owners of automobiles were made responsible for medical treatment expenses and to compensate victims of accidents, and therefore were required to purchase insurance policies.

Voluntary healthcare insurance schemes were initiated by the private sector and could be accessed through the purchase of insurance policies. These schemes were introduced into Thailand around 1910 by multinational insurance companies. Private sector healthcare insurance is more attractive to wealthy people, and its scope is undergoing a steady expansion. Several home-grown insurance companies are also engaged in this business and by the end of 2001, individuals holding such insurance policies accounted for 1.2% of the total population.

Table 3-3 - Features of the healthcare insurance schemes in existence prior to the introduction of the UC scheme

Type	MSW	Card	Civil Servant Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)	Protection of the right of the people affected in road accident	Insurance company
Inception	1974	1975	1978	1990	1993	Around 1910
Type in general	State welfare	State-sponsored voluntary scheme	State welfare	State-sponsored compulsory Scheme	State-sponsored compulsory scheme impose on automobile owners	Insurance company
Model	Public/integrated model	Voluntary integrated model	Public reimbursement model	Public contracted model	Public reimbursement model	Voluntary reimbursement model
Targeted groups	The poor and the needy	The persons above poverty line but uninsured	Bureaucrats employees of state enterprise and their familial members	Employees of the private sector	The persons affected by road accident	Welfare people

Type	MSW	Card	Civil Servant Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)	Protection of the right of the people affected in road accident	Insurance company
Coverage year to which this data refers	30%	23.4%	8.5%	7.6%	Every body	1.2%
Finance						
Source of Fund	Budgetary allocation by the state	Sponsored by the state and household	Budgetary allocation by the state	Equal contribution by employer employee and the state	Owners of auto mobiles	households
Supervisors of the funds	MoPH	MoPH	The Ministry of Finance	The Social Security Office		Insurance Company
co payment	None	None	Patients reliant on the services provided by private sector	Emergency service with the cost exceed the limit exceeding		Exceed the limit
Per capita expenses (baht)	>363 + subsidies	534 + subsidies	2,106	1,558	Data unavailable	Data unavailable
Main problems	Not covering the poor	Poor distribution of risk	Dramatic and continual increase of expense	Covers only the period of employment	Delayed compensation	Selection of risk

Source: Adapted from MoPH (2008) and Tangcharoensathien (2002)

3.4 The three current health security schemes and their sources of funding and benefits provided to participants

3.4.1 The healthcare system in Thailand

There are three types of healthcare security schemes operating in Thailand: the CSMBS, SSS, and UC schemes. The first is a fee-for-service type, exemplified by the Civil Servant Medical Benefit and State Enterprise Scheme (CSMBS). Hospitals providing services to patients covered by the scheme would get fees at specified rates for different treatments paid by the government. This is the most generous publicly funded scheme because it allows the highest per capita treatment costs. The second is a compulsory contribution type of system, exemplified by the Social Security Scheme (SSS) which depends on equal contributions to the Social Security Fund by the government, employers, and employees. Here the costs of treatments have to be

covered by these funds. Finally, the third is a UCS type of universal healthcare coverage, which is designed to benefit those not covered by the two other schemes.

3.4.2 Medical welfare for bureaucrats

Bureaucrats, pensioners, and employees of bureaucratic organisations are entitled to inpatient and outpatients services. According to the Medical Welfare Act of 1980, civil servants can use the services provided by all state-run hospitals. The expenses covered by the CSMBS are:

1. Drug, blood, blood components and other chemicals used as substitutes for blood, nutrients and others items used in treatment;
3. Artificial organs, medical equipment, and the cost of their maintenance;
4. Service fee, examination fee, diagnosis fee, but the fees for nursery and extra services are not included;
5. Room service and food supply during treatment; and
6. Annual medical examination and an annual examination contributing to the public healthcare service.

The scheme also covers a civil servants' spouses and familial members who are lawful offspring yet to come of age, or have come of age but legally deemed incapable or nearly incapable and under the care of their parents who are entitled to the welfare. Adopted children or the children adopted by others are not entitled to the benefits.

Reimbursement is calculated by the number of times they use the services and hospitals can directly seek reimbursement from the comptroller general's department through an electronic system when civil servants become inpatients. Payment is made in accordance with the diagnosis related group (DRG). Outpatients must show to which organisation they belong and hospitals then again directly seek reimbursement for them. Payment is based on the rate of service fee set by the hospitals.

Since 2004 the cost for outpatients has continually increased whilst that for inpatients has decreased as the DRG method has been used to calculate expenses. Increased expenses are due to: 1) the open-ended allocation of funds which allows excessive claims to be made; 2) a large proportion of the scheme are pensioners and their familial

members; and 3) payment is based on the number of times services are provided and this has resulted in hospitals becoming motivated to seek profits through the dispensation of costly drugs, etc. (Health Insurance System Research Office, 2009).

3.4.3 The Social Security Scheme (SSS)

The welfare of employees in the private sector is protected by the 1980 Social Security Act. The Office of Social Security is responsible for the management of the social security fund and is guided by the principles of:

1. Workers contribute 5% of their earnings to the fund;
2. The SSS is compulsory in nature;
3. The fund is for paying out compensation and investment in lucrative businesses;
4. The right to obtain compensation depends on previous contributions to the fund; and
5. There is a correlation between earnings, contributions to the fund and the compensation received.

Those who contribute to the fund are entitled to compensation for injury or illness, child delivery, disability, death, child rearing, ageing and unemployment. Those who contribute to the social security fund are entitled to the following medical welfare benefits:

1. The selection of a hospital according to personals preference, either state-run or private hospitals joining the SSS. They are also entitled to the services provided by the main hospitals which are considered the primary units and the network of hospitals which are considered the tertiary units.
2. Access to all drugs on the list of essential drugs and also those required by prescription. Artificial organs and other apparatus are included in the per capita allocation for service fees.
3. Access to anti-HIV drugs and antidotes to drug resistant microbes.
4. Organ transplantation, bone marrow transplantation, cataract surgery, and kidney transplantation.

5. Dialysis therapy if afflicted with dysfunctional kidneys.
6. Access to emergency services in cases of sudden illness or injury provided by the nearest units. For sudden illness the service can be used no more than twice annually but there is no limitation for injuries.
7. Pregnancy care and child delivery with the payment of 13,000 baht, limited to two occurrences only.
8. Dentistry services, including tooth removal, lime elimination, and false teeth as required by prescription.
9. Access to the services provided by state-run hospitals for the disabled with full support from the social security fund which bears the cost required for treatment when disabled individuals are treated as outpatients. When they are inpatients then the payment is based on the DRG, as for when services are provided by a private hospital.
10. Claims for the cost of transportation that are not more them 500 baht in cases of sudden injury or illness within localities. The 500 baht limit is for the use of ambulances provided by hospitals, but when hired vehicles are utilised then the limit is 300 baht. If sudden injury or illness occurs in localities in which a scheme participant is not registered as a resident, then the claim for transportation cost is six baht per kilometre.
11. Health promotion and disease prevention.

3.4.4 Universal Healthcare Coverage

Thais who are not covered by the two schemes described above are entitled to the benefits of healthcare services provided by the National Health Insurance Act 2002, which required the establishment of a fund to be managed by the National Office of Health Insurance under the guidelines outlined by the National commission of Health Insurance chaired by the Minister of Public Health.

The finance for this is derived from the annual budgetary allocation, however there are also other sources of finance, such as:

- Local governments, as required by the act;

- Service fees as stipulated in the act;
- Fines as stipulated by the act;
- Contributions to the fund by charities;
- Interests or benefits incurred by the fund;
- Money and properties acquired by the fund; and
- Other forms of contribution to the fund as required by the act.

According to the act, the money and properties belonging to the fund need not be delivered to the Ministry of Finance. According to the National Health Security Act 2002, the costs for the provision of services performed by the service units include:

1. The costs of healthcare promotion and disease prevention;
2. The costs of diagnosis;
3. The costs of examination and care during pregnancy;
4. The costs of therapy and medical services;
5. The costs of drugs, artificial organs, and medical equipment;
6. The cost of child delivery;
7. The cost of living in service units;
8. The cost of the care of infants;
9. The costs of ambulances and other vehicles used in transporting patients;
10. The cost of transporting injured persons;
11. The costs of physical and psychological rehabilitation; and
12. Other necessary costs as stipulated by the act.

In short, the medical welfare scheme for civil servants covers civil servants and their familial members, the provision of welfare to employees of state enterprise is based upon the regulations of the organisation to which the employees belong, and the SSS is marked by contributions to the social security fund by the state, employers, and employees, although some private firms purchase policies from insurance companies

for their employees. The UC scheme was therefore created to provide medical welfare to Thais who were not covered by any of the other schemes.

Table 3-4 - Differences between the three existing healthcare insurance schemes in Thailand

Details	CSMBS	SSS	UCS
Coverage	5 million people (8%)	9.36 million people (15.8%)	47 million people (76%)
Principle	Welfare	Social security	Basic right
Sources of finance	Budgetary allocation of 32,000 million baht in 2011	Equal contribution by employers employee and the state, with the expenses of 25,749 million baht in 2009	2,100 baht in 2010
Benefits	All round including special room	All round compensation for child delivery child rearing death and disability	All round compensation as stipulated by article 41
Service providers	All state run hospitals	The hospitals under the contract with state, private hospitals and their networks	The hospitals under the contract with state private hospitals and their networks
Payment	Payment for outpatient DRG-based payment	Extra payment by cases	Capitation for outpatient and DRG weighted global budget

Source: Thammathat-aree (2010)

After the enactment of the National Health Security Act in 2002, which resulted in the implementation of the UC scheme, the number of people who gained access to healthcare services dramatically increased. In 2010 the coverage of these three healthcare insurance schemes accounted for 99.36% of the total population, or 63.47 million people out of the total 65.01 million people, as shown in Table 3.5.

Table 3-5 - Number of people covered by the three healthcare security schemes 2003-2010 (million people)

Item	Scheme	Million people								
		2002	2003	2004	2005	2006	2007	2008	2009	2010
1	The UC scheme	45.35	45.97	47.10	47.34	47.54	46.67	46.95	47.56	47.73
2	Social Security Scheme (SSS)	7.12	8.09	8.34	8.74	9.20	9.58	9.84	9.62	9.90
3	Civil Servant Medical Benefit Scheme (CSMBS)	4.05	4.02	4.27	4.15	4.06	5.13	5.00	4.96	4.92
4	Others (1)				0.22	0.23	0.24	0.24	0.23	0.52
5	People not covered by healthcare insurance	4.60	4.37	2.83	2.36	1.36	0.78	0.52	0.33	0.41
6	People covered by healthcare insurance	61.12	62.45	62.54	62.81	62.39	62.41	62.55	62.70	63.47

Item	Scheme	Million people								
		2002	2003	2004	2005	2006	2007	2008	2009	2010
7	Coverage of the health insurance schemes (1-4)	56.52	58.08	59.71	60.45	61.04	61.63	62.02	62.36	63.06
8	Percentage of coverage	92.47	93.01	95.47	96.25	97.82	98.75	99.16	99.47	99.36
9	People whose identities need to be proved. (2).				0.00	0.45	0.90	1.16	1.44	1.35
10	Thai expatriates (3)	0.03	0.03	0.06	0.06	0.06	0.06	0.06	0.01	0.02
11	Foreigners			0.26	0.27	0.28	0.30	0.31	0.32	0.18
12	Total number of the expatriates and foreigners	0.03	0.03	0.32	0.34	0.80	1.25	1.52	1.78	1.54
13	Total population	61.15	62.48	62.86	63.15	63.19	63.66	64.07	64.47	65.01

Sources: The data collected during 2002-2010 by the Office of Insurance Information. The data collected during 2009-2010 by the office of the management of lee fund of the Nation Health Insurance Office.

Notes:

1. Veterans, private teachers and people with issues relevant to their status and their rights, and ethnic minorities who were yet to be granted Thai nationality.

2. Dead people, missing persons, problem related to Thai expatriates exercising their rights, erroneous codes on identity cards, persons moving to other provinces without informing the authorities, and migrants.

3. The census data shows a lower number of Thai expatriates than the data collected by The Centre for the Election in Foreign Countries and the Immigration Office.

3.4.5 Comparison of the benefits offered by the three healthcare schemes

Compared to those covered by the SSS and the UC scheme, those covered by the CSMBS enjoy more benefits. They have access to drugs not on the list of essential drugs, including expensive imported drugs; are eligible for more benefits when undergoing any surgery; can deliver a child through surgery; can opt for surgery facilitated by the use of visual equipment; and can access a longer period of hospitalisation when suffering from pneumonia, a stroke, or cerebral thrombosis (Health Insurance Research Office, 2009).

There is also a large disparity between the benefits offered under the SSS and those under the UC scheme (Pokpermdee, 2010). In 2011 the per capita expenses of the SSS was 2,106 baht, which was supplied by contributions from employees, employers, and the state. In contrast, the per capita expenses of the UC scheme were 2,546.48 baht which was totally funded by the state. For inpatients covered by the SSS, payments

were made through capitation, but for those covered by the UC scheme these were based upon the DRG.

The differences in the benefits offered by the SSS and UC scheme include:

- **General service**

The SSS permits the participants in the scheme to choose their hospital, either state-run or private hospitals under contract to the scheme. Participants in the UC Scheme have their names registered as users of a particular primary unit (hospital). They are also required to use the service provided by such units first before being eligible to get transferred to other units, although this is not true in the case of accidents.

- **Emergency services**

The SSS allows the participants to use their nearest units no more than twice per year, although if they are injured there are no restrictions. In contrast, the UC scheme allows its participants unlimited access to their nearest service units.

- **Access to drugs**

The SSS participants have access to all drugs on the list of the essential drugs and also to additional drugs. However, members of the UC scheme only have access to the drugs on the list of essential drugs and drugs that must be prescribed by medical professionals.

- **Health promotion**

The SSS sets aside no funds for healthcare promotion as this is regarded as a responsibility of the MoPH, whilst the UC scheme appropriates funds from its budget to serve the purpose of healthcare promotion for all Thais, no matter what healthcare insurance scheme they are covered by.

- **Transportation costs**

The SSS views general illnesses as the responsibility of the hospitals in which a participant of the scheme is registered as a user. If a SSS participant suffers a sudden illness or injury within the locality in which they are resident, then they are eligible for reimbursement; this is limited to 500 baht for the use of an ambulance and 200 baht for

a hired vehicle. If a sudden illness or injury occurs when they are away from their residence locality then the repayment is at the rate of six baht per kilometre. Payment for UC scheme members is also based on the number of kilometres covered; however, payment for the cost of water transportation cannot be more than 35,000 baht and air transportation, such as by helicopter, cannot exceed 60,000 baht (The Office of Social Security, 2010).

3.5 Health insurance schemes provided by the private sector

Private hospitals play a vital role in providing healthcare services, especially in urban areas where there is a high density population and an ensuing high demand for medical services. Urban residents have substantial purchasing power and private hospitals have specialised in targeting medical services to customers in different income ranges. As a result, private hospitals tend to be concentrated in urban areas.

Private firms providing medical services fall into four categories:

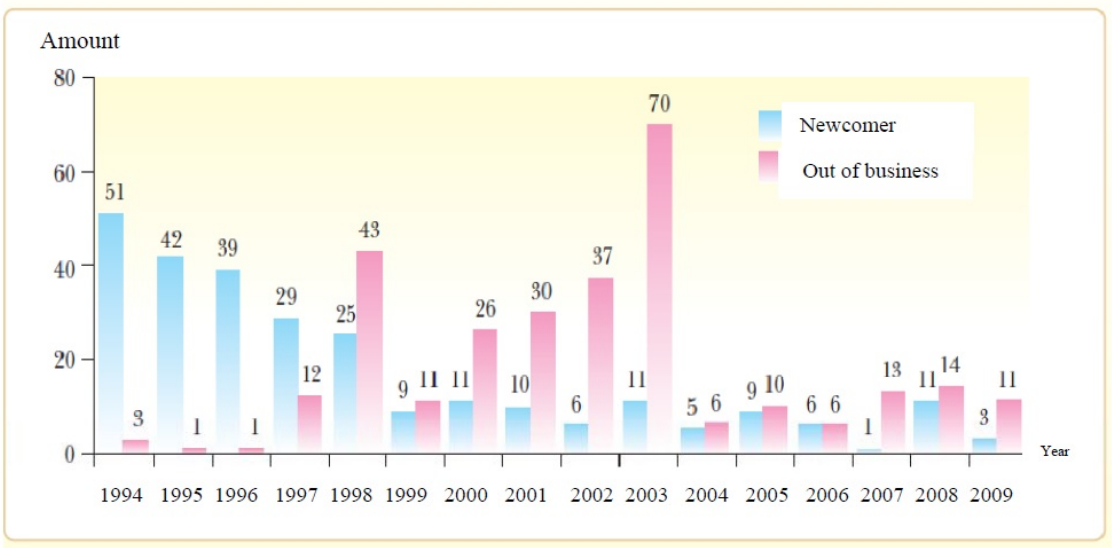
1. Dispensaries, which can be further categorised into:
    - Dispensaries dealing in modern medicine;
    - Dispensaries exclusively dealing in modern medicine already packaged and their use requiring no prescription by a medical professional; and
    - Dispensaries dealing in traditional medicine.
2. Clinics, which are defined as places for treatment but with no beds for overnight stays.
3. Hospitals, which are defined as a place for treatment with the availability of beds for overnight stays.
4. Massage parlours for health and beauty, and health spas, which are defined as places for healthcare promotion.

Private healthcare units play a vital role in providing treatment to the public and of the 322 private hospitals in Thailand, 96 are located in Bangkok and the remaining 226 are in the regions, with most being medium-sized hospitals with 50-100 beds (Table 3.6).

Table 3-6 - Private hospitals in 2009

Healthcare units	Bangkok		Regions		Total
	Number	%	Number	%	
Clinics (no beds for overnight stay)	3,878	21.9	13,793	78.ja	17,671
Hospitals (with beds for overnight stay)	96	29.8	226	70.2	322
Number of beds	13,933	41.7	19,472	58.3	33,405

Figure 3-1 -The turnover of private hospitals with beds for overnight stay, 1994-2009



Source: MoPH 2010

Between 1998 and 2009 the number of private hospitals closing their doors was larger than the number of new hospitals. In 2003 alone, ten private hospitals terminated their operations with only 11 new hospitals opening, whilst in 2009, 11 private hospitals closed and only three opened (Figure 3.1).

Health insurance services provided by the private sector take a number of different forms:

1. Individual life insurance policies also covering hospitalisation;
2. Group life insurance policies that also covers hospitalisation and surgery;
3. Group life insurance policies that include healthcare and accident insurance;

4. Individual healthcare insurance policies offered by an insurance company; and
5. Group life insurance policies offered by an insurance company.

A healthcare insurance policy is a contract made by the person who is to be insured and the company that is to insure them. The insuring company promises the insured person to compensate them for expenses on medical services, including those for surgery, diagnosis, care, and others as specified in the contract. The compensation for such expenses is impossible without the insured person's obligation to pay the premiums to the insuring company.

Intense competition in this market has resulted in the evolution of five forms of policy, in order to make them more appealing to the prospective customer. The combination of healthcare and accident insurance, and healthcare insurance and a saving account in a single insurance policy is a common practice. The policies are similar in their compensation for medical services expenses but differ in the other benefits offered to policy holders, such as the interest rate of saving accounts (Tangcharoensathien, Pitayarungsarit & Sahapatana, 2002).

3.5.1 Benefits offered by health insurance schemes initiated by the private sector

A study conducted in 2000 on the benefits of possessing an insurance policy showed that only inpatients received compensation for their medical expenses, including food and room service, ICU, general treatment, diagnosis, laboratory tests, consultations, emergency services, and surgery. As the compensation reflected the fee for these services, its limit was defined. Some insurance companies offered policies that covered outpatients, child delivery, and catastrophic illnesses; however, all the insurance companies stipulated a limit to the compensation or benefits and the types of patients insured and most will not insure people prone to certain diseases or those already afflicted with heart disease, cancer, diabetes, epilepsy, and high blood pressure (Tangcharoensathien, Pitayarungsarit & Sahapatana, 2002).

In 2010, 28% of the population of Thailand had some form of private healthcare insurance. This insurance sector has expanded steadily, but is still relatively underdeveloped compared to Singapore and Malaysia, where respectively 90% and

60% of the total population possess policies (The Manager Newspaper, 2011). Most of the healthcare insurance policy holders are the well-to-do middle class. In 2009 there were 12,913,848 insurance policies, with a total insurance figure of 2,685,907,862 baht or 86,642,289 USD. In the same year 1,954,026 individual accident insurance policies were sold, as shown in Table 3.7.

Table 3-7 - The number of insurance policies and their value in 2009

Ordinary	Number of Policies	Sum Insured
Whole life	4,421,405	815,355,240
Endowment	7,630,975	1,480,074,308
Term	861,199	390,346,577
Others	269	131,737
Total	12,913,848	2,685,907,862

Source: Office for the Promotion of Insurance Business 2010

Note: By 2009 the number of personal accident insurance policies was 1,954,026, with the value of the sum insured equal to 1,167,111,310 million baht (1 USD is approximately 31 baht).

In 2006 there were 429 privately owned hospitals and healthcare units throughout the country, and the number of patients using these privately owned healthcare units was 48 million. Most of these were as outpatients, accounting for 94.5% or 45.3 million patients, with the remaining 2.6 million patients accounting for 5.5% as inpatients.

Bangkok had the largest number of private hospitals as, according to the statistics, 130 were located there in 2006, and these attracted the largest number of patients using private facilities. In 2006 private hospitals in Bangkok attracted 23.3 million patients, accounting for 48.6% of the total number of patients using the services provided by private hospitals. Meanwhile, the private hospitals in the central region attracted 15.3 million patients accounting for 31.8%, and those in the northern and north-eastern regions attracted 3.7 and 3.3 million patients accounting for 7.7% and 6.8% respectively. The private hospitals in the southern region attracted the smallest number of patients with the patients using the services provided numbering 2.4 million and accounting for 5.1% of the total number of patients using services provided by private hospitals.

The average number of patients nationwide using the services provided by private hospitals was 111,795 per hospital, with the average number of outpatients and inpatients at 105,669 and 6,126, respectively. Private hospitals in Bangkok have the

largest average number of patients per hospitals at 179,191, whilst the average number of patients per private hospital in the central, northern, north-eastern, and southern regions was 106,671, 66,132, 57,514 and 56,502, respectively (Table 3.8).

3.6 The growth in health tourism

The economic recession in 1997 meant it was necessary for healthcare unit in the public and private sector to come up with new strategies to contribute to their survival. High-end private hospitals faced an acute problem of vacant beds and a number began to adopt measures to attract customers with high purchasing power from Japan, Europe, and the Middle East. Concurrently, the Department of Export Promotion of the Ministry of Commerce began to be interested in the idea of obtaining revenues from the provision of medical services to foreigners. Thai medical services had a good reputation within the Asian and Southeast Asian regions and had already attracted customers from neighbouring South Asian countries and even from the Middle East. The plan was now to attract customers from developed countries, as well as to attract pensioners from developed countries to come and live in Thailand.

The strategy for the promotion of Thailand as the centre of healthcare services in Asia was formulated in May 2003 by working groups from the MoPH, the Ministry of Tourism and Sports Affairs, the Ministry of Finance, and the Ministry of Commerce, as well as from private hospitals and other businesses. The MoPH was instrumental in formulating a five-year strategy (2004-2008) which was divided into three operational plans: the improvement of healthcare services and products; the improvement of their management; and marketing co-ordination and public relations (MoPH, 2003). The introduction of such a strategy was based upon the idea that the presence of the UC scheme which had resulted in the nationwide distribution of medical services paved the way for private hospitals with a surplus capacity to improve their services and facilities to non-resident customers. Non-resident medical services customers were viewed by policymakers as a new source of national income with a good growth potential (MoPH, 2003). A fund of 564.5 million baht was therefore allocated to finance the operational plans to improve the medical services, healthcare services, and herbal and healthcare-related products.

Table 3-8 - The number of patients attending private hospitals

Regions	Total		IP		OP		The average number of patient per private hospital			The average number of patients per population		
	number (1,000)	%	number (1,000)	%	number (1,000)	%	total	IP	OP	number (1,000)	IP	OP
Nationwide	47,959.0	100	2,628.0	5.5	45,331.0	94.5	111,795	6,126	105,669	62,828.70	0.04	0.72
Bangkok	23,294.4	100	923.4	4.0	22,371.0	96.0	179,191	7,103	172,088	5,695.95	0.16	3.92
Central	15,253.6	100	761.6	5.0	14,492.0	95.0	106,671	5,326	101,345	15,264.73	0.05	0.94
Northern	3,703.4	100	308.4	8.3	3,395.1	91.7	66,132	5,505	60,628	11,890.75	0.02	0.29
North-eastern	3,278.2	100	368.4	11.2	2,909.8	88.8	57,514	6,464	51,050	21,376.83	0.02	0.14
Southern	2,429.6	100	266.4	11.0	2,163.2	89.0	56,502	6,195	50,307	8,600.43	0.03	0.25

Source: Adapted from National Statistical Office 2007

Notes: IP – Inpatients
OP – Outpatients

Private hospitals had the capacity to accommodate foreign patients and Table 3.9 illustrates how the number of foreign patients hospitalised in Thailand grew dramatically during 2001-2005. This is especially notable in 2003, which was the year of the government's strategy to make Thailand the hub for medical services in Asia, and the number of foreign patients hospitalised in Thailand increased by 50%.

Table 3-9 - The number of foreign patients hospitalised in Thailand 2001-2007

Nationality	The number of foreign patients							
	2001	2002	2003	2004	2005	2006	2007	Total
Japan	118,170	131,584	162,909	247,238	185,616	n/a	233,389	1,078,906
USA	49,253	59,402	85,292	118,771	132,239	n/a	136,248	581,205
South Asia	34,857	47,555	69,574	107,627	98,303	n/a	85,412	443,328
U.K.	36,778	41,599	74,856	95,941	108,156	n/a	110,286	467,616
Middle East	n/a	20,004	34,704	71,051	98,451	n/a	169,091	393,301
Asian	n/a	n/a	36,708	93,516	74,178	n/a	115,561	319,963
Taipei/China	26,893	27,438	46,624	57,051	57,279	n/a	29,783	245,068
Germany	19,057	18,923	37,055	40,180	42,798	n/a	41,313	199,326
Austria	14,265	16,479	24,228	35,092	40,161	n/a	42,688	172,913
France	16,102	17,679	25,582	32,409	36,175	n/a	37,251	165,198
South Korea	14,419	14,877	19,588	31,303	26,571	n/a	26,259	133,017
Scandinavia	n/a	n/a	19,851	20,990	22,921	n/a	49,817	113,579
Canada	n/a	n/a	12,909	18,144	18,177	n/a	22,907	72,137
Eastern Europe	n/a	n/a	8,634	6,728	6,120	n/a	9,413	30,895
Others	220,367	234,460	315,018	127,054	302,834	n/a	264,389	1,464,122

Nationality	The number of foreign patients							
	2001	2002	2003	2004	2005	2006	2007	Total
Total	550,161	630,000	973,532	1,103,095	1,249,948	1,330,000	1,373,807	7,210,543
Rate of increase (% a year)		14.55	54.53	13.31	13.32	6.40	3.29	16.48

Source: The Office for the Promotion of Service Businesses affiliated to the Department of Export Promotion of the Ministry of Commerce

Note: 1. The data is incomplete because it was collected from only 55 private hospitals in 2007.

2. It was probable that the data collected since 2003 included return cases.

Medical services for foreign patients represented an important source of national income with the potential for growth evident in the steady increase in the revenues obtained from the provision of medical services to foreigners from 36,000 million baht in 2006 to 106,640 million baht in 2007, and in 201 the revenues were expected to be up to 107,419 million baht. The growth in the revenues obtained from the provision of services to foreigners was due to their high purchasing power which resulted in a higher average cost per capita than that of domestic patients. Factors contributing to the expansion of the medical treatment businesses catering to foreigners were:

1. A wide variety of medical services of high quality.
2. The cost of treatments was lower than in Singapore, the regional medical hub.
3. The location of Thailand in the Southeast Asian region was close to countries with less developed medical facilities.
4. The country's reputation as a major tourism destination.
5. The country's reputation for providing high quality services.

However, there were constraints that emerged due to the supply of personnel and their poor skills in communicating in foreign languages (The Thai Farmer Bank Research Centre, 2010).

3.7 Health expenditure

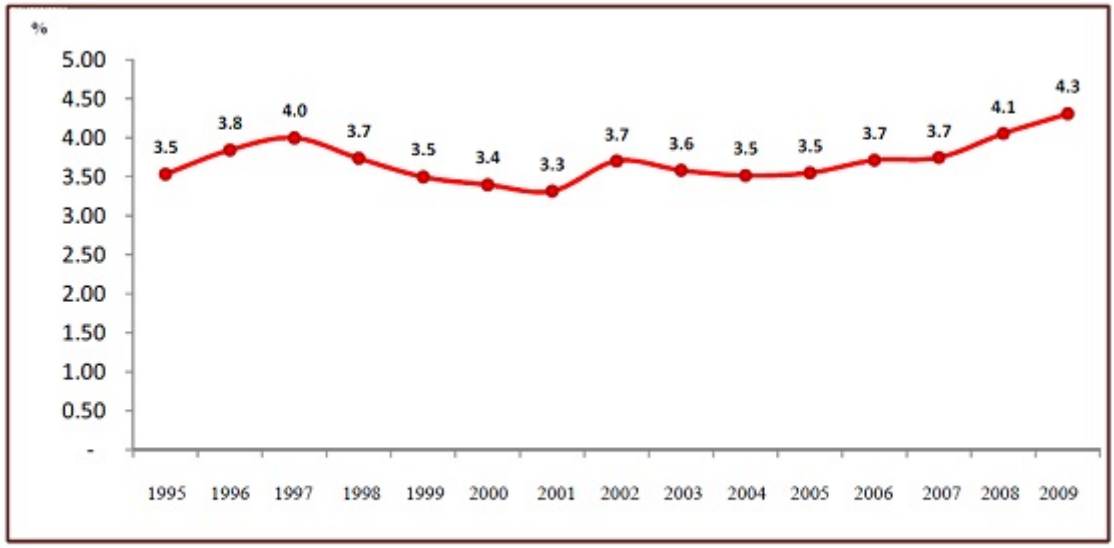
It was found during a comparative study that healthcare expenditure increases in proportion to the level of economic development. In 2007, healthcare expenditure in wealthy countries accounted for 11.2% of their GDP, whilst healthcare-related spending in middle income countries was around 4.3-6.4% of their GDP. In Thailand,

the information gleaned from the national accounts related to healthcare expenditure showed that this accounted for 3.5-3.7% of the GDP for the years 2002-2007 and it increased to 4.2% in 2008, with a dramatic increase coming from the public sector. The public sector's healthcare expenditure increased from 45% of total healthcare expenditure in 1994 to 46% in 2001, and increased further to 71-72% during 2007-2008.

Before the introduction of the UC scheme, healthcare expenditure accounted for 15% of the public sector's total expenditure; however, after its introduction healthcare expenditure accounted for 20% of the public sectors total's expenditure. In 2008 healthcare expenditure accounted for 22% of the public sector's total expenditure, which was considered to be high, and a sharp increase in the public sector's healthcare expenditure occurred during 2001-2002, when the UC scheme was introduced.

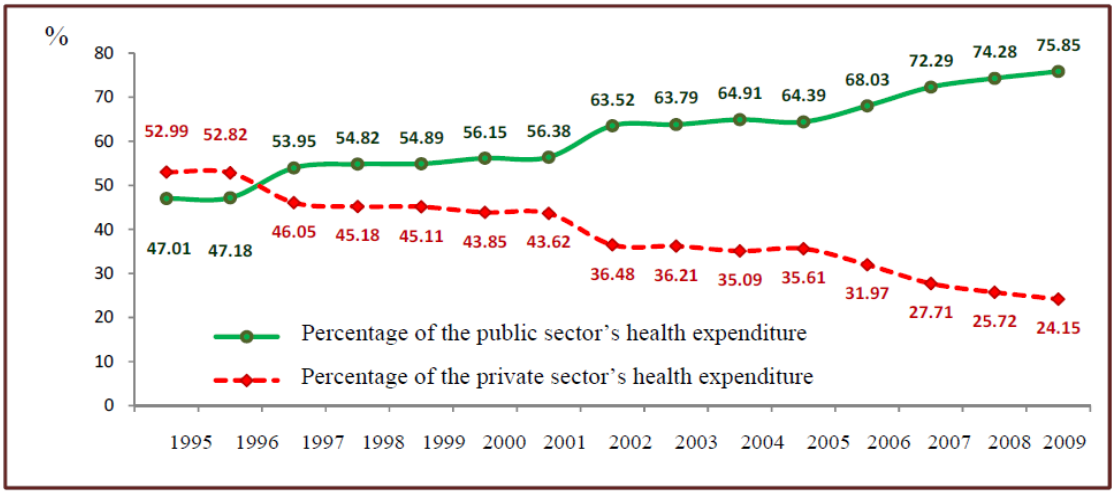
In general, the proportion of healthcare-related expenses as a fraction of GDP has been stable; between 3.5-4.3% of the GDP (Figure 3.2). However, there has been a change in the proportion of the public sector's healthcare expenses compared to that of the private sector. Health expenses for the public sector have increased rapidly since 2001 following the introduction of the UC scheme. In 2009, public sector healthcare-related expenses accounted for 75.8% of the total expenditure on healthcare, as shown in Figure 3.3. This reflects the crucial role of the public sector in sustaining healthcare-related programmes in Thailand. The proportion of healthcare-related expenditures, 4.3% of GDP in 2009, was small, compared to that of developed countries such as the United States, where it was 16.2% of GDP, the United Kingdom with 9.3% of its GDP, and Japan with 8.3% of its GDP. However, when compared to south-east Asian countries, such as Singapore and Malaysia, the proportion of healthcare related expenditures in Thailand differed by only a small amount. It is worth noting that the proportion of expenditure on the UC scheme within the national budget has dramatically increased.

Figure 3-2 The proportion of healthcare-related expenditure as a percentage of GDP 1995-2009



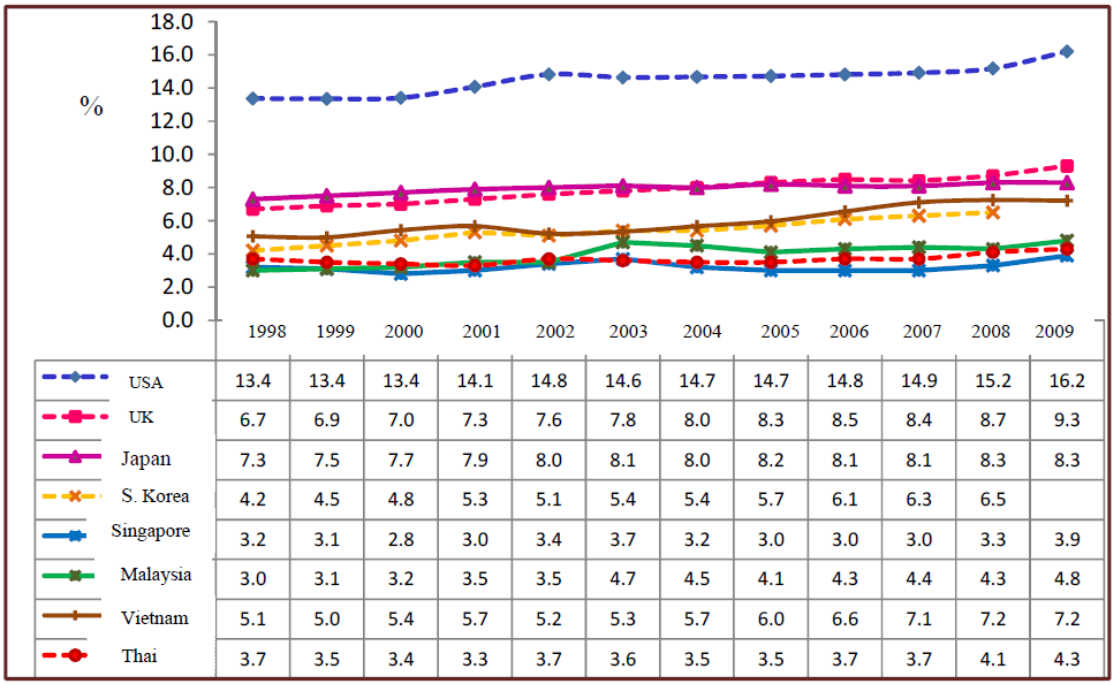
Source: http://www.who.int/nha/country/tha/en/, Last updated: April 2011 cited in NHSO 2010

Figure 3-3 Health expenditure for the public and the private sectors as proportion of the country's total expenditure on healthcare



Source: http://www.who.int/nha/country/tha/en/, Last updated: April 2011 cited in NHSO 2010

Figure 3-4 - A comparison of the proportion of healthcare-related expenditure as a percentage of GDP between countries 1998-2009

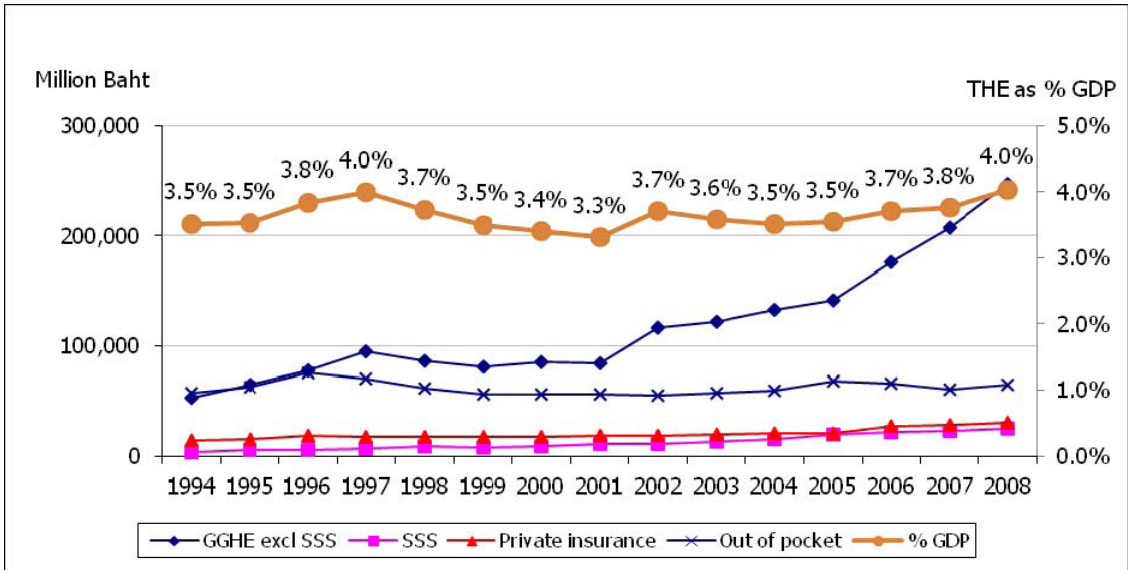


	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
USA	13.4	13.4	13.4	14.1	14.8	14.6	14.7	14.7	14.8	14.9	15.2	16.2
UK	6.7	6.9	7.0	7.3	7.6	7.8	8.0	8.3	8.5	8.4	8.7	9.3
Japan	7.3	7.5	7.7	7.9	8.0	8.1	8.0	8.2	8.1	8.1	8.3	8.3
S. Korea	4.2	4.5	4.8	5.3	5.1	5.4	5.4	5.7	6.1	6.3	6.5	
Singapore	3.2	3.1	2.8	3.0	3.4	3.7	3.2	3.0	3.0	3.0	3.3	3.9
Malaysia	3.0	3.1	3.2	3.5	3.5	4.7	4.5	4.1	4.3	4.4	4.3	4.8
Vietnam	5.1	5.0	5.4	5.7	5.2	5.3	5.7	6.0	6.6	7.1	7.2	7.2
Thai	3.7	3.5	3.4	3.3	3.7	3.6	3.5	3.5	3.7	3.7	4.1	4.3

Source: http://www.who.int/nha/country/tha/en/, last updated: April 2011 cited in NHSO 2010

Health expenditure by the government increased from 84.5 billion baht in 2001 to 110.6 billion baht in 2001 and then to 240.8 billion baht in 2008, an increase of 76% from 2002. During the same period, the expenditure on the SSS remained constant, whilst the households' expenditure decreased from 33% of the total healthcare expenditure in 2001 to 15% in 2008, which was nearly the same as the average figure for countries belonging to the Organisation for Economic Co-operation and Development (OECD). As Thailand's GDP continued to grow, the proportion of healthcare expenditure in terms of GDP has remained at 3-4%, as shown in Figure 3.5.

Figure 3-5 - Total healthcare expenditure by source and as percentage of GDP, 1994-2008, current year price



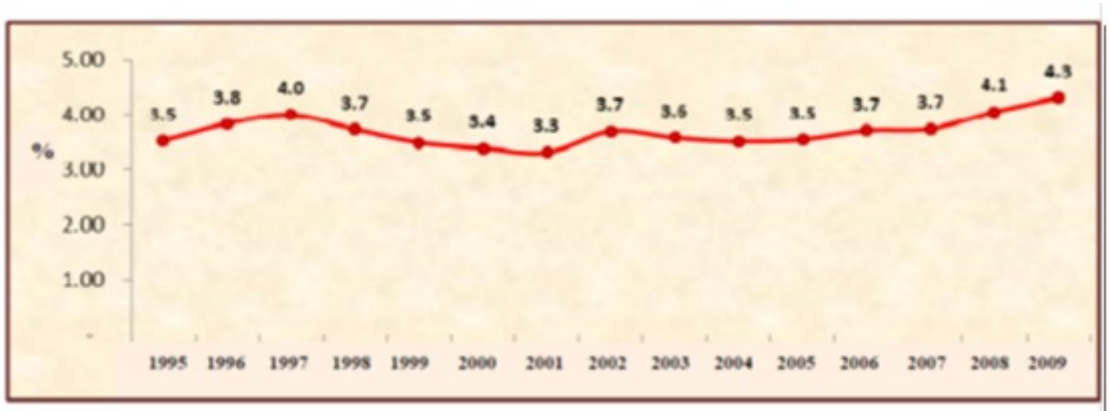
Source: HSRI, 2012, An independent assessment of the first 10 years (2001-2010)

Increased government expenditure has contributed to a great improvement in the UC scheme, resulting in more benefits related to medical treatment and healthcare promotion, contracts with the healthcare units participating in the Scheme, the allocation of funds per capita for outpatients, and the close-end allocation of funds based on DRG for inpatients, in addition to the requirement for patients to register with the hospital located in the area in which they are regarded as domiciled. It was thus obvious that the UC scheme has provided standardised services to users, and not simply low-quality services to the poor.

3.7.1 Macro financing of the Universal Healthcare Coverage scheme

In 2001, expenditure on healthcare accounted for 3.3% of the GDP as shown in Figure 4.4, which increased to 4.3% in 2009, an increase of 1% following the introduction of the UC scheme in 2001. In total, state expenditure on healthcare accounted for 56.38% of the total expenditure on healthcare, comprising 1.6% of the GDP. In 2009, the percentage of the public sector's healthcare expenses increased to 75.85%, as shown in Figure 3.5 whilst that of the private sector decreased to 24.15%. The increase of 1% in the proportion of the total expenses on healthcare in terms of GDP was thus due to the increase in the public sector's expenses after the introduction of the UC scheme, which

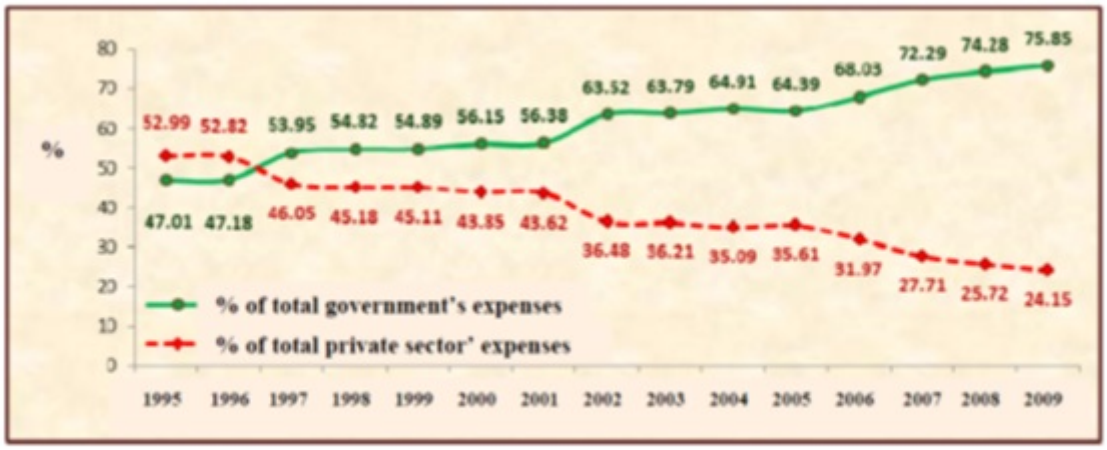
Figure 3-6 - Health expenditure compared to GDP, 1995 - 2009



Source: http://www.who.int/nha/country/tha/en/. Last updated April 2011 cited in NHSO 2010

could be attributed to it subsidising the private sector's healthcare units that participated in the UC scheme.

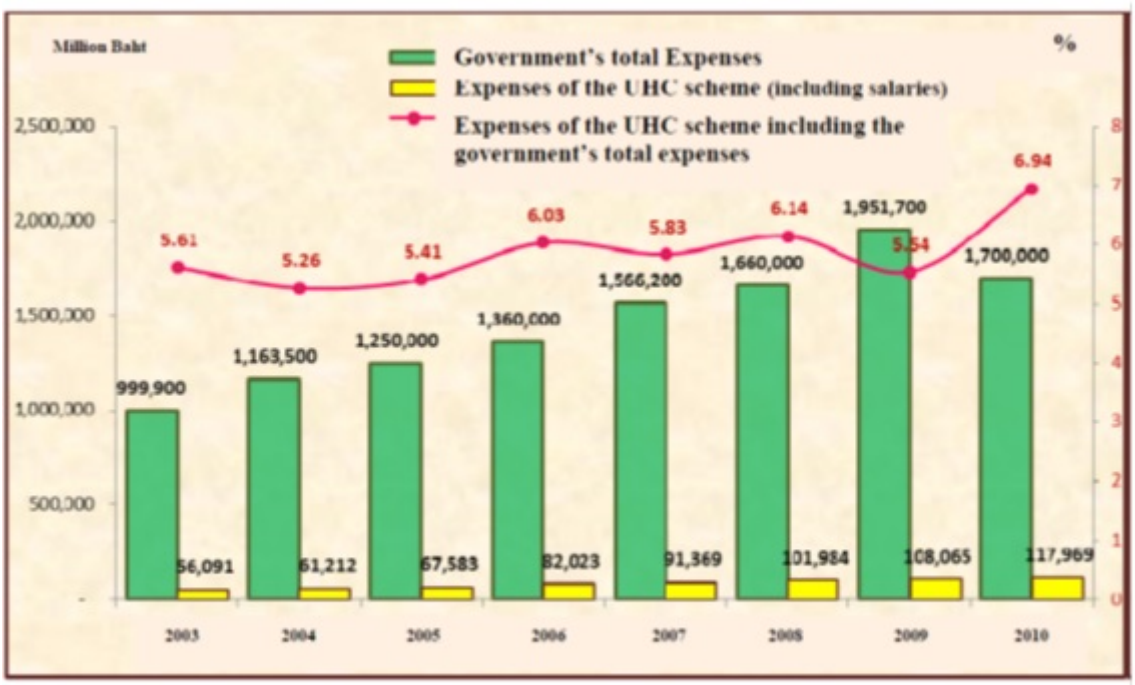
Figure 3-7 - Comparison of private and public healthcare expenditure, 1995 - 2009



Source: http://www.who.int/nha/country/tha/en/. Last updated April 2011 cited in NHSO 2010

The proportion of the budget allocated to the UC scheme within the government's total expenditure grew slightly from 5.6% in 2003 to 6.94% in 2009, as shown in Figure 4.4

Figure 3-8 - The expenses of the UC scheme, 2003 – 2010



Source: NHSO 2010

3.8 The Health Insurance Act and the change in Thailand's health insurance practice

In Thailand, universal healthcare coverage has long been a concern among academics and researchers, particularly those in the MoPH. The vision to achieve universal healthcare coverage was discussed at the healthcare financing conference in 1993, organised by the MoPH and the World Bank. By that time, 50% of the population had insurance coverage. The proportion of population with healthcare insurance protection has been gradually increased since then, and many healthcare insurance schemes have been developed independently at different times. However, until 2000, the healthcare system was far from able to ensure 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 the UCS as also one of the

goals in the 8th national Social and Economic Development Plan (1997), there was insufficient interest among policy makers to implement the UC policy.

Health insurance schemes in various forms had existed in Thailand for a long time and there were five broad areas of coverage:

1. Support was available for low income earners and other vulnerable groups such as the old, the disabled, and children.
2. State-provided healthcare insurance was also available based upon a person's willingness to join the healthcare insurance scheme organised by the state. This scheme was characterised by the sharing of the premium costs between the state and the people participating in the scheme, and was informally known as the '500 baht card programme'.
3. Free healthcare services were available to bureaucrats and employees of state enterprises, as well as their children.
4. Compulsory healthcare insurance was available for workers in the formal sector consisting of a compensation fund and a social security fund to which they contributed.
5. Private healthcare insurance was widely provided by the private sector whereby individuals could purchase a healthcare insurance policy from an insurance firm.

These five forms of healthcare insurance covered 70% of the country's total population, but the remaining 30%, equivalent to 19 million people, were left without any form of healthcare insurance (NESDB, 2002). The excluded groups were mainly the poor in the informal and agricultural sectors as we have already discussed earlier.

Before the enactment of the National Health Insurance for All Act in 2002, the state assumed responsibility for the expenses of the medical services provided to bureaucrats and their families, whilst workers in the private sector were entitled to reimbursement from a compensation fund and social security fund to which they were required to contribute on a monthly basis. Those not covered by the previous two schemes were entitled to medical services free of charge if they could not afford to pay due to

poverty, or if they could afford it, they could purchase low priced healthcare insurance policies for 500 baht for themselves and their families on a monthly basis.

After the introduction of the National Health Insurance for All Act, financial reforms were instituted within the MoPH. These reforms, regarded as primarily affecting hospitals and healthcare personnel, involved the introduction of a budgetary allocation according to the size of the local population in response to the financial implications of the new Act. This method of budgetary allocation was applied to three quarters of the MoPH's financial resources and was expected not only to create equal access opportunities to healthcare services, but also to increase the purchasing power of the hospitals located in heavily populated areas currently lacking the resources necessary for the operation of their healthcare programmes. The reforms were also expected to encourage the fair distribution of healthcare related personnel and resources.

The government's budgetary allocation for healthcare was crucial for the effective performance of the programme. From 2002 to the time of writing in 2015, three governments have been formed in Thailand and all have perceived the importance of supporting the Universal Healthcare Coverage Scheme, and so the finances available for the healthcare programme have been steadily increasing. Existing healthcare related services and facilities have been improved and renovated, and new facilities built. The private sector has also been encouraged to take part in the universal healthcare programme and initially many private hospitals participated in the programme believing that it would turn out to be a financially viable programme.

3.9 Administrative structure of the Universal Healthcare Coverage Scheme

The National Health Security Act required the establishment of a commission responsible for the administration of the healthcare security system. The commission, consisting of national politicians, local politicians, civil servants, NGOs and experts, numbered 30 people in total. The variety of stakeholders in the commission was undertaken to ensure the inclusion of all those with different interests who had a stake in the UC scheme.

The Minister of Public Health was the chairman of the commission and one of the key national politicians represented within the commission. Civil servants included the

permanent secretary of the MoPH, the permanent secretary of the ministry of finance, the permanent secretary of the ministry of commerce, the permanent secretary of the ministry of the interior (or home ministry), the permanent secretary of the ministry of labour and social welfare, the permanent secretary of the MoPH, the permanent secretary of the ministry of education, and the director of the budgetary bureau. Local politicians included representatives of municipalities, provincial administrative organisations, Tambon (sub-district) administrative organisations, and other forms of local government. Each form of local government had one representative within the commission. NGOs had five seats, and covered children and youths, women, the elderly, the disabled, the mentally ill, HIV patients, the chronically ill, workers, slum dwellers, peasants, and ethnic minorities. Five medical professionals were represented by members of the doctors' council, the nurses' council, the pharmacists' council and representatives of the private hospitals association. These five medicals professionals were included to set the standard of professional practice for their members and the organisations elected their own delegates to represent them in the National Health Security commission. Seven experts were appointed by the cabinet, including specialists in the field of healthcare insurance, medicine and public healthcare, Thai traditional medicine, alternative medicine, finance, law, and social sciences.

The act also established the NHSO which is a state agency with the status of a legal entity under the supervision of the MoPH. The NHSO acts as the secretariat or executive office charged with the implementation of the decisions of the commission and any sub-committees established by the commission. The secretary general of the NHSO acts as the secretary of the commission and as the director of the national security office.

3.10 A network of health care units connected to the 30 baht Scheme

The healthcare units identified as service delivery points for the 30 baht scheme were hospitals, health stations, and clinics. The National Health Insurance Act of 2002 required all state-run healthcare units to become part of the UC scheme, whilst participation in the scheme by private healthcare units was voluntary and they were subject to quality tests before admission. Health care units joining the UC scheme can therefore be categorised as:

1. State-run healthcare units affiliated to the MoPH.
2. State-run healthcare units not affiliated to the MoPH – these are instead mostly affiliated to the Ministry of Education and most are associated with medical schools or affiliated to the Ministry of Defence, such as army, naval and air force hospitals, there are also state-run hospitals affiliated to the Ministry of the Interior, such as those run by local governments and the Bangkok Metropolitan Administration.
3. Private healthcare units.
4. Healthcare units run by the local government.

Health care units affiliated to the MoPH are ranked in accordance with the level of complexity or sophistication of treatment of which they are capable:

1. Health stations or health service centres currently converted into hospitals for health promotion in 'Tambons' or villages.
2. Community healthcare centres or primary cure units (PCU) arising out of the implementation of the UC scheme. They were designed to act as hospitals within community neighbourhoods.
3. Community hospitals providing medical services in 'Ampurs' or districts, with 10-150 beds, covering 10,000 or more people.
4. General hospitals located in the capitals of provinces or in large Ampurs (districts), with 200-500 beds.
5. The main hospitals located in the provincial capitals, with 500 or more beds and medical professionals in all fields of medical science.

The number of state-run healthcare units who have joined the 30 baht scheme is shown in Table 3-10.

Table 3-10 - Public healthcare units participating in the UC Scheme 2004-2010

Units and their affiliation	2004	2005	2006	2007	2008	2009	2010
The MoPH	821	828	830	834	849	839	844
Hospitals	818	825	826	830	836	830	831
Health stations/community clinics	3	3	4	4	13	9	13

Units and their affiliation	2004	2005	2006	2007	2008	2009	2010
State-run healthcare units not affiliated to the MoPH	114	114	148	153	155	83	81
Hospitals	74	74	72	73	75	72	75
Community clinics	40	40	76	80	80	11	6
Local governments	-	-	-	-	-	10	12
Hospitals						10	2
Community clinics						-	10
Total	935	942	978	982	1,004	932	937

Source: Adapted from the annual report, NHSO, 2010

The number of private hospitals joining the UC scheme decreased from 71 in 2004 to 49 in 2010, but the number of private community clinics joining the scheme increased from 89 in 2004 to 169 in 2010 as shown in Table 3.11. Community clinics are small primary units operating as a subsidiary of a private hospital, a medical service franchise or an autonomous clinic found by a proprietor.

Table 3-11 - Private healthcare units participating in the UC scheme 2004-2010

Units	2004	2005	2006	2007	2008	2009	2010
Hospitals	71	63	61	60	55	50	49
Private community clinics	89	105	116	152	150	167	169
Total	160	168	177	212	205	217	218

Source: Adapted from the annual report, NHSO, 2010

Funds were allocated per capita to community clinics according to the size of the UC scheme population under their care, and their services were exclusively for outpatients, as there were no beds to accommodate inpatients. These clinics were responsible for the cost of transferring outpatients and the NHSO was responsible for the cost of transferring any inpatients. This approach to organising the entire network of service units facilitated the participation of the private sector in the UC scheme as the cost of investing in community clinics was not high in terms of personnel and equipment.

The operation of the hospitals joining the UC scheme gradually improved in terms of those achieving the hospital accredited (HA) standard, and the number of accredited hospitals steadily increased from 6.1% in 2003 to 23.5% in 2010. The number of

hospitals classified as being in a development phase and at the first level of acceptance has steadily decreased.

In 2010, the number of accredited hospital was 232, accounting for 23.5% of the total, with 185 affiliated to the MoPH and four private hospitals out of the 49 that joined the UC scheme. The number of hospitals gaining the second level of accreditation were 648, accounting for 65.6% (Table 3.12).

Table 3-12 - Number of the hospitals participating in the UC scheme at the different development stages of the hospital accredited standard 2003-2010

Stages of development	The number of the hospitals							
	2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Developing	538 (55.8)	488 (50.6)	170 (17.6)	83 (8.6)	56 (5.8)	37 (3.8)	27 (2.7)	9 (0.9)
First level of acceptance	213 (22.1)	255 (26.5)	615 (63.6)	526 (54.7)	416 (42.9)	250 (25.4)	143 (14.4)	99 (10.0)
Second level of acceptance	154 (16.0)	156 (16.2)	48 (5.0)	200 (20.8)	304 (31.3)	474 (48.2)	556 (56.7)	648 (65.6)
Fulfilment of the requirement of HA standard	59 (6.1)	65 (6.7)	134 (13.9)	152 (15.8)	194 (20.0)	222 (22.6)	264 (26.7)	232 (23.5)
Total	964 (100)	964 (100)	967 (100)	961 (100)	970 (100)	983 (100)	990 (100)	988 (100)

Source: The Institute for the Development of Health Care Units 2010, analysed by the Office of Improving Service Standard of the NHSO, 2010

3.11 Service units joining the Universal Healthcare Coverage Scheme

According to the National Health Security Act, it is obligatory for all healthcare related facilities in the public sector to join the UC scheme. Health related facilities in the public sector include those affiliated to the MoPH and those who are not affiliated, such as military hospitals, hospitals operated by medical schools affiliated to the Ministry of Education, and hospitals affiliated to local governments. Participation in the UC scheme by private sector healthcare-related facilities is voluntary. The majority of public sector service units are affiliated to the MoPH, numbering 844 in 2010 (831 hospital 13 clinics) out of a total number of 1,155, and accounting for 73% of the total number of the healthcare-related facilities joining the UC scheme. Public sector facilities not affiliated to the MoPH numbered 81 (75 hospitals and 6 clinics), with 12 affiliated to local governments (2 hospitals and 10 clinics), and all joined the UC

scheme. Privately owned healthcare-related facilities numbered 218 (49 hospitals, and 169 clinics).

3.12 Coverage

3.12.1 Access to health insurance for the poor

Before the emergence of state-sponsored healthcare insurance programmes, state-run hospitals and some private hospitals, affiliated to particular religions in most cases, set aside funds for providing services to the poor. However, how the funds were allocated and used depended on the discretion of the management of the hospitals (TDRI, 2004). The Thai government has financed social welfare programmes for the poor since 1975, but rules and regulations regarding this issue constantly undergo adjustments to reflect the changing situation and to match new policies, although until the UC scheme healthcare insurance had yet to achieve mass coverage. People covered by the MWS, which targeted the poor, the disabled, and those deemed deserving of state help, accounted for 30% of the country's population in 2001, those joining the VHCS accounted for 23.4%, whilst the participants in the CSMBS, which also covered employees of state enterprises, accounted for 8.5%, and the SSS, which covered a number of people, accounted for only 7.6%. Only 1.2% of the population were covered by a healthcare insurance policy offered by insurance companies. Therefore, in total, 30% of the population did not have access to healthcare insurance (MoPH, 2007).

Poverty has been frequently identified in Thai academic studies as an obstacle to accessing healthcare services, and in many cases, those suffering from illnesses do not seek treatment because they are without healthcare insurance. Many of this section of the population were therefore afflicted by worsening healthcare conditions and some became disabled due to delayed treatment (Siamwalla, 2001). The accessibility of healthcare insurance before the implementation of the UC scheme can be accessed via the inpatient statistics for 1996, as those without healthcare insurance were the least likely to attend a hospital. (Table 3-13). The average frequency of this latter group for attending a hospital was 1.5 times per year, which was more than three times that of those without healthcare insurance (Pittayarangsarit, 2004).

Table 3-13 - Admission rates for people covered by the six healthcare insurance programmes in 1996

Scheme	Admission rate
Medical Welfare Scheme (MWS)	0.10
Voluntary Health Card Scheme (VHCS)	0.08
Civil Servant Medical Benefit Scheme (CSMBS)	0.08
State Enterprise (CSMBS)	0.06
Social Security Scheme (SSS)	0.05
Private insurance	0.15
Uninsured	0.04
Total	**0.56**

Source: Adapted from National Statistic Office 1996, cited in Pitayarangsarit, 2004

Note: The admission rate is the proportion of inpatients supported by each scheme.

Before 2002, the government helped to finance the MWS, which provided targeted medical assistance to low income earners. In 1979, the government allocated 300 million baht to the MWS, accounting for 7-8% of the finances allocated by the state for public healthcare (TDRI, 2004). The government later contributed more funds to the MWS and by 2000, the fund per capita was 403 baht per year. However, the amount received by healthcare units was reduced by 2.5% and the deducted amount was allocated to a fund for more costly treatments which was used to finance hospitals which provided these services. The salary costs, which accounted for half of the total costs, were not included in the MWS budgetary allocation. The total expenses of the MWS, which included other costs incurred from the implementation of the scheme, were 800 baht per capita per year less than the expenses of other healthcare insurance programmes, such as the SSS which had operational costs of 1,606 baht per capita per year and the CSMBS which had operational costs of 5,000 baht per capita per year (TDRI, 2004).

As the budgetary allocation for the MWS for the poor was limited and did not reflect the real workloads and operational costs, the personnel of healthcare units viewed the poor as an unnecessary burden and therefore limited their access to healthcare services in terms of treatment and drug dispensing (TDRI, 2004). The shift in the budgetary process to a per capita allocation system improved the situation as primary healthcare units received more finance as a result of the per capita allocation based on the size of

the population under the responsibility of the unit. Formerly, the allocation of funds was based on the size of a hospital, and so primary healthcare units, which were smaller in size, received less funding than larger hospitals.

The UC scheme incorporated the MWS and the VHCS. The poor, who were already covered by the MWS and thus benefited from free medical services, were exempt from the payment of the 30 baht fee when they joined the UC scheme. Those covered by the VHCS who could afford the 500 baht gold card had to pay the 30 baht fee. In the 2006 fiscal year 24.97 million people were eligible for exemption from fee payment, whilst the remaining 22.57 million people who were also poor had to pay the fee. Less than half of all the poor therefore had to pay any fees and whilst the remainder paid only a nominal fee.

In late 2006 the 30 baht charge was entirely removed, thus making the entire UC scheme a free service. Government compensation of 24.11 baht per capita was calculated as a required additional payment for hospitals as a result of the termination of the fee, and this raised the per capita allocation to hospitals under the scheme to 1,899.69 baht.

3.12.2 Obstacles faced by low income earners

Before the introduction of the UC scheme, the government issued MWS cards which facilitated the poor's access to healthcare services. There were, however, a number of poor individuals who were beyond the reach of the surveys through which the cards were allocated and thus had no access to healthcare. This problem was periodically investigated: a study jointly conducted by the MoPH and Mahidol University in 1988 found that only 28% of the poor held the cards, whilst a study conducted by the National Institute of Developmental Administration (NIDA) on the issuing of card in 14 provinces during 1990 – 1993 found 73% of the poor held cards, however only 54% of cardholders were deemed to actually be poor. The poor were finally accessing healthcare services but nearly half of the cards went to people who did not qualify for them (TDRI, 2004).

In 2000 the Bureau of Policy and Strategy of the MoPH conducted the sixth two year study (1998-2000) on the issue of coverage and targeting of MWS cards within 12 provinces (Table 3-14). The study found that the nationwide coverage was 16-17% on

average, which was considered to be very low and indicated that only a sixth of the poor held cards. With regards to the issue of targeting, the study found that only 28% of cardholders were actually poor and only 35% of the households holding the cards were actually poor according to the survey results on household incomes. This indicated that the majority of cardholders were not impoverished. Mistakes in targeting frequently occurred in the municipal areas, but there were no areas where the percentage of correct targeting was above 40%. This reflected the problem of correct targeting which was attributed to the difficulty in determining those who were really poor, not to mention the tremendous costs involved in surveying. As a result, a shift from a poverty targeting scheme to universal healthcare coverage was promoted (TDRI, 2004).

Table 3-14 - Coverage and targeting of medical welfare scheme cards, 1998-2000

	Nationwide	Municipal areas	Outside municipal areas	Central region	Northern region	North-eastern region	Southern region
Coverage (% households)	17	20	16	11	39	19	10
Right targeting (% households)	35	20	39	32	20	40	17
Coverage on average(% population)	16	22	15	11	17	18	11
Right targeting (% population)	28	14	32	29	28	31	15

Source: Bureau of Policy and Strategy and Bureau of Provincial Public Health 12 provinces, 2000

Note: row 1 denotes the number of poor households holding cards/the total number of poor households; row 2 denotes the number of poor households holding cards/the total number of households holding cards; row 3 denotes the number of poor holding cards/the total number of poor; and row 4 denotes the number of poor holding cards/all persons holding cards

3.12.3 The coverage of the Universal Healthcare Coverage Scheme

Between 1991 and 2010 healthcare insurance coverage in Thailand steadily increased from 33.50% to 99.36%, resulting from the implementation of the MWS, VHCS, CSMBS, and SSS. The introduction of the UC scheme brought about a step change that included the previously uninsured group which accounted for 29% of the population in

2001. The UC scheme enabled this previously uninsured group to gain access to the healthcare system

Table 3-15 - Allocation per capita to hospitals participating in the UC scheme 2003

Services	Allocation per capita
1. Outpatients	574
2. Inpatients	303
3. Health promotion and prevention	175
4. Costly treatments	32
5. Medical emergency services	10
6. Investment costs for the acquisition of new equipment	83.4
Total	**1,202.4**

Source: NHSO, 2003

When the financing for the UC scheme was set up, a portion of the fund was set aside for use in healthcare promotions which were aimed at benefitting all Thais, regardless of which healthcare related schemes they belonged to. This same portion was also used in the provision of emergency services for all Thais, again regardless of which healthcare related schemes they belonged to. After the enactment of the Medical Emergency Act, this funding allocation was incorporated into the National Institute of Medical Emergency, although the budgetary allocation for the UC scheme was not reduced.

The National Health Security Act of 2002 requires the inclusion of the wages and salaries of relevant healthcare service personnel into the expenses of the UC scheme, with the amount to be deducted determined by the Budgetary Bureau and the government agencies involved. State-run healthcare units are eligible to claim the deducted amount from the comptroller general's department in accordance with the annual Budget Act.

The finance for the UC scheme included wages and salaries for the relevant healthcare service personnel in the state-run healthcare units, including those employed in the state-run hospitals affiliated to the MoPH and to other ministries. Wages and salaries were fixed costs deducted from the overall finance of the UC scheme by the comptroller general's department in accordance with the agreement between the MoPH

and the NHSO. The remaining portion of the finance was allocated to various funds for the provision of medical services to the people covered by the UC scheme.

3.12.4 Public access to treatment and disease prevention services

Those covered by the UC scheme had easier access to treatment services as well as disease prevention services, as they could notify the authorities at their district office or hospitals in their neighbourhood that they were registered as participants in the scheme of their intention to exercise their right to access medical services. Participants were allowed to change their healthcare units where they sought treatment no more than twice per year. In case of an emergency, they were eligible for hospitalisation in the nearest hospital, which might either be state-run or private before being transferred to another hospital accredited to the UC scheme. The NHSO was responsible for the payment of all service fees.

The fund for healthcare promotion and disease prevention was allocated through the UC scheme to hospitals and local governments for the benefit of all Thais regardless of which healthcare insurance scheme they participated in, be it the MWS, CSMBS, SSS, or the UC scheme.

- **Treatment**

The number of inpatients and outpatients who used the UC scheme rose rapidly. In the early years, many of those who were eligible did not understand their entitlements and did not use the system. However, as time progressed the number of users for treatments and of services increased steadily; the outpatients rate of use of hospitals increased from 2.41 to 3.28 times per year between 2004 and 2010, whilst the inpatients rate of use of hospitals grew from 0.089 to 0.116 times per year (Table 3-16).

Table 3-16 - Frequency of service use by those covered by the UC scheme 2004-1010

Topic		2004	2005	2006	2007	2008	2009	2010
Out-Patients	Number (million)	112.49	111.62	114.76	119.29	128.76	147.60	153.41
	Average number of hospital visits	2.41	2.37	2.42	2.55	2.75	2.99	3.28
In-Patients	Number (million)	4.16	4.34	4.73	4.88	5.17	5.29	5.57
	Average number of hospital visits	0.089	0.092	0.100	0.105	0.110	0.112	0.116

Source: Adapted from the annual report NHSO, 2010

Inpatients enjoyed easier access to specific treatments and the admission rate of hospitals specialising in cardiovascular increased from 198.32/100,000 in 2005 to 269.60/100,000. The percentage of patients afflicted with heart circulatory problems at the level of St-elevation (STEMI) who received drugs used to dissolve congealed blood rose from 0.49 in 2005 to 9.88, 17.41 and 32.15 in 2008, 2009 and 2010, respectively (NHSO, 2010). The access to treatment for other diseases is shown in Table 3-17.

Table 3-17 - Treatment of specific diseases 2006-2010

Diseases		2006	2007	2008	2009	2010
Kidney	**Target**	na	na	400	7,727	9,521
	output	na	na	972	10,875	16,509
	%	na	na	243	140.74	173.39
HIV AIDS						
First line drugs	**Target**	na	100,000	120,000	120,000	134,000
	output	na	74,130	103,800	111,196	134,382
	%	na	74.13	86.5	92.66	100.28
Second line drugs (after treatment failure)	**Target**	na	8,000	6,000	5,000	4,000
	output	na	na	na	5,186	8,682
	%	na	na	na	103.72	217.05
Tuberculosis (TB)	**Target**	na	na	na	60,000	60,000
	output	na	na	na	30,178	44,150
	%	na	na	na	50.30	73.58
Cataract	**Target**	17,800	80,000	33,000	35,000	50,000
	output	73,210	105,139	97,563	98,236	114,933
	%	411.29	131.42	97.56	98.24	114.93
Haemophilia	**Target**	1,500	700	576	620	926
	output	483	718	889	927	1,039
	%	32.20	102.57	134.70	149.52	112.02
Leukaemia/Lymphoma	**Target**	na	na	na	1,326	1,457
	output	1,079	1,831	1,448	1,466	1,252
	%				110,56	85.93
Diabetes (new patient)	**Target**	na	na	na	2,379,150	1,379,954
	output	na	na	na	1,363,375	1,363,375
	%	na	na	na	57.31	58.00
Hypertension (new patient)	**Target**	na	na	na	1,939,003	2,107,741
	output	na	na	na	7,387,812	7,387,812
	%	na	na	na	26.25	28.53

Source: Adapted from the annual report NHSO, 2010

Notes: na – not available

- **Targeting of people prone to specific diseases**

Metabolic diseases such as diabetes, high blood pressure, and obesity, stem from improper healthcare-related behaviour. These diseases tend to be chronic and thus pose a long-term healthcare problem for the country. Therefore, the National Health Security commission assigned the NHSO with the task of targeting all Thais aged over 15 years who were prone to these diseases with preventing them from developing. Between 2008 and 2010 30,350,085 people out of the total number of 51,808,062 (58.58%) identified as being prone to metabolic diseases were specifically targeted (Table 3-18). The fund for supporting this task was derived from a portion of the per capital allocation used for healthcare promotion and disease prevention. This funding portion has steadily increased, and in 2011, the portion used in healthcare promotion and disease prevention was planned to increase to no less than 14% of the whole per capita allocation (NHSO, 2010).

Table 3-18 - Number of people targeted as prone to metabolic diseases 2008-2010

Topics	2008	2009	2010
1. The number of people aged 15 or over belonging to all healthcare security schemes (CSMBS, SSS, UC)	50,900,905	51,054,752	51,808,062
2. The number of those further screened	8,461,063	10,620,879	12,190,681
3. Percentage of those further screened	16.62	20.80	23.53

Source: NHSO, 2010

The number of people prone to specific diseases increased between 2008 and 2010: those prone to diabetes increased from 6.43% to 14.3%; to cerebral thrombosis increased from 28.46% to 36.43%; whilst those prone to high blood pressure decreased from 45.31% to 43.09%; and to obesity from 40.06% to 30.25%. More details are provided in Table 3-19.

Table 3-19 - The number of people targeted for metabolic diseases 2008-2010

Fiscal years	The Number of people targeted	People prone to diseases							
		Diabetes		High blood pressure		Cerebral thrombosis		Obesity	
		People	%	People	%	People	%	People	%
2008	8,584,900	551,985	6.43	3,890,032	45.31	2,433,130	28.46	3,439,018	40.06
2009	10,620,879	671,931	6.33	3,936,258	37.06	2,413,857	22.73	5,195,769	48.92

Fiscal years	The Number of people targeted	People prone to diseases							
		Diabetes		High blood pressure		Cerebral thrombosis		Obesity	
		People	%	People	%	People	%	People	%
2010	12,190,681	1,754,055	14.39	5,253,422	43.09	4,441,428	36.43	3,688,248	30.25

Source: NHSO, 2010

A systematic approach to data collection has contributed to the more accurate targeting of women prone to specific diseases. Table 3-20 shows the number of women prone to cervical and breast cancers during 2004-2009.

Table 3-20 - Number of women targeted for cervical and breast cancers 2004 – 2009

Targeting	2004	2005	2006	2007	2008	2009
Cervical Cancer	1,333,748	1,656,705	1,841,173	1,801,371	1,903,368	1,793,464
Breast Cancer	3,690,017	6,623,294	7,254,948	7,508,514	9,460,820	7,675,945

Source: NHSO, 2010

- **The increase in benefits resulting from the 30 baht Scheme**

Successive governments have recognised the importance of improving the scheme's coverage and service delivery. An important feature of this has been to enhance the accessibility of costly treatments. The National Health Security commission acts as the board of the NHSO, which in turn collects and analyses the data for use in decision making in order to increase the benefits of the scheme.

The committee of 1March 2006 made the entire treatment of leukaemia and lymphatic cancer available, including all the stages from the filtering of patients to their treatment and rehabilitation after treatment. If the healthcare unit to which a patients is admitted is unable to provide the treatment then patients are to be transferred to other healthcare units with the capability to treat cancer. The treatment is patient-centred and the NHSO monitors the progress of the treatment to its conclusion and subsequent patient rehabilitation. In 2006, a network of tertiary Centres of Excellence were set up as centres to which appropriate patients could be transferred and 21 heart centres, 29 cancer centres and 28 emergency accident centres have been established (NHSO, 2010).

Additional funding has also been provided for critical areas, in particular for services to AIDS patients, which has included the provision of drugs since 2006. The fund for the

treatment of AIDS was separated from the aggregate per capita allocation in 2007 and a cabinet resolution of 30 October 2007 also approved in principle the provision of services to patients with dysfunctional kidneys. The National Health Insurance commission, acting as the board of the National Institute of Health Insurance, proposed a resolution to commence the provision of a kidney transplantation service free of charge to old and new patients who were in a critical condition from 1 January 2008. A small allowance was also provided for treatments using Thai traditional medicines, and the per capita allocation for Thai traditional medicine services increased from 1 baht in 2006 to 2 baht in 2010 and 6 baht in 2011. In 2009 the National Health Insurance commission also approved the use of the drugs Risperidone and Setraline for patients suffering from mental illnesses (NHSO, 2011).

In 2009, the government sought to facilitate public access to healthcare services by introducing the use of a single card, and the original gold card was replaced by an all-purpose identity card. The Ministry of the Interior was assigned to create smart cards containing not only basic information on individuals, but also their healthcare insurance scheme (NHSO, 2010).

Between 2005 and 2010 the types of treatments covered by the UC scheme were expanded to include more expensive treatments such as those for heart disease and cancer, and also brain surgery (NHSO, 2010). The number of patients receiving heart surgery, brain surgery, a CT scan, physical therapy and rehabilitation has increased. The percentage of patients undergoing heart surgery due to ischaemic heart disease has increased from 3.81 in 2005 to 10.29 in 2010, whilst the percentage of stroke patients receiving CT scans has increased from 27.73 in 2005 to 64.78 in 2010 (NHSO, 2010). The number of cancer patients having access to treatment has increased from 150.15 per 100,000 people in 2005 to 193.85 per 100,000 people in 2010. Outpatients receiving chemotherapy has increased from 6,047 to 25,214, an increase of 316.97%, and the number of times patients underwent chemotherapy increased from 21,846 in 2005 to 105,275 in 2010, an increase of 381.90%.

- **Increased access to necessary healthcare services**

A survey of households conducted by the National Statistical Office and the International Health Planning and Policy Organisation (IHPP) in 2010 found that Thais

whose healthcare needs were unmet were small in number. However, the UC population was more likely to face difficulty in accessing basic healthcare services than those individuals covered by the CSMBS and SSS. It was reported that the needs of 0.4% of outpatients and 1.4% of inpatients were unmet needs due to them having no time to see doctors, being unconfident regarding treatment, and facing travelling difficulties, as shown in Table 3-21.

Table 3-21 - Unmet needs for inpatient and outpatient care, 2010

Prevalence of unmet need, national average	Inpatient (%)	Outpatient (%)
	1.44	0.40
CSMBS	0.80	0.26
SSS	0.98	0.20
UCS	1.61	0.45
Reason for unmet need		
Too far to travel	13.6	17.4
No time to seek care	24.3	17.2
Cannot afford to pay for treatment	1.3	16.7
No one to accompany them to hospital	3.5	9.6
Not sure there is effective treatment	16.3	5.6
No confidence, having bad impression of providers	5.3	2.3
Cannot afford transportation fee	1.3	0.0
Other reasons	34.4	31.3
Total	100	100

Source: Health System Research Institute (HSRI), 2012, cited from the analysis of the 4th wave of panel SES, 2010

The percentages of outpatients and inpatients whose access to services was blocked due to their inability to afford services were 1.3 and 16.7 respectively, which was considered low in comparison to the figures obtained from the OECD countries.

- **The poor's access to medical services**

The National Statistics Office reported an increased outpatient use of UC scheme services from 66% in 2006 to 80% in 2009, with in the north-east region population being more dependent on UC scheme services than their counterparts in other regions, whilst the UC scheme population in Bangkok was the least dependent. The use of inpatients UC scheme services rose from 18.4% in 2006 to 91% in 2009, and the population in the north and north-eastern regions were most dependent on these services, whilst those in Bangkok were the least dependent (Table 3-22).

Table 3-22 - The use of UC scheme services by region 2006-2007 and 2009

Region	2006		2007		2009	
	Outpatient (%)	Inpatient (%)	Outpatient (%)	Inpatient (%)	Outpatient (%)	Inpatient (%)
Bangkok	40	44	57	61	64	76
Central	58	79	58	85	78	91
Northeast	72	88	68	94	84	92
North	67	89	60	91	78	92
South	60	82	57	85	80	91
Total	**66**	**84**	**62**	**90**	**80**	**91**

Source: Adapted from Health System of Thailand 2012, HRSI 2012

Between 2004 and 2010 the number of users increased steadily, both for outpatients and inpatients. The rate of service use by an outpatient in 2004 was 2.41 but in 2010 the figure was 3.22. Similarly, the rate of service use by an inpatient was 0.089 times per year in 2004 and increased to 0.111 in 2011 (Table 3-23).

Table 3-23 - Service use of participants in the UC scheme 2004-2011

		2004	2005	2006	2007	2008	2009	2010	2011
Out patients	**The number of times of service using (million)**	112.49	111.62	114.76	119.29	128.76	147.60	153.41	153.81
	Rate	2.41	2.37	2.42	2.55	2.75	2.99	3.22	3.23
In patients	**The number of times of service using (million)**	4.16	4.34	4.73	4.88	5.17	5.29	5.57	5.34
	Rate	0.089	0.092	0.100	0.105	0.1104	0.112	0.116	0.111

Source: NHSO, 2011

Compliance rates of the use of UC scheme services during 2003-2007 and 2009 were also found to be higher. The figures for outpatients went up from 75.95 in 2003 to 79.56 in 2009, (Table 3-24) whilst the figures for in patients went up from 79.81 to 90.63 in the same period (Table 3-25), with the use of services provided by hospitals run by medical schools, state-run hospitals not affiliated to the MoPH, and private clinics and hospitals.

Table 3-24 - Compliance rates of use of UC scheme services by outpatients 2003-2007 and 2009

Year	Health stations	Community hospitals	Central and General hospitals	Hospitals run by medical schools	State-run hospitals not affiliated to the MoPH	Private clinics	Private hospitals	Others	Average
2003	98.09	98.33	93.05	51.51	66.83	1.76	36.34	25.84	75.95
2004	96.22	97.06	92.64	29.57	71.57	0.84	31.54	14.91	71.36
2005	98.47	98.27	93.78	60.93	78.28	1.48	32.54	6.38	74.80

2006	98.85	97.61	93.32	56.72	62.67	0.86	20.63	1.62	65.56
2007	98.43	98.33	95.84	51.98	86.99	1.44	29.32	2.25	61.87
2009	96.59	98.20	92.22	76.03	94.59	4.36	37.16	19.86	79.56

Source: NHSO, 2010

Note: The rates were calculated from the number of time outpatients who comprised UC population used the UC services at the healthcare units participating in the UC scheme

Table 3-25 - Compliance rates of use of UC scheme services by inpatients 2003-2007 and 2009

Year	Community hospitals	Central and General hospitals	Hospitals run by medical schools	State-run hospitals not affiliated to the MoPH	Private clinics	Private hospitals	Others	Average
2003	93.84	84.03	35.68	69.50	7.69	17.04	23.33	79.81
2004	92.22	89.62	61.96	60.17	16.05	13.08	83.84	82.33
2005	92.52	90.10	59.62	67.05	10.97	14.84	30.86	83.28
2006	93.45	89.69	75.00	76.64	27.07	19.45	13.13	84.02
2007	96.66	95.46	81.25	86.49	16.55	32.28	-	89.71
2009	97.56	95.19	86.92	93.17	45.34	70.23	-	90.63

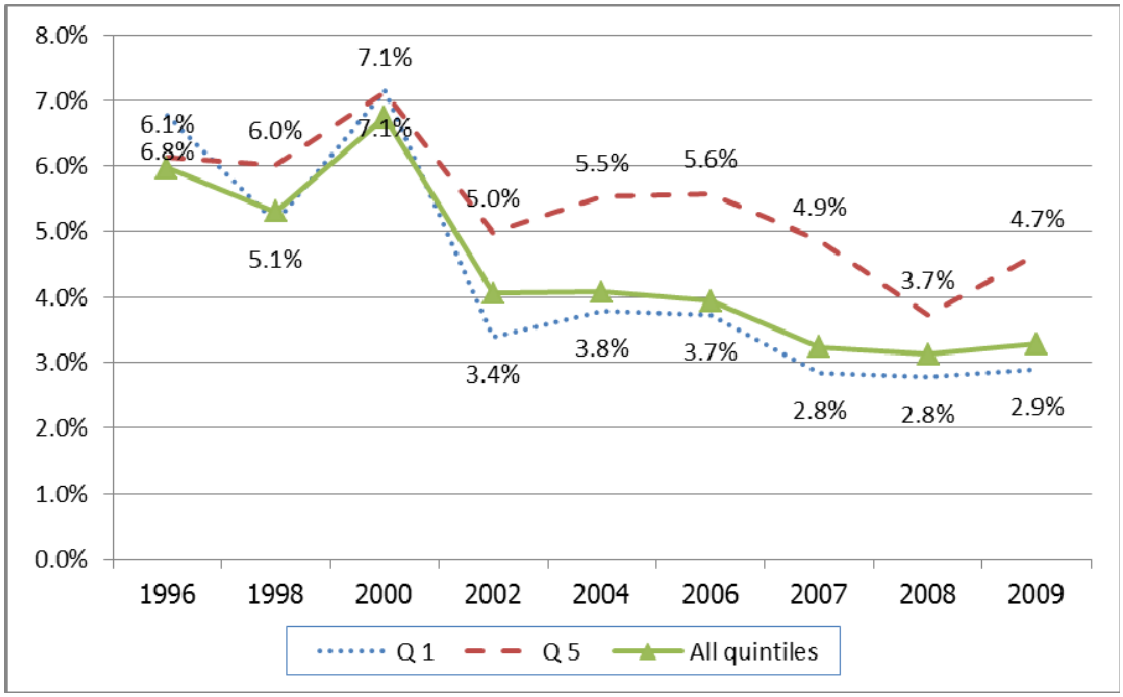
Source: NHSO, 2010

3.13 Impact of the UC Scheme

3.13.1 Lessening of poverty

After the introduction of the UC scheme in 2002, the healthcare expenses of households steadily decreased. Although the UC scheme was similar to the welfare scheme for the poor in terms of benefits, it received much more finance from the state. This support by the state contributed to the decrease in households' healthcare expenses. Health spending of the poorest households (Quintile 1) decreased from 6.8% of their total spending in 1996 to 2.9% in 2009, whilst healthcare spending in middle-income households (Quintile 5) as show in figure 3-9 also decreased from 6.1% of their total spending to 4.7%. Thus, it can be said that the introduction of the UC scheme brought about a decreased in the number of households going bankrupt because their high expenditure on healthcare exceeded 10% of their total expenditure calculated to have prevented 291,840 households from healthcare impoverishment during 2004-2009 as shown in Figure 3-10

Figure 3-9 - Incidence of catastrophic healthcare expenditure by wealth quintile, 1996-2009

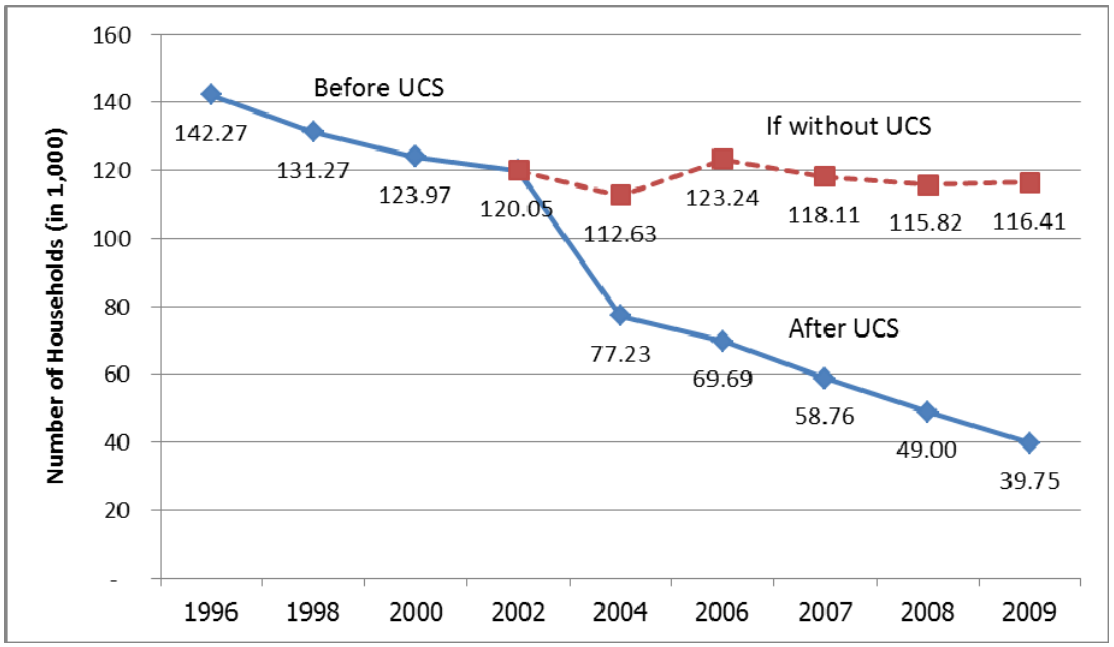


Source: HSRI, 2012 An independent assessment of the first 10 years (2001-2010)

Note: Catastrophic healthcare expenditure refers to household spending on healthcare >10% of the total household consumption expenditure.

More benefits have been added to the UC scheme: since 2003 anti-HIV drugs have been made available, and since 2008 kidney treatment services have been provided, including haemodialysis, peritoneal dialysis, and kidney transplantation. Entitlement to such services offered by the UC scheme has played a vital role in decreasing the number of households falling below the poverty line because of their healthcare expenses (Limwattananon, Tangcharoensathien and Prakongsai, 2011).

Figure 3-10 - Number of households prevented from healthcare impoverishment 1996 - 2009



Source: HSRI, 2012 An independent assessment of the first 10 years (2001-2010)

The number of households suffering from bankruptcy which is attributable to healthcare expenses decreased from 5.97% in 1996 to 3.29% in 2009, especially in the poorest north-eastern region of the country, where the number of households suffering from healthcare impoverishment decreased from 3.4% in 1996 to 2.3-2.4% in 2002 and to 0.8% in 2009 (HSRI, 2012).

3.14 Conclusions

This chapter has described the evolution of the Thai healthcare systems, from a collection of six schemes to the current three, CSMBS, SSA and the UC scheme. At the same time, healthcare coverage under these schemes has increased from around 75% to 99% of the total population. However, there are disparities in the benefits offered by these schemes, with the CSMBS offering the most and the SSS the least, even though the three schemes share the same healthcare-related resources and personnel. Many hospitals participate in multiple schemes, and it is highly probable that the same doctors and nurses have alternately worked for the three schemes. In private hospitals the same staff may also share the treatment of private fee paying and insurance patients.

Most of the poor depend on the services of local healthcare stations, whilst most of the rich use the services of private hospitals which are much better equipped. Meanwhile, a

proportion of the healthcare-related resources is diverted to foreign patients, who fulfil the purpose of the policy aimed at making Thailand the medical hub of Asia. The presence of the UC scheme enhances the poor's access to healthcare services, lowers their expenses on healthcare and thus renders them less prone to the risk of bankruptcy due to high spending on healthcare, although problems of increased workload, shortage of doctors, and the private hospitals' opting out of the scheme have arisen. Insufficiency in the budgetary allocation has stemmed from increased hospitalisation and as a result of the allocation of funds on the service fee rates of 1996, especially in the case of inpatients.

Chapter 4. Politics and the 30 baht Health Care Scheme

This chapter features the background of the political economy and healthcare system in Thailand and the role of political actors in pressuring for the formulation and implementation of the 30 baht scheme, as well as the impacts of the scheme's implementation.

4.1 The political climate

4.1.1 Social, economic, and political context

Thailand is a democratised country, with a constitutional monarchy. Its population was estimated in 2001 to be 62 million, of which 35% lived in urban areas. Thailand is considered a lower middle-income country. The Thai political system was transformed from an absolute monarchy to a constitutional monarchy in 1932, and democratisation of the country came after the demise of military dictatorship during the 1970s and 1980s. There are three main groups which have dominated the political elite, namely the aristocrats, bureaucrats, and the army, and they relied on businessman for their financial support.

After the abolition of absolute monarchy in 1932, Thailand was mostly under the rule of military *junta* until 1973 when a popular uprising brought down the military *junta*. From 1973 business interests gradually took control of government. Elections held consecutively helped business interests tighten their grips on the government and they finally gained domination over the bureaucrats and the military. However, their corrupt behaviour provided the pretext for the military to stage a coup d'état in 1991 with the support of the middle class. Later, the middle class realised that their prosperity was adversely affected by the coup, and made their successful move to overthrow the military *junta* in May 1992.

After the 1992 uprising, the whole society reached the unanimous agreement on great reform. The committee overseeing the reform effort was set up in 1995. The result of the operation of the committee was the 1997 constitution which sought to establish a

strong government in Thailand and to empower the general public and civil society. These made their move to introduce universal healthcare coverage into Thailand.

In the wake of 1997 economic crisis caused by monetary liberalisation policy, nationalist fervour arose among the middle-class opposed to the privatisation of state enterprise vital to public interests, and Thaksin capitalised on such nationalist fervour to increase his popularity.

The economic condition prior to the rise of populism that spurred the introduction of the UC scheme into Thailand was summarised by Pitayaransarit and Jongudomsuk (2004):

> 'Thailand's economy has developed from an agrarian economy to an industrial-based economy. It grew by leaps and bounds after 1985, with Thailand opening its door to welcome foreign investments. 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). However, with the economic burst in 1997, the Thai economy contracted by 10.5% in 1998. The major causes of the economic crisis were attributed to short-term foreign debts, private-sector investment in non-productive business like in the real estate inefficient production structures, foreign-capital dependency, monetary liberalisation policy without an effective monitoring and inspection system, and insufficiency of public sector management. To maintain its overall economic stability, Thailand adopted a manage-float-currency-exchange system in 1997 and requested financial and technical assistance from the International Monetary Fund on 14 August 1997. 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 ultra-poor. Household healthcare expenditure reduced by 24% in real time. Self-medication as preferred to institutional healthcare, especially in poorer households, private hospitals were in debt as their services were obviously not much needed'.

The government in 1995 appointed a committee to consider political reform, and this sparked the process of constitution-drafting, a series of public hearings, and the promulgation of 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 political parties' power over parliament by election of members of parliament 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 Interior to an independent election commission.

By doing away with the bureaucratic monopoly on 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 civil society to propose new healthcare laws (Phongpaichit, 2004).

Although the 1991 constitution had addressed the right of citizens to access healthcare and 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). The access to healthcare services for all as also started in the 8th National Socio-economic Development Plan (1997-2001). Due to the economic downturn and lack of political support, however, there was no follow-up with an action plan (Pitayaransasarit, 2004).

Following the crisis, Thailand began to implement measures for reform of the financial sector, corporate governance, security of national and international borrowing, and policies 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 in spite of the global economic slowdown. 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.

4.1.2 The economic crisis and Thaksin's ascendancy

The economic crisis of 1997 was a turning point in modern Thai history. Those in the agricultural sector and outside the formal sector of economic activities, though not responsible for the crisis, were nevertheless severely and adversely affected by it as they were either laid off or compelled to accept lower wages. Their resulting frustration turned to political anger and led to a wave of demonstrations demanding that the government address the debt problem. At the height of this widespread dissatisfaction, Thaksin Shinawatra formed his political party and planned to attain the premiership,

hoping to exploit the prevailing public sentiment to realise his ambition. During the five years of his first tenure, he relied on his strong leadership and charisma, whilst promoting his populist political platform. Thaksin declared a war against poverty which was immediately extremely popular in the dire economic circumstances of the time. A number of welfarist and populist projects were initiated, such as the universal healthcare insurance scheme, which was known as '30 baht cures all illnesses', housing projects for the poor, as well as schemes aimed at providing funding for villages and computers in all communities. These schemes brought hope to a large number of people, especially those in the large informal sector in Thailand, outside the formal domain of registered economic activities, and he understood the importance of these people in contributing to the consolidation of his political power. This awareness was gained after successfully pleading for their support in his defence against the various legal accusations that began to emerge very early on in his premiership, such as covering up his stockholdings. Thaksin was acquitted on the grounds that his misdeed was committed due to his unintended carelessness. Far from damaging him, his appeal to the poor, and the successful outcome that was achieved, led to a further surge in his popularity rating, which rose from 30% to 70%. His soaring popularity in turn allowed him to take a leading role in instituting populist schemes within Thailand that would further consolidate his power (Phongphaichit, 2004).

4.1.3 Economic crisis and the change in the balance of political power in Thailand

The 1997 economic crisis and the advent of the popularly approved constitution in the same year were significant milestones in Thailand's political economy as these events eventually led to a change in the balance of political power within the country. The paradox was that on the one hand there was a shift towards a more people-oriented and populist set of strategies, but at the same time a narrower range of business interests gained control over the state compared to the earlier period in the country's history. One of Thailand's biggest businessmen, Thaksin Shinawatra, who was once one of many businessmen receiving the patronage of the state, became prime minister and gained direct control over the state. Thaksin's political strategy was to consolidate his power by offering a wide range of benefits to the large constituency of the relatively poor, and using the political power he thus acquired to capture a growing range of

benefits for his own business interests. Thaksin's strategy conspicuously weakened the bureaucracy and other established political interests as the rule of law was manipulated to achieve his political and economic goals.

An important result of this strategy was to alienate a broad alliance of the urban middle classes and business interests, whilst consolidating a coalition of the lower middle classes and the poor in support of the Thai Rak Thai Party (TRT). The latter emerged as a virtually undefeatable coalition of interests in several subsequent elections. This resulted in the lasting political standoff between the 'Reds' (the supporters of Thaksin's Thai Rak Thai Party) and the 'Yellows' (the broad coalition of the middle classes and business interests appealing to traditional values and the king) who opposed Thaksin in increasingly confrontational politics in the 2000s (Phongphaichit, 2003).

The 1997 constitution contributed to the crisis by allowing a centralisation of power in the hands of the prime minister. Article 180 of the 1997 constitution prohibited the legislature from taking part in budgetary allocations, but a prohibition of the same nature was not applied to the executive, and as a result budgetary allocation passed entirely into the hands of the executive. This gave those who controlled the executive an advantage over other political and bureaucratic interests. It also made it easier for the executive to make bureaucrats compliant to their demands as the executive controlled political resources. Compared to the power that Thai bureaucrats had traditionally wielded in making decisions about public resource allocation, bureaucrats under Thaksin had to be either highly compliant with the agenda of the executive or risk becoming individually redundant.

Academics have highlighted that the economic depression of 1997 contributed to Thaksin Shinawatra's rise to power as people expected him to resolve in a drastic and effective manner the economic problems that the previous administration had failed to deal with. The landslide victory for the party in the general election held on 6 January 2001 reflected Thaksin's immense popularity and helped consolidate his power base during the period marked by the abatement of the economic crisis. Thaksin's landslide victory was unprecedented in Thai history, and it was the first time that a political party formed ostensibly by big business interests won the majority of parliamentary seats in the country. However, Thaksin was no ordinary businessmen. His financial power came

from his telecommunication firm which had been granted concessions by the state. This was a large, highly valued firm, which possessed huge growth potential. However, the ethos of the firm was not on providing reasonably priced services with good quality, but rather on accumulating huge profits using its monopoly power (Phongpaichit and Baker, 2004).

Thaksin proved by his subsequent actions that he was not even interested in maintaining his stake in the high-profit telecommunication business. Rather, he sought to make quick profits even if it meant selling his shares and leveraging the money to acquire more political power. Whilst Thailand was used to businessmen acquiring and using political power to further their business interests, Thaksin was a new type of businessmen who used his businesses to acquire political power for its own sake. The political power was then used to raise more money through 'business' ventures that were often opportunistic and speculative rather than productive, but the aim was always to consolidate his hold on power (Khan, 2012). This strategy proved not only to be extremely successful as a political strategy, it also effectively locked out Thailand's traditional elites in business and the bureaucracy because they were not able to come up with any counter political strategy that could defeat Thaksin's party in elections. The universal healthcare plan was thus not just a highly desirable welfare programme that served a genuine need in society, it was also an important part of a political strategy of a politician who played a problematic part in Thailand's history at the critical juncture after the financial crisis of 1997. This dual character of the strategy, and the difference between its political motivation and its welfarist content, is important to understand because it had an impact on the care taken in its design and the steps taken to ensure its financial viability.

The coincidence of Thaksin's rise to power and his immense popularity with the executive being granted further powers by the constitution placed Thaksin in a position which enabled him to come up with policies, rules, and regulations which were favourable for the protection and consolidation of his political and financial power whilst meeting with minimal resistance. Political economists in Thailand described the behaviour of politicians who exercised their financial 'clout' to seize control of the state in order to serve their purpose of profit seeking as 'money politics'. The profits of such politicians are derived from their position which authorises them to control and

distribute an ‘economic rent’, which may be in the form of a concession, subsidy or special privilege, and their control of this ‘economic rent’ is more profitable than their involvement in productive activities in a competitive market (Phongpaichit, 2005).

4.1.4 The people in the informal sector: major voters

The people employed in the non-industrial sectors account for most of Thailand’s employment. However, the incomes or wages in the industrial sector are generally higher than those in agriculture and most services, and many poor people find industrial employment relatively attractive. However, employment growth in the industrial sector is limited as Thailand is a middle income country and has already moved rapidly towards the mechanisation and computerisation of its industrial sector. As a result, the industrial sector has not been able to absorb the surplus labour from the agricultural sector and this is one of the primary causes of persistent poverty in some important parts of the country. The surplus population in agriculture has instead moved to urban areas and become involved in a variety of unregistered informal economic activities, such as street vendors, employees of small unregistered enterprises, garbage collectors, and domestic servants, not to mention their employment in illegal businesses, and this group of the informally employed accounts for 26% of the country’s total workforce (Phongpaichit, 2003). Thus, the pockets of poverty in agriculture and in some segments of the low-paid informal service sector activities in the cities are deeply connected. Moreover, workers in agriculture and the informal service sector are often interchangeable and there is a lot of seasonal movement from one sector to another.

On the positive side, the incomes that poor people can earn in informal service sector activities in urban areas helps to support many families remaining in the agricultural sector who would otherwise have been more impoverished. On the negative side, this pattern of economic activity means that the poor are often difficult to identify, they move between locations, and their places of employment are not registered, making the delivery of healthcare and other services to the poor much more difficult. In particular the two sectors in which the poor are concentrated are beyond the jurisdiction of the formal regulations covering economic activities and labour affairs, and they fail to benefit from the laws on labour protection and social welfare. In total, this group constitutes two thirds of the country’s entire workforce (Phongphaichit, 2005), and to a

political strategist, their presence has a large political significance, as they comprise the largest number of voters yet enjoy the least protection from the state in terms of their welfare.

4.2 Formulation of the Universal Healthcare Coverage

The proposition to consider the introduction of a universal healthcare insurance in Thailand was first mooted more than 10 years before the enactment of the National Health Insurance Act in 2002. The motivation originally was not political, but rather based on the idea of healthcare insurance for all as a way of enhancing social justice. All the seminars organised by the Institute for Public Health Research and their project on healthcare service reforms held during 1999 and 2000 featured a discussion on healthcare insurance. Whilst the National Health Insurance Act was being drafted in 2000, the Office of Health System Reform asked Prof. Dr Ammar Siamwalla to oversee the preparation of a report entitled *A Proposal for a Health Insurance for All*. The working committee chaired by Prof. Dr Siamwalla completed a draft of the report in early 2001 and the Minister of Public Health, who acted as the supervisor of the project during its first year, always referred to the draft as the 'bible for the 30 baht programme' (TDRI, 2002).

Non-governmental organisations (NGOs) proposed their own version of the National Health Insurance Act shortly before the government's version of the Act was issued. The draft proposed by NGOs was for an act by the people and for the people. Unfortunately, an examination of the identity of the people signing their names to this proposal (apparently for authentication) was undertaken for eight months but was never completed (Nitayarumphong, 2003). Whilst this alternative version of the act was being proposed by the NGOs, Thaksin seized the opportunity to introduce the government version of the act to complete the legislative process allowing it to be enacted quickly and enabling him to use the act to enhance his popularity. During the earlier stages of the programme's implementation, and in accordance with the act, the government launched a public relations campaign in order to increase public understanding of the programme. The programme was heavily publicised and then informally renamed as the 'Just 30 baht for the treatment of all illnesses programme' to increase public awareness. During the first stage of its implementation, pilot projects were organised to

cover six provinces, the second stage of the programme implementation saw the extension of the operational sphere to include more than 15 provinces, and the programme was introduced in all provinces during the third stage of its implementation. Bangkok was the last province to be included in the programme's operational sphere but from beginning to end it took only one year for the government to achieve the nationwide implementation of the programme.

Although the programme in its broad principles was a highly desirable shift in the Thai healthcare system, the early stages of its implementation proved daunting. The implementation and management of the programme faced a number of difficulties, and the initial results were very mixed. Nevertheless, the intrinsic improvements in public welfare that were achieved ensured that despite the financial and implementation difficulties, the programme became more and more institutionalised over time, even when the financial problems were only being addressed on an ad hoc basis. Its implementation was also prioritised by successive governments formed over the next ten years, as surveys of ordinary people consistently showed that the majority were highly satisfied with the project and the benefits they were getting (NESDB, 2007).

Detractors of the programme argued that its design was highly political in nature and that the ruling politicians had initiated the programme largely to achieve political popularity and retain power rather than for the welfarist purpose of guaranteeing the welfare of the masses through access to almost free healthcare services. The latter would be the case if the government had undertaken a proper estimation of the financing costs and designed the programme to stay within these limits. The relatively vague guidelines with which the programme was initiated were also viewed as detrimental to the country's budget, as the funds set aside for the programme were not sufficient to meet the demands of its implementation. Ad hoc transfers from sources such as the Social Security Fund and the Medicare Fund for bureaucrats were perceived to be likely from the very outset if the programme was to be financed. The existence of the programme brought about tension and conflict, with many groups opposing the programme. Compared to earlier programmes with the same objective, this one was subject to the harshest criticism; meanwhile, the number of people accessing the programme grew rapidly due to the easier access to healthcare services and a politically motivated public relations campaign. This resulted in stress among healthcare

personnel as people developed high expectations of their performance (Nitayarumphong, 2003).

Though the programme did not originate from the Thai Rak Thai Party's think tank, its adoption and subsequent implementation had a large impact on the Thai public healthcare system which was unprecedented over the last 30 years. The '30 baht cures all illness programme' formally guaranteed the accessibility of healthcare services to all, yet among the middle classes there was concern over the quality of the services provided and the possibility of dilution of the services the middle classes were already used to through various insurance schemes. This group did not constitute a major vote bank for the Thai Rak Thai Party, and their concerns were therefore of lesser significance for the ruling party. The middle class also rightly feared that the expansion of free healthcare services to the poor would sooner or later also lead to higher taxation for those who could be taxed.

4.3 The '30 baht cures all illness programme' and the Thai Rak Thai party

The TRT party won its landslide victory in the 2001 general election because of the party's promise to implement its policies. The party leader, Thaksin Shinawatra, on becoming prime minister of Thailand, announced at a press conference on election day, 6 July 2001, 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'. As UC policy had been part of TRT party's campaign under the slogan of '*Sam sib baht rak sa thuk rok*' ('30 baht treating all diseases'), the '30 baht' policy became one of the government's top priority policies to be implemented after the election.

Health policies of the TRT party announced on 26 March 2000 were aimed:

1. To provide healthcare insurance for 62 million people according to the need and households contribute according to ability to pay.
2. To provide choices for people to register with healthcare provider from both public and private sectors. The healthcare provider will receive an adequate

budget according to the number of registered population in order to shift the healthcare services authorities back to the citizens.

3. To provide quality hospitals with geographic accessibilities.
4. To support healthcare promotion in children, adolescents, adults and the elderly as national priorities.
5. To provide disease prevention by healthcare education and universal coverage of vaccination.
6. To integrate medical strategy, social strategy, and moral strategy to reduce the number of AIDS patients.
7. To set the national accident prevention plan to educate people, encourage private and public collaboration, and prevent and cope with accidents.
8. To use all types of mass communication to increase healthcare knowledge and healthcare skills of people.

Source: TRTP (2000).The new profile of the public healthcare services. Policy declaration to the parliament by 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 aimed to reduce the national healthcare expenditures with 30 baht out-of-pocket per episode and provide accessible and equitable quality healthcare services. Health policy under a social sector policy aimed to implement healthcare system reform by establishing a National Health Security Fund through the legislation of National Health Security Act.

The ‘30 baht cure all illnesses programme’ was presented to the public by the Thai Rak Thai party in late 2000 prior to the general election, and was speedily implemented when the party won the general election in early 2001. It was mainly implemented by the Ministry of Public Health (MoPH), and the National Health Insurance for All Act of 2002 provided the legal basis for the project. This was not the only social welfare programme in Thailand as there were two other related healthcare programmes, one covering bureaucrats and employees of state enterprises, and a second providing some healthcare insurance as part of the social security net covering workers in the private sector. The 30 baht Scheme was filling the gap left by these other two programmes, as

it covered those who were not entitled to the benefits from these two programmes. During the earlier stages of the 30 baht scheme the politicians involved in the project always referred to the project as the 'filling the gap programme' (TDRI, 2002).

Although the programme was promoted by the Thai Rak Thai party, the idea of a national healthcare scheme covering all individuals was not a new one in Thai policy discussions and debates. The contribution of the Thai Rak Thai party was the introduction of the nominal figure of 30 baht that a patient was required to pay on the initiation of a course of treatment, and that would cover the full treatment. As 30 baht was less than one dollar, this was in effect making healthcare services virtually free for the poor. In fact, half of the people entitled to the benefits of this programme were not required to pay anything at all, as they have already been exempted from payment by a law establishing free healthcare as part of the welfare programmes for the old, the disabled, and children which existed prior to the introduction of the 30 baht scheme (TDRI, 2002).

4.4 Ideology of the UC scheme

The principles of Universal Healthcare Coverage were:

1. Equity has to do with equal access to standardised service fair and progressive distribution of cost burden.
2. Efficiency concerns the most economical use of resources. The role of primary care networks is stressed as their operation costs are lowest.
3. Choice has to do with the opportunity enjoyed by people to have their access to wide variety of services including the ones provided by the private sector.
4. Health for all that is achieved through healthcare promotion and disease prevention campaigns.

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 TRT party because it had a potential to win votes and gain popularity. The UC policy content was in line with Thai people's constitution right to healthcare services.

The ideology behind the UC policy may be said to be egalitarianism or equal access to healthcare for all Thai citizens whose rights are 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 healthcare providers. Because of Thailand's liberalisation policy, private profit-making hospitals were also allowed to operate within the so-called free market.

4.5 The actors

4.5.1 Policy elites

The policy elites in the UCS policy formulation process were the elected politicians, the prime minister, the minister of health, 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 permanent secretary of the MoPH, the secretary general of economic and social development board, the director general of the comptroller general's department, and the secretary general of the civil servant commission.

4.5.2 Prime minister

The prime minister Thaksin Shinawatra won the 2001 election with a majority of seats 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 measure to help farmers and villages. He was also a change-agent bringing about reforms in the healthcare system with the UC scheme. With his learning for business-based politicians' power, the decline in bureaucratic power was inevitable (Pitayarangsarit, 2004). However, it is noted by scholars that the scheme provided benefits to him.

> '….After the start of UCS, Thaksin managed to buy a large number of the stocks of large private hospitals. Only large hospitals were his objects of acquisition. X who acted as Thaksin's proxy formed BGS Group managed to acquire 32 hospitals through the countries under the brands of Bangkok, Smitivej, BNH, Payathai, and Paolo. BGH is the largest healthcare

conglomerate in ASEAN expecting to reap benefits from the AEC...' *(A scholar)*

'…Thaksin, projects are good to the public but insincere. They are aimed at contributing to Thaksin's popularity. As for 30 baht scheme, people seek to use the services offered by the scheme in their irresponsible way. Drunken people can come to the hospitals and ask for free service. People can come to hospitals at 2 a.m. asking for drugs after spending their nights at nightclubs. They used the services irresponsibly without the knowledge about the limit of the projects. Thaksin never educated people about this. People look upon Thaksin with gratitude. They can be likened to desert travellers who encounter cool water vendors, but the cool water sold by Thaksin is very expensive…' *(Doctor of a hospital)*

4.5.3 Bureaucrats

The bureaucrats were dominated by medical doctors. UCS, a rationally based policy change, was suppressed to maintain the bureaucrats' power over public healthcare through the centralised hierarchical structure. However, a few reformist bureaucrats played autonomous roles in healthcare service and financing research, and formed a strong body of national researchers who had long studied problems and alternatives in the healthcare sector. They had close relationships and strong capacity. Many graduated from the same medical school and most of them were trained in healthcare policy and financing, and had attended post-graduate universities abroad. In 2000, a number of researchers were commissioned by the Health Systems Research Institute (HSRI), an autonomous research institution under an executive board chaired by the Health Minister, to suggest alternatives to achieve UC. All alternatives suggested that UC would change the healthcare financial structure and change the role of the MoPH in the control of the budget for healthcare services. This role would be partially transferred to consumers' hands, administered under a board which reported directly to either the health minister or the prime minister (Pitiyarangsarit, 2004).

One particular health reformist, Dr Sanguan Nitayarumphong played a central role as a 'policy entrepreneur' by pursuing UC for a long time and when he met the TRTP leader, he took advantage of the subsequent discussions to promote UCS.

4.5.4 Civil groups.

The 1997 constitution had increased civilian power in policy decision-making. Firstly, state control over the appointment of the upper house was replaced by direct elections

of senators representing civil society. Many non-governmental organisation representatives were elected as senators and voted in parliament for the public interest. Secondly, the constitution eliminated the bureaucracy's monopoly over public policy formulation in favour of public participation. Moreover, civilians are eligible to propose a law regarding rights. Thirdly, it transfers the bureaucracy's role of election administration to an independent election commission.

Civil society in Thailand includes non-governmental organisations (NGOs). The development of NGOs started in the 1970s. The prototype was the Thailand Rural Reconstruction Foundation founded in 1969 which benefits the rural people. The foundation stood for development which benefits the rural people (Phongpaichit & Baker, 1995). In the UCS case, voices in support came from a communication network of those interested in UCS who received information from reformist bureaucrats, not from independent technocrats as in other social movements.

4.5.5 Policy stakeholders

UC policy stakeholders fall into six categories as follows:

1. Political actors;
2. Agencies in the public sector;
3. Service providers;
4. UC users;
5. The NHSO;
6. A number of organisations involved in peripheral ways.

1. Political actors are the ones formulating national policy and approving financial allocation to the UC scheme.
2. Agencies in the public sectors are responsible for implementing policy after financial allocation is approved, such as the budgetary office and audit general office.
3. Service providers are the service units registered as service providers in the UC scheme. They include public hospitals affiliated or not to the Ministry of Public Health and private hospitals and clinics participating in the scheme.

4. Users are Thai citizens entitled to the benefits offered by the UC scheme. As for Thais who are entitled to the benefits from the social security scheme, they are entitled to the service related to healthcare promotion and disease prevention.
5. Health Security commission formulated policy for NHSO. The commission is chaired by the minister of public health.
6. Other agencies involved include:
    - The association of healthcare-related personnel who have a role in determining entitlements and the conditions related to the provision of services. They include the council of doctors, the council of nurses, the council of pharmacists, the council of dentists, and the private hospitals association.
    - Non-profit organisations such as the organisation working for the improvement of the welfare of youths, women, the elderly, the disabled, people with mental disorders, workers, peasants, and ethnic groups.

4.6 Conflict of interests and impact of the policy

Since the National Health Security Board (NHSB) comprised all the stakeholders, and the majority of its members were representatives of healthcare providers and healthcare professionals, there was a tendency to postpone or not to support decision that could put pressure on providers to improve efficiency, quality and responsiveness, especially on healthcare providers under the jurisdiction of the MoPH (Tangcharoensathien, 2004). The power struggles between NGO representatives, the government ex-officio representatives, and the healthcare professionals were evident in NHSB meetings. The interviewed data from key informants showed as follows;

> '...Many members of the board of the National Health Security commission are involved in conflicts of interests as they still hold their position in the non-governmental organisations...'. *(Doctor of a hospital)*

> '...Local politicians used the UCS's healthcare promotion fund to increase their own popularity. They lied to local people that they used their own money to support healthcare promotion projects...' *(An officer of local healthcare office)*

> '...Many members of the board of the National Health Security commission also have their positions in the commission's sub-committees, with some even having their positions in nine sub-committees...' *(A politician)*

'…In Singapore, the doctors at the public hospital get good salaries at a similar rate to that of the private hospitals. They were prohibited to work for private hospitals. This provides the solution to the problem of the doctors at the private hospital sending their patients to use the facilities of public hospitals. Private hospitals were thus forced to invest in sophisticated equipment…' (*A scholar)*

4.6.1 Budgetary allocation and management

The budgetary request for supporting the operation of the UC scheme was based upon an estimation of costs and was submitted each year to the cabinet. The budgetary allocation for the UC scheme in 2003, the first year of the scheme, was based on a calculation that allocated 1,202.20 baht per capita for that year. This estimation was based upon a breakdown of the likely service costs per capita dividend into outpatient services, inpatient services, healthcare promotion, emergency services, equipment costs, and an allowance for costly treatments. The financing required for the UC scheme was calculated by utilising the figure of 45,613 million people registered as participants in the scheme, which resulted in a budgetary allocation of 56,055.677 million baht.

4.6.2 Increased allocation of funds for the Universal Healthcare Coverage Scheme

The funding for the UC scheme was increased according to the rate of inflation. In the fiscal year for 2011 the per capita allocation was increased to 2,546.48 baht covering 47.996 million people, and Table 4-1 shows the different services funded. The increased per capita allocation from 1,308.50 baht in 2004 to 2,546.48 baht in 2011 reflected not only inflation, but also the growing number of patients undergoing costly treatments as a result of heart-related ailments and various kinds of cancer. In addition, dentistry services for children and the latest dentistry technology were introduced in 2011, in addition to an increase in the per capita allocation to the primary units of 11.24 baht for the promotion of the role of these units.

Table 4-1 - Allocation per capita 2003-2011

Services	Per capita (baht/Population)							
	2004	2005	2006	2007	2008	2009	2010	2011
Total	1,308.50	1,396.30	1,659.20	1,899.69	2,100	2,202.00	2,401.33	2,546.48
1. Outpatients (OP)	488.2	533.01	585.11	645.52	645.52	666.96	754.63	795.39

Services	Per capita (baht/Population)							
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
2. Inpatients (IP) OP**+**IP for community hospitals	418.3	435.01	460.35	513.96	845.08	837.11 72.25	885.94 72.25	954.72
3. Additional services in particular areas – desolate places and dangerous zones	10	7.07	7	30	30	-	-	64.09
4. Accidents/Emergency treatment (AE)	19.7	24.73	52.07	51.02	-	-	-	-
5.High cost treatments (HC)	66.3	99.48	190	209.56	-	-	-	-
(4+5). High cost treatments/Accidents/ Emergency treatment/ Specific diseases/ Indispensable drugs					145.26	179.48	194.34	209.45
6.Emergency Medical Service(EMS)	10	6	6	10	12	-	-	-
7. Health promotion and disease prevention	206	210	224.89	248.04	253.01	269.66	283.15	312.50
8. Dentistry	-	-	-	-	-	-		2.25
9. Medical rehabilitation	-	4	4	4	4	5	8.08	12.00
10. Traditional Thai medicine and alternative medicine	-	-	-	-	1	1	2	6.00
11. Compensation for the lifting of 30 baht fee	-	-	-	24.11	-	-	-	-
12. Depreciation in value	85	76.8	129.25	142.55	143.73	148.69	148.69	148.69
13. Additional payment in proportion to the quality of service	-	-	-	20	20	20	40	25.00
14. Basic financial aid provided to users in accordance with Article 41	5	0.2	0.53	0.53	Using the remaining finance	1	Using the remaining finance	2.68
15. Basic financial aid provided to users	-	-	-	0.4	0.4	0.85	0.78	0.97
16. Fund for primary services	-	-	-	-	-	-	10.63	11.24
17. Fund for tertiary services requiring specific expertise	-	-	-	-	-	-	0.84	1.50

Source: Adapted from NHSO, 2011

The National Health Security commission undertook the planning and the policy formation for the UC scheme. The policy formulated by the commission had an effect on the increases or decreases in budgetary allocation to the various funds supporting the operation of the UC scheme, which resulted in an increase in the rise of operational

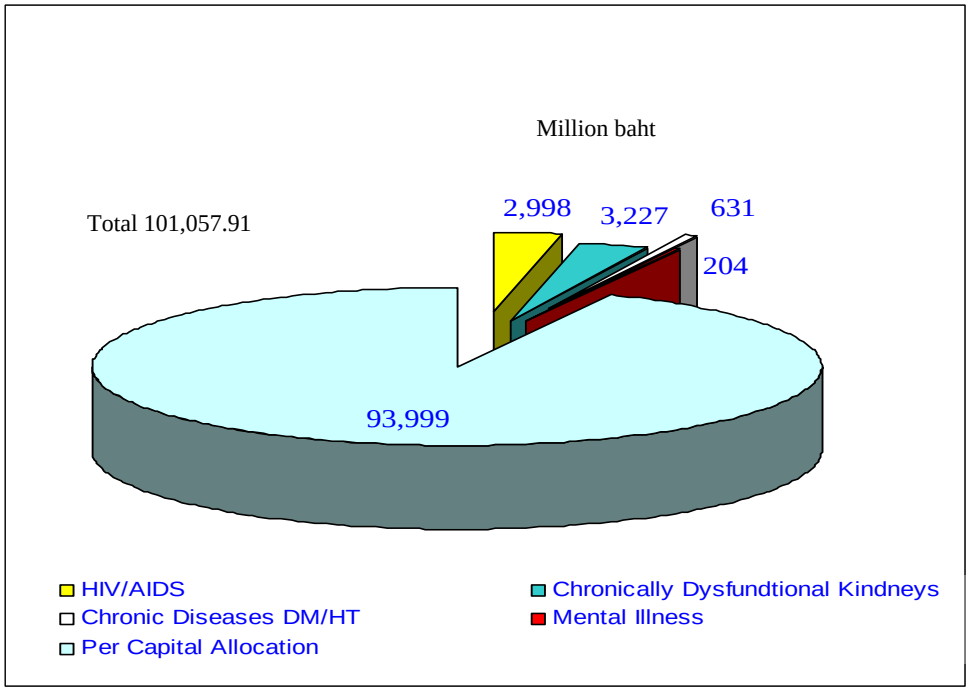
costs of the scheme. The commission set up several sub-committees assigned with the task of determining an appropriate budget reflecting inflation and the increases in benefits for the people covered by the scheme. The focus of these sub-committees included strategic co-ordination, the development of services and benefits, and the development of fiscal planning.

The funds allocated to the UC scheme were distributed to the service units under contract to the NHSO. Those service units which did not provide a particular service did not receive funding for it, for example, units with no Thai traditional medicine service were not provided with the funds to support a Thai traditional medicine service.

The budgetary allocation was divided into the five funds in order to achieve efficiency and flexibility in the budgetary management, and the NHSO was able to demonstrate how the calculation for each fund had been performed based upon data related to the number of patients. In addition to the cost calculations based on the number of patients, the methods of treatment and the amount of the funds to be allocated were outlined. The budgetary allocation for the UC scheme in 2011 totalled 122,222.38 million baht in order to cover 47,996,600 million people. From this, 28,272.98 million baht was set aside for the payment of salaries to personnel and thus the fund was reduced to 93,999.40 million baht.

In addition to the per capita allocation, a fund of 7,058.499 million baht was set up to support the treatment of specific diseases. This fund was sub-divided into treatment for HIV, chronic dysfunctional kidneys, chronic diseases, and mental illness, as shown in Figure 4.1. Money from this fund was allocated to service units under contract to provide treatment for AIDS, diabetes, high blood pressure, dysfunctional kidneys, and mental illness to the UC scheme population.

Figure 4-1 - Budgetary allocation for the UC scheme 2011



Source: Adapted from NHSO, 2010

4.6.3 Increased funding in proportion to the increase in benefits

Allocation per capita has been the practice for funding the UC scheme since 2002. The practice of budgetary allocation led to the establishment of five large funds that were then sub-divided into smaller funds was aimed at attaining transparency and efficiency in budgetary management. When making a request for a budgetary allocation, applicants were required to provide information related to the number of patients, method of treatment, and to specify the amount of needed. The fund for patients with dysfunctional kidneys and for AIDS patients were set up in this manner, whilst the budgetary allocation to healthcare units was based upon the assessment of their capacity to provide services, with units capable of providing many services being better financed.

Increases in the funding for particular hospitals and service providers were in proportion to the specific services they provided. By 2011, the finance for UC scheme was categorised into:

1. A per capita allocation;
2. A fund for the treatment of AIDS;

3. A fund for the treatment of chronically dysfunctional kidneys; and
4. A fund for the prevention of chronic illness.

Figure 4-2 - Comparison of the requested amount and the actual allocation, 2002 - 2010

Source: NHSO 2010

Notes: 'Requested' represents the request for increased funds from the government, whilst 'allocation' is the budgetary allocation already approved by the government

The per capita allocation fund was a large fund from which smaller funds were derived, such as those for outpatients, inpatients, healthcare promotion and disease prevention, and costly treatments. Hospitals provided with funds for outpatients were assigned the responsibility for UC population within their zones, which were demarcated based on the local geography. The funds for outpatients were allocated per capita at the beginning of the fiscal year, whilst the funds for inpatients were allocated per capita at the beginning of fiscal year but before the account was settled at the end of the fiscal year. The fund for traditional Thai medicine in 2011 was allocated at 6 baht per capita, with a total value of 285,000,000 baht (47.5 million x 6). The pre-requisites for the allocation of the funding was the presence of a Thai traditional medicine service that included massage, steaming, herbal treatments, and rehabilitation after child delivery.

The per capita allocation increased steadily due to increasing wages, the increasing use of services, and inflation. However, although the funding increased each year, it was always less than the amount formally requested, accounting on average for 87.67% of

the amount formerly requested. In 2010, the allocation of the budget for the UC scheme, in reality, was 89.62% of the amount formally requested, as shown in Figure 4.2.

4.6.4 The increasing expenses of the Universal Healthcare Coverage Scheme

Full operation of the UC scheme in 2002 resulted in an increase in the total expenditure on healthcare, from 81,273.10 million baht in 1999 to 106,608.20 million baht in 2003. The implementation of this healthcare insurance scheme required 100,000 million baht which the government was obliged to fund. The budgetary allocation of 100,000 million was an increase of 20,000 million baht from the previous funding for healthcare insurance programmes before the introduction of the UC scheme.

In 2002 46 million people were covered by the UC scheme, and the budgetary allocation for it amounted to 53,093 million baht or 1,202 baht per capita, accounting for 49.8% of the total expenditure on healthcare. This increase in expenditure on the UC scheme resulted in a decrease in expenditures on non-UC schemes, from 65,209.9 million baht in 2000, to 22,144.8 million baht in 2003, accounting for 66.04% of the funds allocated to the MoPH as show in Table 4-2

Table 4-2 - Government's expenditures on healthcare

	Spending (Million baht)				
	1999	**2000**	**2001**	**2002**	**2003**
Total government's expenditures on healthcare	81,273.10	90,504.10	94,221.80	106,608.20	107,806.20
Annual increase	-0.2	11.4	4.1	13.2	1.1
30 baht Scheme	-	-	1,909.90	53,093.80	55,708.90
Civil Servant Medical Benefit & State enterprise Scheme (CSMBS)	15,253.00	17,058.00	19,180.00	20,475.00	20,519.00
Social Security Scheme (SSS)	3,552.70	8,236.20	8,148.10	8,196.10	9,433.50
Ministry of Public Health (Non-UC)	62,467.40	65,209.90	64,983.20	24,843.30	22,144.80

Source: Adapted from the framework of budgetary planning and allocation 1999 – 2003 (NESDB, 2003)

4.6.5 Satisfaction and complaints with the Universal Healthcare Coverage Scheme

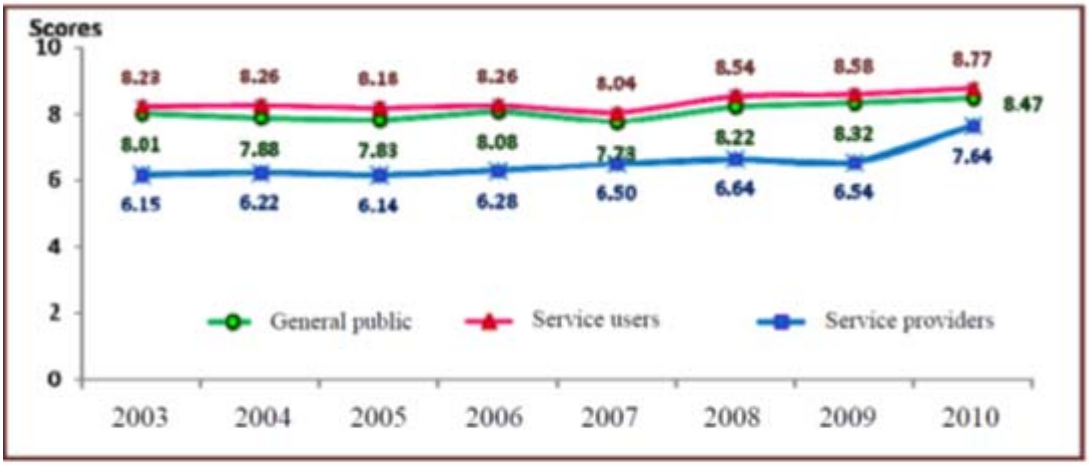
A satisfaction survey of UC scheme users and service providers conducted by the Assumption University found that 89.76% of users were satisfied with the services, and the average satisfaction score was 8.77 on a ten-point scale, whilst 78.75% of service providers were satisfied with the services, giving an average satisfaction score of 7.64 on a ten-point scale. Satisfaction scores from users have increased annually, although the latest scores were nearly the same as those for last year. Similarly, the satisfaction scores of service providers from 2003-2008 has also increased annually. A survey conducted in 2010 found the highest of all the satisfaction scores for the last eight years, as shown in Figure 4.3.

Figure 4-3 - Satisfaction survey results from UC scheme, 2003 - 2010

Source: Survey of the opinions of the general public and service providers for the UHC scheme conducted by the Assumption University 2003-2010

Note: Percentage of satisfaction is derived from the combination of the percentage of people who were satisfied and highly satisfied with the scheme

Figure 4-4 - Average satisfaction scores for the UC scheme, 2003 - 2010



Source: An opinion survey of the general public and service providers for the UHC scheme was conducted by the Assumption University 2003-2010

The UC scheme has contributed healthcare benefits to the public since 2003.

> '…It seems to be a very good project, but you should know the quality of treatment is deteriorating and the money of the middle and higher class flows to the capitalists who have cultivated connections with politicians. Right now are there politicians, highly ranked bureaucrats, and doctors who exercise their 30 baht right?' (*A scholar)*

> '…On the whole, the adoption of universal healthcare put us on the right path, but the finance allocated to the project needs to be increased and, if necessary, a tax hike is a must…' (*A scholar*)

> '…It's a good project as it helps resolve the problem of income disparity to a certain extent. I'm not knowledgeable about medical science and I'm well off enough to waive the right of the 30 baht scheme. I think those who don't have enough money to afford treatment aren't serious about the poorly standardised services. They just want to be cured and then go the work the next day. They aren't serious about their long-term health condition…' *(A scholar)*

Formal complaints made by users of the UC scheme provide a broad sense of the types of problems many poor users face. Complaints were made through the emergency line 1330, which was staffed by personnel of the National Health Security 24 hours a day and even healthcare units were allowed to make complaints and seek consultation via

this line. Most complaints referred to are being denied access to services to which card-holders were formally entitled. In 2007, 973 complaints concerned this issue, accounting for 34.80% of all complaints, and in 2008, 1,871 complaints of this type were made, accounting for 44.14% of all complaints. However, in 2009 the number decreased to 1,640, accounting for 38.18% of complaints, as shown in Table 4.3.

Table 4-3 - Types of complaints registered about UC scheme 2007- 2009

Complaints	Fiscal Year 2007		Fiscal Year 2008		Fiscal Year 2009	
	No.	%	No.	%	No.	%
1. Standard of services	489	17.81	727	17.15	673	15.64
2. Inconveniences	546	19.53	781	18.42	906	21.08
3. Demand for payment	779	27.86	860	20.29	1,079	25.10
4. Denial of access to services to which they were entitled	973	34.80	1,871	44.14	1,640	38.18
Total	2,796	100	4239	100	4,298	100

Source: Adapted from the annual report NHSO, 2009

The interviewed data from key informants showed as follows;

> '…They (politicians) have already got hospitals and targeted customers. However, the acquisition of doctors still proves costly for them. So, they intend to produce more doctors with no attention paid to the quality of doctors. They forced the central hospital to produce doctors in addition to the doctors produced by medical schools. As a result, novice doctors are of poor quality. They cannot perform surgeries, be they appendectomy or birth delivery. But at least, doctors' salaries become lower…' (*A scholar)*

> '…An interesting point is that the private hospitals of the BGH group managed to acquire doctors of good quality at the very low costs as they did not want to deal with such a workload with a low salary and to work in a stressful atmosphere, as they were criticised by patients for the service not being up to the standard. UC provides service of a poor quality, considering doctors, drugs, and others. The gap between the rich and the poor keeps getting wider…' (*A scholar)*

- **The financial impact**

The budgetary allocation to the provinces by the MoPH in the first year (2001) of the UC scheme was based on a payment proportionate to the number of people registered under the scheme at a particular hospital. This capitation-based payment covered the full cost of the healthcare services provided under the scheme, including the salaries of doctors and nurses. A fund of 5,000 million baht was also set up to support the

operation of hospitals affected by this new method of budgetary allocation; however, these hospitals were required to submit plans for improvements to their services to the commission.

The financial impact of the UC scheme was characterised by an inadequacy in budgetary allocation per capita, especially for inpatients (Srithamrongsawad & Torwattanakitkul, 2005). This stemmed from basing the cost per capita on figures for 1996, which had a significant impact particularly on inpatient costs due to the increases between 1996 and 2001. The service cost per capita in 2001-2002 was calculated to be higher than the actual per capita allocation by 212 baht (Prakongsai, et al., 2002), as the calculation was based on data related to the cost per unit incurred from the provision of hospital services.

In the first full year of operation of the UC scheme outpatient expenses increased from 17,077 million baht to 27,111 million baht, an increase by 59%, whilst the cost for inpatients increased by only 9%, from 13,814 million baht to 15,090 million baht. In 2003, the total expenses of the MoPH decreased as requests to the security fund established to support hospitals adversely affected by the presence of the UC scheme decreased from 5,000 million baht in the first year of the operation of the scheme to 500 million baht in the second year.

Stringent cost controls were imposed on the UC scheme as a limit was set on the funding of the scheme. However, due to the politicians offering excessive benefits, service providers suffered operational losses (Siamwalla, 2005), and the scheme only survived because the participating service providers were affiliated to the MoPH. The stringent cost controls imposed by the MoPH on the service providers caused further problems, such as the registration of people without their consent in order to access more funding, as budgetary allocation is based on the size of the UC scheme population under the responsibility of the service provider. Another problem was the restriction of free competition from the private sector for the sake of the survival of the service provider affiliated with the MoPH, which was achieved by assigning a smaller UC scheme population to the private hospitals. Furthermore, salary cuts aggravated the problem of the poor distribution of personnel and also resulted in confusion regarding

the role of the provincial public health offices which simultaneously acted as purchasers and service providers (Leesmith &Pitayarangsarit, 2005).

Budgetary allocation based on the size and distribution of population resulted in less financial support for provinces where there was a low doctor-patient ratio and more financial support for provinces with a high doctor-patient ratio, such as in the north-eastern provinces and community hospitals (Srithamrongsawad &Torwattanakitkul, 2005). The interviewed data from a doctor of a hospital, a scholar, a user showed as follows;

> '…It's a good project but those who are eligible for the benefits should be the ones whose incomes are low enough. Those who can afford the treatment on their own should pay to maintain the standard of service. As for costly treatment, the level of incomes of those eligible for the benefits of the services should be determined beforehand. If what I have said is done, all Thais, regardless of the class to which they belong, will enjoy the service not much differing in quality…' (*A doctor of a hospital).*

> '…If the 30 baht scheme is to be successful, healthcare system with the emphasis of disease prevention is to be fully developed to reduce the cost of treatment of complex diseases. In addition, the number of taxpayers has to be increased to make the scheme sustainable in the long run…' (*A scholar*)

> '…I am well off enough to afford treatment by myself. I once paid 30,000 baht to a public hospital for the operation cost to save the life of my son. However, I'm not a rich person. The 30 baht scheme thus helped me save a considerable amount of my money. And I often used the services offered by the scheme. I would like to share my experience in using the services of many public hospitals to which I took my son. After my son was admitted, they gave me the documents to be signed. The documents showed the costs of my son's hospitalisation that included the costs of room, bed, and food. I realise, I took the mat and had my son lie on the mat whilst staying overnight during hospitalisation. But the costs totalled 3,000 baht. Is this corruption? And who's behind the corruption? Thaksin?' (*A user)*

4.6.6 Adjustments made by hospitals

Provincial hospitals could earn income from other services, such as the CSMBS, SSS, foreign labourers, and payments by individual patients. The idea of obtaining revenue from the CSMBS was highly appealing, as the payments to service providers, made every time services were used, had no limitation. Furthermore, additional revenue could be obtained through an increase in the rate of service fees and thus it came as no surprise that the expenses of the CSMBS increased dramatically; 13% annually from

1994-1998 and 10% annually from 1999-2003. During the same time period of 1996-2003, the number of people covered by the gold card scheme or UC scheme decreased on average by 1.6% annually, due to the government's policy relating to the enhancement of operation and the reduction of manpower (Srithammarongsuwad &Torwattanakitkul, 2005).

From the introduction of the UC scheme in 2002 until 2011, 57 private hospitals have opted out of the scheme; 22 had 100 or more beds, whilst 35 had fewer than 100 beds, with 13 of them in Bangkok, 7 of them in the northern region, 11 of them in the north-eastern region, 23 of them in the central region, and 3 of them in the southern region. The earlier years of the UC scheme witnessed more hospitals opting out of the scheme, with 15, 11, and 9 leaving in 2003, 2004, and 2005, respectively (NHSO, 2012).

The practice of making payments for the SS was based on capitation as in the UC scheme. To obtain increased revenues from the SSS hospitals had to have more participants registered as users of the services provided by a hospital. However, participants in the SSS tended to be less inclined to use a hospital's services than participants in the UC scheme. Therefore, from the hospital's viewpoint it was preferable to register individuals under the SSS than under the UC scheme, as the profits from providing healthcare insurance to foreign labourers were similar in nature those obtained from the SSS. However, only the hospitals located in areas with significant numbers of migrant non-resident foreign labourers had the opportunity to obtain such revenues by providing healthcare insurance to foreign labourers.

Provincial hospitals were in a more advantageous position than community hospitals to obtain revenues from individual patients, although all hospitals were desirous of the extra revenues which could be obtained from the service fees charged to individual patients. However, provincial hospitals well equipped in terms of equipment were attractive to individual patients who could afford special services arranged for them.

Other cost cutting measures adopted by all hospitals participating in the UC scheme hospitals included delaying payment for the acquisition of drugs, limiting the dispensation of essential drugs, dispensing domestically produced drugs instead of imported drugs, reducing the number of workers other than doctors and nurses working overtime, cutting costs not related to medical services, and delaying long-term

investment in equipment, infrastructure, and training. The interviewed data from a scholar and NHSO officer informants showed as follows;

> '…Hospitals tried to take profits as much as possible from the drugs not included in drug lists. Those drugs were sold to bureaucrats as the cost of those drugs borne by bureaucrats could were disbursed from the comptroller general. The hospitals thus promote the use of those drugs by pricing those drugs as high as possible…' (*A scholar)*
>
> 'Service units failed to learn the disbursement process properly, so the funds were not disbursed in full. It is thus unfair to say that UC scheme caused losses…' *(One of the NHSO officers)*
>
> 'The approaches to fund management were changed very often and were so detail-oriented I could hardly catch up with the change…' *(A staff member of a provincial health office)*
>
> 'The approaches to fund management were changed very often. We hardly caught up with the changes. Once we were accustomed to the rules, they were changed. We had to start learning them again…' *(Staff member of a hospital)*
>
> 'To be free from losses, hospitals should be assigned with enough UC population under their responsibility. The small hospitals with 20-30 beds should have at least 25,000 UC populations under their responsibility…' *(A director of a hospital joining UC)*

4.6.7 Improvement in the services provided by primary units

The per capita allocation of funds to community healthcare units under the UC scheme enabled them to afford drugs, equipment and other items necessary for improving services at locations that were much more convenient for many, particularly rural, users of healthcare services. This raised the status of community healthcare stations to community centres for healthcare promotion and disease prevention and enabled the deployment of professional nurses to these centres and improved medical services. Thus, the per capita allocation model did improve the operation of primary healthcare units located close to many rural populations (Srithamrongsawad & Lapying, 2003).

Improved services provided by community healthcare units attracted more users as capitation required users to use the services provided by the hospitals with which they were registered, before they were eligible to be transferred to a hospital with the capacity for more sophisticated treatment. The number of users of community hospitals increased during 2001-2002, whilst the number of users of general and tertiary

hospitals decreased. This was due to the adoption of the DRG approach to payment which was also applied to the general hospitals, whilst the cost of providing services at the community hospitals were lower (Pannarunothai & Kongsawat, 2001). The introduction of DRG resulted in the equal allocation of funds to hospitals, whether they were provincial or community hospitals and the lower costs of providing services at community hospitals resulted in a surplus in the funds allocated to them under the DRG payment system. Community hospitals were therefore motivated to seek users for their services, resulting in an increase in the users of their services.

4.6.8 Effects of Universal Healthcare Coverage Scheme on health-related personnel

The presence of the UC scheme effectively reduced the price of accessing healthcare services for a sizeable part of the population, and this inevitably increased the demand for healthcare services. Thus there was an immediate effect was on healthcare sector professionals, with their workloads increasing by 70% in 2003 compared to 2001. According to a survey of the state of healthcare and welfare conducted by the National Office of Statistics, the use of outpatient services increased by 25% during 2001-2003, whilst the consumption of drugs without prescription and the use of services provided by unregistered healthcare units decreased by 8%. The use of inpatient services also increased by 9%, whilst the use of outpatient and inpatient services provided by private hospitals decreased, as shown in Table 4.4

Table 4-4 - Provision of services to the participants in the gold card scheme as inpatients and outpatients 2001 and 2003

	Outpatients			Inpatients		
	2001	2003	% +/-	2001	2003	% +/-
The number of times of service using by an individual patients	2.846	3.547	24.6	0.076	0.083	8.8
% of Gold Card using (UC scheme)		56.6			80.9	
The use of service provided by unregistered healthcare units	30.6	28.0	-8.5			
Community healthcare units	22.2	26.2	18.0			
Community hospital	14.2	22.0	54.9	30.0	54.4	81.0
Provincial hospitals and tertiary healthcare units	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 survey of the state of public healthcare and welfare

Note: 2001 data includes participants in the MWS for the poor, the gold card scheme and uninsured people

4.6.9 Increased workloads

According to a study conducted from 2002 to 2009, doctors stationed at the community hospitals were assigned the highest workloads, followed by doctors at the general hospitals, whilst doctors at the university hospitals were assigned the lowest workloads. The amount of work assigned to the doctors at private hospitals was similar to that of public central hospitals.

Table 4-5 - Workload of doctors 2002-2009

Hospitals	2002		2007		2008		2009	
	Workload of an individual doctor	Comparison index	Workload of an individual doctor	Comparison index	Workload of an individual doctor	Comparison index	Workload of an individual doctor	Comparison index
Community	34,379	2.2	28,487	2.0	25,728	1.7	23,006	1.5
General	18,805	1.1	19,742	1.4	16,680	1.1	17,260	1.1
Central	12,020	0.7	13,305	0.9	14,373	0.9	11,721	0.7
University	4,931	0.3	2,701	0.19	2,937	0.2	3,353	0.2
Private	12,849	0.8	15,681	1.1	15,168	1.0	15,295	1.0
Total	16,535	1.0	14,469	1.0	15,340	1.0	15,808	1.0

Source: The report on healthcare related resources (MoPH, 2010)

Community hospitals, especially in the north-eastern region, have suffered from a lack of doctors. In general, a shortage of doctors has posed a great obstacle to the extension of the UC scheme (Srithamrongsawad & Torwattanakitkul, 2005). In 2002 the number of doctors resigning from bureaucratic posts in government hospitals was twice that of 2001. These resignations have stemmed from increased workloads whilst salaries remained low and stagnant (ABAC, 2003; Suan Dusit, 2004). The interviewed data from scholars showed as follows:

> '…You may think doctors lose interest from the existence of UC. But in reality, doctors do not care much about increased workloads. They find services not up standard unacceptable. Even many doctors who are university professors and work for private hospitals are opposed to the project, even though they stand to reap benefits as the number of patients at the public hospital decreases. They view that the poor get service of a low quality and the middle class's money flows to politicians…' (*A scholar)*

> '…What is happening is that skilful doctors join private hospitals whilst inept doctors remain in public hospitals, having to bear hard work and be offered with low salaries whilst providing services of low quality…' (*A scholar)*

4.6.10 The public sector's loss of health-related personnel

The public sector has lost healthcare-related personnel to the private sector and some have switched to other professions. The move of a large number of healthcare-related personnel to the private sector has not resulted in a loss to the whole healthcare system but has adversely affected the provision of medical services to the public, as the majority of rural people depend on the medical service provided by the MoPH.

There has been a growing tendency among medical professionals to leave their jobs in the public sector. In 1996 just prior to the economic crisis, 21 community hospitals were found to be without doctors, although paradoxically, the situation improved in 1997 as the economic recession caused a slump in the demand for doctors in private hospitals. However, during the time of the economic recovery in 2001-2003, the issue of doctors resigning from their jobs at the MoPH again became acute, and during 2005-2009, 600-800 doctors resigned from their jobs (MoPH, 2010).

4.7 Evaluation of the performance of the Universal Healthcare Coverage Scheme during its first year

The failure to achieve universal coverage of the whole healthcare insurance scheme before 2002 was, according to the National Economic Development Board, due to the existence of various programmes under the responsibility of various agencies. No action was taken to promote co-operation among those agencies; moreover, fiscal planning of the operation of healthcare related programmes was lacking (NESDB, 2003). According to the NESDB's report, 43.9 million people, accounting for around 70% of the total population, gained access to healthcare insurance, but the remaining 19 million people, accounting for around 30% of the total population, were yet to gain access to healthcare insurance.

4.8 The reformed health insurance scheme

The 9th National Economic and Social Development Plan, which was in effect from 2002-2006, featured a strategy for human development and social protection, which resulted in reforms aimed at improving the existing five categories of healthcare insurance, as well as to accelerate access to healthcare insurance for people previously

without healthcare insurance. The whole healthcare insurance system was reshaped, resulting in three forms of healthcare insurance programmes which remain in place to this day:

1. Medical welfare for bureaucrats and employees of state enterprises.
2. Compulsory healthcare insurance programme consisting of a compensation fund and social security fund.
3. Universal healthcare coverage, the 30 baht scheme.

The service fee of 30 baht, or around one US dollar, was charged to the users of the 30 baht scheme. However, this group of people includes the poor, children up to 12 years of age, the disabled, and veterans who were exempt from fee payment.

After the coup d'état, the Surayudh Chulanond administration ordered the charging of the 30 baht fee to be cancelled on 31 October 2006. The justification for this was to enhance the accessibility of the UC scheme, and it was later renamed the 'Gold Card Scheme'. A public relations campaign was launched to improve public awareness of the change in the name of the scheme; however, many people continued to refer to the UC scheme as 30 baht scheme as this was the name during Thaksin's premiership.

4.9 Conclusions

The UC insurance system in Thailand has evolved from the various forms of healthcare insurance that existed before the National Health Insurance Act of 2002. The UC scheme was an addition to the already existing insurance systems and extended healthcare services coverage to new and previously excluded groups. The National Health Security Act passed during Thaksin's premiership came to be known as the 30 baht Scheme, and was adeptly used to promote the popularity of the Thaksin administration.

The history of the evolution of universal healthcare coverage can be traced back to 1980, when healthcare cover for civil servants and their families was introduced. In 1990, the social insurance programme for workers was introduced, in addition to the implementation of an assistance programme for the needy, which was characterised by the provision of healthcare services to the impoverished, the elderly, and children. A healthcare insurance policy with a relatively low premium of 500 baht per person per

year was also developed at this time. This led to there being five forms of healthcare insurance in Thailand:

1. MWS for the poor and the needy;
2. VHCS, which was established by the government and shared the responsibility for the cost of treatments or co-payment;
3. CSMBS for civil servants and employees of state enterprises;
4. SSS for the formal private sector employees;
5. Private Insurance covering around 1.4% of the country's population, with premiums depending on the conditions of the insurance policy.

Nearly half of those covered by the UC scheme were already covered under previous schemes, such as the MWS for the poor and the needy, who were already exempt from payment for services. The introduction of the UC scheme has had the most significant impact on the practice of public healthcare in Thailand in the past 30 year (TDRI, 2009) as it was through this scheme that universal healthcare coverage was actually introduced. Unlike other projects initiated by the Thai Rak Thai party, the UC scheme appears to have stood the test of time. In fact, it has not been politically possible for subsequent governments to abolish it and it is therefore even more important to understand the limitations of the project design and to determine the implications of reform in different directions.

Other policies of the populist Thai Rak Thai party have been subjected to criticism regarding corruption, a lack of transparency, and unsustainability. It is very likely that the 30 baht Scheme was also part of its populist programme for buying support from particular constituencies, regardless of the financial viability of the programme. Nevertheless, once the National Health Insurance Act in 2002 was passed, Thailand achieved a national universal healthcare system and political imperatives have ensured that the scheme has evolved in different ways as successive governments have attempted to make it sustainable by increasing its budgetary claim and reforming the method of its application

Chapter 5. Financial management of the Universal Healthcare Coverage Scheme

This chapter analyses the management of the fund for financing the service units joining the UC scheme. The allocation of funds was guided by regulations that were subject to revisions reflecting the changing conditions and priorities of successive administrations. Changes to these regulations and the criteria for fund allocation affected the finance obtained by different types of service units joining the UC scheme.

5.1 Management of the Universal Healthcare coverage fund

Management of the UC fund has frequently undergone revisions in response to the changing situation. A major revision was undertaken at the beginning of the 2002 budgetary year commencing on 1 October 2001 and the UC scheme underwent an expansion during this period to cover all 15 provinces except Bangkok. The major shift in the approach to budgetary allocation based on the size of population at this time caused a significant change in the operation of healthcare facilities, especially those affiliated to the MoPH (TDRI, 2004). In 2005 principles for financing healthcare facilities were introduced which aimed to achieve a number of objectives:

1. The allocation of funds in accordance with the needs and demands of different healthcare facilities (Differential Capitation).
2. The allocation of funds in a close-end fashion (see chapter 4).
3. The same rate of payment for patients grouped together with the same diseases (DRG) was introduced with the intention of fixing or standardising the cost of treatment. However, this was not aimed at achieving equality in access to treatment for all patients with the same disease.

In 2007 the principles of financing healthcare facilities were further refined to include the following additional objectives:

1. Allocation of funds to ensure equality to indispensable but costly services, with the rates of payment fixed approximately in line with the costs of hospitals. Different hospitals could charge different rates for the same diseases if their

costs were different, but the rate could not vary significantly from the fixed rates resulting from the calculation based on DRG.

2. The introduction of a disease management and managed referral system for diseases with high treatment costs. Referral is the transferring of patients to larger hospitals within a particular UC zone and is necessitated by smaller hospitals' inability to treat complex diseases. The costs of the referral of inpatients were borne by the NHSO, whilst the costs of the referral of outpatients were borne by the referring hospital in accordance to their agreement.
3. Assurance of equal access to emergency services in cases of accidents and sudden illnesses, including a referral system for patients to other UC zones.
4. Supplementary funding for healthcare facilities located in sparsely populated areas, and dangerous zones, meaning areas experiencing violent conflict, such as in the Deep South and frontier areas.

In 2009, a further objective was added and the principles of financing healthcare facilities were amended. This new objective was that patients with diseases requiring long-term and costly treatment should have their cases separately managed to ensure equal access.

In 2010, priority was given to the role of local government in healthcare services. To improve the efficiency of fund management, the 9th regional office in Nakhonratchasima and the 13th regional office in Bangkok were empowered to make their own decisions related to fund management in order to suit the particular needs of these areas, such as the use of funds for capital replacement, healthcare promotion and disease prevention, and medical rehabilitation for outpatients.

In 2011, the original principle related to the objective of assuring public access to efficient healthcare services remained in place and the capitation of 101,057.91 million baht was allocated for this purpose. Funds for AIDS patients (2,997.74 million baht), patients with chronically dysfunctional kidneys (3,226.55 million baht), patients afflicted with chronic diseases like diabetes and high blood pressure (630.60 million baht), and patients afflicted with mental illness (203.62 million baht) were established, the latter two only in 2011.

The budgetary allocation to the NHSO was divided into two parts:

1. That used for financing the provision of effective and efficient healthcare services and in securing public access to such services. The allocation of these funds increased annually, as shown in Table 5.1.
2. Funding for the management of the NHSO which was then sub-divided to support routines and the implementations of policies or strategies.

Table 5-1 - The capitation management of the National Security Fund 2004-2011

Budgetary allocation	Fiscal year							
	2004	2005	2006	2007	2008	2009	2010	2011
Per capita allocation (baht)	1,308.50	1,396.30	1,659.20	1,899.69	2,100.00	2,202.00	2,401.33	2,546.48
UC population (million)	46.82	47.00	47.75	46.07	46.48	47.03	47.24	48.00
Allocation to the fund (inclusive of salaries) (million baht)	61,212.39	67,582.60	82,023.00	91,369.05	101,984.10	108,065.09	117,969.00	129,280.89
Fund for salaries (million baht)	27,639.52	26,692.65	27,594.37	24,002.66	25,385.30	27,467.40	28,584.23	28,222.98
Allocation to the fund (salaries not included) (million baht)	33,572.87	40,889.95	54,428.63	67,366.39	76,598.80	80,597.69	89,384.77	101,057.91

Source: Adapted from NHSO, 2012.

5.2 Budgetary allocation of the Universal Healthcare Coverage Scheme

The allocation of the National Health Security Fund by the NHSO was based on rules and criteria, which, as already discussed, are constantly subject to revision. During the earlier years of the UC scheme (2002-2004), the per capita allocation to smaller funds deriving from capitation was based upon the age structure of the people eligible for registration, and the demand of local service units as dictated by the problems they encountered. The budgetary allocation was for the support of outpatients, inpatients, and healthcare promotion and disease prevention.

The allocation of support for outpatients was based upon the age structure of the UC population, although the difference in the amount allocated to the funds provided to each province was no more than 10% on a per capita basis. The allocation for supporting conscripts and college students, however, was beyond the application of such rules but instead based upon the calculated value (NHSO, 2004).

The MoPH provided 65,876 million baht in 2002 and the allocation to the UC scheme accounted for 72.8% of the total allocation to the MoPH, amounting to 47,988 million baht. This allocation to the UC scheme was used as follows:

1. Salaries for personnel and finance for service units, amounting to 23,850 million baht.
2. General subsidies in addition to salaries, amounting to 22,138 million baht.
3. A central fund for the development of a central database, amounting to 2,000 million baht.
4. A contingency fund amounting, to 5,000 million baht.

After the deduction of salaries and the central fund, the allocation to the UC population was 45,000 million baht, but with the intended per capita allocation of 1,202.40 baht, only 37 million people could be covered instead of the 46.6-50.3 million people as estimated by the MoPH (TDRI, 2004).

A contingency fund was established to compensate for the losses of the service units. Compensation was provided on condition that they demonstrated operational plans featuring details on revenue and expenses and including a cost reduction plan. In the 2002 fiscal year the contingency fund has paid out compensation four times to 183 hospitals in 51 provinces, to the value of 4,419 million baht. After the deduction of salaries amounting to 383 million baht, the remaining 4,036 million baht was the figure actually used as compensation from the losses incurred.

The better financial condition of some service units led to a reduction in the amount of funds provided to these units, and some even received demands to make repayments. In total, 181 service units were financed by the contingency fund in 2002, to the value of

3,527 million baht, which was lower than the 5,000 million baht contained in the contingency fund, whilst two hospitals were required to make repayments.

The budgetary allocation to the UC scheme was based upon the size of the population from the very beginning of the scheme in 2001, with the fund for salaries being separated from the per capita allocation. The allocation of funds according to the size of the population was in contrast with the allocation of funds according to the size of hospitals or the availability of healthcare-related resources, be they personnel or equipment, as experienced by hospitals before the introduction of the UC scheme in 2001. This shift in budgetary allocation practice from the basis of the availability of resources to the size of the population was introduced in 2001 and meant that the availability of hospital resources was no longer the factor determining the amount of funds provided to a hospital.

This shift in budgetary allocation practice resulted in a significant increase in the budgetary allocation to the hospitals in the north-eastern provinces with a large UC population, despite their limited resources in terms of personnel and equipment before the introduction of the UC scheme. In contrast, the budgetary allocation to provinces like Ratchaburi in the central region which had a smaller population but where there were four large hospitals did not increase. The MoPH propose two ways to divert more funds to large hospitals:

1. Separation of the fund used as salaries for healthcare-related personnel employed by the service units affiliated to the MoPH in the provinces from the funds provided per capita to the UC population. The funds used for salaries were provided to hospitals in proportion to the size of the UC population. This practice negated concerns about the payment of salaries in large hospitals, salaries were overseen by all service units in each province.
2. The separation of inpatients from outpatients was considered the solution to the problem characterised by the reluctance of service units, mostly community and district hospitals, to admit patients and to refer inpatients. This practice ensures the inflow of income to large hospitals to certain extent because they have more inpatients.

Provinces were granted autonomy to choose one of the two methods described above by which to divert more funds to large hospitals. In reality, their choices were varied but small hospitals tended to avoid sharing risk with large hospitals.

To cushion the impact of the shift to budgetary allocation according to the size of population, the Budgetary Bureau set up a contingency fund valued at 5,000 million baht in 2002. In the 2002 fiscal year the contingency fund provided financial assistance to 55 large central and general hospitals affiliated to the MoPH, 60% of all large hospitals, and accounting for 83% of the financial support provided by the contingency fund. In addition, 122 community hospitals, accounting for a sixth of all community hospitals, were provided with financial support from the contingency fund. Large hospitals on average received 52 million baht, whilst small hospitals on average received 5 million baht.

5.3 Finance of the UC Scheme

5.3.1 The financing requirements of the 30 baht Health Scheme

The '30 baht cures all illnesses' scheme is the biggest healthcare insurance scheme ever organised in Thailand, and its introduction caused extensive changes within the MoPH. Financing the scheme was complex, and it was based upon a matrix system characterised by a combination of various methods of financing. For example, there is a difference between the financing method applied to hospitals and that applied to primary healthcare units, such as community clinics and urban healthcare centres (NHSO, 2011).

The implementation of the healthcare insurance for all schemes in 2002 caused a rise in the public sector's healthcare expenses from 90,504 million baht in 2000 to 106,608.2 million baht in 2002, a growth rate of 13.1%. The finance supplied by the state was valued at 100,000 million baht, with a 20,000 million baht increase attributed to the implementation of the healthcare scheme based on the principle of universal coverage. However, this figure does not include individual citizens' expenditures on healthcare, which was found to decrease from 55 billion baht to 47 billion baht per year after the introduction of the healthcare scheme based on universal coverage. This decrease in the

individual expenditures on healthcare was equivalent to 14.5% (Tungcharoensatien, 2002, cited in NESDB, 2002).

In 2002, the government provided 53,093.82 million baht (1,202 per capita) to the 30 baht scheme which was to cover 46 million people, and expenditure on this scheme accounted for 49.8% of the total finance for all healthcare insurance schemes. The increase in finance for the scheme led to a decrease in expenditure on other healthcare related schemes which were not universal coverage in their nature from 65,209.9 million baht in 2000 to 24,843.3 million baht in 2002, a decrease of 61.9%. In 2003, the finance for the 30 baht scheme was increased by 4.9% from that of 2002 to 55,708.9 million baht, whilst expenditure on non-universal coverage schemes decreased by 10.9% to 22,144.75 million baht. The dramatic decrease in expenditure on non-universal coverage schemes was a concern since any unexpected event requiring an increase in non-universal coverage schemes would adversely affect the operation of the 30 baht scheme (NESDB, 2003).

The National Health Insurance Act requires all state-run hospitals to serve as providers of services, whereas the participation of private hospitals in the scheme is on a voluntary basis. A number of private hospitals have withdrawn from the scheme since the commencement of its operation: in 2003 there were 88 private hospitals participating in the scheme, but the number was reduced to 71 in 2004, 63 in 2005, 61 in 2006, and 60 in 2007. However, the number of private clinics joining the schemes as a Primary Care Unit (PCU) rose from 89 in 2004 to 105, 116 and 152 in 2005, 2006, and 2007, respectively (NHSO, 2009). This rise in the number of private clinics (as opposed to hospitals) participating in the scheme indicates the scheme's potential as a source of revenue for private clinics that have undergone an adjustment in the management of their services and finances as a result of the changing situation. However, private clinics as PCUs must establish a connection with hospitals in case they have to transfer patients for treatments which they are unable to provide.

In the early stages of the scheme there were three primary constraints concerning its operation (NESDB, 2002):

1. The database of service users was incomplete and thus unusable, giving rise to problems due to the inaccuracy of the information on those eligible for

the service and leading to confusion and duplication in card issuing. People experienced inconvenience in accessing services and hospitals failed to be subsidised as agreed in their contracts.

2. Proper cost accounting was not introduced, and as a result, salaries for personnel were included in the 30 baht scheme's expenses per capita, whilst care was provided to people already covered by other healthcare insurance schemes.
3. The allocation of funds for the support of the scheme was delayed due to bureaucratic procedures. This was also related to a lack of information on the size of population in a particular area which could be used to determine the allocation of funds to hospitals within a particular area.

5.3.2 Internal resource allocation

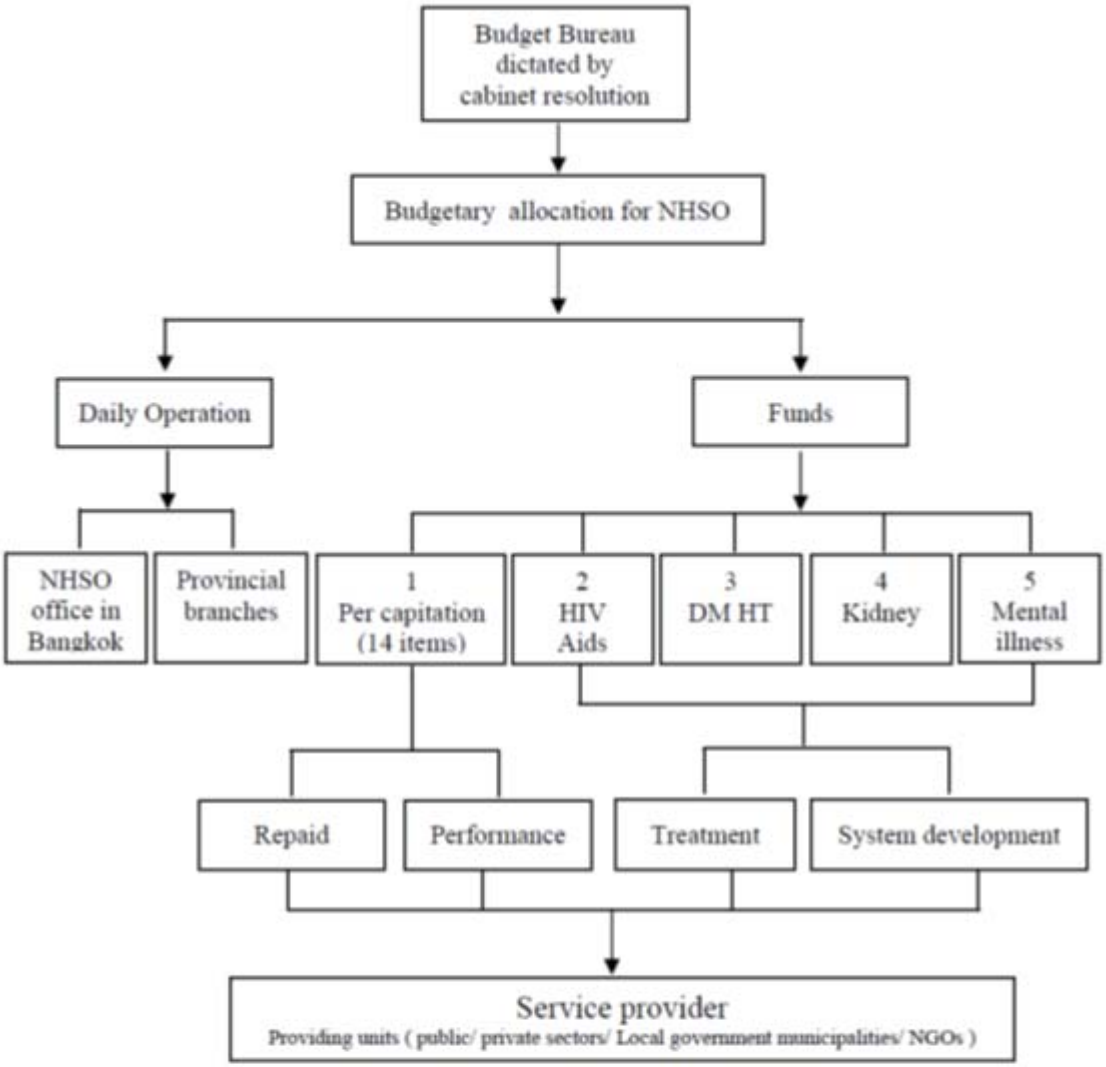
The Universal Healthcare Coverage Scheme (UC) depends on the budgetary allocations made by the government to cover the services that are provided under the scheme. The rules of allocation of funds for the operating costs of service delivery under the scheme initially recognised that not all types of services could by jointly financed by a single transfer without important and expensive services falling out of the remit of many hospitals as they specialised in less expensive treatments. To prevent this, the financing model provided a general operating fund to hospitals but then tried to identify a number of critical areas for which special funds were allocated from the outset to ensure that some critical services were ring-fenced and therefore protected. The National Health Security Fund initially limited its additional allocation to the five following funds:

1. The fund for supporting the general provision of services to all those covered by the UC scheme (this was based on a per capita allocation to hospitals to cover all the UC patients registered with them).
2. The fund for supporting the provision of services to those who have HIV.
3. The fund for supporting the provision of services to those chronically afflicted by dysfunctional kidneys.
4. The fund for supporting the prevention of diabetes and high blood pressure.

5. The fund for supporting the provision of services to those afflicted by mental illness.

In the 2011 fiscal year the budgetary allocation to these five funds totalled 129,280.8881 million baht, whilst the budgetary allocation for the daily operation part of the budget totalled 961.30 million baht, thereby accounting for only 0.74% of the total budgetary allocation of funds. The financing for the scheme's daily operation and for the five different funds was allocated to branches of the National Health Security Office (NHSO) located in the Bangkok Metropolis and in the provinces. Together, these branches made up the 13 administrative units of the NHSO in 13 regions spread throughout the country. The budgetary allocation to those branches enabled the five funds and the scheme as a whole to operate.

Figure 5-1 - The budgetary allocation of finance



Note

1) Budgetary allocation to five funds totaled 129,280.8881million Bahts in fiscal year of 2011
2) The deductions from the funds to be used as wages and salaries amounted to 28,222.977 million Bahts
3) HIV Aids 2,997.7366 million Baht , DM HT 630.59 million baths, Kidney 3,226.5505 million Baht, Mental illness 203.624 million Bahts
4) The finance for supporting daily operation amounted to 961.30 million Baht (0.74%). It was provided to central and regional offices and provincial branches of the NHSO

Source: Adapted from Manual for the Management of the National Insurance Funds: 2010

The per capita allocation was sub-divided into 14 parts, as shown in Table 4.4 Generally, the per capita allocation was divided into a larger part which was used to support treatments and the acquisition of drugs, and a smaller part which was used to develop the system and ensure there were resources to invest in improving efficiency and ensuring the efficient use of resources.

Table 5-2 - Services covered by per capita allocation in 2011

Services	
1	Outpatients
2	In patients
3	Additional services provided by healthcare units located on specific areas
4	Costly treatment/ accident/ sudden experience of illness/ necessary but hardly accessible drugs
5	Health promotion and disease prevention
6	Dentistry services for children and false teeth
7	Medical rehabilitation
8	Thai traditional medicine and alternative medicine
9	Depreciation of medical equipment
10	Additional wages for staff to reward quality of work
11	Preliminary financial aid to users according to article 41
12	Preliminary financial aid to providers
13	Finance for primary services
14	Finance for specific tertiary services

Source: Manual for National Health Insurance in the fiscal year of 2011

In the fiscal year 2011, the per capita allocation amounted to 2,546.48 baht per capita per year. The per capita allocation comprised not only the expenditures on the medical services to which inpatients and outpatients were entitled under the UC scheme, but also on healthcare promotion and disease prevention, medical rehabilitation, depreciation in value of investments in medical equipment, the preliminary aid provided to those adversely affected by treatment (under Article 41), and the cost of necessary drugs and hard to access drugs, as shown in Table 5-2

The finance supporting the provision of outpatient services was also separated from that supporting inpatient services. The allocation for the two was based on the number of registered patients in a hospital adjusted to reflect the age structure of the population, and data on the services provided to individual outpatients, healthcare promotion and disease prevention services provided to individuals, and the financial condition of

healthcare units. The amount allocated to inpatient services was calculated using a weighted average for a sample of patients. The relative weight based on these calculations was then used to divide the allocation between inpatients and outpatients.

The allocation to healthcare units located in specific areas was to cover the fixed costs incurred as a result of introducing the provision of services as required by UC scheme. Some less developed areas required a supplementary allocation to cover the fixed costs of setting up new service delivery arrangements. The allocation to the emergency fund for accidents and sudden illness was divided to support outpatients and inpatients. The fund created from this allocation was managed in the same manner as the central fund. The allocation to support costly treatments was calculated using a point system for different diseases and treatments with a cut-off ceiling within the global budget.

Funding for healthcare promotion and disease prevention programmes was considered to apply to all Thais, regardless of their healthcare insurance scheme. Consequently, part of the allocation went to local governments to support their healthcare promotion and disease prevention programmes. Support for Thai traditional medicine and alternative medicine services was as an additional allocation to outpatients. This was aimed at promoting Thai traditional medicine services and included massage, steam treatments, the use of herbal vapours, and traditional methods of rehabilitation after delivery.

5.4 Financial impact during the early years of the Universal Healthcare Coverage Scheme

The government proposed two measures to cushion the impact of the shift in budgetary allocation: separation of the funds for salaries at the provincial level according to the wishes of the provinces, and providing a contingency fund for affected hospitals. These measures resulted in effective capitation received by hospitals being different from the rate of per capita allocation (1,202.40 baht) used as a reference for the entire scheme (Naranong, 2004). Effective capitation for the service units affiliated to the MoPH as determined by the TDRI were of three types: 1) capitation with the inclusion of salaries; 2) capitation with the exclusion of salaries; and 3) capitation with the exclusion of salaries and the costs of service fees demanded by hospitals from each other, so that the real hospital incomes would be revealed (TDRI, 2004). Contingency

funds, regarded as income, were taken into consideration in order to establish the actual income of a hospital.

Hospitals receiving contingency funds were categorised as large or small hospitals. Large hospitals included central hospitals, general hospitals and hospitals not affiliated to the MoPH, such as psychiatric and paediatric hospitals, whilst small hospitals were community hospitals.

The TDRI found that the nationwide effective capitation plus salaries of the large hospitals (150 beds or more) affiliated to the MoPH was 1,306 baht per capita per year, which was higher than the figure of 1,037 baht per capita per year which was as derived from the per capita allocation of 1,202 baht minus the vaccination costs of 165 baht. The average effective capitation for community hospitals was 924 baht per capita per year. The difference in the rates of effective capitation between large hospitals and community hospitals stemmed from the separation of salaries at the provincial level, which occurred after the effective capitation for each province had been determined, and so salaries were omitted from the effective capitation and the remaining sum was used in the provision of medical services to the UC population in each province. Currently, 50% of the provinces in Thailand opt for the separation of salaries at the provincial level.

Effective capitation with the exclusion of salaries for large hospitals was 91 baht per capita per year, whilst that of community hospitals was 595 baht per capita per year. However, large hospitals also obtained revenues by accepting referrals from medium-sized and small hospitals, which leads to an increase in the effective capitation for large hospitals to 230 baht per capita per year, whilst the effective capitation for community hospitals is lowered to 583 baht per capita per year.

Effective capitation inclusive of salaries differed from region to region. Large hospitals in the north-eastern region received the highest effective capitation inclusive of salaries at 1,568 baht per capita per year, followed those in the eastern region (1,430 baht), northern region (1,315 baht), southern region (1,277 baht), central region (1,152 baht), and western region (1,099 baht). Effective capitation inclusive of salaries for community hospitals throughout the country did not differ much, with 995, 950, 946,

933 and 932 baht for community hospitals in the Western, northern, southern, north-eastern and central regions, respectively. The highest effective capitation received by large hospitals in the north-eastern region was due to the separation of salaries at the provincial level, which led not only to higher effective capitation for large hospitals but also to lower effective capitation for community hospitals (TDRI, 2004).

With the separation of salaries, the average effective capitation for a large hospital was 485 baht per capita per year, not much lower than that of a community hospital which was 68 baht per capita per year. With the inclusion of income from accepting referrals from community hospitals, the effective capitation for a hospital in the north-eastern region was increased to 736 baht per capita per year, higher than that of community hospitals in the same region. The average effective capitation after the exclusion of salaries for hospitals in the southern region was 56 baht per capita per year, whilst that of hospitals in other regions dropped to zero.

With the inclusion of incomes derived from accepting referrals from community hospitals, the average effective capitation for large hospitals improved. However, for some hospitals in the central, western, and eastern regions the average effective capitation remained at zero. With the inclusion of incomes derived from accepting referrals from community hospitals, the average effective capitation after the exclusion of salaries for hospitals in the southern, northern and north-eastern regions were 152, 112 and 736 baht, respectively.

Effective capitation after the exclusion of salaries but inclusive of incomes derived from accepting referrals for community hospitals in the central, eastern, western, southern, northern and north-eastern regions were 435, 486, 524, 492, 536 and 686 baht per capita per year, respectively, which were higher had been previously received before the introduction of the UC scheme by nearly 50%. However, communities in 19 provinces, including Pitsanuloke, Uthaithani, Maehongsorn, Uttaradit, Singburi, Angthong, Nakornnayok, Samutssongkram, Nontaburi, Rayong, Trad, Prachinburi, Ratchaburi, Chumporn, Ranong, Pattalung, Pangnga, Phuket, and Satun, received less per capita per year than had previously received (Naranong, 2004).

It was found that hospitals not provided with finance from the contingency fund received an effective capitation with the exclusion of salaries but inclusive of incomes derived from accepting referrals from community hospitals at 581 baht per capita per year, which was higher than that received by hospitals provided with finance from the contingency fund at 492 baht per capita per year. Community hospitals not provided with finance from the contingency fund received an effective capitation at 611 baht per capita per year, higher than the rate for hospitals provided with finance from the contingency fund at 491 baht per capita per year. Hospitals in the north-eastern region not provided with finance form the contingency fund received the highest effective capitation minus salaries but inclusive of incomes from accepting referrals, with an effective capitation of 771 baht per capita per head for large hospitals and 688 baht per capita per year for community hospitals. Hospitals in the central region not provided with finance from the contingency fund received the lowest effective capitation after the exclusion of salaries but inclusive of incomes from accepting referrals, with an effective capitation of 320 baht per capita per year for large hospitals and 481 baht per capita per year for community hospitals.

For hospitals provided with finance from the contingency fund, those in the southern region received the highest effective capitation after the exclusion of salaries but inclusive of incomes derived from the service fees charged to each other, 665 baht per capita per year, followed by those in the eastern region, 619 baht per capita per year. The figures for the community hospitals are shown in Table 5-3

Effective capitation that included only the budgetary allocation from the UC scheme did not reflect the real state of a hospital's finances, especially large hospitals whose sources of income were more varied. In assessing the financial condition of hospitals, the net revenues were thus to be taken into consideration. The TDRI found that separation of salaries from effective capitation affected the revenue of hospitals, resulting in the net revenues of 80% of large hospitals (74 out of 92 hospitals) to drop to zero, whilst the net revenue of 15% of community hospitals (105 out of 717 hospitals) also dropped to zero. The availability of finance from the contingency fund contributed to the reduction of the number of large hospitals whose revenues dropped

to zero (26 out of 92 hospitals, whilst the number of community hospitals whose net revenue dropped to zero was also reduced (18 out of 717 hospitals) (TDRI, 2004).

Table 5-3 - Average effective capitation at the provincial level

Hospital	All hospitals						Hospitals not provided with contingency fund						Hospitals provided with contingency fund					
	Capitation inclusive of salaries		Capitation after the exclusion of salaries		Capitation after the exclusion of salaries but inclusive of fees demanded from other hospitals		Capitation inclusive of salaries		Capitation after the exclusion of salaries		Capitation after the exclusion of salaries but inclusive of fees demanded from other hospitals		Capitation inclusive of salaries		Capitation with the exclusion of salaries		Capitation with the exclusion of salaries but inclusive of fees demanded from each other by hospital	
	Mean LH	Mean SH	Mean LH	Mean SH	Mean LH	Mean SH	Mean LH	Mean SH	Mean LH	Mean SH	Mean LH	Mean SH	Mean LH	Mean SH	Mean LH	Mean SH	Mean LH	Mean SH
Total	1334	940	91	595	230	583	1443	938	412	623	581	611	1837	1208	384	509	492	491
North	1315	950	-13	570	162	536	1406	949	169	607	444	572	1835	1249	462	616	586	594
Northeast	1568	933	485	686	736	686	1601	932	522	688	771	688	1458	1261	318	688	601	692
Central	1152	932	-75	451	-33	435	1158	932	319	495	320	481	1874	1232	175	399	268	372
East	1430	917	-194	505	-110	486	1273	927	654	549	654	529	2293	1001	523	333	619	325
West	1099	995	-229	541	-182	524	1321	993	379	572	429	556	1457	1559	20	397	66	359
South	1277	946	56	504	152	492	1405	939	386	552	429	541	1835	1187	553	465	665	448

Source: Adapted from the calculation of effective capitation really received by service units 2002, TDRI, 2004

Notes: Effective capitation of each case was calculated from data obtained from service units weighted by UC population to determine the average value at the provincial, regional, and national level

Contingency fund finance was calculated from the data in the report prepared by the Office of Health Service Development of the MoPH

LH – large hospital, SH – small hospital

The net revenue figure still did not necessarily reflect the financial condition of a hospital. Although the net revenue of hospitals dropped to zero, this might not indicate that the hospital faced severe problems regarding their financial condition (TDRI, 2004) and so the MoPH used the ratio of total revenue to salaries as an index of financial condition. Total revenue should be more than two fold higher than salary costs and the MoPH categorised hospitals into four groups according to this ratio. Hospitals with a ratio equivalent to more than two were considered as having no problem regarding the shortage of operational funds, whilst those with a ratio of 1.5-2.0 were considered to be overstaffed and were advised to scale down their workforce to reduce salary costs. Hospitals with a ratio of 1.0-1.5 were regarded as not sufficiently staffed to provide decent services to patients and those with a ratio of less than 1 were considered as not having sufficient revenues to bear the cost of salaries. The MoPH employed this ratio as a criterion in making its decision to provide contingency fund finance to hospitals.

Table 5-4 - Revenue to salary ratio as an index of a hospital's financial condition

Group	Description	Ratio of total revenue to salaries
1	No problem	> 2
2	In need of adjustment	1.5-2.0
3	In need of reform	1.0-1.5
4	In crisis	< 1

Source: TDRI, 2004

The use of this ratio in assessing the financial condition of hospitals affiliated to the MoPH revealed that the financial condition of the hospitals provided with finance from the contingency fund were similar, whatever the method employed for the separation of salaries from effective capitation. The separation of salaries within a hospital network in a province resulted in the financial condition of 10 hospitals and 56 community hospitals in the <1–1.5 category. Separation of salaries at the provincial level resulted in the financial condition of 5 large hospitals and 60 community hospitals falling in the <1–1.5 category. The use of this ratio in assessing the financial condition of the hospitals affiliated to the MoPH also revealed that the provision of finance from the contingency fund in the early years resulted in 69 hospitals affiliated to the MoPH facing financial problems accounting for 8% of the total number of the hospitals affiliated to the MoPH, as shown in Table 5.5 (TRDI, 2004).

Table 5-5 - Financial condition of the hospitals affiliated to the MoPH that were provided with finance from the contingency fund in 2002

Hospital		Revenue with the addition of contingency fund							
		General Hospital		Community hospital		Hospitals not affiliated to the MoPH		Total	
1. Capitation with the deduction of salaries within the hospital network in the province									
Group1	> 2	42	46%	518	72%	10	56%	570	69%
Group2	1.5 - 1	40	43%	143	20%	5	28%	188	23%
Group 3	1 – 1.5	10	11%	54	8%	1	6%	65	8%
Group 4	< 1	0	0%	2	0%	2	11%	4	0%
Total		92	100%	7.7	100%	18	100%	827	100
2. Capitation with the deduction of salaries at the provincial level									
Group1	> 2	60	65%	480	67%	10	56%	550	67%
Group2	1.5 - 1	27	29%	177	25%	5	28%	209	25%
Group3	1 – 1.5	5	5%	55	8%	2	11%	62	7%
Group4	< 1	0	0%	5	1%	1	6%	6	1%
Total		92	100%	717	100%	18	100%	827	100%

Source: Adapted from TDRI, 2004

5.5 Withdrawal of hospitals from the Universal Healthcare Coverage Scheme

As early as the third year of the UC scheme (2003), two groups of hospital sought to withdraw from the scheme. The first group was comprised of hospitals affiliated to the MoPH but which were not under the control of the office of the permanent secretary, whilst the second group consisted of private hospitals. Nine out of the 16 hospitals affiliated to the MoPH withdrew in 2003 on the grounds that their work was mostly concerned with healthcare promotion and disease prevention. These hospitals were the mother and child hospitals and local healthcare promotion centres. Five private hospitals withdrew from the scheme on the grounds that the per capita allocation they received failed to cover their operating costs (TRDI, 2004).

Table 5-6 - Numbers of registered hospitals and target populations

	Dec 2001		Sep 2002		May 2003	
	Number	%	Number	%	Number	%
Total Number of hospitals within the UC scheme	967	100	1,006	100	1,000	100
Central/General	92	9.5	94	9.3	94	9.4
Community	720	74.5	719	71.5	720	72

	Dec 2001		Sep 2002		May 2003	
	Number	%	Number	%	Number	%
Total Number of hospitals within the UC scheme	967	100	1,006	100	1,000	100
State hospitals beyond the control of the office of the permanent secretary of the MoPH	17	1.8	16	1.6	7	0.7
State hospital not affiliated to MoPH	60	6.2	70	7.0	74	7.4
Private	67	6.9	93	9.2	88	8.8
Others	11	1.1	14	1.4	17	1.7
Total population under the UC scheme (millions)	40.68	100	45.33	100	45.61	100
Central/General	8.93	22.0	9.96	22.0	10.29	22.6
Community	29.3	72.0	30.95	68.3	31.21	68.4
State hospitals beyond the control of the office of the permanent secretary of the MoPH	0.55	1.4	056	1.2	0.4	0.9
State hospitals not affiliated to the MoPH	1.11	2.7	2.02	4.5	1.98	4.3
Private	0.79	1.9	1.84	4.1	1.73	3.8
Others	0.1	0.2	0.17	0.4	0.19	0.4

Source: Adapted from the report entitled 'the first year of the UC scheme' TRDI, 2004

5.6 The problems associated with the Universal Healthcare Coverage Scheme during its early years

The early years of the operation of the UC scheme were marked by problems associated with the extension of coverage through the issuing of so-called 'gold cards'. The UC scheme was originally meant to be named 'the gold card scheme' but it came to be known as the 30 baht scheme which denoted the public share in the responsibility for the costs incurred through the provision of medical services. As issuing of gold cards was based upon information provided by registered households, there were problems with the accuracy of the information available due to people relocating without informing the proper authorities. There was also a problem related to the timing of the recording of data by the MoPH. Full coverage was not achieved during the earlier years of the scheme and people who did not receive the gold cards included workers who had been employed for less than three months who were yet to benefit from the SSS. This group was excluded from the gold card scheme due to the perception that they automatically benefited from the SSS upon their employment. There were also those workers who had left their jobs and stopped contributing to the SSS but who were still

entitled to its benefits, and the database of the UC scheme also failed to include these people.

Prior to the presence of the NHSO, the Office of Health Security, which is affiliated to the MoPH, was responsible for issuing cards. The office was also in charge of checking the identity of the people to be provided with cards and card issuing was based upon information on residence registration prepared by the Ministry of Interior. For the cards issued during the first three months, October to December 2001, 5 million did not pass the validity test, accounting for 16% of the total number of cards issued during that time (TDRI, 2004). In addition, as the information for issuing cards came only from registered households, this made the UC scheme inaccessible to the poor who tended to be itinerants without a fixed address, not to mention tribal people who did not possess identity cards.

5.7 Availability of supportive funds in the early years of the Universal Healthcare Coverage Scheme

Supportive funds could be likened to bank deposits, as these funds were collected revenues and profits that were reserved to be used for sustaining operations in accordance to the rules set out by the Ministry of Finance. The management of the hospitals and provincial healthcare offices assessed solvency through the consideration of revenue and expenses. The reserve fund, in addition to the yearly allocation to hospitals, formed part of the revenue and in times when the allocated funds were insufficient or delayed, then the supportive fund could be used to sustain operations.

Supportive funds have increased since 2002, especially those of community hospitals which have risen by nearly 50% to 2,453 million baht. This increase in supportive funds is probably due to the budgetary allocation based upon the size of the UC population. In contrast, the supportive funds possessed by central and general hospitals has remained nearly the same as that in 2002. However, it must be taken into consideration that the supportive funds possessed by some central and general hospitals have increased whilst in others it has decreased. This fluctuation is connected to the time of budgetary allocation to service units in the provinces. The amount available in supportive funds dramatically increased in March 2002, and at the time 80% of funds were allocated to service units in advance as a solution to the problem of the delayed acceptance of

registered clients of the UC scheme. However, the latter part of 2002 saw a decrease in the amount of supportive funds available due to the poor performance of hospitals and inadequate cash flow, which resulted in the delayed allocation of funds, in fact some of the per capita funds were delayed until November 2002 (Naranong, 2004).

Table 5-7 - The supportive fund reserves 2001-2002

	Sep 2001	Dec 2001	Mar 2002	Jan 2002	Sep 2002
Nationwide reserve of supportive funds (million baht)	11,855.67	11,940.24	15,515.79	16,118.57	14,305.48
Central and general hospitals	8,079.93	8,130.79	9,125.32	8,977.12	8,037.51
Community hospitals	3,734.51	3,739.26	6,295.51	7,040.64	6,187.28
The hospitals not under the supervision of the permanent secretary of the MoPH	26.66	40.73	33.52	11.26	4.19
The hospitals in the public sector but not affiliated to the MoPH	14.57	29.40	61.44	89.55	76.51

Source: Adapted from Naranong, 2007

5.7.1 Fund provision characteristics

Depending on the type of fund, payments from government to hospitals could be made either prior to or after the delivery of services (NHSO, 2011).

1. Pre-payment was marked by the transfer of funds in advance during the first three months of the fiscal year, so that service units could use the funds in their operation. Pre-payment was applied to the outpatient fund, some parts of the healthcare promotion fund, and also some of the inpatient fund; in total, 60% of funds were supplied to service units as pre-payments.
2. Post-payment was the allocation of funds based on services provided, and the quality of work was monitored before payments were made. Post-payment was applied to the Thai traditional medicine fund, the costly treatment fund, and the fund for patients suffering from sudden illness or accidents; in total, 40% of funds were provided to service units as post-payments.

5.7.2 The transfer of funds

The NHSO utilised three means for the transfer of funds endorsed by the National Health Security commission (NHSO, 2011):

1. Direct transfer from the NHSO to service units.
2. Transfer via the provincial offices of the NHSO, which acted as system managers empowered to establish the rules to suit the need of the UC population under their responsibility. These rules were required to be within the bounds of the main rules set by the NHSO. The funds allocated to provincial offices were then relayed to service units according to the work output or quality of work, as well as per the agreement. Monitoring the quality of work was achieved through studying the reports submitted to the provincial healthcare office by service units. Agreements were forged between service units and provincial healthcare offices to accomplish some tasks and payment was made upon the accomplishment of such tasks.
3. Transfer of funds to other service units within the province, outside the province, and outside the zone of responsibility. This type of funds transfer was a form of payment of fees that the service units demanded from each other.

The Provincial Health Offices are assigned with the following duties:

1. Collecting and analysing data on the operation of healthcare services.
2. Registering service users, service units, and networks of service units.
3. Financing service units and networks of service units.
4. Checking and verifying the bills used in collecting service fees by service units.
5. Assigning people to service units, responding to the people's request to change their service units, and providing people with the information on service units.
6. Ensuring that the operation of service units follows the line of the National Health Security commission, providing convenience in lodging complaints.
7. Carrying out the routine works of the Provincial Health Security commission and their sub-committee, carrying out any tasks related to healthcare security.

8. Carrying out other duties in accordance with other laws or regulations, or other duties assigned to them by the National Security commission, the Office of Health Standard, and the National Health Security Office. (NHSO, 2010)

5.7.3 Costs of treatment borne by the hospitals joining the Universal Healthcare Coverage Scheme

The cost of treatments varied according to the size of a hospital; those of large hospitals were generally higher than those of small hospitals. Although the cost of treatment at large hospitals was higher, the quality of treatment was also higher due to the availability of better equipment and supporting systems, in addition to better qualified personnel and availability of specialists.

Due to their better equipment and personnel, large hospitals attracted larger numbers of patients. People tended to opt for treatment in large hospitals, even when suffering from a less severe disease which could be treated by healthcare stations and community hospitals. The high expectation of the quality of hospitals led to a huge investment in personnel, equipment, facilities, and infrastructure to support these large hospitals, in turn causing the cost of treatment to increase. The MoPH set up a separate fund for supporting the investment in infrastructure for hospitals affiliated to the Ministry. As the investment was undertaken by the hospitals in the public sectors affiliated to the MoPH, profits were not taken into account as a factor in making the decision to invest. Instead, investment was undertaken as a public service.

In the early years of the UC scheme a number of concerns about large hospitals were raised (Naranong, 2002):

1. The availability of better personnel, equipment, and supporting systems enjoyed by large hospitals, which were generally located in urban areas, drew larger number of patients, both as inpatients and outpatients who could be afflicted with uncomplicated diseases. This resulted in a higher cost per capita being borne by large hospitals and the revenue they obtained from treating complicated diseases might not be enough to cover the costs of their operation.
2. Their per capita allocation, especially inclusive capitation that was directed to districts resulted in a fear among large hospitals that small hospitals might keep

patients to themselves. Inclusive capitation was the means by which large hospitals obtained their revenue through the allocation of funds that were to be used for the treatment of inpatients and outpatients. The allocation of funds to hospitals through inclusive capitation resulted in hospitals receiving large sums of money that they did not want to lose through referring patients to other hospitals, as the hospital to which patients were referred would then charge treatment fees from the hospitals referring the patient.

3. As large hospitals regarded the fund for inpatients as insufficient, they feared that the revenue from the DRG-based programme would result in further reductions.

Consequently, a contingency fund was set up to address these problems.

5.8 Cost of treatment in hospitals run by medical schools

The cost of treatment in hospitals run by medical schools affiliated to the Ministry of Education was generally higher than that of hospitals affiliated to the MoPH, be they central or general hospitals. This was because (TRDI, 2004):

1. A large number of patients referred to hospitals operated by medical schools had undergone treatment in community hospitals, general hospitals, or even central hospitals, but the diseases afflicting them had not been cured. The hospitals operated by medical schools therefore became a repository for patients with difficult diseases.
2. The treatment in the hospitals run by medical schools tended to use more sophisticated drugs and technology.
3. In addition to providing treatment, the hospitals affiliated to medical schools were responsible for teaching medical students. Performing the double duties of providing medical treatment and providing medical instruction added to their running costs. However, the cost of teaching should not be added to cost of treatment, as teaching costs, should in theory, be covered by the fees charged to students or allocation of funds by the government to pay for the teaching.

The participation of the hospitals run by medical schools proved to be profitable for them as a lot of people found them appealing and became registered users of the

hospitals. However, the majority of registered users were not ill and so a large part of their per capita allocation was not required to cover the cost of treatments and was instead kept as profit (TDRI, 2002).

5.9 The financial condition of the hospitals affiliated to the Ministry of Public Health

The presence of a UC scheme did not result in serious problems for hospitals affiliated to the MoPH, except for those with a small registered UC population or located in distant areas or along the border, which faced severe financial problems (MoPH, 2010). The financial condition of a hospital could be determined by the availability of their net reserve funds which increased continually from 2003-2009, as shown in Table 5.8. Net reserves can be likened to accumulated profits and were derived from the inflow of revenue from many sources, including profits from operational costs and even donations. Revenues measure the financial healthiness of a service unit and a large reserve is a good indicator that service units are in a good financial condition. Hospitals in specific areas plagued by financial problems have been provided with financial assistance from the NHSO and the MoPH (MoPH, 2010).

Table 5-8 - Financial condition of the healthcare related service units during 2003 - 2009

Items	Fiscal Year (million baht)						
	2003	2004	2005	2006	2007	2008	2009
The number of the hospitals providing complete information	783	662	711	792	809	818	822
1. Cash left	15,635	15,734	21,158	18,468	28,141	43,276	42,963
2. Supply left	2,990	2,972	3,590	3,783	4,294	4,818	5,241
3. Debt	6,938	9,513	16,672	16,054	12,316	15,825	16,626
4. Net reserved funds	11,687	9,193	8,076	6,197	20,119	32,270	31,579

Source: MoPH, 2010, cited by the NHSO

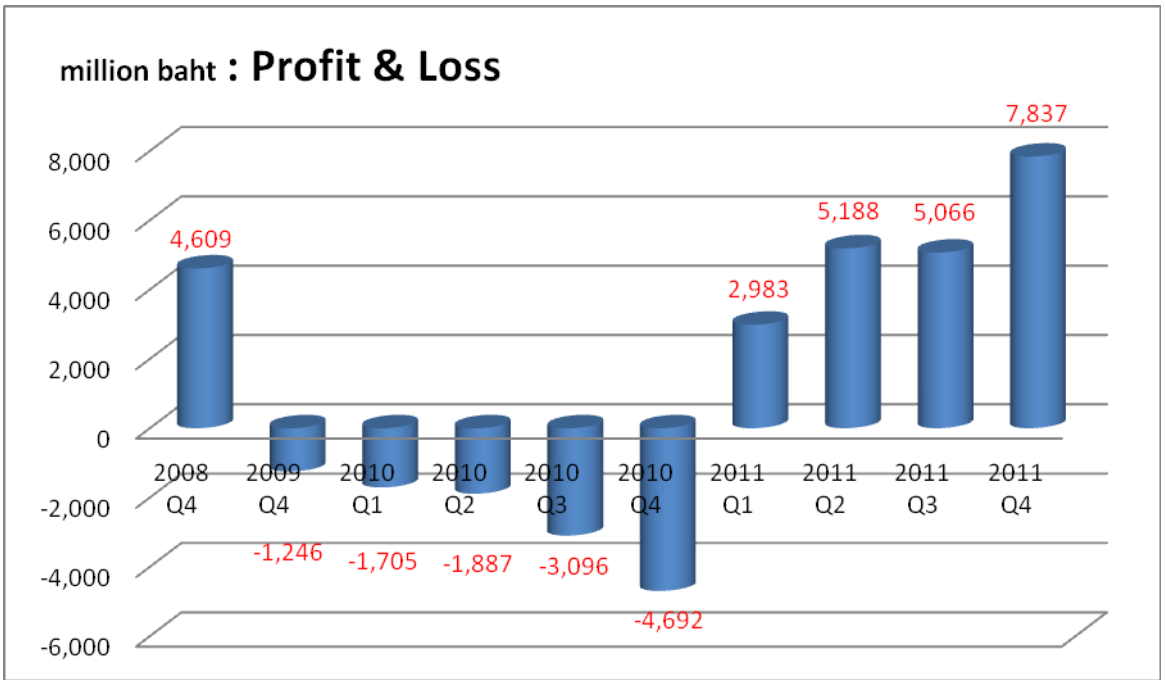
5.10 Financial condition of service units 2007-2011

5.10.1 Hospitals affiliated to the Ministry of Public Health

Hospitals affiliated to the MoPH suffered losses from the fourth quarter of 2009 to the fourth quarter of 2010, totalling 4,692 million baht. Financial conditions began to improve in 2011 and profits increased every quarter of the year, totalling 7,837 million

baht, thereby reflecting the continual increase in net reserve and supportive funds as shown in Figure 5.2 (MoPH, 2012).

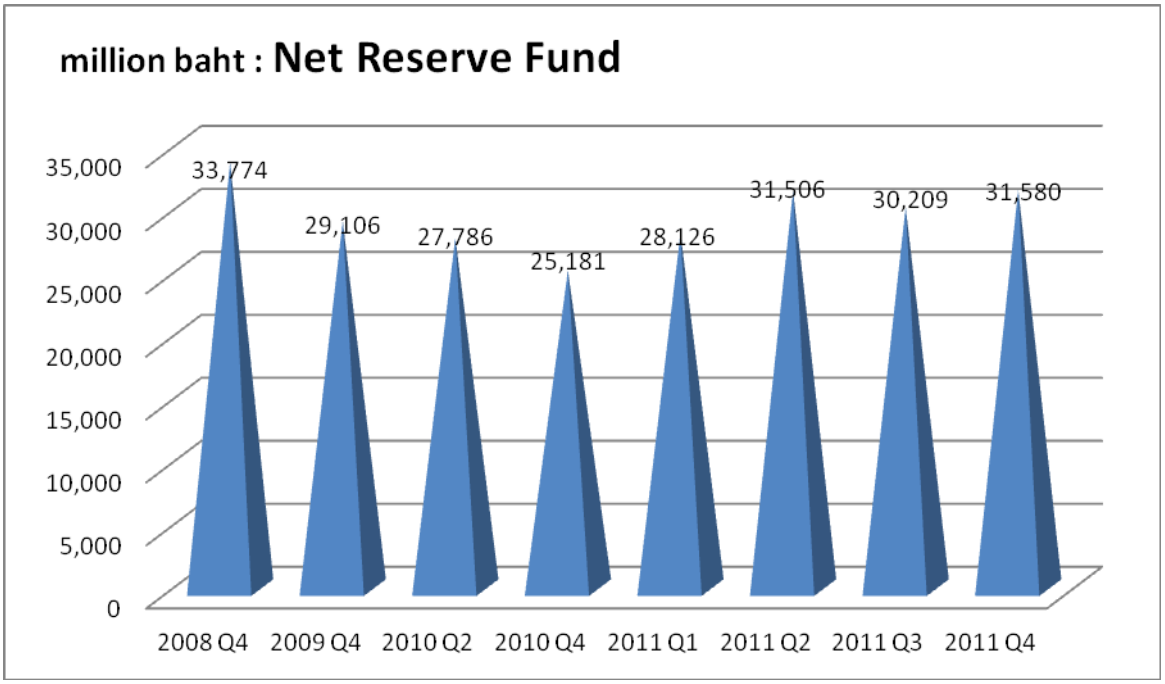
Figure 5-2 - Profits and losses of the service units affiliated to the MoPH, 2008-2011



Source: MoPH, 2012

In 2011, the net reserve increased from 28,126 million baht in the first quarter to 31,580 million baht in the fourth quarter, indicative of the availability of cash for unit operation (net reserve = current assets including cash and inventories - current liabilities) as shown in Figure 5.3.

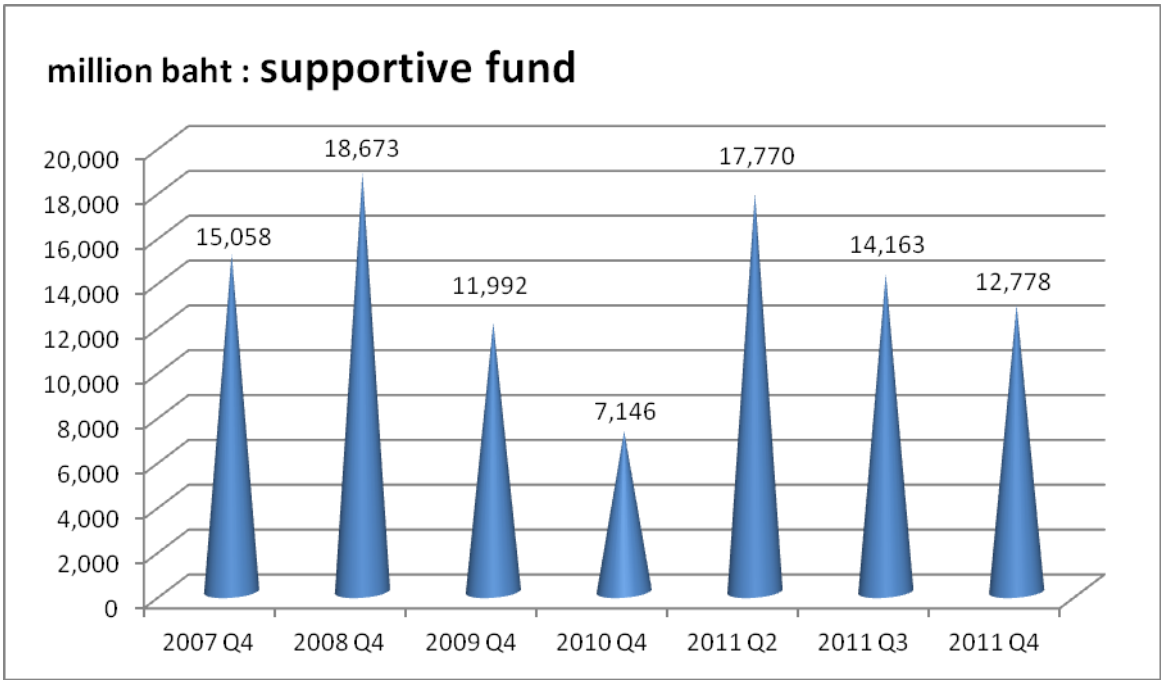
Figure 5-3 - Net reserve of hospitals affiliated to the MoPH, 2008-2011



Source: MoPH, 2012

Supportive funds were a factor of financial security and thus indicative of the capability to spend: supportive funds = cash + assets that could be translated into monetary value – liabilities and committed long term liabilities. In general, supportive funds increased from the first quarter of 2011 onwards, although they decreased slightly in the third quarter, but then rose again (Figure 5.4).

Figure 5-4 - Net supportive funds for hospitals affiliated to the MoPH, 2008-2011



Source: MoPH, 2012

The financial crisis experienced by the hospitals affiliated to the MoPH worsened in the fourth quarter of 2010, when 71% of hospitals suffered from a combined loss of 7,388 million baht, whilst the remaining 29% of hospitals gained a total profit of 2,727 million baht. The situation was much improved in 2011 when the number of hospitals suffering from losses was reduced to 37%, totalling losses of 2,566 million baht, whilst the remaining 73% of hospital reported total profits of 10,403 million baht. The MoPH attributed the better financial condition to the increase in budgetary allocation for the UC scheme by 15,000 million baht (MoPH, 2012).

Taking into consideration the two factors of the net reserve and profits from a unit's operation, the MoPH categorised hospitals into four groups according to their level of financial risk in the fourth quarters of 2010 and 2011. It was found that the percentage of hospitals in the highest risk category had dropped from 72.25% to 36.74%, whilst the percentage of the hospitals in the lowest risk category from 28.74% to 36.74%. According to the MoPH, the hospitals in the highest risk category in 2010 remained in the same category in 2011, and an analysis of the cause of this is yet to be made, as shown in Table 5.9 (MoPH, 2012).

Table 5-9 - The hospitals affiliated to the MoPH categorised according to the level of financial risk 2010-2011

Level of risk	Net reserve	Profits	2010 (Q4)		2011 (Q4)	
			No. of hospital	%	No. of hospital	%
Highest	negative	negative	217	26.43	115	13.99
High	positive	negative	368	44.82	187	22.75
low	negative	positive	41	4.99	60	7.3
No risk	positive	positive	195	23.75	460	55.96

Source: Adapted from MoPH, 2012

5.10.2 The better financial condition of hospitals affiliated to the Ministry of Public Health

Generally speaking, the financial condition of hospitals affiliated to the MoPH improved during 2009-2011 (MoPH, 2012). By the end of 2009, 505 hospitals accounting for 63% of the total, suffered total losses of 5,575 million baht, whilst 302 hospitals accounting for 37%, reported total profits of 4,329 million baht. By the end of 2010, the number of the hospital suffering from losses increased to 585 with total losses of 7,388 million baht, whilst 236 hospitals reported total profits of 2,727.19 million baht. At the end of 2011, the situation improved further, with 525 hospitals reporting total profits of 10,403 million baht whilst only 303 hospitals suffered from losses totalling 2,566 million baht (Table 5.10).

Table 5-10 - Profits and losses from operation of the hospitals affiliated to the MoPH, 2009-2011

Profits and losses from operation	2009		2010		2011	
	The number of hospitals	Million baht	The number of hospitals	Million baht	The number of hospitals	Million baht
Losses	505	5,575	585	7,388	303	2,566
Profits	302	4,329	236	2,727	525	10,403
Total	807	n.a.	821	n.a.	828	n.a.

Source: MoPH, 2012

In 2011, 828 out of a total of 841 hospitals provided information on their financial condition to the MoPH. These were 25 central hospitals, 69 general hospitals, 727 community hospitals and 6 community medical centres. Net reserve funds were found to have increased by the end of 2011 by 6,399 million baht compared to the end of

2010. This indicated that financial stability had become better and higher net reserve funds meant better financial performances.

The NHSO determined the level of financial risk of hospitals in order to assess their financial condition, taking into account the net reserve and ratio of revenue to salaries. Financial risk was characterised as eight levels, ranging from level 1 which denoted high risk to level 8 which denoted no risk. In the fourth quarter of 2012, 644 hospitals affiliated to the MoPH reported their financial condition and 57 of 79 large hospitals and 294 of 565 small hospitals were classified as level 8, Considering the solvency of hospitals region by region, it was found that 16 of 17 large hospitals in the northern region, 10 of 13 large hospitals in the north-eastern region, 23 of 37 large hospitals in the central region, and 8 of 12 large hospitals in the southern region were classified as level 8, as shown in Table 5.11 (NHSO, 2012).

The MoPH attributed the decreasing losses to the allocation of more funds from the NHSO to service units (MoPH, 2012). It was also suggested that the deduction of salaries from the per capita funds should be undertaken at the national level, as at present (2012), salaries are deducted from capitation within the provinces. The amount of finance to be allocated to hospitals is determined by multiplying the number of people under the responsibility of each hospital by the number of funds, such as that for healthcare promotion and prevention. This multiplication results in the amount of money to be allocated to hospitals before the deduction of salaries. Provincial Health Offices are empowered to make requests for increases to the in outpatient fund, inpatient fund and part of the promotion and prevention funds for some hospitals with a large number of personnel, which require money from these many funds to be used as salaries, despite the smaller size of the UC population under their responsibility. As more finance is used for salaries, the fund for supporting the provision of treatment needs to be replenished.

Table 5-11 - Risk level of the hospitals affiliated to the MoPH in the last quarter of 2012

Region	Risk level (highest → lowest)								
	1	2	3	4	5	6	7	8	Total
North									
Large hospital	1	-	-	-	-	-	-	16	17
Small hospital	21	12	9	11	4	-	8	70	135
Northeast									
Large hospital	-	3	-	-	-	-	-	10	13
Small hospital	25	29	5	25	3	4	18	89	198
Central									
Large hospital	-	1	-	3	3	3	4	23	37
Small hospital	-	7	7	3	7	2	19	96	141
South									
Large hospital	1	-	-	1	-	1	1	8	12
Small hospital	17	7	1	2	2	2	21	39	91
Subtotal large hospital	2	4	-	4	3	4	5	57	79
Subtotal small hospital	63	55	22	41	16	8	66	294	565
Grand total	**65**	**59**	**22**	**45**	**19**	**12**	**79**	**351**	**644**

Source: NHSO, 2012

Note: 1) Large hospitals include central and general hospitals

2) The NHSO divided the area under its responsibility into 13 zones

3) Financial risk was characterised by eight levels, ranging from level 1 highest risk to level 8 lowest risk

5.11 Private hospitals

The number of private clinics joining the UC scheme has increased since 2004 but the number of private hospitals joining has dropped as show in Table 5-12

Table 5-12 - The number of private service units joining the UC Scheme 2004-2011

Private service units	2004	2005	2006	2007	2008	2009	2010	2011
Hospitals	71	63	61	60	55	50	49	44
Clinics	89	105	116	152	150	167	169	167
Total	160	168	177	212	205	217	218	211

Source: NHSO, 2012

Private clinics joining the UC scheme can be categorised by size and capacity for providing services as branches of hospitals, franchised clinics and standalone clinics.

The revenue of clinics has been derived from the budgetary allocation based upon the size of UC population under their responsibility, and funds used for screening, such as for patients with diabetes, high blood pressure, and strokes, as well as providing care to pregnant women, flu vaccinations, and birth control consultation. Capital replacement has also been allocated to hospitals according to their operational costs incurred for inpatients, outpatients, and healthcare promotion and disease prevention during the previous year. Funding is also supplied to support approved projects.

It is clear that clinics can derive their revenue from many sources and profits can be gained from the inflow of additional revenue and the implementation of effective cost controls. The increasing number of private clinics joining the UC scheme testified to the profitability of joining the scheme. No research has been conducted on the financial condition of private service units joining the UC scheme; however, it can be ascertained that their retained participation in the scheme is profitable.

5.12 Conclusions

Budgetary allocation to service units that were parts of the UC scheme has been subject to change; however, the main objective has been maintained. The allocation of funds has been adjusted to be responsive to differences in the age structure of patients, as children and the elderly are more prone to diseases, and consequently more finance has been allocated for the purpose of their treatment and the provision of services encouraged by the NHSO, such as healthcare promotion and disease prevention services. Funds have also been made available to the service units in remote areas so that they could provide services with high fixed costs to smaller populations. The allocation of funds according to disease groups has also been introduced. This method of fund allocation has led to different units providing different types of services. Ten years after the implementation of the UC scheme there have been many complaints about actual or impending insolvency of hospitals and clinics due to the insufficient allocation of funds. The National Health Security commission recognised these problems and made adjustments to the budgetary allocation in order to resolve these issues, taking into account the quantity and quality of services provided by units and their financial conditions which were subject to the fiscal limitations of the public healthcare sector of the government. The health security commission has made an

annual demand for an increase in the per capita fund and the government has complied by increasing the annual funds allocated to the UC scheme. The government has also yielded to the demand that the per capita allocation be separated from the allocation of funds to support the treatment of dysfunctional kidneys, diabetes, high blood pressure, and mental illness. The allocation of funds to clearly targeted groups has contributed to increasing public access to healthcare services.

Chapter 6. Case Study 1: B-Care Medical Centre: a case of non-viability and opting out

B-Care Medical Centre was a private hospital which joined the UC scheme at the beginning of the 2002 fiscal year on 1 October 2001(B-care Hospital, 2001). Although its core mission was to be a private hospital catering to relatively high fee-paying patients, it voluntarily joined the UC scheme believing that the delivery of state-financed healthcare services to an excluded group would be both financially feasible and socially responsible. After several years of attempts at making the experiment work, the hospital decided to leave the scheme in 2006. The reasons for it joining the scheme and later leaving provide valuable insights into the relative costs and benefits of providing services to the different categories of patients and the consequences of the financing formula for the hospitals participating in the scheme (B-care Hospital, 2007). During the five years of its participation in the UC scheme it also provided services to private patients (general patients) and those covered by the SSS (the Social Security Scheme, also financed by the government and discussed earlier). According to the director of the hospital, the hospital withdrew from the UC scheme at the end of fiscal year 2006 on 30 September 2006, due to the dramatic increase in UCS patient numbers that adversely affected the quality of their services and the image the hospital was attempting to project as a premium hospital and a provider of high quality healthcare services to all its patients including the UCS ones. Interestingly, the hospital also temporarily exited from the SSS in 2011 for two years as a cost-reducing measure that will also be discussed later as it is relevant to understanding the types of calculations that hospitals have to make in order to balance their books.

This case study draws on numerical and accounting data as part of the analysis of the hospital's strategy for joining and eventually withdrawing from the UC scheme. The case study therefore highlights a number of common problems and difficulties faced by private hospitals joining the scheme, and some general conclusions can be drawn regarding the feasibility of the participation of private hospitals in the UC scheme.

6.1 Background

B-Care Medical Centre was founded in 1999 by medical doctors with over fifty years of collective experience. As doctors and entrepreneurs they understood both the medical needs and the service expectations of patients. Even though Thailand went through an economic crisis after 1997, the opening of the hospital on 16 September 1999 was not affected and it was relatively successful from the outset. It is located in an area adjacent to the Paholyothin Road in the north of Bangkok, near the old airport, which is now used mainly for domestic flights. During the years of its participation in the UC scheme, the hospital was regarded as a Contracted Unit of Primary Care (CUP) (B-care Medical Centre, 2004).

The relative profile of the B-Care Hospital compared to other private hospitals can be seen in detail for 2012. Although this is after the period that is the focus of this study, this is the earliest period for which comparable data are available. As the relative size of the hospital did not change considerably after 2006, the comparison gives an accurate estimate of the relative size and financial profile of the hospital relative to the average private sector hospital. B-Care is considered to be a relatively large private hospital (above average size), the B-Care Medical Centre had 120 beds and in 2012 it accommodated 6,168 inpatients, which was 77.75% of the average number of inpatients in private hospitals in Bangkok, whilst its outpatients numbered 147,695, around 68.43% of the average number of outpatients of a private hospital in Bangkok. To provide services to patients, the hospital employed 598 personnel who were responsible for providing treatments, higher than the national average of 429 employees for a hospital (B-care Hospital, 2012).

The hospital's revenue was approximately 34,570,000 baht, in the same year compared to the average revenue of a private hospital in Thailand of 37,270,000 baht. B-Care Medical Centre's revenue was thus 92.91% of the average revenue. A comparison with patient numbers suggests that relative to other private hospitals, this hospital specialised in higher quality services for its patients as it was very close to the average revenue of a private hospital but with much less than the average number of patients. The intermediate expenses of the hospital amounted to 30,231,000 baht, higher than the

national average which was 22,390,000 baht. A summary of the financial profile of the hospital relative to the average private hospital is shown in Table 6.1.

Table 6-1- General statistics for private hospital in 2011 and those of B-Care Medical Centre

Vital Statistics	All	B-Care	Comparison
The number of private hospitals	321		
< 31 beds	59		
31 – 50 beds	50		
– 100 beds	108		
> 100 beds	104	120	
Number of patients(IP + OP)	46,335,100	153,863	0.3321%
Inpatient **(**nationwide**)**	2,176,800.00		
Average number of inpatients in Bangkok	7,933.00	6,168	77.75%
Outpatients **(**nationwide**)**	44,158,300		
Average number of outpatients in Bangkok	215,838	147,695	68.43%
Number of personnel	137,598		
Average number of personnel of a private hospital	429	598	139.35%
Revenue (million baht)	119,447.50		
Average revenue obtained by a private hospital (million baht)	372.10	345.70	92.91%
Operation costs	71,881		
Average operation costs of a private hospital	223.90	302.31	135.02%
Added value (million baht)	47,566.50		
Average added value of private hospital (million baht)	148.20	43.39	29.28%

Source: 1) Adapted from 'The 2012 Private Hospital Survey': National Statistical Office 2012

2) B-care Medical Centre, 2012

Note: Operating costs= Administrative costs + other expenses (which includes all other costs, such as medicines, equipment, all staff) – (land rental, taxes, depreciation, interest)

Added value = Revenue – Operating expenses
Revenue = Revenue from providing treatment + Revenue derived from other sources

The hospital had an above average number of personnel in charge of treatments. In 2012 there were 598 personnel, with 401 of them working full time and 197 part-time. In comparison, the national average for private histories was 429, with 337 working full time and 92 part-time. Whilst the average number of doctors employed by a private hospital was 70, B-Care Medical Centre employed 104 doctors, of which 100 were specialists and 4 were general practitioners. The hospital also employed 18 dentists, three times higher than the national average and 113 professional nurses, again higher than the national average which was 75. In addition, the hospital had an above average number of medical personnel such as radiologists, physical therapists, and pharmacists.

In conclusion, B-Care Medical Centre is a large private hospital focusing on higher valued services compared to the average for private hospitals, provided by specialist

doctors. It employs medical personnel, such as doctors, dentists, nurses, pharmacists, and physical therapists, at a level higher than the national average, as shown in Table 6.2.

The hospital has been engaged in providing a number of services, but focuses on services relating to child delivery, healthcare for mothers and their babies, and healthcare promotion and disease prevention. Sophisticated medical equipment is also used, generating additional income for the hospital, including a 16-slice computer tomography machine, digital fluoroscopy, 4-dimension ultrasonography, gasto-colonoscopy, laparoscopy, C-arm fluoroscopy, computer-assisted arthroplasty, extracorporeal shockwave lithotripsy, and a cosmetic laser. Supplementary services generating income for the hospital include therapeutic Thai massage, a spa, and special care for mothers (B-care Hospital, 2012).

The quality of treatment services provided is comparable to that of Thai teaching hospitals and the hospital is accredited with ISO version 9001-2008, and the Hospital Accreditation mode HA-HPH (B-care Hospital, 2012). Though focusing on services provided by specialist doctors, the revenue obtained from all categories of patients was mostly through ‘standard medical treatment’. However, the proportion of its revenue obtained through ‘high value medical treatment’ increased during 2010-2012. In 2010 the revenue obtained from high value medical treatment accounted for 26% of the total revenue from treatment, 445,971,000 baht. In 2011 it rose to 28.08% of the total revenue of 493,781,000 baht, and in 2012 it grew further to 32.86% of the total revenue from treatment of 345,704,000 baht, as shown in the Table 6.3. In 2000 when the hospital entered the UC scheme, the share of high valued services was lower, but it was not less than 20% of the total and the aspiration of the hospital managers was to increase that share whilst also delivering the healthcare required under the UC scheme. There was no reason to believe on the basis of the available information in 2000 that this would prove to be an almost impossible task.

Table 6-2 - Average number of personnel employed by a private hospital in 2012 compared to that for B-Care Medical Centre

Personnel	Average number of personnel in a private hospital			B-Care		
	Total	Full time	Part time	Total	Full time	Part time
Total	429	337	92	598	401	197
•Administrators	28	27	1	20	18	**2**
•Personnel in charge of treatment	241	161	80	379	201	178
Doctor	70	20	50	104	17	87
-General Practitioners	14	4	10	4	2	2
-Specialist doctors	56	16	40	100	15	85
Dentists	6	1	5	18	1	17
Nurses	79	57	22	113	45	68
-Professional	75	55	20	113	45	68
-Technical	4	2	2	-	-	-
Assistants	20	19	1	4	4	-
Nurse assistants	57	55	2	113	108	5
Child care and delivery	1	1	-	-	-	-
Other kinds of nurses	7	7	-	27	26	1
•Personnel in charge of medical services	55	46	9	42	25	17
Radiologists	5	4	1	8	3	5
Physical therapists	4	3	1	5	4	1
Medical technicians	6	5	1	Sub-contract		
Pharmacists	9	6	3	16	5	11
Nutritionists	2	2	-	2	2	-
Other kinds of medical Technicians	29	28	1	11	11	-
•Workers in charge of daily routines	105	102	3	157	157	-

Source: 1) Adapted from the 2012 Private Hospital Survey, National Statistical Office 2012
2) B-care Medical Centre, 2012

Table 6-3 - Revenue from standard medical treatment and high value medical treatment for all groups of patients 2001-2012

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Revenue (G,SSS,UC) (unit 1,000 baht)	140,126	176,222	213,130	258,136	294,033	293,798	343,270	381,426	445,971	493,781	345,704
Standard Medical Treatment	116,541 (83.17%)	134,912 (77.00%)	163,720 (76.82%)	217,630 (84.31%)	257,109 (87.44%)	271,029 (92.25.%)	248,466 (72.38%)	340,216 (89.20%)	328,597 (74.00%)	355,140 (71.92%)	232,113 (67.00%)
High Value Medical Treatment	23,585 (16.83%)	41,310 (23.00%)	49,410 (23.18%)	40,506 (15.69%)	36,924 (12.56%)	22,769 (7.75%)	94,804 (27.62%)	41,210 (10.80%)	117,374 (26.00%)	138,641 28.08%)	113,591 (32.86%)

Source: B-care Medical Centre, 2012

Note: Medical Treatment is as follows:

1. Standard Medical Treatment
    a. Application of other wound dressing
    b. Suture of skin and subcutaneous tissue of other sites
    c. Application of other cast
    d. Other incision with drainage of skin and subcutaneous tissue
    e. Other incision of eyelid
    f. Injection of insulin
    g. Injection or infusion of cancer chemotherapeutic substance
    h. Removal of nail, nail bed, or nail fold
    i. Dilation and curettage following delivery or abortion
    j. Debridement of open fracture of tibia and fibula
    k. Other caesarean section of unspecified type
    l. Low cervical caesarean section
    m. Others
2. High Value Medical Treatment
    a. Singleton, born in hospital
    b. Diarrhoea and gastroenteritis of presumed infectious origin
    c. Acute upper respiratory infection, unspecified
    d. Attention to surgical dressings and sutures
    e. Follow-up examination after other treatment for other conditions
    f. Acute pharyngitis, unspecified
    g. Acute bronchitis, unspecified
    h. Delivery by elective caesarean section
    i. Pneumonia, unspecified
    j. General medical examination
    k. Others

SSS patients made the most frequent visits to the hospital as the figures from 2008-2011 show that their number of outpatient visits was more than 50% greater than that of general patients, as shown in Table 6.4, and is increasing over time.

Table 6-4 -The number of B-Care Medical Centre's visiting patient falling into groups 2002-2012

Year	Patients														
	General					SSS					UC Scheme				
	No.	OP visits	%	IP visits	%	No.	OP visits	%	IP visits	%	No.	OP visits	%	IP visits	%
2002	NA	67,539	95	3,333	5	29,740	72,729	99	900	1	21,555	16,262	97	492	3
2003	NA	79,373	96	3,351	4	44,526	105,287	98	1,706	2	20,176	19,256	97	690	3
2004	NA	88,506	96	3,272	4	52,113	123,555	98	1,995	2	27,137	37,603	95	1,828	5
2005	NA	88,572	97	3,192	3	60,561	147,422	98	2,596	2	29,710	44,395	97	1,583	3
2006	NA	88,891	97	3,117	3	65,859	185,580	98	4,701	2	27,416	31,875	96	1,167	4
2007	NA	104,062	96	4,379	4	68,629	184,474	98	3,779	2	-	-		-	
2008	NA	114,811	96	5,028	4	74,618	227,209	98	4,695	2	-	-		-	
2009	NA	112,626	96	5,112	4	80,256	249,663	98	5,036	2	-	-		-	
2010	NA	119,442	95	5,974	5	84,201	264,258	98	5,414	2	-	-		-	
2011	NA	105,294	95	5,339	5	81,329	237,331	98	4,570	2	-	-		-	
2012	NA	140,091	95	6,927	5	NA	NA			NA	-		-		-

Source: B-care Medical Centre, 2012

Note: IP – inpatient, OP – outpatient

6.2 The decision to join the Universal Healthcare Coverage Scheme

Interviews with hospital management revealed that management carefully considered the UC scheme on the basis of the available evidence and decided to join for a number of reasons. According to the hospital, its decision to join the UC scheme was based on the consideration of a number of factors:

1. The number of general patients and the patients covered by the Social Security Scheme (SSS) was not large, so there was sufficient space and equipment for use in the medical treatment of a broader group of patients. As the fixed costs were already paid for, the opposition should have been viable as long as the marginal costs of additional treatments based on the available equipment could be covered.

2. The hospital needed to increase its flow of funds to finance its daily operations and management in the early years of its operation. The UC scheme offered an

enhanced flow of funds and could therefore have usefully complemented its existing business model by being added on to the existing systems.

3. Moreover, fewer benefits and treatments were offered by the UC Scheme to patients in the earlier years of its implementation which made it feasible for hospitals to control costs.

6.3 Income

Before its withdrawal from the UC scheme and the SSS, the hospital obtained its income from three main sources: general (private) patients; SSS patients; and the UC scheme patients. During the five year period of 2002-2005, the percentage of income from general patients, which represented the largest proportion of total income, dropped from 57% in 2002 to 52.8% in 2003, 43.4% in 2005 and then 37.1% in 2006. In contrast, the percentage of the income from the SSS increased from 25.2% in 2002 to 50.5% in 2003 and from the UC scheme it decreased from 16.9% in 2002 to 13.8% in 2003, and 13.6% in 2004, then rose to 17.6% in 2005 before dropping to 12% in 2006, as shown Table 6.5.

Table 6-5 - Sources of income for the hospital 2002-2006

Sources of income	2002	2003	2004	2005	2006
General patients	79,871 (57%)	93,057 (52.8%)	108,916 (53.4%)	112,091 (43.4%)	106,662 (37.1%)
SSS	35,351 (25.2%)	57,999 (32.9%)	74,073 (32.5%)	99,279 (38.5%)	151,017 (50.5%)
UC scheme	23,617 (16.0%)	24,381 (13.8%)	28,888 (13.6%)	45,409	35,297 (12.0%)
Others	1,287 (0.9%)	785 (0.4%)	1,253 (0.6%)	1,357 (0.5%)	1,057 (0.4%)
Total	140,126 (100%)	176,222	213,130	258,136	294,033

Source: B-care Medical Centre, 2012

Note: unit 1,000 baht

After its withdrawal from the UC scheme the hospital got its income mainly from two sources. In 2007, the income from general patients amounted to 157.18 million baht, comprising 54% of the total revenue, in 2008 it increased to 223.57 million baht, accounting for 65%, in 2009 it increased to 241.02 million baht, accounting for 63%, in

2010 it grew to 277.54 million baht, accounting for 62%, and in 2011, it grew further to 310.38 million baht accounting for 63% of the total revenue. Meanwhilst, the income from the SSS also increased over the same period, from 132.30 million baht in 2007 to 119.70 million baht, 140.40 million baht, 168.42 million baht, and 183.39 million baht in 2008, 2009, 2010, and 2011, respectively. With the deduction of pre-taxation costs and capital replacement, the revenue gained by the hospital always remained higher than its costs, as shown in Table 6.6.

Table 6-6 - Costs and revenue derived from providing services to patients of all categories 2002-2011

Revenues (unit 1,000 baht)	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
General	79,871	93,057	108,916	112,091	106,662	157,185	223,569	241,022	277,544	310,385
SSS	35,351	57,999	74,073	99,279	151,017	132,301	119,700	140,403	168,427	183,395
UC	23,617	24,381	28,888	45,409	35,297	4,311	-	-	-	-
Total (3 schemes)	138,839	175,437	211,877	256,779	292,976	292,062	335,101	373,144	436,481	483,088
Others	1,287	785	1,253	1,357	1,057	1,736	8,169	8,282	9,490	10,693
Total revenues	140,126	176,222	213,130	258,136	294,033	293,798	343,270	381,426	445,971	493,781
Costs (all three categories)										
Drugs	17,961	22,538	31,374	39,267	45,322	41,436	51,394	60,234	76,870	81,276
Disposable medical materials	13,376	2,147	2,869	3,787	4,457	4,925				
Doctors	22,765	30,194	39,916	47,638	60,136	66,101	76,857	87,137	98,019	104,270
Personnel	10,473	25,959	32.325	41,384	48,612	55,547	85,799	91,647	111,705	122,215
Network of clinic and other hospital	454	2,777	2,630	6,316	5,976	8,105	5,398	6,125	13,101	12,641
Administrative costs	25,711	40,022	52,942	59,725	79,483	89,609	80,225	97,762	98,312	105,811
Total costs	90,741	123,638	162,058	198,119	243,988	265,726	299,676	342,908	398,009	426,215
Revenues higher than cost	49,384	52,583	51,071	60,016	50,044	28,072	43,594	38,518	47,962	67,565

Source: B-care Medical Centre, 2012

Note: 1) The hospital opted out from the UC scheme in 2006
2) Administrative costs exclude interest and depreciation

Revenue from the UC scheme demonstrated a general increase from 2002-2006. However, when taking costs into account, profits from the scheme tended to decrease. In 2001 the per capita profit was 679.49 baht, but this decreased to 575.42 baht and 184.25 baht in 2003 and 2004, respectively. In 2005 it increased to 273.44 baht but this turned to a loss of 13.36 baht per capita per head in 2006, as shown in Tables 6.7 and 6.8.

Table 6-7 - UC scheme revenue

	2002	2003	2004	2005	2006	2007
UC scheme registered users	22,915	20,774	24,225	35,190	22,648	-
Average per capita income from the UC scheme	1,030.63	1,173.63	1,192.48	1,290.39	1,558.50	
Revenue(unit 1,000 baht)						
• Outpatients	-	-	-	19,511	15,624	-
• Inpatients	22,744	18,763	24,324	14,553	8,084	-
• Private patients	-	-	-	3,285	3,236	199
• Investment costs/Capital replacement	-	3,565	1,675	2,406	2,274	-
• High cost treatments	-	-	467	2,001	892	127
• EXC/RW	-	-	-	3,285	5,073	180
• Insurance costs	346	369	612	765	702	-
• Added value	526	1,683	1,808	2,886	1,518	3,180
• Others	-	-	-	-	2,439	623
Total revenue	23,617	24,381	28,888	45,409	35,297	4,311
Costs (unit 1,000 baht)						
• Drugs	1,153	2,359	4,813	7,577	6,568	-
• Disposable medical materials	207	268	531	776	790	-
• Doctor	1,507	1,630	3,899	5,902	7,191	-
• Personnel	1,180	2,325	4.147	6,146	6,411	-
• Network of clinic and other hospital	-	1,146	1,024	3,059	1,158	-
• Administrative costs	3,997	4,697	10,008	12,323	13,478	-
Total costs	**8,046**	**12,427**	**24,424**	**35,786**	**35,599**	**-**
Net revenue	**15,570**	**11,953**	**4,463**	**9,622**	**-302**	**4,311**

Source: B-care Medical Centre, 2009

Note: Administrative costs exclude interest and depreciation

Table 6-8 - UC scheme net revenue and cost per capita

	2002	2003	2004	2005	2006
UC registered users	22,915	20,774	24,225	35,190	22,648
Average per capita income	1,030.63	1,173.63	1,192.48	1,290.39	1,558.50
Average per capita cost	351.14	598.21	1,008.23	1,016.95	1,571.84
Net Revenue per capita	679.49	575.42	184.25	273.44	-13.36

Source: B-care Medical Centre, 2009

6.4 Cost and expenditures

The hospital's operational costs fell into six categories, which continually increased from 2002-2011:

1. Drugs
2. Medical equipment and materials
3. Doctors salaries
4. Personnel salaries
5. Network of clinics and other hospitals - transfer of patients
6. Administrative costs

Details of these costs are provided in Tables 6.9- 6.13.

Table 6-9 - B-Care Medical Centre patient costs 2002-2003

Costs	2002				2003			
	Private Patients	**SSS**	**UC scheme**	**Total**	**Private Patients**	**SSS**	**UC scheme**	**Total**
Number of patients	NA	29,740	22,915		NA	44,526	20,774	
Cost per capita (baht)		883.46	351.14			958.59	598.21	
Cost by patients (unit 1,000 baht)								
Drugs	12,104	4,704	1,153	17,961	13,513	6,666	2,359	22,538
Disposable medical materials	11,830	1,339	207	13,376	946	932	269	2,147
Doctors	17,842	3,416	1,507	22,765	22,193	6,371	1,630	30,194
Personnel	5,610	3,683	1,180	10,473	14,064	9,570	2,325	25,959
Network of clinic and other hospital	-	454	-	454	-	1,631	1,147	2,778
Administrative costs	9,037	12,678	3,997	25,712	17,813	17,512	4,697	40,022
Total	**56,423**	**26,274**	**8,046**	**90,741**	**68,529**	**42,682**	**12,427**	**123,638**
Percentage	**62.2**	**28.9**	**8.9**	**100**	**55.5**	**34.5**	**10.0**	**100**

Source: B-care Medical Centre, 2012

Table 6-10 - B-Care Medical Centre patient costs 2004-2005

Costs	2004				2005			
	Private Patients	SSS	UC scheme	Total	Private Patients	SSS	UC scheme	Total
Number of patients	NA	52,113	27,137		NA	60,561	29,710	
Cost per capita (baht)		1,138.28	1,008.23			1,231.02	1,016.95	
Cost by patients (unit 1,000 baht)								
Drugs	16,510	10,050	4,814	31,374	17,559	14,131	7,578	39,268
Disposable medical materials	1,127	1,212	531	2,870	1,299	1,712	776	3,787
Doctors	24,095	11,922	3,899	39,916	29,097	12,639	5,903	47,639
Personnel	16,107	12,071	4,147	32,325	18,591	16,647	6,146	41,384
Network of clinic and other hospital	-	1,607	1,024	2,631	-	3,256	3,060	6,316
Administrative costs	20,477	22,457	10,008	52,942	21,235	26,167	12,323	59,725
Total	**78,316**	**59,319**	**24,424**	**162,058**	**87,781**	**74,552**	**35,786**	**198,119**
Percentage	**48.3**	**36.6**	**15.1**	**100**	**44.3**	**37.6**	**18.1**	**100**

Source: B-care Medical Centre, 2012

Table 6-11 - B-Care Medical Centre patient costs 2006-2007

Costs	2006				2007			
	Private Patients	**SSS**	**UC scheme**	**Total**	**Private Patients**	**SSS**	**UC scheme**	**total**
Number of patients	NA	65,859	27,416		NA	68,629	0	
Cost per capita (baht)		1,779.50	1,571.84			2,062.26	NA	
Cost by patients (unit 1,000 baht)								
Drugs	18,080	20,674	6,568	45,322	20,153	21,284	-	41,437
Disposable medical materials	1,341	2,326	791	4,458	1,984	2,942	-	4,926
Doctors	26,785	26,159	7,192	60,136	39,850	26,251	-	66,101
Personnel	20,479	21,722	6,411	48,612	24,858	30,689	-	55,547
Network of clinic and other hospital	-	4,817	1,159	5,976	-	8,106	-	8,106
Administrative costs	24,508	41,498	13,478	79,484	37,350	52,259	-	89,609
Total	**91,193**	**117,196**	**35,599**	**243,988**	**124,195**	**141,531**	**-**	**265,726**
Percentage	**37.4**	**48.0**	**14.6**	**100**	**46.7**	**53.3**	**-**	**100**

Source: B-care Medical Centre, 2012

Table 6-12 - B-Care Medical Centre patient costs 2008-2009

Costs	2008				2009			
	Private Patients	SSS	UC scheme	Total	Private Patients	SSS	UC scheme	Total
Number of patients	NA	74,618	0		NA	80,256	0	
Cost per capita (baht)		2,113.23	NA			2,289.92	NA	
Cost by patients (unit 1,000 baht)								
Drugs	24,104	28,350	-	52,454	25,967	35,367	-	61,334
Disposable medical materials	1,999	3,096	-	5,095	2,181	3,700	-	5,881
Doctors	47,674	29,183	-	76,857	52,095	35,043	-	87,138
Personnel	28,306	33,846	-	62,152	41,119	54,748	-	95,867
Network of clinic and other hospital	-	5,447	-	5,447	-	6,125	-	6,125
Administrative costs	39,908	57,763	-	97,671	37,766	48,797	-	86,563
Total	**141,991**	**157,685**	**-**	**299,676**	**159,128**	**183,780**	**-**	**342,908**
Percentage	**47.4**	**52.6**	**-**	**100**	**46.4**	**53.6**	**-**	**100**

Source: B-care Medical Centre, 2012

Table 6-13 - B-Care Medical Centre patient costs 2010-2011

Costs	2010				2011			
	Private Patients	**SSS**	**UC scheme**	**Total**	**Private Patients**	**SSS**	**UC scheme**	**Total**
Number of patients	NA	84,201	0		NA	81,329	0	
Cost per capita (baht)		2,577.17	NA			2,978.79	NA	
Cost by patients (unit 1,000 baht)								
Drugs	29,529	40,294	-	69,823	32,908	44,987	-	77,895
Disposable medical materials	2,651	4,397	-	7,048	2,680	4,583	-	7,263
Doctors	58,769	39,250	-	98,019	64,420	42,036	-	106,456
Personnel	49,047	62,658	-	111,705	54,573	72,569	-	127,142
Network of clinic and other hospital	-	13,102	-	13,102	-	12,325	-	12,325
Administrative costs	44,329	57,299	-	101,628	45,775	65,762	-	111,537
Total	**184,325**	**217,000**	**-**	**401,325**	**200,356**	**242,262**	**-**	**442,618**
Percentage	**47.4**	**52.6**	**-**	**100**	**46.4**	**53.6**	**-**	**100**

Source: B-care Medical Centre, 2012

6.5 Outcome of operation during the hospital's participation in Universal Healthcare Coverage Scheme

Detailed discussions and access to its broad accounting data show that income from the UC scheme funds were adequate to cover the operating costs of the scheme for the hospital during the first four year of its participation in the Scheme. However, in the last year of its participation in the UC scheme its suffered losses due to the higher proportion of costs for the treatment of severe and chronic diseases, as the hospitals admitted more patients with cancer, heart diseases, diabetes, and high blood pressure. A significant problem was that adequate funds were not provided to the hospital to support the treatment of severe and chronic diseases and as a result, the hospital had to bear much of the higher costs itself.

Most of the revenue for the hospital from UC scheme came through payments for standard medical treatments during 2002-2006. In 2002, the revenue from standard medical treatments amounted to 12,379,600 baht, accounting for 83.17% of the total, whilst the revenue for higher value medical treatments within the scheme amounted to 2,505,400 baht, accounting for 16.83% (Table 6.14).

Table 6-14 - Revenue from standard medical treatment and high value medical treatment UC 2001-2012

Year	2002	2003	2004	2005	2006
Total Revenue (unit 1,000 baht)	14,885	16,788	28,887	43,062	40,566
Standard Medical Treatment	12,379.60 (83.17%)	12,852 (76.55%)	20,329 (70.37%)	22,785 (52.91%)	29,205 (71.99%)
High Value Medical Treatment	2,505.40 (16.83%)	3,936 (23.45%)	8,558 (29.63%)	20,277 (47.09%)	11,361 (28.01%)

Source: B-care Medical Centre, 2009

Note: Some examples of medical treatments in standard and high-valued categories are given below.

Table 6.15 shows that the profit/revenue ratio achieved in the general group of private patients remained steady, although there was a slight decline, from 29.35% in 2002 to 26.36% in 2003, before increasing to 28.10% in 2004, but then dropping to 21.61% in 2005 before dramatically decreasing to 14.50% in 2006. In contrast, the profit/revenue share in the Social Security (SSS) group remained quite stable at 20-26%, while the profit/revenue from the UC scheme, like those of the general group, steadily declined

and finally turned negative in 2006. The losses from the UC scheme, together with the much lower revenues obtained from this scheme compared to the revenues gained from patients in the other categories was the background to the hospital decision to withdraw from the UC scheme.

Table 6-15 - Profit/revenue from the services provided to each group of patients 2002-2006

Patients		2002	2003	2004	2005	2006
Private patients (unit : 1,000 baht)	Revenue	79,871	93,057	108,916	112,091	106,662
	Cost	56,423	68,529	78,316	87,781	91,193
	Profit	23,448	24,528	30,600	24,310	15,469
	Profit share in revenue (%)	29.35	26.35	28.10	21.69	14.50
Social Security Fund	Revenue	35,351	57,999	74,073	99,279	151,017
	Cost	26,274	42,682	59,319	74,552	117,196
	Profit	9,077	15,317	14,754	24,727	33,821
	Profit/revenue (%)	25.67	26.41	19.92	24.91	22.39
Universal Healthcare Coverage	Revenue	23,617	24,381	28,888	45,409	35,297
	Cost	8,044	12,427	24,423	35,786	35,599
	Profit	15,573	11,954	4,465	9,623	(302)
	Profit/revenue (%)	65.93	49.01	15.46	21.19	-0.85

Source: B-care Medical Centre, 2010

Note: unit is 1,000 baht

6.6 Withdrawal from the Universal Healthcare Coverage Scheme

The hospital's participation in the UC scheme led to a number of problems. Table 6.15 shows that the returns to joining the scheme were very high for private hospitals in the early years the per capita payments for registered patients came in immediately but the demands on the hospital for treatments, particularly for high cost treatments were low in the early years as newly registered UC patients took time to work out their entitlements and their more chronic diseases and requirements took time to diagnose. In a couple of years, however, expensive treatment regimens were engaged in for increasing numbers of patients in the UC scheme. Table 6.15 also shows that the revenue coming from the government also increased, as the ad hoc payments that were discussed in earlier chapters began to come in to cover the rapidly increasing costs of the scheme. However, the increase in revenues coming from the government could not keep pace with the

rapidly increasing costs of delivering services to UC patients and the hospital eventually went into a financial deficit on the UC patient account.

Interviews with hospital management suggest that they did not have access to clear projections by the government on the likely costs of the scheme based on a clear financial model of the finances that would be available to cover specific treatments, the treatments that would be allowed under the scheme, and the rules for dealing with cases that were expensive. Private hospitals in Thailand like the B-Care Hospital potentially have very sophisticated treatments for difficult cases, and these are based on the private side of the hospitals' service delivery. Costs can rapidly increase beyond the government's ability to match it with tax-based revenues. A clearer understanding on the part of policy-makers about how to manage expectations by defining the treatments that were available under the scheme would have enabled private hospitals to manage their UC service delivery model better.

Instead of a clear business model, what happened was an initial level of optimism on the part of the hospital that it would be able to provide a high level of service to the UC patients based on some of the same equipment and treatments that were available to its private patients and that the government would at least cover the operating costs of these treatments. It soon transpired, however, that this expectation was misplaced.

Management discovered that quality control was difficult to maintain as staff got overloaded with work and this gave rise to low quality services and led to complaints being made either directly to the hospital or by being posted on the internet. The complaints mostly came from UC scheme inpatients and outpatients concerning the long waiting times for examination, treatment, and surgery. As the demand for service delivery to the UC patients increased rapidly, the hospital evolved informal ways of internal rationing that led to longer waiting times for the UC patients because there was a much lower level of financial support for the treatment of these patients coming from the government.

Nevertheless, the dissatisfaction of the UC patients could not be insulated from the general image of the hospital. The hospital was trying to maintain a positive image as a provider of high quality healthcare services to its paying patients because the bulk of its

profits came from this sector, and the projection was to raise that part of the hospital's activities even more. From this perspective, the hospital management found that the problem of the UC scheme was a negative impact on its reputation as a provider of high quality services unless it could find a way of providing high quality services to the UC patients with the limited resources available. The hospital management argues that the steep decline in profits attributed to the UC service delivery side reflects the fact that the hospital tried its best to maintain service delivery to the UC patients even at the cost of declining profits, and eventually losses. However, even so, it could not protect itself from the dissatisfaction of the UC customers because some decline in the quality of service delivery was inevitable and the same level of service could not be provided to the UC patients. The expectations of the UC patients were however in line with the somewhat better services they saw being delivered to the paying customers.

A negative attitude towards the hospital was thus developed among its UC service users and as a result, the image of the hospital as a premium hospital was adversely affected. The complaints of the UC customers affected the general reputation of the hospital and this was deemed even more damaging to the hospital than the low profits or small losses associated with the UC scheme. Being seen as a premium hospital was crucial to its brand image and had to be maintained at any cost to sustain the revenue flow that was necessary even for subsidising the UC scheme. By 2006, the hospital management decided they could no longer accept the deterioration of the environment in the UC part of the hospital to one comparable to that of public hospitals caused by the influx of UC scheme users. Paradoxically, even though UC customers were complaining about delays and queues, the problem for the private hospitals was that many UC customers preferred to register in a private hospital rather than in a public hospital because the conditions and environment were relatively better. This caused an overload on the private hospitals that exacerbated the problem of maintaining service quality. By 2006, the deterioration of the hospital environment began to have an effect on the attractiveness of the hospital for paying customers and the hospital began to lose the growth in revenue that it had projected from these customers. This exacerbated the losses in operational costs that were experienced by the hospital on its UC scheme registered users (B-care Hospital, 2006; 2012).

6.7 Conclusions

UC allows for the participation of private hospitals. Participation of private hospitals in large numbers in UCS helps strengthen the scheme in that it increases the availability of service units, and patients enjoying easier access to services due to such availability will provide their steady support to the scheme, not to mention that the politicians who back the scheme from the start will increase in popularity. As for the private hospitals participating in the scheme, they will benefit in terms of higher revenues, marketing and public image. As a result, private hospitals are expected to continue their support for the scheme.

The experience of B-Care was not untypical. Many private hospitals discovered that the UC scheme would not cover the full costs of treatment for UC patients at the level that was being delivered to their private paying customers. The result was an informal two-tier system that satisfied neither the UC patients, who compared their service delivery to the private patients, nor the private patients who were affected by the complaints of the UC patients. The private hospitals thus had a choice. They could either downgrade their services overall, to cater fully to the UC type of patient or they would have to opt out of the UC scheme. The strategy of maintaining a two-tier system was neither desirable (though some private hospitals continue to attempt this), nor feasible for hospitals like B-Care which wanted a transparent quality of service across the full body of patients.

In the case of B-Care the problem of a two-tier system emerged even more quickly because the hospital had been set up to cater to the demands of affluent private patients delivering high value medical services. The hospital was meant to be a premium hospital employing an above average number of medical personnel, especially specialist doctors. However, most of the hospital's income came from standard medical treatment, despite its huge investment in the best qualified personnel and sophisticated equipment. However, after joining the UC scheme, the hospital found that the most likely growth area for future incomes was high value medical treatments. After leaving the UC scheme, high value healthcare for private patients has grown rapidly in importance as a proportion of the hospital's total revenue. This is a trend across the private sector hospitals in Thailand as the more affluent sections of Thai society are able to afford

increasingly expensive treatments and Thailand is also emerging as a regional centre for high net worth patients from neighbouring countries.

However, despite this, the hospital continues to deal with state supported Social Security (SSS) patients. Indeed, these patients comprise the most frequent service users of the hospital, and are considered the mainstay of the hospital's revenue and profits in addition to general patients. This anomaly shows that private hospitals can deal with state supported patients provided they are relatively few in number and are adequately funded.

It can be deduced from the figures presented in this chapter that healthcare insurance schemes such as the SSS remain an important source of revenue for premium private hospitals such as B-Care Medical Centre. Funds from this income source have contributed greatly to the hospital's financial viability. The hospital hoped to gain a similar income from the UC scheme. However, the reality fell far short of this expectation and resulted in the hospital making losses as a result of the inadequate resources received by the hospital through the funding formulae. The UC claimants registering under the UC scheme had rapidly rising expectations and the state funding formulae fell short of adequately supporting the costs involved in providing a high level of healthcare services to these patients.

Compared to the UC scheme, the SSS guaranteed a steady flow of income to the hospital because it allowed hospitals to draw in as many SSS patients as possible based on the reputation of the hospital and its specialisations. The number of SSS patients per a hospital is not fixed, and as a result, many high quality hospitals such as B-Care Medical Centre can attempt to attract as many SSS patients as possible. In contrast, the number of UC scheme patients assigned to a hospital is constrained by the UC population under its responsibility and so the number cannot be increased nor can extra revenue be generated.

Chapter 7. Case Study 2: Baanpaew Hospital: A case of viable evolution

7.1 Background

Baanpaew Hospital is a public hospital in the province of Samutsakorn that has been granted autonomy in its management and operation. As a result, it is no longer subject to the normal rules guiding public hospitals in general, even though it remains under public ownership and is under the direction of the state (Baanpaew Hospital, 2011). Many public hospitals struggle to deliver the UC services, but unlike private hospitals, they had no choice and could not opt out of the scheme. Most public hospitals suffered from severely enhanced workloads and delays in the treatment of patients as a result of the inadequate funding of the programme (Pitayarangsarit, 2004). However, Baanpaew Hospital was one of the few public hospitals that were able to innovate new ways of service delivery and achieved specialisation in the delivery of particular services that served to reduce or limit the escalation of their costs (Baanpaew Hospital, 2011). What the hospital achieved will be considered, and later the implications for the long-term viability of the UC scheme will be discussed. The one significant difference of Baanpaew Hospital relative to other public hospitals is that it was an autonomous public hospital that was exceptional in its ability to restructure itself. It also benefited from exceptionally good leadership and vision in its higher management, that enabled it to design new and effective ways of delivering healthcare services at relatively low cost.

Baanpaew Hospital began as a first-rate public healthcare station in 1965, and then became a medical Centre and district hospital in 1975 and 1976, respectively, with its name changing to Baanpaew Hospital in 1981. Its size gradually expanded and it became a 30-bed hospital in 1982. The number of beds further increased to 60, 90, and 120 in 1991, 1994, and 1996, respectively (Baanpaew Hospital, 2000).

Before being granted autonomy under a royal decree of 2002, the hospital was effectively semi-privatised in its management but with allowances for public participation as it remained formally a public hospital. The hospital contracted out to the private sector items such as the food supply for patients and the maintenance of

elevators, as well as entering into a partnership with the private sector to provide a CT-scanning service. In the bidding arrangement for equipment and construction, representatives of the community have seats on the hospital development committee and have been invited to witness the bidding process and to help bargain with the bidders (Baanpaew Hospital, 2011).

The hospital was founded by a royal decree in 2002 based on the Public Organisation Act enacted in 1999, and the hospital has been in operation in its present form since 11 September 2002. The intention of the Ministry of Public Health (MoPH) in enabling these decrees was to establish autonomous hospitals as a condition of receiving loans for such hospitals from the Asian Development Bank. The history of this policy package can be traced back to the suggestions made by analysts at the Health System Research Institute in 1997 to representatives of the Asian Development Bank (HealthSystems Research Institute, 2011a, 2011b). At present, the hospital has nine branches:

1. Baanpaew Hospital, two in the province of Samutsakorn.
2. A branch in the Prommitr area in Bangkok.
3. A branch in Changwattana in Bangkok, an area where government administrative offices are located.
4. A branch in the Kasetpattana area in the province of Samutsakorn.
5. A branch in the Lakha area in the province of Samutsakorn.
6. A community medical centre in Ratbamrung in the province of Samutsakorn.
7. A community medical centre in Laksam in the province of Samutsakorn.
8. Thonburi Kidney Treatment and Dialysis centre in Bangkok.
9. Thonburi Medical Centre in Bangkok.

In allowing some public hospitals like the Baanpaew hospital to achieve operational autonomy, the central government had a number of objectives that are listed below. However, the implementation of the autonomy-granting policy to fulfil these objectives was limited to particular public hospitals which were deemed ready for autonomous operation outside the bureaucratic controls and limits of most public hospitals. The objectives of the government in the implementation of this policy included the following: (MoPH, 2000).

1. *Reduction of administrative complexity*

   This was reduced through improvements in the regulation of budgetary management, salary payments, the acquisition of equipment, and the recruitment of personnel. The management of Baanpaew Hospital was free to make changes to the rules and regulations in order to enhance administrative flexibility, subject to cabinet supervision and was required to report to the cabinet. However, the allocation of funds to the hospital was based on the same formula and criteria as was used by the MoPH for all hospitals.

2. *Efficient resource allocation*

   This was associated with the allocation of funds, equipment, and personnel to meet the specific needs of particular areas which was only made possible through the elimination of external bureaucratic rules. Local service providers like the different branches of the Baanpaew hospital identified local requirements and acquired equipment and personnel to meet these needs.

3. *Enhancement of efficiency and effectiveness*

   Efficiency relates to the outcomes of operations relative to the resources invested, whilst effectiveness refers to the outcomes of operations viewed as a fulfilment of the stated objectives of the operation. Reductions in the complexity of the administrative structure and the efficient allocation of resources were believed to contribute to the enhancement of efficiency and effectiveness.

4. *Accountability*

   This is in relation to the evaluation of performance, assessment of the quality of hospitals and personnel, as well as public participation in assessing and improving the operation of a hospital. The autonomous public hospitals like Baanpaew were still accountable to public boards and ordinary citizens participated in the operational committees of the hospital.

5. *Political objectives*

There was in addition a political objective of the reformers to carry out these bureaucratic reforms to achieve a decentralisation of authority. This was one of the key objectives of the government.

6. Community participation

This is closely related to the question of accountability. The policy-makers supporting the autonomy of public hospitals believed that autonomy together with community participation was crucial for achieving the objective of serving the whole community, not just those who are privileged or well-informed.

To achieve these aims the following measures were taken (Thammathat-aree, 2001).

7. Deregulation

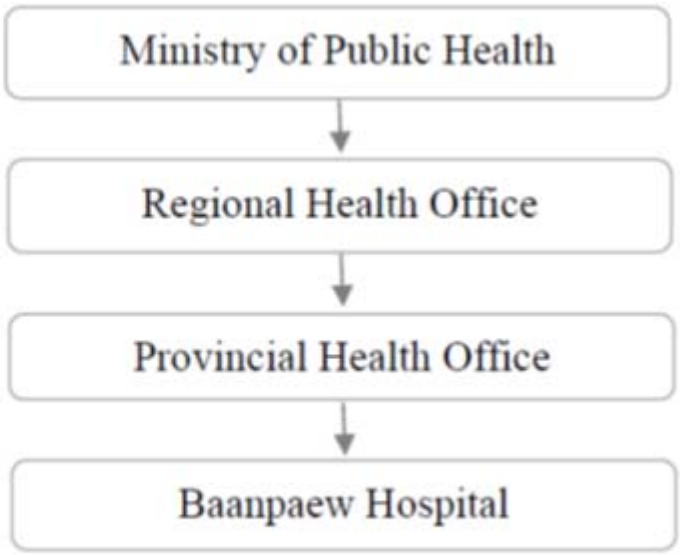
The royal decree granting the status of public organisation to the Baanpaew Hospital made the hospital autonomous in the following ways:

- The role of the director of the hospital was not set by the central authorities but was to be determined by the executive committee of the hospital.
- The hospital was free to determine positions for jobs, the conditions of employment, the qualifications of employees, salary levels etc. It was also free to deal with recruitment, appointments to positions, evaluations of job performance, dismissal from posts, disciplining and punishment, the management of finance and property, and the welfare of its employees. However, the hospital was subject to inspection from agencies such as the office of the general auditor of Thailand and the healthcare accreditation institute.
- The chain of command within the hospital was shortened as it was left to the hospital to determine its own administrative structure.
- The hospital was free to issue bonds to raise further funds.
- The hospital was free to enter into partnerships with other legal entities.
- The hospital was free to keep all its revenues from the provision of services and donations from the public.

8. Re-organisation

The aim of the re-organisation was to shorten the chain of command and this was actually achieved. The old chain of command before the hospital was granted autonomy is represented in Figure 7.1 and we can compare it with the organisational map of the hospital after autonomy had been granted.

Figure 7-1 - Chain of Command before autonomy was granted



Source: Autonomisation Process of Baanpaew Hospital 2001

The new chain of command after the hospital was granted autonomy is shown in Figure

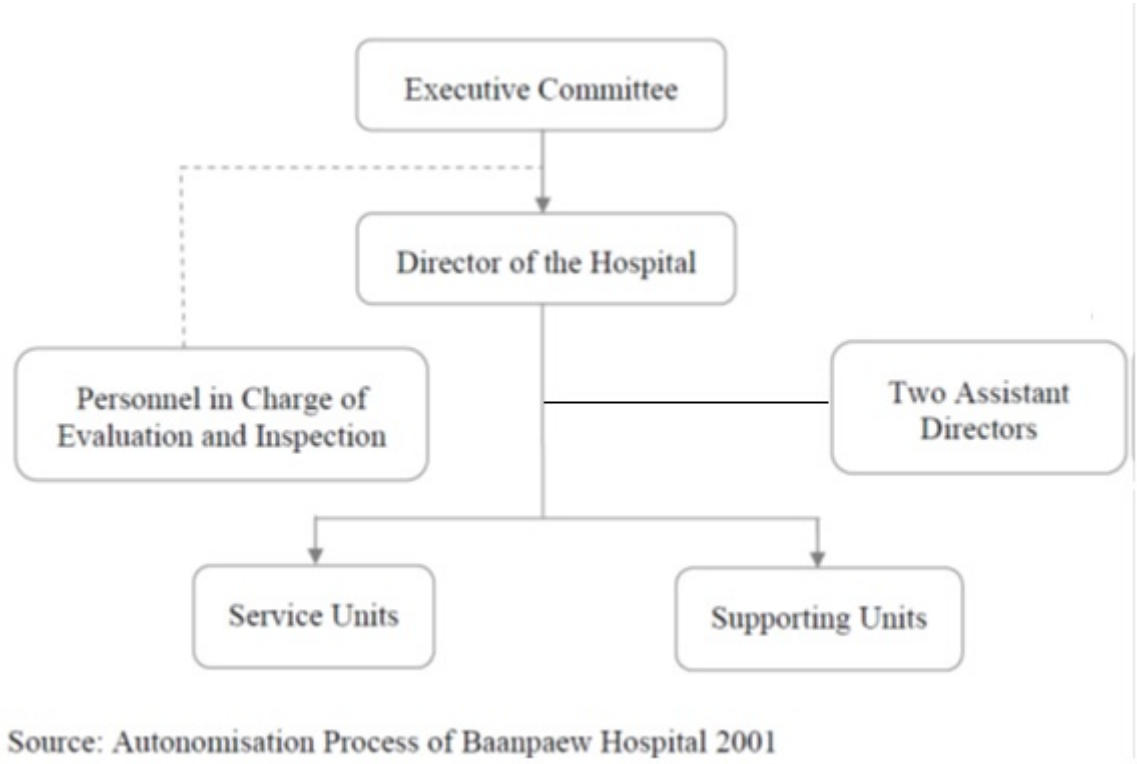
Figure 7-2 - Chain of Command after autonomy was granted

Source: Autonomisation Process of Baanpaew Hospital 2001

Once autonomy had been granted to the hospital, the administration was also re-structured. The administrative restructuring was particularly important for the reforms

that the hospital was able to carry out to achieve the successful delivery of UCS services. Figure 7.1 represents the old administration structure of the hospital.

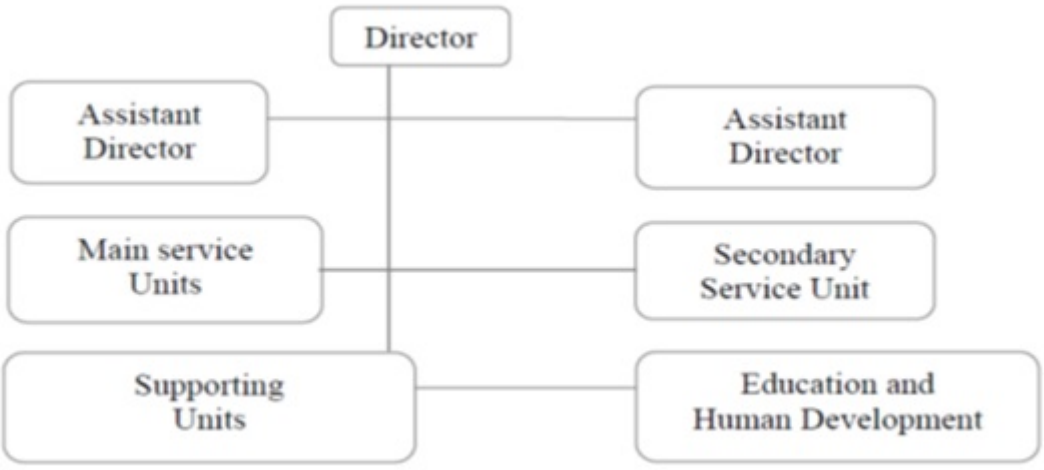
Figure 7-3 - Administrative structure after autonomy was granted



Source: Autonomisation Process of Baanpaew Hospital 2001

The main service units dealt with outpatient services for surgery, childbirth, emergencies, paediatrics, eye treatment, neck treatment, nose treatment and dentistry, bone surgery, healthcare promotion, epidemiology and disease prevention, psychiatry and mental health, hygiene and safety. Ratbamrung Medical Centre and the second branch of the Baanpaew Hospital were also included in the main service units. The secondary service units dealt with inpatient services for surgery, paediatrics, childbirth rooms, the physical health of mothers after child delivery, pharmacies, operation rooms, radiology, anaesthetics, diagnostics, special in-patient cases, and kidney treatment and dialysis.

Figure 7-4 - Administrative structure before autonomy was granted



Source: Autonomisation Process of Baanphaew Hospital 2001

The supporting units dealt with healthcare security, the acquisition of equipment, personnel management, accounting and financial management, and public relations. The education and human resource development unit dealt with the development of the quality of the hospital, disease prevention, personnel development, the hospital library, planning and evaluation, information management, and statistics and registration. The re-organisation resulted in a new administration structure shown in Figure 7.4.

The service units dealt with surgery, childbirth, paediatrics, treatment of eyes, ears, throat and nose, orthopaedics, healthcare promotion and disease prevention. Baanpaew 2 Hospital treated in-patients, and provided pharmacy and radiology services. Supporting units dealt with healthcare security, general management, public relations, and quality development.

Re-organisation resulted in: (Baanpaew Hospital, 2011)

1. Real autonomy for the hospital as the executive committee and director of the hospital were authorised to determine the rules and regulations relating to the operation and administration of the hospital.
2. The hospital was free to transfer and dismiss personnel, as well as to increase or lower salaries, based on its own rules and regulations.
3. The private sector was approached to take over the dispensing of drugs. The prices of drugs are agreed upon and payment to the private sector is made after

the drugs are dispensed on a monthly basis. In developed countries when the private sector dispenses drugs, the costs can increase because the seller has an incentive to provide expensive drugs. This did not happen with Baanpaew as the drugs were specified in advance.

4. Personnel were allowed to negotiate their full and part time wages.
5. The management of the hospital adopted marketing principles in attracting patients to the hospital by publicising what the hospital was doing.
6. The allocation of human resources to the hospital was no longer through the Civil Service Commission and the MoPH. The hospital is free to recruit personnel who are considered to be employees of public organisations rather than bureaucrats. Their salaries are also higher than those of bureaucrats. When the hospital was turned into a public organisation, the bureaucrats who continued to work for the hospital became employees of a public organisation, and this resulted in a 50% increase in their salaries.
7. The hospital is able to acquire drugs from various sources.
8. The hospital is free to invest in expensive equipment, land and buildings with the approval of the Executive Board alone and no approval from the MoPH is required as in the past.
9. The hospital has a better ratio of doctor/dentists per head of population, compared to the other hospitals located within its service radius.

The royal decree under which the hospital was founded in 2002 required the setting up of an executive board, which is comprised of: (Baanpaew Hospital, 2000).

1. A Chairman who is a qualified professional and not a bureaucrat.
2. Three persons who are appointed on the basis of their currently held positions. These are representatives of the MoPH, the Governor of the Samutsakorn province, and the head of the Provincial Health Office.
3. Three community representatives who are selected from the local residents and who must have been resident there for at least two years. These are nominated by the local government and civic groups in the district of Baanpaew.
4. Three qualified persons based on their experience in the fields of public healthcare, finance, accountancy, law, or any other profession which would contribute to the

operation of the hospital. At least one must not be a salaried bureaucrat or an officer of a government agency.

5. The director of the executive board acts as a board member and secretary to the executive board.

Many members of the executive board are residents of the community in which the hospital is located, and the three community representatives and three qualified persons are residents of the Baanpaew community.

Upholding the principle of public participation is also evident in the establishment of the joint committee which was expanded to include government officials and residents of the community in accordance with article 12 of the Royal Decree. This committee performs useful functions such as settling disputes between patients and hospital personnel. As an autonomous hospital there are few restrictions on the expansion of its services to new areas and consequently it has extended its services to other areas such as kidney dialysis and dental surgery. The hospital also sends its personnel to community hospitals to achieve a co-ordinated approach to healthcare promotion and disease prevention at the primary level of healthcare provision (Baanpaew Hospital, 2011).

In conclusion the administrative structure was horizontally reorganised to achieve greater flexibility in its management and efficient communication. Regulations were changed to suit the needs of the organisation and to allow it to be responsive to the changing situation. The Executive Board contains qualified individuals as well as representatives from the community and other agencies to ensure there are checks and balances in its policy-making and delivery. The hospital was able to create its own flexible financial system that was approved by the executive board and costs have been systemically controlled and planned as a result.

> ‘The first seven years of our being a public organisation was marked by our lack of funds despite our being blessed with a number of specialists. We had to spend economically and strictly observe ‘transparency’. During those days, if the roles set to achieve ‘transparency’ in operation were not enforced, we would have witnessed much waste and inefficiency’ (the executive of Baanpaew Hospital).

Decision making has also been based on ‘transparency’. The decision to extend services to other areas in the district of Baanpaew and the range of treatments offered, such as

cataract surgery, were approved by the executive board. Information on the decision making process of the hospital's executive board can be accessed through websites, local radio broadcasting, and the hospital's public relations unit, and therefore the hospital is subject to public scrutiny and 'transparency' is achieved.

7.2 Human resource management

Salaries of the hospital personnel are based on a different pay structure to that of other public hospitals, and are also increased in proportion to their workloads. Employees and their direct relatives are entitled to the benefits offered by the SSS for public servants. As the hospital is autonomous its executive board is free to provide additional financial and other incentives to the hospital's personnel to maintain their job motivation. Personnel are guaranteed their salaries and receive extra payments corresponding to their performance. In addition, a pension fund has been created. Personnel, especially doctors, can enter into a contract with the hospital to further their education and are allowed to take paid leave to study (Baanpaew Hospital, 2011).

However, the executive board is also aware that financial incentives are not the only factor which keeps its personnel motivated. Therefore all staff at the hospital is given the opportunity to be innovative and demonstrate their abilities, and can do so with flexibility and ease, as they are not restricted by bureaucratic procedures. The hospital has also developed a monitoring system to check the health and satisfaction of their personnel on a regular basis.

> 'Salary increases have meant that many of our doctors have got salaries of many hundreds of thousands of baht, starting from 60,000 baht, I remembered signing salary checks worth 3-4 hundred thousand baht.' (The executive of the Baanpaew Hospital)

Whilst a newly graduated nurse stated:

> 'My salary is 12,000 baht, but when OT, professional practice fees, and other benefits are included, it totals 27,000-30,000 baht. My friends at private hospitals get 30,000-40,000 baht, but they said costs of living are high and they were also required to contribute to the hospital's 'Social Security Fund'. They asked me if I was interested in higher salaries offered by private hospitals. At first, I found such offers attractive, but on balance I prefer to be here.'

Data concerning the personnel at Baanpaew Hospital are given in Tables 7.1 and 7.2.

Table 7-1 - Baanpaew Hospital personnel

Category	Budgetary Years		
	2008	2009	2010
Physicians	36	40	58
Dentists	5	6	8
Pharmacists	9	12	16
Nurses	134	146	171
Medical technicians	6	6	7
Physical therapists	4	4	4
Radiologists	2	2	2
Public healthcare analysts	23	43	45
Health educators	3	3	3
Others	472	466	550
Total	694	728	864

Source: Human resource department of the Baanpaew Hospital, 2011

Table 7-2 - Turnover rate 2010

Data	All personnel	Medical personnel
New recruits (person/month)	14.70	1.80
Personnel leaving (person/month)	7.50	0.60
Total personnel	870.25	326.75
Turnover rate	0.86%	0.18%

Source: Human resource department of the Baanpaew Hospital: 2011

The data on staff retention and turnover shows that the hospital was very successful in retaining staff despite the increase in pressures on delivery as the UC scheme was rolled out. Unlike other public hospitals, the increasing workloads did not result in a loss of morale and the intention to look for jobs in the private sector. In Baanpaew Hospital, staff were happy to remain in a public sector hospital (admittedly an autonomous one) because the hospital was able to rapidly increase salaries to close to private sector levels, and could offer additional benefits and the chance to work for the public purpose that the private sector hospitals could not.

7.3 Health services

Over the period of 2001 to 2010, the average daily number of outpatients serviced by the hospital increased from 800 to 1519, a 90% increase. During the same period, the

annual number of inpatients increased from 14,272 to 18,783, a 32% increase. The rate of bed occupation increased from 72 to 88%, and the average length of hospitalisation per patient increased from 3.03 to 4.75 days. In 2010 43.3% of outpatients were participants in the UC scheme followed by participants in other public insurance schemes (CSMBS, SSS) totalling 26.3%. Participants in the UC scheme accounted for 52.7% of the hospital's resource usage, followed by participants of the SSS who accounted for 20.1%. Details of the hospitals usage are provided in Tables 7.3-7.6.

Table 7-3 -Service usage for Baanpaew Hospital, 2001-2010

Budget year	Outpatient visits	Visits/day	Inpatient cases	Rate of bed occupation	Average hospitalisation (days)
2001	292,359	800	14,272	N/A	N/A
2002	360,769	988	14160	N/A	N/A
2003	345,536	946	12,205	83%	3.96
2004	360,118	1,000	15,572	80%	3.03
2005	399,503	1,105	16,041	81%	3.34
2006	422,974	1,158	17,670	88%	3.19
2007	444,060	1,216	15,365	85%	3.64
2008	496,444	1,360	15,010	83%	3.67
2009	518,014	1,419	16,636	79%	4.75
2010	551,538	1,519	18,783	72%	4.57

Source: Information Centre, Baanpaew Hospital, 2011

Table 7-4 - Outpatients under the different healthcare schemes 2007-2010

Scheme	Units	2007	2008	2009	2010
1. UC scheme	Patients	55,381	57,327	60,798	39,793
	(%)	(48.7)	(49.7)	(47.5)	(43.3)
Visit	No.	235,667	276,401	285,857	185,918
	(%)	(53.1)	(55.5)	(55.2)	(52.7)
Daily average		646	757	783	509
2.CSMBS	Patients	13,041	14,778	17,812	8,531
	(%)	(11.5)	(12.8)	(13.9)	(9.3)
Visit	No.	36,693	49,280	58,689	42,754
	(%)	(8.3)	(9.9)	(11.3)	(12.1)
Daily average		101	135	161	117
3.SSS	Patients	21,200	19,003	20,237	19,359
	(%)	(18.6)	(16.5)	(15.8)	(21.1)
Visit	No.	107,848	107,660	103,215	70,757
	(%)	(24.3)	(21.6)	(19.9)	(20.1)

Scheme	Units	2007	2008	2009	2010
Daily average		295	295	283	194
4.Other schemes	Patients (%)	24,067 (21.2)	24,337 (21.1)	29,245 (22.8)	24,128 (26.3)
Visit	No. (%)	63,852 (14.4)	64,396 (12.9)	70,268 (13.6)	53,049 (15.1)
Daily average	Patients	175	176	193	145

Source: Baanpaew Hospital, 2011

Note: 2010 data was collected October 2009 to May 2010.

Table 7-5 - Patients covered in healthcare promotion and disease prevention campaigns

Items	Samutsakorn Hospital	Kratumban Hospital	Baanpaew Hospital
UCC Thalassemia screening	886	533	-
UC Thalassemia examination of foetus	-	-	1,402
UC screening Iodine deficiency and Thyroid	1,899	770	-
(0-1 month)			
Rehabilitation UC	13,054	10,602	-
Rehabilitation other	78,969	1,107	4,931
Home visits	6,371	1,513	850
UC	36,415	3,070	839
UC (0-5) DPT vaccination	3,686	1,147	2,971
UC (0-5) BCG vaccination	1,910	881	598
UC (0-5) MMR vaccination	1,059	360	18
UC (0-5) Hepatitis B vaccination	3,755	1,201	73
UC (0-5) Dental	4,919	1,749	263

Source: NHSO, 2009

Table 7-6 - Hospital re-visits following treatment 2006-2010

Indicators	2006	2007	2008	2009	2010
Percentage of days after treatment inpatients re-visited the hospital within 28 days (complications)					
1.Diabetes	-	-	-	2.8	3.74
2.High blood pressure	-	-	-	4.4	0
3.Cerebral Thrombosis	-	-	-	0.59	1.73
4.Within 14 days after surgery	-	-	-	0.002	0.06
5.Within 14 days after child delivery	-	-	-	0.14	0.58
The percentage of diabetes patients undergoing treatment					
1.For annual checks of eye nerves	63	65	67	67	81
2. For annual checks of feet	-	-	-	68.6	81

Indicators	2006	2007	2008	2009	2010
3.For annual checks of kidneys	-	-	-	68.05	83
Percentage of AIDS patients receiving anti-HIV drugs on time	-	-	100	100	94.6

Source: Baanpaew Hospital, 2011

On a scale of 0-100 for satisfaction, the hospital scored 80 in responses from outpatients, inpatients and the whole community (Table 7.7). However, it scored poorly in terms of time spent waiting for treatment. In 2009 and 2010, on average the waiting times in queues for normal patients was 116 minutes and 106.2 minutes, respectively. For patients with complications, the average time was 190 minutes in 2001, but this reduced to 107 minutes and then to 103.7 minutes in 2009 and 2010, respectively. The hospital uses these figures to monitor patient satisfaction and tries to take remedial measures.

Table 7-7 - Satisfaction indicators 2006-2010

Indicators	2006	2007	2008	2009	2010
Satisfaction with hospital	-	-	-	81.99	-
1. Outpatients	-	84.9	-	78.3	77.2
2. Inpatients	83.6	88.1	83	85.6	84.6
3. Community	88	-	87	-	82.8
Percentage of complaints	0.01	0.01	0.02	0.01	0.007
Percentage of inpatients unwilling to stay	-	3.91	3.49	2.46	0.06
Outpatients' waiting time (minutes)					
1.Casual visit	67	55	92	116	106.2
2.Visits with appointment	48	42	53	30	31.8
3.Visit caused by complications (under treatment)	92	88	190	107	103.7
Percentage of people within the area of responsibility of the hospital having healthcare insurance	-	-	98	99.04	98.54
Percentage of cataract patients having surgery within 20 days	-	75.95	76.92	67.22	65.7

Source: Baanpaew Hospital, 2011

7.4 Interview data

A former director of the Baanpaew Hospital was interviewed and the following section is an account of the findings from these interviews.

When the hospital was affiliated to the MoPH, Baanpaew Hospital was subject to bureaucratic rules and regulations that were obstacles to the enhancement of flexibility in the provision of services, resulting in limited opportunities for improving service delivery to the general public, and limitations in supporting human resource development. Doctors retired without learning anything new relative to their initial skills.

> 'There were more or less 1,000 hospital affiliated to the MoPH with different specialisations. Community hospitals had very limited functions and powers, and central hospitals was placed under many bureaucratic restrictions, which resulted in limited access to services for the general public, and low opportunities for human resource development. Training to improve human resources could only happen piecemeal; and many doctors retired without having the opportunity to learn anything new. Baanpaew Hospital thus used to be a low quality hospital.'(*A former director of the Baanpaew Hospital*)

As reliance on the MoPH and the budget bureau posed an obstacle to development, the hospital decided to become self-reliant. As a doctor who had gained a lot of experience from working in district hospitals, the management relied on the director's extensive experience to initiate new programmes to assist the development of the hospital. Firstly, he instilled a new service delivery mentality among the existing hospital personnel. He introduced them to new ideas concerning the provision of services and for improving customer care, believing that the talent of the hospital personnel would bloom once bureaucratic restrictions were lifted. Most importantly, the management of the hospital adopted a new positive attitude towards the broader community they were servicing.

The management of the hospital had to be left to leaders with management skills, not those with surgical and other medical skills. The executive initiated the development of the hospital as early as 1987 in order to increase its capacity so that people would not have to travel to Bangkok to seek treatment. He believed that if the hospital could convince the community that it had the quality and the capacity to serve them, they would place their trust in the hospital and participate in creating a new high quality local healthcare system. He invited the community to donate resources to the hospital, not just to collect funds but also to create a sense of local ownership and participation. This strategy was very successful, not only in fundraising but also in involving the community in long-term relationships with the hospital. The management team spent

ten years in turning the hospital around using a slow process of building community trust and improving the service delivery mentality within the hospital. During this period data was constantly collected to monitor progress and to identify progress or obstacles in the achievement of the action agenda.

7.4.1 Changing attitudes in the community

Ties with the community were essential for the success of Baanpaew Hospital, and this was brought about by instituting transparency in its management and ensuring the wider participation of community residents in the management of the hospital. Emphasis was placed on public participation, with the personnel being taught how to be people-oriented and community residents being taught to be responsible for their own health, and not be totally reliant on the hospital. People's responsibility for their own healthcare helped reduce excessive drug dispensation and thus improved the hospital's operating costs. According to the executive, people were often neglecting their basic healthcare and this could be resolved by making them more aware and responsible for their own health. Some problems required public participation to resolve, but as people gained a better understanding of the system, they were willing to participate more actively in developing the emerging local healthcare system that the hospital was developing. A campaign was launched by the hospital in 1987 to convince community residents of the capacity of the hospital so that they would feel no need to travel to Bangkok to seek simple treatments. The development of the concept of a community hospital helped local people develop their ties with the hospital, which was very important to make the project sustainable. The involvement of patients in the hospital made, for instance, patients more aware of resource limitations and made waiting times more acceptable, local residents were also made more aware of the quality of services so that they did not feel they had to go to Bangkok. It also made doctors more responsive to patient demands.

The executive highlighted that this strategy was risky because the hospital could provide people with all the assistance they needed, but it may not be enough to achieve patient satisfaction or even to sustainably improve their health. For example, patients who were not aware of their health conditions and responsibilities may fail to take the drugs provided to them as regularly as prescribed by doctors. This was why a system of

communication with patients was thought to be important in order to improve patient care and health outcomes.

According to the executive, health issues concern all people, and thus require public participation; they cannot be the sole responsibility of the government. The community was also an important source of funds for the hospital and community residents could donate collectively donate substantial funds, buildings, areas of land, and equipment. The hospital encouraged this and made itself open to public donations. This also entitled the community to play an active role in the management of the hospital and provided a strong sense of ownership. Participation by community residents was sought in all aspects of the development of the hospital, together with participation in the management of the hospital by the representatives of the community. The hospital received an initial donation of 100 million baht from the community to construct a building and such donations demonstrated the growing trust in the hospital and helped build further trust. The local community residents soon saw the hospital as theirs, and this sustained a flow of contributions to the hospital. According to the current director of the hospital, one of the salient facts about Baanpaew Hospital is that most of the management team of the hospital are natives of the Baanpaew community. Three representatives of the community and three qualified persons on the management team are in fact natives of Baanpaew.

The formation and implementation of development plans were done in a way that contributed to the achievement of the objectives set by the government. According to a doctor at the Baanpaew Hospital:

> ‘As a public organisation, the hospital still pursues the same objectives as those assigned to it during the time when it was part of the healthcare bureaucracy. Those objectives are to attend to all aspects of healthcare of the community. We have to deal with mental and physical health as well as healthcare promotion and disease prevention and rehabilitation.’

The success of the hospital in terms of achieving the government healthcare objectives is confirmed by healthcare bureaucrats. According to the head of the Provincial Health Office in the province of Samutsakorn, the hospital has been noted by NHSO for its high level of efficiency and flexibility compared to public hospitals in Bangkok.

The management focus on efficient delivery resulted in improvements in the efficiency in the use of equipment. This in turn helped to reduce the cost per unit of treatment:

> 'In the early years we didn't have a lot of funds. We had to rely on the equipment lent to us from private companies wanting to test their products. As our finance was limited during the first seven years of our life as a public organisation, we had to be thrifty and relied on our specialisations and management capabilities. But first of all our operations had to be transparent and open to public scrutiny because we understood the importance of building trust.' (*A former director of the Baanpaew Hospital*)

As medical equipment was expensive, the hospital had to use equipment as efficiently as possible. Mobile surgery units were developed to achieve economies of scale as such units could provide treatment to large numbers of patients. The vehicles used by the hospital were also donated by community residents. The presence of mobile surgery units provided the hospital with the capacity to deal with the numerous surgical cases without the need to purchase a lot of equipment. According to the executive, dealing with all these surgeries also helped to improve the skills of surgeons and in turn increased their incomes.

The shift towards a mass treatment strategy required the treatment of a larger number of cases in order to reduce costs. The executive described a local appendectomy case which no hospital in Bangkok would admit and instead had to be referred to a hospital in more distant Nakhonpathom. In response, he suggested setting up an appendectomy centre to perform mass appendectomies and saw that it could be profitable if certain conditions could be met. If doctors and nurses at the centre were sufficiently skilful to accomplish each appendectomy operation within 20 minutes, then the centre could prove profitable.

The hospital management took the view that the capability of the personnel had to be constantly developed and improved. Whilst the doctors at the hospital accepted the condition that they had to be on call twenty-four hours a day, acceptance of such conditions provided them with the opportunity to continually improve their skills. Dealing with a large number of surgical cases helped to improve the surgical skills of the doctors as well as increasing their own income and that of the hospital. This too had a positive effect in lowering the turnover rate of personnel, as doctors were more

satisfied with their incomes. According to the executive, the effective and efficient management of the personnel and equipment was essential for the survival of the hospital.

A new concept of a production line was borrowed from industrial Fordism and in an appropriately adapted form was put into practice by the management of the hospital in the development efficient treatments. The adaptation of the concept of a production line to treatments resulted in the clear division of functions of different members of staff and contributed to the development of their skills through specialisation and increased their efficiency and the rapidity of treatment. This was directly borrowed from Fordist industrial production, but its adaptation to the very different and more complex world of medical treatment was a significant achievement by the management.

Access to social security funds was essential to strengthen the financial position of the hospital. The hospital thus sought to have its status elevated from a primary care unit to a secondary care unit. According to the executive, the hospital took the position of supplementing its social security income with contributions from the community but it had to primarily rely on the flow of funds from official sources. To this end it had to ensure that its access to social security funds was secure. Donations from community residents were received without any condition. However, the hospital had to convince the whole community that change would occur if they could work together but they also had to ensure government funds through the SSS would be received. The hospital had many specialists who initially had low aspirations but soon supported the change in the status of the hospital, from being a subcontractor to being a main contractor of the SSS. The executive argues that during its reform process, the hospital seriously took the SSS into consideration during their budgeting process. Based on their estimate that the per capita allocation provided to the hospital would be 750 baht, the hospital concluded that it could provide a range of primary to tertiary services provided it sustained its efficiency in service delivery.

The hospital used its own resources to improve the range and availability of its services. The reach of its services was extended to remote areas through co-operation with hospitals in sub-districts in an effort to reduce inequality in access to healthcare

services. According to the executive, the hospital felt that all citizens were entitled to medical treatment provided by the hospital, regardless of the healthcare security schemes to which they belonged (CSMBS or SSS or other). The patients who wanted extra services, like extra room service, were required to make extra payments and sacrifice their social security rights. The hospital effectively operated a private ancillary system in parallel for those patients who could afford to pay for additional services, without sacrificing the equitable distribution of healthcare services.

The following factors contributed to the sustainability of the Baanpaew Hospital business model:

1. Co-operation from all sectors of society contributed to an increase in the hospital's annual revenue, from 100 million baht to 1,000 million baht
2. The strategy of increasing the number of operations and allowing skilled doctors to make more money reduced the turnover rate and improved staff morale and doctors' satisfaction levels.
3. The growing availability of sophisticated equipment helped to keep doctors motivated to learn more and to continue to work for the hospital.
4. The growing prestige of the hospital made its personnel feel that they did not work for a district hospital but for an important metropolitan hospital. The low morale problem in district hospitals was effectively removed.

According to the executive, the experience of Baanpaew Hospital does not mean that all public hospitals should be converted to public organisations in the same way. However, the model could work for hospitals in large provinces such as Phuket and Pattaya, where scale economies could be achieved by a hospital with management autonomy. He also highlighted that the design of the healthcare social security systems in Thailand was excessively complicated and arbitrarily placed people in disadvantageous positions. He is a strong advocate of simplifying the system and funding public healthcare out of a single consolidated fund.

The following qualitative data was obtained from customers and healthcare related personnel pertaining to the efficiency in the operation of the hospital. According to the

interviewees, the hospital's reputation attracts a number of customers who have been satisfied with the services provided. The problems of tardy services were overcome, and customers were pleased with the flexibility regarding the provision of services, for example they were happy to be allowed to attend to their hospitalised relatives. In addition, service fees were deemed to be low relative to the quality of the services provided. However, the hospital did not perform well with regard to healthcare promotion and disease prevention, as it had to co-operate with local healthcare stations still encumbered by bureaucratic rules.

The data obtained from interviewing the management of the hospital and members of local government indicates that;

1. The district of Baanpaew and Baanpaew Hospital have a large number of healthcare-related personnel compared to the number in the provincial capital and in the district of Kratoomban. The increase in healthcare-related personnel in the district of Baanpaew went hand in hand with the increase in the capacity of Baanpaew Hospital.
2. Baanpaew Hospital continues to monitor patient satisfaction, be they inpatients or outpatients, through systematic research.
3. The hospital, through its cooperation with local healthcare stations, has formed a network with the district healthcare system for providing treatment, as well as for launching healthcare promotion and disease prevention campaigns. The hospital supplies the network with funds, drugs, and personnel.
4. The hospital is open to new management ideas and has adopted the production line system used in Fordist factories. It places an emphasis on cost control and the efficient use of resources and has adopted a proactive approach to the provision of its services.

Over the past ten years the hospital's capacity to provide services to inpatients and outpatients has increased, and it now has a higher capacity for inpatient services than those of Samutsakorn Hospital and Kratoomban, but is similar to those of other general hospitals. Half of the hospital's outpatients are UC scheme participants, followed by SSS and general patients who pay for their services. The number of patients who are

bureaucrats has increased slightly, whilst the number of other patients has slightly decreased. The increased usage by bureaucrats also signifies the improvement in the quality of services provided by the hospital. A priority of the hospital is to match the quality of its services to the needs of the community. Evaluations of the hospital's performance are regularly conducted and a flexible approach to changing the mix of services provided is attempted (Baanpaew Hospital, 2011).

7.4.2 Examples of satisfaction among personnel

> 'There's no wide gap between the rates of salaries here and the ones of private hospitals, and I'm satisfied with this. And salary levels are determined by work and responsibility assigned to each doctor.' (*Doctor at the hospital*)
>
> 'Compared with private hospitals, salary levels here are satisfactorily high. Specialists at private hospitals surely get slightly higher salaries, but here we get pleasure from serving our patients. Profits and salaries are not our priority.' (*Doctor at the hospital*)
>
> 'If we purchase everything with money, we destroy the culture of our organisation and there'll be no more loyalty to the organisation. Retention of personnel will be more difficult if we try to do that only by offering higher salaries than other hospitals.' (*Director of the hospital*)

The hospital puts a very high emphasis on the satisfaction of its personnel and continues to monitor satisfaction. It also takes proactive measures to respond, often pre-emptively with new schemes to ensure that personnel satisfaction is maintained at a high level. Examples of the types of schemes and proposals that the hospital has adopted in this regard include the following.

1. The development of new incentives for personnel in addition to financial incentives, as the latter alone cannot prevent the turnover or departure of personnel.
2. Creation of a new culture within the organisation, with an emphasis on organisational development.
3. Providing doctors and other hospital personnel with the opportunity to demonstrate their abilities. Rewards to personnel are awarded depending upon their performance, as they hold no bureaucratic rank or position.
4. Introduction of performance-related pay, with salaries as a guaranteed minimum and additional payments based on different measures of performance.

5. At a higher level, management realised that none of this would be possible without taking continuous steps to generate sufficient revenue for the survival of the hospital.

Data obtained from interviews highlights the merit of a public organisation in term of public participation. The organisation is autonomous but it is still responsive to governmental policy and the public's needs. However, the successes of the hospital's operation were heavily dependent upon the performance of its director and the executive board. In that sense the hospital is an example of the achievements of strong leadership rather than simply the operation of a different set of institutional rules governing financing, pay and monitoring.

Whilst other public hospitals were not willing to engage in frank discussions about their financial and personnel problems under the UC system, we were able to informally interview doctors and other care providers in other public hospitals in Bangkok. The picture that emerged was uniformly one of an increased level of financial and personal stress after the inception of the UC scheme. The reasons that were commonly given included much longer working hours without adequate compensation, longer queues and lower customer satisfaction, and most important of all, growing financial deficits that were being covered on an ad hoc basis by government transfers. The growing financial deficits and the political pressure to not reveal this to the public was one of the main reasons why many of our hospitals were extremely reluctant to talk to us openly about the situation after the introduction of the UC scheme. Unlike Baanpaew Hospital, most public hospitals were unable to respond in flexible and creative ways to raise money and motivate their staff to deliver services, whilst making the public aware of the constraints by involving them in management. Such a strategy may not even have been feasible in many public hospitals which faced more severe demands (for instance because of their location in particularly deprived areas) and which did not have the entrepreneurial leadership that this particular hospital was fortunate enough to enjoy at a critical juncture.

7.5 Conclusions

Thaksin was so interested in re-structuring the Baanpaew hospital and implementing the 30 baht scheme through the hospital that he personally became involved in the supervision of change in the hospital. He hoped the repetition of Baanpaew's success in other hospitals would contribute to his popularity and thus his victory in the next election. Therefore, in addition to the leadership and vision of the hospital's management, the government's intervention also contributed to the change

Baanpaew Hospital was a public hospital which joined the UC scheme like all other public hospitals. It was made autonomous in an experimental ordinance in order to circumvent bureaucratic restrictions and to improve efficiency in the provision of services. This experiment proved to be successful in this case and the flexibility turned out to be essential for responding to the financial and personnel pressures that were unleashed by the UC scheme. The achievement of greater efficiency with reasonable levels of equity in the operation of the hospital can be traced to the following three factors:

1. The management of the hospital was in the hands of an executive board that included representatives of the local community and this promoted public participation by local people. The users of the hospital's services felt that the hospital belongs to them. As a result, they contributed donations to the hospital's finances that added up to significant sums, allowing the construction of new buildings and the purchase of machinery. This also contributed to consumers of services having higher levels of patience in receiving scarce care services.
2. The human resource management of the hospital was radically adapted so that it became more flexible in setting salary levels and a training system was set up to change the mind-set of staff and adapt their behaviour so that they could perform multiple tasks. For example, the training of nurses who were to work in primary units were carried out by existing staff in the hospital and staff were re-trained to carry out operations in new 'Fordist' style operations that were new innovations in the context of Thailand.
3. The financial management of the hospital was also radically changed from the norm observed in Thai public hospitals. The hospital looked for flexible funding

opportunities for particular projects and activities, relying on a variety of funds ranging from donations to partnerships with private companies, but always subject to scrutiny and inspection.

Baanpaew Hospital is the first public hospital to switch from bureaucratic administration to administration as an autonomous public organisation, which is characterised by the presence of an executive board supervising the administration of the hospital. This is composed of the chairman who is a qualified person but not a bureaucrat, representatives from the MoPH, the provincial governor, the provincial public health officer, three representatives from the community, three qualified persons, and the hospital director who acts as the secretary. The hospital has been successful in terms of both profits and customer satisfaction, and has also established nine additional branches. This model of autonomous public hospitals can be seriously considered as an attractive one for planned expansions of the public health system, though it may be too disruptive to attempt a transformation of most public hospitals to this institutional arrangement at this stage.

A clear policy guideline to expand and enhance the provision of some healthcare services by autonomous public sector hospitals would therefore be a useful policy position that could be released for further consultation and discussion within the sector and in the broader public domain.

Baanpaew Hospital, with its specific form of administration, represents one way to promote access to healthcare services for the poor and to achieve sustainability through the UC scheme. This became possible due to it being granted autonomy with greater public participation in its administration. Its autonomy was used very effectively in the flexibility exhibited when recruiting full time and part time employees, and in acquiring medical equipment. This flexibility contributed to the efficiency of its operation, and as its location was in a city with a larger population than that of many districts, economies of scale were not hard to achieve to reduce costs through changing procedures of operations and treatments, and it was also successful in mobilising local resources through charities and donations.

The hospital’s objectives as featured in the royal decree legalising its establishment include:

1. Providing medical treatments, disease prevention, healthcare promotion, and rehabilitation services.
2. Supporting the state's healthcare policy.
3. Engaging in other activities consistent with the state's policy and the needs of the community.

The principles of its operation were set out as follows:

2. Provision of services based on public participation.
2. Responsiveness to the needs of the community.
3. Equality in access to services.
4. Improvements to services without any profit motive.
5. Efficiency in resource allocation.

The hospital regularly conducts satisfaction surveys on various issues including the services provided, personnel, facilities, and quality of services, in order to formulate appropriate operational plans. Personnel are encouraged to develop a service mind-set and to be aware of public interests. They are also encouraged to further their education. The cost accountancy adopted by the hospital is marked by its effectiveness, and is successful in tracking its financial situation in real time, and this is a vital tool in the effective management of the hospital.

Chapter 8. Concluding discussion

This chapter features the results of data analysis based on the conceptual framework presented in chapter 2. The conceptual framework is derived from the review of literature relevant to political economy and public policy. It helps elucidate political pressure shaping policies, the economic explanation of 'efficiency', 'equity', 'viability', and policy evaluation. The conceptual framework is based on the assumption that the UC scheme is the result of the complex interplay of political, economic, social, and personal factors comprehensible only through a multidisciplinary approach.

In this chapter, the 30 baht scheme initiated by the Thai Rak Thai Party is subject to analysis. The conceptual framework from chapter 2 is used to analyse political motivation, economic factors leading to success or failure of the scheme, and the viability of the scheme assessed by the conduct of two case studies. As set out above, the objectives of the research are as follows:

1. To study the political economy of the Universal Healthcare Coverage Scheme and the impact on policy implementation
2. To study the access to the Universal Healthcare Coverage Scheme in Thailand
3. To study the financial management of the Universal Healthcare Coverage Scheme in Thailand
4. To study the implementation of the Universal Healthcare Coverage Scheme through case studies of particular hospitals

8.1 The political economy of the Universal Healthcare Coverage Scheme

The political economy both of the 30 baht scheme and Thai politics in general have undergone great changes since 1992 when a military *junta* came to power. The growing domination of capital, rapid economic growth, and growing popular demands for more effective government responses to their needs led to the emergence of populist politics within a major party, the Thai Rak Thai. A new system of procuring votes for promises of formal service delivery, particularly in healthcare, began to supplant the traditional patronage system in the countryside created by local strongmen. This was a new and

more formal version of populism. The range of constituents that this populist political platform brought in proved to be an undefeatable one for other parties that were still relying on the traditional systems of mobilisation and patronage. However, the price was the introduction of a system that, initially at least, led to rapidly growing strains on the healthcare service providers and the provision of inadequate funds to finance these programmes.

The 30 baht scheme was an important part of the populist programme put forward by the increasingly dominant Thai Rak Thai Party and it contributed greatly to the popularity of Thaksin's administration among the poor. However, the populist programmes initiated by the Thaksin administration were not acceptable to significant taxpayers, who were mostly from the upper and middle-classes. Taxpayers feared that the escalating spending on the risky populist programmes would impose heavy tax burdens on them, and have an adverse effect on the financial institutions providing credit to the public sector. However, the populist programmes helped the Thai Rak Thai Party led by Thaksin to win the support of the majority of the poor in the north and north-eastern regions of the country, and they in turn collectively added up to form the majority of voters. Their support for the Thai Rak Thai Party contributed to the Party's victory in every election held over the past ten years. The only way in which the party has been removed has been through military intervention, which happened twice, once in 2008 and again in 2014.

Though the NHSO and the Ministry of Public Health are independent from each other, they remain engaged in co-dependency. The NHSO depends on the hospitals affiliated to the Ministry of Public Health, as the number of private hospital joining the UC scheme is still limited, whilst the hospitals affiliated to the Ministry of Public Health depend on the financial supply form the NHSO.

However, the NHSO has no authority to impose reform on the Ministry of Public Health and the Ministry of Public Health has no authority to apply rules and regulations to the NHSO, nor does it have authority to make the suggestions based on scholarly research to the NHSO.

The law requires the Minister of Public Health to preside over the executive board of the NHSO, but as the NHSO executive board comprises of people from diverse

backgrounds, the minister can take only limited control of the NHSO. However, in the unusual situation in which the permanent secretary of the ministry acts as minister, problems may arise if the ministry and the NHSO do not agree on policy.

8.2 Process of the Universal Healthcare Coverage Scheme in Thailand

The idea of universal healthcare coverage had been around in Thailand for 10 years before the introduction of the National Health Security Act 2002 which guarantees the right of all Thais to have access to necessary healthcare services. The act is consistent with the 1997 constitution and the WHO's principle of "Health for All" adopted by Thailand as an objective for development.

Civil societies, NGO, bureaucrats, and politicians were engaged in the campaign for the introduction of the National Health Security Act for years; and their effort became fruitful during Thaksin's premiership. The National Health security Act stipulates that "the Thai population shall be entitled to a healthcare service with such standards and efficiency as prescribed in this Act". Additionally, there shall be a fund in the National Health Security Office called the "National Health Security Fund", aimed at expenditures to promote and encourage the arrangement of the healthcare service of healthcare units. The Minister of Public Health acts as the chairperson of the fund, which is managed by the National Health security office under the leadership of the secretary to the office.

The management of the fund is in accordance with the rules contained in the National Health Security Acts. The fund comprises smaller funds concerning with outpatients, inpatients, health promotion, HIV AIDS, kidney disease, etc. The services are provided through both public sector and private sector service units. The act requires public sector service units (hospitals) to be included in the healthcare coverage scheme. The participation of the public sector outlets is on the voluntary basis. Service charges are based on per capita per head in the case of inpatients and DRG in the case of inpatients.

The initiation of projects, such as disease prevention and healthcare promotion projects, are based on individual project. The presence of a universal healthcare coverage scheme enables Thailand, a lower-middle income country to achieve universal healthcare coverage for all Thais. All Thais can have access to healthcare services they require.

The number of people bankrupted by healthcare expenditures was greatly reduced. They have steadily been highly satisfied with services provided by the scheme.

The scheme has always been positively viewed by the general public. As a result, politicians always reiterate to voters that they themselves initiated and implemented the scheme to contribute to the public welfare.

8.2.1 Impact on the health security system in Thailand

The scheme can be beneficial in one way but generate other problems. As a result of the introduction of the UC scheme, three quarters of the budget of the MoPH was allocated on a per capita basis to hospitals to cover the UC scheme population. This method of financial allocation increased the importance of hospitals with larger UC scheme populations under their responsibility, despite the fact that these hospitals were often less well-equipped and had lower costs of maintenance and depreciation of expensive medical machinery. However, at the same time, the significantly increased workloads in some public hospitals compelled some personnel to leave their jobs in the public sector and join private hospitals.

People were generally satisfied with the UC scheme, and indeed at a popular level strongly supportive of universal healthcare, although there were many complaints made directly to service units. A number of problems still need to be addressed in terms of the administration of the scheme. Citizens without identity cards cannot access services, and there are still people in remote areas without identity cards. The scheme's coverage in terms of available hospitals is still low as is the availability of information on participating hospitals and methods of enrolment. These problems mean that even after a decade of operation, the coverage of the targeted population has not been fully achieved. In addition to the problems of achieving a sustainable level of finance, maintaining a minimum level of services and the quality of the service, and achieving full or a high level of public participation are also important. Services, especially those related to primary care, need to be subject to improvement and development. Primary care, with its proximity to people and communities, is likely to induce links between service providers and communities, resulting not only in cost reductions but also the welfare of people and communities. The development of primary care is thus highly

important and depends upon a proper understanding of the critical role of primary healthcare care among service providers.

Thus the issues that need to be addressed in the healthcare reform campaign are better quality services within the budgetary limitations, and public participation in the healthcare security system to improve the accountability and sustainability of the healthcare system. These changes have to be achieved in a technocratic and professional way, outside the imperatives of political promises and rhetoric. The rollout of the UC scheme was very rapid because of the political imperatives of the ruling party of that time, but this advantage was balanced by the disadvantage that the politics of populism meant that adequate arrangements were not made to ensure that the financing was feasible, that healthcare targets and institutional arrangements had been adequately set to achieve the highest level of healthcare feasible with equity and effectiveness.

8.2.2 Conflict of interest

The UC fund is managed by the committee comprising representatives of various groups and chaired by the Minister of Public Health. The representatives of local governments, high-ranking bureaucrats from several ministries and the comptroller general, the representatives of the non-governmental organisations, and the representatives of the associations of healthcare-related professions all have their seats in the committee. The management by board or committee represents an attempt to achieve balance of power that further contributes to efficiency. However, the board being comprised of many group having their stakes in more than 100,000 million baht budget gives rise to conflict of interests. Some of the types of problems include the following:

1. The allocation of UC's fund to the organisations in which committee members they have their positions, such as the allocation of the fund used in healthcare promotion and disease prevention to the non-governmental organisations in which they serve as chairpersons or board members.
2. Board members have held positions in various sub-committees administering the scheme, further compounding conflicts of interest.

3. Local politicians on the board have used UC funds to promote their own interests, for instance by allocating funds for healthcare promotion and disease prevention in their local areas. This has sometimes been good pressure for accelerating delivery, but it can also distort priorities.

8.3 Access to the Universal Healthcare Coverage Scheme in Thailand

Outpatient use of UC scheme services increased from 66% in 2006 to 80% in 2009, with the north-east region population being more dependent on UC scheme services than their counterparts in other regions. The population in Bangkok was the least dependent on the UC scheme. The use of inpatient UC scheme services rose from 18.4% in 2006 to 91% in 2009, and the population in the north and north-eastern regions were most dependent on these services, whilst those in Bangkok were the least dependent. In 2010 it was found that Thais whose healthcare needs were unmet were few in number. However, the UC population was more likely to face difficulty in accessing basic healthcare services than those individuals covered by the CSMBS and SSS. It was reported that the needs of 0.4% of outpatients and 1.4% of inpatients were not met due to the patients having no time to see doctors, not being confident about getting the treatment, or facing travelling difficulties.

8.4 The budgetary allocation for the Universal Healthcare Coverage Scheme and the problems relating to budgetary allocations

The right to freely access healthcare services is a basic right that Thailand has long sought to institutionalise and recognise. The campaign to achieve healthcare security for all was led by doctors, civil society and NGOs and enjoyed broad support in Thai society. The demands for healthcare reforms and healthcare security for all were derived from a growing awareness across society that the poor healthcare of many people was due to high healthcare-related costs, and an emphasis on curing diseases rather than preventing them, resulting in a non-holistic approach to healthcare, and an unacceptable level of inequality in the access to healthcare services.

The introduction of the UC scheme in Thailand in 2002 represented the stepping stone to the establishment of healthcare services in Thailand marked by equity, efficiency, and social accountability. The Health Security Act of 2002 resulted in a large number of

changes, many of which are desirable and some of which are debatable. Nevertheless, the improvement in the equality of access to healthcare services has become a generally accepted and institutionalised fact, evident in the increasing number of people entitled to benefits under the UC scheme and the rise in the number of inpatients and outpatients, the number of referrals, and an increase in the number of cases involving costly treatments.

The inequality problem has not yet been totally solved, especially where resource allocation and the provision of services are concerned. The National Health Security Act 2002 facilitated the establishment of universal healthcare coverage in Thailand, which has greatly contributed to facilitating access to healthcare services for the majority of Thais through three healthcare security schemes: the UC scheme, SSS and CSMBS. However, there remain some discrepancies in the entitlements to general healthcare care, emergency care, access to drugs, disease prevention, and transportation in the three schemes, and the UC scheme is the least well-funded.

The UC scheme should therefore not be seen in a one-sided way. It is an important experiment and the idea of universal healthcare has become established in the political arena and institutionalised to a large extent. Many aspects of the UC scheme are also highly desirable based on the experiences of other countries. For instance, the principle that people should have the right to choose their hospitals is a very good one in terms of patient choice and also for ensuring that hospitals do not have a captive set of customers, which may result in lower levels of service. At the same time, as we know from the experiences of other countries, like the United Kingdom, choice assumes that patients also have clear and simple information on the basis of which they can make simple choices. Otherwise, some hospitals can become overburdened and others suffer a low level of income for no good reason.

Subjects for future debate and consideration include the unification of the three healthcare systems. This would simplify the management and financing of healthcare and make it truly universal, but the short-term consequences may be to raise the overall average cost of public healthcare by increasing the standard of healthcare offered under the UC scheme to the level of the other better-financed schemes. Another issue for debate and consideration is the proper role of the public and private sectors in the

provision of healthcare services. The private sector is generally a higher cost service provider because it is increasingly specialising in higher cost treatments that the more affluent parts of the population in Thailand and the region can afford. This means that a simple integration of the public and private sectors as was initially attempted is not a sustainable model. On the other hand, dedicated private hospitals can emerge to service this sector as a distinct business model. The autonomous Baanpaew Hospital shows that the provision of high quality services based partly on government subsidies and partly on marketed revenue streams and donations can be an effective business model. How replicable this can be on a larger scale remains to be tested. Other issues include refining the funding model and making it simpler and easier to predict. For instance, the incorporation of personnel salaries into the capitation calculation may help to address the perpetual deficits that some public hospitals have been facing. The experiences of particular hospitals therefore need to be incorporated and studied further in better designing the funding model, to maintain the financial viability of hospitals whilst at the same time capping costs at acceptable levels and providing incentives to the care providers to provide high quality services.

8.5 The role of political actors that affect 'efficiency, equity, and viability'

As political actors became involved in initiating the UC scheme, the scheme was viewed as part of the political populism that is widespread in Thailand. However, the scheme enables the poor to get access to healthcare services which is their constitutional right, rescuing them from healthcare-related bankruptcy. Besides, allocation of healthcare-related resource is more efficient than ever before as a result of the implementation of the UC scheme. Assessment of the scheme in terms of the three components of successful policy – efficiency, equity, and viability – can be summarised as follows.

8.5.1 Efficiency

Efficiency is achieved through the separation of user and provider which are the NHSO and the Ministry of Public Health, respectively. Funds are allocated directly on a per capita basis to service units, with the state, service units, and patients sharing the costs of treatment.

To achieve efficiency, effort was made to:

1. Improve the allocation of funds to meet the demand of users. Funds were allocated to service units according to the size of the population in the areas for which service units were responsible.
2. Downsize the administrative structure of the Ministry of Public Health. Service units were allowed to be more autonomous. The service units with financial strength were promoted to the status of public organisation.
3. Establish the network of service units to achieve co-operation in providing services including transfers of patients across hospitals to maximise the delivery of services within the given overall budget.

8.5.2 Equity

Equity has been the main objective of the healthcare reforms that followed the popular uprising of 1973. An important consequence of the popular uprising of 1973 was to shift the focus of fund allocation from large hospitals to community hospitals and local healthcare stations. The office of the permanent secretary of the Ministry of Public Health was established. A decentralisation effort was also made through the establishment of the provincial healthcare office. The popular uprising in 1992 led to the drafting of the 1997 constitution and the establishment of the National Health Security Office (NHSO) in 2002 to achieve the equity in the delivery of healthcare policy. Local healthcare funds in which local authorities were involved were set up in 2006.

Health reform has always advocated a better distribution of healthcare services in the countryside. Health services in the countryside are usually not profitable and high levels of service delivery in these areas may be considered to be economically inefficient. Thus, equity can sometimes conflict with efficiency.

8.5.3 Viability

The first and ultimate objective of the UC scheme was to facilitate the exercise of the constitutional right of procuring access to healthcare services by all Thais. It is thus obligatory for the state, regardless of the political parties coming to power, to contribute to the financing of the UC scheme, but as financial allocations to the scheme kept rising

and growing even more burdensome with the ageing of the population, the scheme faced growing opposition from middle-class taxpayers. The latter prefer to use services provided by private hospitals on grounds of greater convenience and higher quality of services. Improving the quality of services under the UC scheme to a level that could draw the middle class into the scheme would certainly contribute to the political viability of the scheme in terms of middle class taxpayers being willing to fund it. In reality, such a level of improvement in service delivery quality is unlikely in the near future. Instead, efficiency is currently emphasised so that hospitals are expected to become self-sufficient and not be a financial burden. Clearly this can happen at the expense of equity, as hospitals in rural areas will not provide a full range of services if they have to be self-sufficient given their target locality. Moreover, efficiency is difficult to achieve because attempts to increase revenues whilst decreasing expenses usually face huge constraints in the healthcare sector. In reality, hospitals' expenses do not decrease whilst revenues keep stable. Varying levels of subsidy are therefore a permanent feature of hospitals in a public healthcare system, and the levels of subsidy have to vary across hospitals and over time.

8.5.4 Case studies

- **B-care Medical Centre – an unviable model of UCS participation**

Our case study of the private hospital, B-Care Medical Centre, shows some of the problems that emerged as a result of inadequate information about financing, expected service quality and patient expectations. This hospital joined the UC scheme during the early years of the scheme and then withdrew due to the problems of failing to achieve sufficient increases in the financial allocations and the conflict of falling standards with the brand marketing that was important for a private hospital. There were discrepancies in the expectation of the quality of services between the UC and SSS scheme patients and general patients. Whilst the UC scheme and SSS patients expected standardised services, the general patients expected premium services, and when the provision of premium services was perceived to be negatively affected by the queues and problems affecting the public patients, the general patients began to switch to other private hospitals. This resulted in a significant decrease in the revenue from general patients after the hospital began to admit increased numbers of UC scheme patients. In addition,

the hospital faced financial issues as the profits gained from providing services to each group of customers did not reflect the real costs, and the complex cross-subsidies affected financial planning and service quality within the hospital.

The experience of this private hospital with the UC scheme provides some general lessons for the future overhaul and review of the scheme.

- It is important to make transparent the categorisation of customers into general patients, UC scheme patients, and SSS patients.
- To achieve a financially viable service delivery model, it is important to have a system for assessing the needs of each group of patients to and establish appropriate service plans for each.
- As the premium private customers are in an entirely different type of category of healthcare consumption, it is important to separate the services provided to general patients demanding premium services from those provided to UC scheme and SSS patients who are satisfied with standardised services. Different groups of customers should therefore be given different service facilities, such as buildings, equipment, and drugs. This may appear to fly in the face of an equitable distribution of healthcare services, but in fact such a strategy may be essential for maintaining equity and viability within the full range of publicly financed healthcare services.
- The interviews with management also suggested the importance of adopting effective cost accountancy because management in this hospital appeared not to be prepared for the managing the complexities in financing arrangements across different categories of customers.
- The experience of this hospital also suggested the importance of management keeping on top of the financial and medical operational objectives of the hospital. One solution could be to institutionalise a regular analysis of costs/revenue at least every three months in hospitals within the scheme so that a regular evaluation of the achievement of objectives and the costs of achieving these objectives is available of management.

Recruiting private hospitals with the objective of providing premium services to the UC scheme is inappropriate, as different private hospitals have different capabilities in the

services they provide to different levels of customers. However, some private hospitals have specialised in the provision of healthcare services to poorer customers, and these hospitals would be particularly relevant for inclusion in the UC scheme with the right incentives and disciplining rules.

- **Baanpaew Hospital – a viable model of adaptation**

A different set of insights emerge from the experience of Baanpaew Hospital. This public hospital achieved autonomous status and quickly set about undertaking a small revolution in the public provision of healthcare services. It established the principle that the promotion of the access to healthcare services by the poor could be achieved by improving and elevating local healthcare stations attached to local hospitals and then establishing a network of these hospitals. An active role for local healthcare volunteers was also established whereby these volunteers were vigilant in identifying outbreaks of diseases at an early stage and providing care to children, the elderly, and the disabled within their community.

A greater number of public hospitals could move towards the operational principles of the Baanpaew Hospital to improve their performance under the UC scheme. In doing this, policy-makers should consider the following:

1. It is easier to grant autonomous status to newly-established hospitals rather than to take an old hospital and change its status. Hospitals as organisations have many established routines that their personnel follow and trying to change established habits and routines once they have become part of the culture of an organisation can be a very difficult task indeed.
2. The Baanpaew type of hospital strategy requires that communities and community leaders should be prepared to co-operate with these hospitals.
3. It was probably important that the hospital was still publicly owned even if it had become more flexible in its operation. The public ownership part of the equation was important in enabling patients to feel some amount of ownership in the hospital, and this in turn was critical in terms of monitoring service delivery and raising funds locally.

4. The Baanpaew experiment also establishes the importance of hospital management moving from a role of passively using available funds to one where they raise and manage funds in a more active way. This is not the task of hospitals in many countries, but in Thailand given that the expectations from the UC far outstrip the tax resources available, hospitals have to be creative in raising and managing funds.
5. Leadership and management skills were critical in the Baanpaew case and an important lesson for replication is that these skills should be recognised when recruiting the management leaderships of these types of hospitals.
6. The importance of cooperation from society and the private sector was powerfully established in this case, and effective replication would require that public participation should be sought and organised in these types of hospitals.
7. Networks of healthcare stations in districts around public hospitals with the status of public organisations should be established as these play a critically important role in providing primary healthcare, thereby reducing the overall costs of healthcare.
8. An important aspect of Baanpaew's success was to promote self-reliance and preventive attitudes among the general public and these aspects should also be promoted in any replication of this experience to other public hospitals.
9. Baanpaew worked very closely with its network of service units at the primary, secondary, and tertiary levels and these units eventually adopted similar organisational cultures, making it even easier for the different units to cooperate.
10. Achievements of targets should be measurable, as they were in Baanpaew.

Baanpaew Hospital showed that it is possible to be financially viable and even to expand under the UC scheme by adopting a strategy that was exemplary in its autonomy and led and implemented by a flexible management. The result was the achievement of a significant expansion of service delivery under the UC scheme without sacrificing its efficiency in operation and the quality of its services. Autonomy and flexibility in its management combined with greater public participation made it easier for the hospital to neutralise the adverse impact of changes. Assessing the operation of the hospital indicated that its performance became even better as time passed. It can be thus be concluded from that the administrative structure of Baanpaew Hospital was ideal for

promoting public access to healthcare services, without sacrificing equity, quality, efficiency and social accountability.

8.6 Conclusions for public policy

The examination of the UC scheme in this thesis based on the available secondary data and the case studies provides a number of insights for initiating policy discussions about how to improve the scheme in terms of service delivery, equity, effectiveness, and financial viability. The following issues could be considered by policy-makers and hospitals involved with the delivery of services under this scheme.

8.6.1 The National Health Security Office (NHSO) commission

The NHSO commission is a public organisation established in accordance with the National Health Security Act, which acts as purchaser of public healthcare services for all Thais. The commission comprises of representatives from the public and private sectors, NGOs, and qualified persons from various fields. The commission is chaired by the Minister of Public Health, with the permanent secretary to the Ministry of Public Health (MoPH) acting as vice chairman, and the secretary to the NHSO acting as secretary. The outstanding achievement of the commission over the past ten years has been the reduction in the number of families bankrupted by the costs of medical treatment, and the growing satisfaction among people covered by the UC scheme. A large part of the success of the UC scheme can be attributed to the management of the commission.

8.6.2 Good governance

The principles of good governance relevant for the healthcare sector in Thailand are effective participation of different stakeholders, accountability in the decision-making process, and freedom from arbitrary political interventions. The management of the sector through the commission has made good progress in embodying many of these principles of good governance in its day to day operations by incorporating participation and decision-making by consensus. A broad level of stakeholder participation is ensured by the presence of representatives from many sectors; and a consensus among them has to be reached before a decision is made. The UC scheme cannot be entirely freed from

politics and political agendas as politicians played an important role in its establishment and political representatives are represented in the NHSO commission. However political capture has been prevented by ensuring a balance of power among the commission members as they come from many sectors of society, including civil society, and who arguably represent the interests of the general public. Consensus has to be reached before a decision is made on important matters. For important issues if even one commission member disagrees with the decision then a consensus is considered to be absent.

Given the extremely fraught political disagreements in Thailand over the last 15 years between different versions of Thaksin's Party and its opponents (the party was legally barred on more than one occasion and then reappeared under new names and ostensibly different leadership), a free and open public discussion about the design and future direction of the UC policy has not been possible. The institutional arrangements of the NHSO commission described above have therefore been very important for maintaining a level of professional and technical independence in the management of the scheme, even if its broad vision could not be openly discussed.

A challenge for the future is to extend the discussion to these policy levels so that the design of the level and types of services that will be ensured through the UC scheme, and eventually through an integrated public healthcare system, can be transparently identified in the context of the available resource constraints and feasible increases in funding through increases in taxation and other levies. This policy-level discussion could involve the same types of stakeholders as appear on the commission, appropriately expanded, but without being limited to operational and allocative matters. The UC scheme is now sufficiently embedded in the political consciousness of the country as an established right and such a discussion should no longer appear to be threatening to the political project of establishing and maintaining such a scheme.

The NHSO commission has already demonstrated significant success in achieving efficiency in the financial allocation of central funds across different service providers in accordance with performance in terms of outputs and outcomes achieved through the operation of the UC scheme. These objectives are determined annually and quarterly,

the monitoring is fairly effective and the allocative functions are carried out in a professional manner without excessive political intervention.

8.6.3 Fact-based management

Strategic management of a complex sector like the healthcare sector requires an adequate knowledge base that is appropriate for the formulation of plans and policies. The classification of potential patients according to their ages and disease profiles is already being accurately carried out as a result of the availability of accurate and appropriate data. Customer satisfaction, an important factor in the formulation of operation and allocation plans, has also been frequently measured. However, much can be improved in the information systems servicing the healthcare sector, and coordinating information across hospitals, particularly the public hospitals servicing the bulk of the UCS patients. Successful preventive primary care healthcare interventions require information at the local level of the type that Baanpaew Hospital used, to engage primary service units to deliver primary healthcare. This type of information can be collected and made available to all hospitals in a centralised way so that hospitals in a locality can collectively engage with primary healthcare providers and other service providers to ensure a holistic approach to healthcare that would also be cost-saving at a collective level.

8.6.4 Risk management

Proper risk management within primary units and other service providers is crucial to ensure the sustainability of the UC scheme. The survival of primary units guarantees the wide coverage of the scheme, and ensures that access to the scheme is broad-based. To ensure that primary units survive financially, funds were set up to compensate for the costs of referral borne by primary units, when such costs exceeded set limits. This measure reduced the risk of financial losses of primary units but did not do away with the problem entirely. Inpatient referral to hospitals is funded by a fund transfer to primary units that helps reduce the risk of financial losses to these primary units, as the latter have to compensate the hospitals to which they send their patients. These funding calculations have not yet become accurate enough and this is another area in which technical and financial knowledge has to be coordinated to achieve a viable outcome

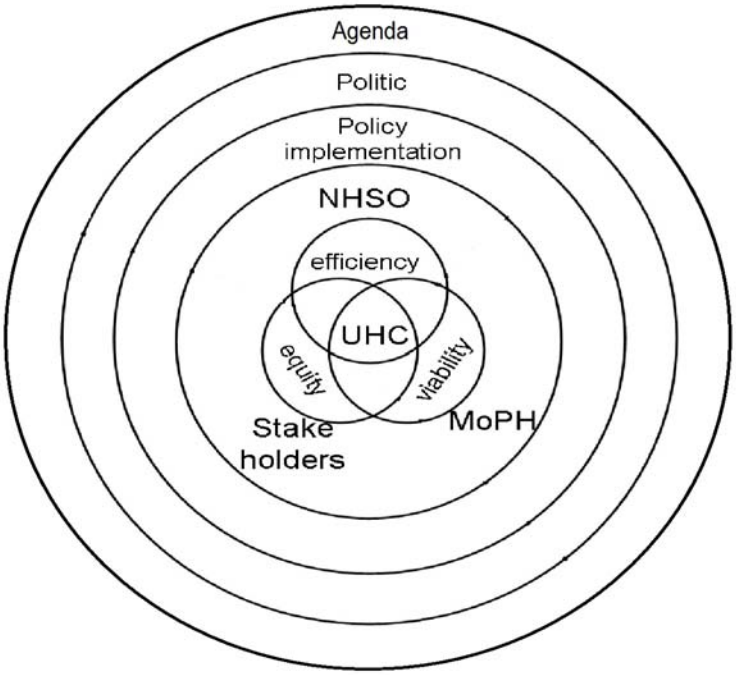
that is appropriate for achieving the equity and effectiveness goals of the healthcare system.

8.6.5 Co-operation and coordination

Co-operation has been established between service providers affiliated to the MoPH, including private service providers, local governments, and civil society groups involved in determining the objectives of services and financial allocations. Such co-ordination is closely watched by regional inspectors from the MoPH.

This study highlights the importance of fact-based risk management, aspects of good governance and cooperation and coordination, as shown below:

Figure 8-1 - The sustainability of UC scheme



8.6.6 Contribution of the policy to Thailand's healthcare system

The introduction of the UC scheme produced a positive welfare effect and its presence has significantly reduced poverty within the poorer socio-economic classes in Thailand. Whilst the thinking and inspiration behind this scheme did not wholly originate in the Thai Rak Thai Party, its coming to power accelerated the enactment of the National

Health Security Act which legislated the implementation of the UC scheme. The scheme was essentially one of free-at-the-point-of-delivery healthcare, but the addition of the nominal 30 baht fee to the UC scheme was publicised in a manner which gave the illusion of the scheme having being initiated by the Thai Rak Thai Party, who had magically reduced the cost of healthcare to an incredible extent. Politicians saw the implementation of the scheme as part of their election strategy and a strategy of building constituency support in a way that replaced the old strategy of personalised patronage through local networks. Their desire to win votes through this new patronage strategy meant that they suddenly pushed through the ongoing policy discussions within the Thai healthcare system to establish a universal public healthcare system, supported by rural doctors, civic groups, NGOs, and academics who longed for universal healthcare coverage.

Whatever the history, the UC is now an established part of the rights of Thai citizens and the policy discussion and academic research is essentially focused on improving its financial viability, designing its priorities so that the most important social goals of healthcare are prioritised within the funds available and to set up systems that can ensure professional and participatory decision-making despite the intensely politicised and conflictual nature of contemporary Thai politics. This research will be successful if it can contribute to this important debate. I end by reiterating that I have not attempted a comprehensive assessment of the Thai healthcare system nor provided a comprehensive set of reform proposals. However, by identifying important characteristics of the Thai healthcare sector based on an assessment of the full range of secondary data and statistics, and building on primary research on the experiences of two hospitals in the private and public sectors, the study has contributed to the first step of an important and complex debate.

8.6.7 Contribution to policy making

The effectiveness of the implementation of the UC scheme can be improved to the point that the schemes became institutionalised as the sole healthcare security scheme in Thailand. The existence of a single healthcare security scheme will help eliminate the complexity of healthcare insurance systems that pose an obstacle to the public's access to healthcare services.

The research provides guidelines for policy makers, whether they be politicians or technocrats, for developing a set of policies which may contribute to achieving maximum efficiency of the Universal Healthcare Coverage Scheme in Thailand. Maximum efficiency is impossible without proper co-ordination between the purchaser (NHSO) and providers (service units) which can be achieved if proper measures are undertaken by policy-makers.

The research points out the importance of efficient budgetary allocations in the context of a developing country like Thailand.

It can be inferred from the research the importance of the extension of the scope of taxation to include informal sector, land, property, and inheritance tax to ensure a sufficient supply of finance for welfare programmes like the Universal Healthcare Coverage Scheme.

8.7 Integration of three funds

An important challenge for Thailand is the integration of the three main public healthcare funds – CSMBS, SSS, and UC. This is essential to reduce inequality in access to medical services, be it medical treatment, medical rehabilitation, or healthcare promotion and disease prevention. However, integrating the three funds is a big issue and hard to carry out, due to the huge implications for financing and the possible resistance from those fearing their interests will be threatened. The latter could include participants in CSMBS, doctors in some hospitals and drug companies.

To reduce the impact of the resisting groups, it is necessary to make it clear that the integration of three funds will not result in the cancellation of the rights previously granted to some, and that the integration of the three funds will not result in a reduction of hospitals' revenues.

The integration of three funds could be achieved in the first instance by ensuring

1. The management of the integrated fund by a committee comprising of the representatives of the various groups participating in the funds separately.
2. Standardised disbursement procedures that are efficiently implemented by hospitals.

3. Achieving a universal standard of medical treatment, especially for complex and costly treatments, such as cancer treatment.
4. A universal standard of drugs and drug prices.

If these can be ensured, the integration of the three funds is likely to improve resource use and enhance the protection of the healthcare system against arbitrary political interventions.

8.8 Suggestions for further research

A number of important areas of further research are implicitly identified in this study. First, it would be useful to organise a study on the feasibility of applying the Baanpaew model in other areas or regions. This would involve looking at the full range of types of hospitals and identifying the number of hospitals with characteristics that could be adapted to this successful model. A second area for research would be to examine the effects of particular changes in government policy on the UC scheme. For instance, how might changes in the funding models affect the delivery and sustainability of the UC model? Third, we need to understand better the design of policy that might promote the participation of private hospitals in the UC scheme. Here a survey of the different types of hospitals in the private sector would be very useful to identify the significance of different types, and to identify the types of hospitals in terms of specialisation and commercial approach that are most likely to adapt to becoming service providers under the UC. A fourth area of research would be to study the political factors that may be preventing or supporting the integration of the three healthcare schemes (CSMBS, SSS and UC).

Appendix 1 – An outline for the interview of the management of the hospitals opting out of the Universal Healthcare Coverage Scheme

Name.....Position……

Date.....Hour.....Recording

Equipment.....

Hospital.....

Size (no. of beds) .....

Level (Primary/Secondary/Tertiary) .....

Location.....

Type of hospital in the U.C. scheme (regular service provider/referral unit)

.....

The time your hospital joined the UC scheme.....

The time your hospital opted out of the U.C. scheme.....

1. The reasons for your hospital's participation in the U.C. scheme
   1.....
   2……
   3……
2. What were the amounts of the U.C. funds allocated to your hospital, please specify the amounts of the funds your hospital received annually since participation until opting out……
   ……
3. What was the process of acquiring funds
   …….
4. How was the fund allocation to your hospital segmented into OP, IP, PP, Replacement of values, Thai traditional medicine and others …….....
   The largest proportion of funds went to……..…
   The smallest proportion of funds went to ……..

5. Were the U.C funds sufficiently allocated to your hospital?
   ……
6. What were the problems relating to obtaining funds……
7. What was the proportion of your hospital expenses on the U.C. scheme……
8. Please rank in order the U.C. costs you consider burdensome……
9. What was the quality of service provided under the U.C. scheme provided by your hospital? How was it different from the quality of service provided under other schemes by your hospitals……....
10. What were the UC related costs you had to bear and not covered by the fund allocation by the NHSO?……
11. In case of the inadequate fund allocation by the NHSO, how did you resolve the problem of the shortage of funds? Please give examples of problems and their solution

Problems	Solution
1	
2	
3	
4	

12. What were the problems leading to opting out of the U.C. scheme, such as difficulty in quality control, losses, and problems with management and data base and other? Please rank them in order of their importance
    1.……..
    2……
    3……
    4……
13. What was the disease which incurring the most burdensome U.C. related cost……..
14. Did you negotiate with the NHSO……and How? ……
15. What are the factors that will make you join the U.C. scheme again?
    …….
16. Were their complaints about the quality of medical treatment provided by your hospital, and how did you deal with the complaints or the problems that gave rise to such complaints……
17. In your opinion, what are the long-term problems of the UC scheme.……..
18. Do you think the UC scheme is sustainable and why? ……
19. In your opinion, what are the factors contributing to the survival of the hospitals joining the UC scheme ……

Appendix 2 – Interview outline

An outline for the interview of the management of the hospitals joining the UC scheme

Interviews were conducted on the subject of:

1. The management.
    a. The management by the executive board.
    b. The effect of public participation in the management board on the efficiency and effectiveness of the management in terms of:
        i. Cost reduction.
        ii. Reduction of workload and efficient use of available personnel.
        iii. Streamlined work procedure.
2. The samples of projects carried out with efficiency and thus resulting in profitability.
3. The management of the funds received from NHSO
4. The revenues of hospitals those were higher than UC capitation and their trend, as well as the approach to financial management contributing to sound financial condition of hospitals.

Appendix 3 – Interview schedule

	Interviewees	Subject	Date
1	Politician- head of the political party	Formulation of UC scheme Opinion on budget allocation of UC scheme	15 January 2014
2	Politician – member of parliament	The sustainability of the UC scheme The conflict of interest	20 January 2014
3	B-Care- executive board	The effect of public participation in the management board on the efficiency and effectiveness of the management in terms of cost reduction, reduction of workload and efficient use of available personnel. Streamlined work procedure. The management of the funds received from NHSO The revenues of hospitals those were higher than UC capitation and their trend, as well as the approach to financial management contributing to sound financial condition of hospitals	10 November 2013
4	B-care-managing director		10 December 2013
5	Banpeaw – Director	The effect of public participation in the management board on the efficiency and effectiveness of the management in terms of cost reduction, reduction of workload and efficient use of available personnel. Streamlined work procedure. The management of the funds received from NHSO	25 January 2014
6	Banpeaw – Deputy director		10 February 2014
7	Baanpaew – medical doctor1	opinion on UC scheme work load conflict of interest satisfaction on UC scheme	12 February 2014
8	Baanpaew – medical doctor2		12 February 2014
9	Baanpaew –nurse		1 March 2014
10	NGO 1	conflict of interest impact on UC scheme,	2 November 2013
11	NGO 2		10 November 2013
12	NGO 3		10 November 2013
13	SCHOLARs	conflict of interest impact on UC scheme,	15 October 2014

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