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**The Introduction of the Universal Coverage
of Health Care Policy in Thailand: Policy Responses**

By

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Thesis submitted to the University of London

for the Degree of Doctor of Philosophy

Health Policy Unit

London School of Hygiene and Tropical Medicine



2004

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Abstract

In 2001, Thailand introduced the Universal Coverage of Health Care Policy (UC) very rapidly after the new government came to power. The policy aims to entitle all citizens to health care and includes health system reforms to achieve equity, efficiency, and accountability. The overall question this thesis asks is how did this policy come about, and how likely is it that the policy will achieve its goals?

Literature suggests that understanding the policy process is as important as assessing the content of particular policies when judging policy outcomes. By using an analytical framework to explore four elements: context, actors, process, and content, this thesis aims to generate general understanding of the UC policy process, and to use this analysis to assess implementation. It starts by addressing how and why universal coverage, which had long been discussed in Thailand, got on to the policy agenda in 2001, and then explores how the policy was formulated nationally. It goes on to look at implementation in one province, examining the inter-relationships between provincial, district and community facilities. Data were gathered from key informant interviews, document and media analysis, and group discussion with villagers.

The analysis suggests that Thailand's democratization, created new actors in health policymaking processes which had long been under control of bureaucrats and professionals. The 1997 Constitution encouraged a more pluralistic political system. Universal access to health was advocated by a group of non-government organizations who pushed to get UC through legislation and announced their campaign a few months before the 2001 election. NGO interest was paralleled by a political party campaign, announced in 2000 by the Thai-Rak Thai Party, and implemented as UC when the Party came to power. UC was picked up because it was seen as legitimate, feasible under the existing infrastructure and government budget, and also congruent with the reform intention of the political party. Once it became the government in 2001, an important factor in early policy formulation was the extent to which national research provided evidence to support the policy. The research community was tightly-knit and concentrated in medical-related professions. One member of this policy community played an important role as a policy entrepreneur. This policy community continued to support evidence for debates in policy-making during both policy formulation and implementation. The implementation process was a top-down process; however, there were some spaces for street level bureaucrats to adapt decisions to fit their context. Implementation started through the extension of insurance coverage in four phases under the execution of the Ministry of Public Health. Private providers were only minimally involved in these formulation and implementation phases. The UC policy in 2001-2 was characterised by clear policy goals, limited participation, strong institutional capacity, and very rapid implementation – all factors which anticipated success of the policy. However, the complex technical features of the policy and the big change in system reform were a brake on success. One of the implementation problems was the mobilization of human resources, especially where bureaucrats were resistant to change. It seems that the implementation of the UC policy in Thailand reflected both managerial as well as political problems. Given the findings of this study, policy monitoring should pay attention to political as well as technical assessments.

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Lists of Abbreviations

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

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Chapter 1 - Thailand's radical Universal Coverage policy

1.1 Introduction

The drive to public sector reform from the 1980s pushed health reform policies on to international and national agendas. While reforms in the areas of financing and health service delivery systems focused largely on cost containment, pro-market terms and reducing the role of the state, some countries sought ways to exercise the state's role to ensure their citizens' rights to health care. Thailand is among those who have pursued and achieved universal coverage (UC) in this reform era.

In 2001, Thailand introduced the UC policy very rapidly after the new Thai Rak Thai Party (TRTP) government came to power. The policy aims to entitle all citizens to health care access and includes health system reform to achieve equity, efficiency, quality, and accountability. The government established a subsidized health scheme known as the '30 Baht Scheme' to pool and expand two existing schemes. Its features included predominantly tax-based financing with a minimal co-payment of 30 Baht per medical visit and a comprehensive benefit package covering both prevention and curative care. The scheme covered about 80% of the population, excluding only those in the formal sector who were covered by the Social Security Scheme and the Civil Servant Medical Benefit Scheme. At the same time, the government reformed its health-financing system. The UC policy shifted resources to primary care through a contracting process and incorporated private provider collaboration. The overall question this thesis asks is how did this policy come about, and how likely is it that the policy will achieve its goals?

The literature suggests that understanding the policy process is as important as assessing the content of particular policies when judging policy outcomes (Grindle and Thomas 1991; Walt and Gilson 1994). Policy process studies suggest that political factors are as important as technical factors and can make a policy fail if neglected by policy-makers (Walt 1994). Analyzing political dimensions, policy research scholars have looked at the experience of health care reform in many Western industrialized countries (Flood 2000), yet there are few studies in developing countries. There is little knowledge of what factors are important in the policy process in developing countries and how these factors influence the decision-making and the system change in such countries. Therefore, this thesis tries to provide some answers to these questions by looking at the policy process of Thailand's UC policy.

By using a policy analytical framework, the aims of this thesis are threefold. The first is to generate general understanding of the UC policy process; to answer how and why the UC issue got on to the policy agenda, and how the policy was formulated and implemented. The second

is to explore how the process influenced the design of the policy and how far the design affected implementation. Finally, it aims to assess implementation and the extent to which the policy is likely to achieve its goal.

The thesis is divided into eight chapters. This chapter introduces the rationale for universal coverage, and includes a review of the literature relating to both health care reforms and the Thai context. Research questions are proposed at the end of this chapter.

The next chapter provides the analytical framework of policy analysis and the research methods used. The results are presented in the next five chapters as narrative policy analysis. Chapter 3 describes the agenda setting process; Chapter 4 explains the policy formulation process. Chapters 5 and 6 describe the implementation process at central level and provincial level respectively. Chapter 7 presents the operational level responses including perspectives from villagers. Synthesizing from all results, Chapter 8 discusses the findings and provides the conclusion and recommendations

1.2 Rationale for universal coverage

Under different health systems in different countries, varying shares of the population are provided with adequate access to health services and protection from financial consequences of illness. In particular, some countries ensure universal access to health care while others do not (Abel-Smith 1994). The accepted notion of universal coverage is that it is able to enhance the equity of the health service system (Mills 1998; Veugelers and Yip 2003). However, whether countries introduce UC is dependent on national values, the political influence of different actors, and economies (Abel-Smith 1994; Green 1999; Navarro 1989). The differences in system designs to achieve universal coverage are also important to the extent of guaranteeing equitable and sustainable health care systems.

1.2.1 Why universal coverage is important

The term ‘Universal coverage (UC)’ can be defined as ‘a situation where the whole population of a country has access to good quality services (core health services) according to needs and preference, regardless of income level, social status or residency’ (Nitayarumphong 1998). Where UC is introduced in the health system, it can protect citizens from the financial consequences of health care and ensure all citizens access to health care (Mills 1998). Underlying the concept of UC is the ethical principle that access to health care is a right of citizens that should not depend on individual income or wealth (Green 1999; Mills and Ranson 2001). A definition of equitable health care is the extent of equal access to the available care for equal need (Mooney 1983; Wagstaff 1993a). This could be provided basically by law; however, other considerations should be taken in practice to promote greater equity. These include the

extent to which resources are allocated in relation to social and health needs, the geographic distribution of services, the quality of care (Whitehead 1992), and the efficiency of health services (Kutzin 1998). Universal access to health care can be seen as a primary criterion of the quality of the health service system (Mera 2002).

Where UC has been disregarded, access to health care was seen as similar to access to other goods and services, and dependent on an individual's success in gaining or inheriting income (Green 1999; Mills and Ranson 2001). As a result, the state's role was confined to the regulation of the health care market and the provision of public health measures. Thus, means-tested programs, for example, were provided to protect the poor who were unable to afford health care. However, many argue that market failure in health favours a state role in collective financing arrangements (Mills and Ranson 2001). For example, those who are not protected by the public welfare scheme and have ill health might not be able to afford risk-adjusted private insurance premiums. This is evident by the large number of Americans who are uninsured, being either unwilling to pay or unable to pay for private insurance (Hsiao 1992). There are also doubts about the effectiveness of the means-test procedure. In Thailand, the means-tested medical welfare scheme before UC was not effective in covering the targeted persons (who were poor) in the scheme (Na Ranong and Na Ranong 2002b). A survey in 2000 found that only 16% of the poor had Medical Welfare Scheme cards and only 28% of cardholders (of which the cards were for the poor) were actually poor (Bureau of Health Policy and Planning 2000).

The development of collective financing in many countries started from voluntary and compulsory insurance and included the self-employed in the later stages. In many cases, the state's collective financing systems were established to respond to public demand, and the state's actions were facilitated by the political and economic changes and the strength of the working class (Navarro 1989). For example, in Germany where compulsory insurance was first introduced in 1883, the aim was, on one hand, to benefit the working class, and on the other, to contain socialist and revolutionary pressure by creating new loyalty among workers to their employer and to the State. In Britain, the compulsory health insurance policy of 1911 aimed to win popularity with the working class (Abel-Smith 1994). In South Korea, the social health insurance policy aimed to seek legitimacy of the military government during the political transition to democracy (Moon 1998). In Taiwan (1995), the government implemented universal coverage by law under the increasing challenge of the opposition democratic party who had long advocated the establishment of universal national health insurance. This policy also reflected rising public demand for better health care during economic growth (Cheng 2003). It is clear from the above examples that universal coverage is seen by many as a legitimate state responsibility and is likely to be supported by the public.

1.2.2 Issues on system designs

There are at least two prototypes of the financing system for medical care that countries have developed as mechanisms to achieve universal coverage. The first is the social insurance arrangement (the Bismarck model), and the second is the tax based system (the Beveridge model) (Mills and Ranson 2001). The terms ‘universal coverage of health care’ (Nitayarumphong 1998) and ‘universal health insurance coverage’ (Meyer, Silow-Carroll, and Sardegna 1991; Saltman 1992) are sometimes used interchangeably. Which a country uses is a political choice (Abel-Smith 1994).

From 1920 onwards, many countries developed their system to extend their citizens’ rights to health care to the point of universal coverage. These countries include, for example, Hungary (1920), New Zealand (1938), Soviet Union (1938), Britain (1948), Japan (1960s), Scandinavian countries (1960s), Canada (1970s), Italy (1980s), Portugal (1980s), Brazil (1980s), and Spain (1980s) (Abel-Smith 1994; Preker 1998). South Korea followed in 1989 (Moon 1998), Taiwan in 1995 (Cheng 2003), and recently Thailand in 2001 (Tangcharoensathien et al. 2002b), and the Philippines plan UC for 2010 (Tan 1998).

Some of the countries above developed collective financing systems incrementally extending coverage with various kinds of funds to cover the self-employed. Four main ways have been used. The first was to lower the cost of insurance to affordable levels for everyone, and provide highly subsidized public hospitals, such as in the Scandinavian countries. The second was to make other funds to subsidise those excluded from the compulsory insurance (low income self-employed), such as in the Germany (Abel-Smith 1994). The third was to pass legislation to establish a single compulsory health insurance scheme to include the self-employed and the poor with differential subsidisation from the government, as in Taiwan (Cheng 2003). The fourth alternative was to pass legislation to entitle the whole population to benefits, and turn the system to one of government-financed services for all, such as in the UK.

Looking at financing system design, Kutzin (1998) suggests that the overall objective should be ‘achieving universal coverage with effective health care risk protection at the least cost’ (Kutzin, 1998:29). This relates to three main elements: (1) institutional arrangement (sources of funds, allocation of funds and associated institutional arrangements for health care); (2) broad health system support functions; and (3) the benefit package (Kutzin 1998). As the policy design affects the equity and the sustainability of the financing system, the section below discusses the debatable issues of policy design for the developing countries to achieve universal coverage.

In many developing countries, health care has already been predominately publicly financed and provided (Zwi and Mills 1995). Therefore, the challenge for policy-makers in developing countries is not just to ensure access to a good quality of health services, but also to redesign

and reform their health financing and service delivery systems to guarantee sustainability. The highly debated issues in system designs for developing countries include the pace of reform, source of finance, regulation of the whole system (promoting proactive purchasers), number of organisations involved, and provider payment system (Nitayarumphong 1998).

1.2.2.1 Pace of reform: big bang versus incremental change

It is possible to achieve universal coverage by a fast-track approach, but it needs major reforms and legislative changes, strong political will and government efforts. However, the ‘big bang’ approach might have negative consequences. An example is Taiwan. In Taiwan, the National Health Insurance merged all ten existing schemes in 1995. Though the National Health Insurance followed a half-decade of planning, it was implemented rapidly, just two months after the establishment of the Bureau of National Health Insurance. This hasty inauguration led to chaos and confusion (Cheng 2003).

To avoid inadequate planning of the implementation, incremental changes have been suggested for low and middle-income countries (Carrin, De Grave, and Deville, 1999 quoted in Barnighausen and Sauerborn, 2002). A good historical example is the incremental development of the social health insurance in Germany. This involved three transition phases: from informal to more formal, from voluntary to compulsory, and from small to larger schemes. Whether this incremental development can be adapted to low and middle income countries may be highly contingent on the context (Barnighausen and Sauerborn 2002).

1.2.2.2 Source of finance: insurance premium collection or general tax revenue

There are many ways of funding health care. Two main methods are insurance premium collection and tax-revenue subsidization. The social health insurance (SHI) arrangement is a risk-sharing system in which money is collected from individuals as a percentage of income and as such is seen as equitable and to provide greater consistency of funding. However, it can be regressive depending on the level of the contribution ceiling and the exemption for the low-income groups; i.e. the lower the ceiling of contribution and the amount of exemption, the more regressive the system (Mills and Ranson 2001). Financing by tax revenues is dependent on the government’s revenues and political priority. The degree to which a tax-based system is equitable depends on the progressivity of the tax system and the allocation of health care resources (Green 1999).

The income-based premium collection (in SHI) relies on the formal employment economy; thus, it has limited potential for countries where a large percentage of the population is outside the formal employment sector. Thus, several sources of finance may be used to finance insurance schemes for different population groups. However, this can create duplication of the household

contribution and might be perceived as unfair. This issue has been discussed in the case of South Africa (McIntyre, Doherty, and Gilson 2003).

1.2.2.3 Regulation: purchaser/provider split

In many developing countries, governments have a major role in service provision and have a separate function in purchasing roles. The emphasis on the purchasing role has arisen due to the increasing power of managers to balance the power of providers in order to force providers to operate in the interest of public and technical efficiency (Mills and Ranson 2001). However, the fact that organizations and individuals have to fulfil both purchasing roles and provider roles can be a cause of conflict. Thus, it can be suggested to those countries that institutional reform should be introduced to split purchasers from providers (Cassels 1995). However, whether this can happen is subject to the relative power between the old authority (providers) and the increasingly powerful managers (including politicians).

1.2.2.4 Single fund or multiple funds

Another debate is on whether there should be a single purchaser or multiple purchasers. For private insurance, it is justified to promote competition among each other for clients. However, it is questionable for tax and social insurance funded health systems whether competition leads to positive consequences. If the insured can choose between competing purchasers, the ‘cream-skimming effect’ – the phenomenon where purchasers avoid enrolling high risk people – might occur (Mills and Ranson 2001). If each insured is compulsorily registered to a scheme, the duplicating administration of the multiple schemes might be considered inefficient and might produce inequity in service provision, as has happened in Korea (Nitayarumphong 1998).

In many countries, multiple schemes existed before universal coverage and there may be resistance to merging all schemes to one single scheme. To turn multiple schemes into a single scheme system requires much effort from government and wider political support.

1.2.2.5 Provider payment: closed end payment versus fee-for-service

There are several ways to pay providers (Mills and Ranson 2001). For primary care, individual providers can be paid by salary, fee-for-service, or capitation. Payment by salary is seen to be inefficient as the amount of money is unrelated to workloads. Fee-for-service payment encourages providers to provide more services and expensive investigations, and thus increases the cost of the scheme (Kwon 2003; Rachel Lu and Hsiao 2003). It can be adjusted by a fixed overall budget to lower the fee per item when the volume of services increases as in Germany (Barnighausen and Sauerborn 2002). Capitation payment involves a fixed payment per year per

person. This payment method has cost-containment ability. It supports continuity of care and can encourage doctors to minimize the volume of services.

For hospital care, the payment methods are a fixed annual budget, itemized bill, daily rate, average cost per patient, case adjusted for diagnosis, and contracts by type or volume of services. (For the comparison of these payment methods and their incentives to providers see Mills and Ranson, 2001:545). Each method has advantages and disadvantages, and often a mix of methods is found in practice (Mills and Ranson 2001).

In summary, achieving universal access involves several elements in system design. Which choice countries choose depends on the context in which it introduced. The next section explores the context of international health care reform, which partly influences decision-making in developing countries.

1.3 International health care reform

Health care reform was introduced in an uncertain policy environment, with considerable conflict in values about health care. It was part of a trend of public sector reform, and was dominated by donors and financial institutions such as the World Bank during the 1980s economic crisis and indebted status of developing countries. Many reforms attempted to increase the efficiency of the public sector, limit the role of state, and increase competition by increasing private role in health care provisions (Walt 1998).

Where health care access did not achieve universal coverage, it is questionable whether governments reduced the state's roles following the worldwide reform trend or converted the reform direction to one of expanding the state's role in financing and service provision. This section discusses this point by reviewing the driving forces behind the rise of health care reform, and the reform issues in developing countries.

1.3.1 The rise of health care reform

The evolution of state involvement in the provision of health services has varied between countries based on each country's history (Abel-Smith 1994). Collective financing for health care services was developed gradually, initially to alleviate the crisis of medical funding and later to share risks from the expense of medical expenditure. The extent to which the state has played roles in service provision and collective financing varies between countries, being less in the countries in which health care has been dominated by the free market, for example the United States (Abel-Smith 1994; Mills and Ranson 2001).

The development of the welfare state, especially in the liberal democracies of Western Europe, increased the role of state in health care provision and in ensuring universal access. This growth was directly related to the strength of the working class and economic instruments (Navarro

1989). However, from the 1980s, there were more debates about the roles of state (Mackintosh 1992). Neo-liberal critiques¹ led to a huge shift in the whole social sector questioning, raising doubts about welfare states, and in the health sector, cost escalation and monopoly providers who limited opportunities for the market to exercise customers' choice. The concerns over public spending and questions of the legitimacy and role of government created a trend to improve public sector performance, notably in the term 'new public management'², which brought reforms in the general public sector and to the health sectors.

Various forces around the world caused many countries to search for answers to the question: how should a nation structure its health care system (Flood 2000; Frenk 1994; Hsiao 1992; Saltman and Figueras 1997; Segall 2000; Walt and Gilson 1994). "Health care reform came at a time of considerable financial constraints – world economic recession, indebtedness among many low-income countries, and rapidly became part of a wider program of economic and structural reforms sought by the World Bank and other donors in many low- and middle-income countries" (Walt 2001:684). Inside the health sector, concerns were expressed over the high spending on health care services, the inefficiency of the service delivery system, and the reducing of health care access and quality. For example, the United States and the Netherlands rapidly escalating health expenditures and the lack of universal coverage forced the desire for reform (Zwi and Mills 1995), and South Korea faced rapidly increasing health expenditure from a rapid expansion of the health insurance coverage during 1980-1989 (Lee 2003).

Ideas about reform policies were disseminated worldwide. Policy conditions focused on ways of reducing the role of the state, by, for example, encouraging the private sector (including NGOs) to undertake services previously provided by governments, and mobilizing additional domestic resources. Aid policies were also linked to notions of "good governance", democracy, and the growth of civil society (Walt 2001).

1.3.2 Reform issues in developing countries

In developing countries, economic crisis and countries' health and health sector problems were the underlying roots of health care reform, but the reform approaches were partly imported from other countries. The progress in reform in industrialised countries (OECD 1992) called to some developing countries to reform their health systems along the reform trend of the developed

¹ Neoliberal critiques promote the ideas of economic liberalisation, privatisation, competition reform, labour market deregulation, reduced government spending, and lower taxation by arguing the problems of interest group capture of the welfare state, labour market regulation, and welfare dependency (Mendes 2003).

² New Public Management is a point of view about organisational design in the public sector that usually involves: management styles to improve employee performance; breaking up the command and control of public sector into decentralised corporatised units; and separating public funding from delivery of services (Ferlie, Ashburner, and Pettigrew 1996; Segall 2000). Also see Hood C. 1991. A public management for all seasons? *Public Administration*, 69, 3-19.

world, particularly to encourage competition. The World Bank and bilateral donors had dominant roles in exporting the health care reform theories recommended in the 1993 World Development Report. The components of reform proposals in developing countries were; (1) reorganizing national ministries of health and improving the performance of civil service, (2) organisational heterogeneity and decentralisation, (3) improving the functioning of national ministries of health, (4) broadening health financing options, (5) introducing managed competition³ and (6) working with private sector (Cassels 1995; Collins and Green 1999; Zwi and Mills 1995).

1.3.2.1 Reorganizing and improving the performance of national ministries of health

This issue involves organizational restructuring, improving human/financial resource management, reducing staff numbers, and strengthening the functions of ministries of health.

Restructuring plans have been made in a number of developing countries but many met delays in implementation or are unimplemented. For example, Uganda carried out a comprehensive restructuring of the Ministry of Health in 1995. It changed the function from the ministry for health services to the ministry for health policy development. The size of the civil service was supposed to decrease but it increased, as a result of strong bureaucratic pressure and resistance to decentralization. However, the reform was in progress again after 1997 due to strong political pressure from the President with support from donors (Jeppsson, Osterngren, and Hagstrom 2003). Colombia was also interested in transforming its ministries of health but there was strong resistance. As of 1998, there was no actual implementation (Bossert et al. 1998).

In Zambia, the political change in 1991 opened an opportunity to reconstruct the Ministry of Health (Gilson et al. 2003). The reform decided to transform health staff to become employees of Federation of Health Boards (1996) and to decentralise service provision management to District Health Boards and Hospital Management Boards (Cassels 1995). However, the reform was undertaken from 1993 to 1998 without achieving its goals because of opposition mainly from big hospitals and the political uncertainty, including a coup attempt in 1997 (Blas and Limbabbala 2001).

In Cambodia, reconstruction consisted of gradual infrastructure development and capacity-building especially to monitor and evaluate the implementation of new health systems, operationalising district health systems, and extending and monitoring health care financing schemes (Phua and Chew 2002). The post-conflict environment might partly force the country

³ Managed competition is a term of health care management, which is a blending of the competitive and regulatory strategies. It involves the ways a sponsor manages the market for competing health plans, establishes equitable rules, creates price-elastic demand, and avoids uncompensated risk selection (Enthoven 1993).

to reconstruct its health system. In Central Asia including Kazakstan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan, reforms focused on primary health care as the mechanism aiming to strengthen primary care, hospitals, and the financing system (Rose 1999).

1.3.2.2 Organizational and management changes and decentralisation

Reforms included such policies as the separation of funding and service provision functions, privatisation, and decentralising responsibility for the management and/or provision of health care to local government or to agencies within the health sector (Zwi and Mills 1995). This includes establishing self-governing hospitals or autonomous district boards.

Decentralization was used as a strategy to strengthen health care at district level to improve access in health care in, for example, Kenya (Oyaya and Rifkin 2003) and Malaysia (Merican and Yon 2002).

However, decentralization had also had negative effects. For example, the Philippines radically changed its health system with the devolution of health services to local government, but this had a detrimental effect on health system performance, with only primary care structures at community levels remaining strong. The country has passed a law to establish a national health insurance system and the Health Insurance Corporation, but could not develop many of its operating structures to support the implementation of the universal coverage policy mandated since 1995. In contrast, Vietnam's experience, with its policy centralised under a state-run social insurance system and only operational functions decentralised, has been seen as positive (Phua and Chew 2002).

1.3.2.3 Broadening health financing options

This issue includes the introduction of user fees, community finance, voucher systems, social insurance schemes, and private insurance.

Reform attempts have focused on the generation of private sources for healthcare finance to supplement tax-based finance and improve the quality of care. Most African governments accepted cost recovery income for health care and had introduced user fees for health services or medicines from the 1980s (Leighton and Wouters 1995). User fee implementation was strongly debated, especially around its impact on equity and the access of the poorest. Adverse impacts were seen in Kenya and Zimbabwe (Zwi and Mills 1995). In 1996 South Africa removed user fees for pregnant women, nursing mothers and children under six (Gilson et al. 2003). However, an experiment with user fees in the contract management reform in Cambodia gave a positive impact (Soeters and Griffith 2003).

Compulsory health insurance exists in many countries of Latin America, and has been introduced across Asia and Eastern Europe in recent years, for example in the Philippines, Thailand, Vietnam, Laos (Phua and Chew 2002), and Bulgaria (Pavlova, Groot, and Merode 2000). However, it has been resisted in some countries. In South Africa, concerns about whether it will achieve equity and financial sustainability objectives have delayed progress (Gilson et al. 2003; McIntyre, Doherty, and Gilson 2003). Similar reluctance can also be seen in many Caribbean countries; despite which, the national health insurance law has been passed (Huff-Rousselle, Lalta, and Fiedler 1998).

1.3.2.4 Introducing managed competition and working with the private sector

This issue involves promoting competition between providers of clinical care and/or support services through single or multiple purchasers. It also includes establishing systems for regulating, contracting with or franchising providers in the private sector including NGOs and for-profit organizations. Examples are in Chile, India, and Malaysia.

Chilean health reform has occurred since the 1920s. It introduced the National Health Fund in 1979, followed in 1981 by additional major reforms which decentralized the operational authority of the primary health facilities to municipal governments and created private insurance companies. With the transition of the government from military to Democratic government, reform policies shifted in the 1990s to strengthen the mixed public-private market of health services to meet the expectations of the public. This increased competition at primary level by allowing alternative providers from the private non-for-profit sector to provide services (Jara and Bossert 1995).

In India, reforms have highlighted the current and potential role of non-government health care providers; however, problems related to quality of care and the financial burden of unregulated fee-for-service medicine were common (Berman 1998).

In Malaysia, the government policy adopted privatisation but faced opposition. Thus, the privatisation exercise has covered only non-medical services and drug distribution. Plans for corporatisation of public hospitals are under development (Merican and Yon 2002; Phua and Chew 2002).

1.3.3 Summary

In summary, the reforms of health financing and decentralization were at the top of the policy agenda in many countries during the 1980s and 1990s. The nature of reforms varied, due to the diverse contexts of developing countries (Segall 2000). Though the reform initiatives existed, the implementation in practice was difficult due to much resistance. The countries where the basic management improvements were necessary still continued to strengthen their

infrastructure and the Ministry of Health's functioning. This principle improvement should not be ignored as it is essential for further development (Mills 1997). Some countries where health services have not reached universal coverage are still looking for ways to increase access in health services (Mera 2002). Ultimately, whatever donors had recommended, the reform measures and goals (whether equity or efficiency) had been balanced by the actors driving the reform process in the particular context (Zwi and Mills 1995). Much depends on whether the local actors are strong or weak. Using the experience of the decentralisation reforms in Caribbean countries, Mills et al (2002) concluded that the difference in the nature and the timing of such reforms depended on political and economic factors, the attitude of the public service unions and the medical profession, and external financial supporters (Mills et al. 2002).

1.4 Thai health system and context before the introduction of the UC Scheme

In Thailand, Universal Coverage has long been a concern among academics and researchers particularly in the Ministry of Public Health (MoPH). The vision to achieve universal coverage was announced in the Health Financing Conference in 1993 which was held by the MoPH and the World Bank (Nitayarumphong 1993). At that time, 50% of the population had insurance coverage, and the proportion of population with health insurance protection has gradually increased since then. There are many insurance schemes that have been developed independently at different times. However, until 2000, the system could not ensure universal access of health care to all. Whilst the new Constitution promulgated on 11 October 1997 mandated the issue of equity in health care as a right of Thai citizens, and UC was one of the goals in the 8th National Social and Economic Development Plan (1997) (Wibulpolprasert 2002), there was insufficient interest among policy-makers to implement UC.

1.4.1 Health care delivery and financing system

In Thailand, the MoPH has held both a service delivery role and financing management role. The MoPH invested in the infrastructure of health units to every district and sub-district, and hospitals and health centres were gradually built up in all areas of the country during 1981-1991. The 'Decade of Health Centre Development' policy (1986 to 1996) aimed to establish health centres in all sub-districts (Tambons) in rural areas. Consequently, by 2000 there were few geographic barriers to health care access.

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

but it was not implemented because of resistance from insurance companies and enterprises including state enterprises (Chantaravitul 1985). Though government managed the four schemes, administration was fragmented and the schemes could not cover the total population. In 2000, only 69% of the total population was insured: 37% by MWS for the poor, the elderly, children under 12 and the disabled; 11% by CSMBS for civil servants and families; 9% by SSS for private sector employees; and 12% by VHCS for the general population, especially in rural areas (Siamwalla 2001). Thirty-one percent of the population was excluded.

1.4.2 Problems of access to health care

Many Thais had experience of unaffordable health care. Siamwala et al (2001) reviewed these problems. They found the problems were serious in regard to both the number of people and severity of specific cases. A survey by ABAC-KSC International Poll (2000) found 43.8% of the sample population experienced high health care costs or unaffordable costs. Of that group 62.5% were in debt and 16.6% asked for exemption. Another study of catastrophic payment in public hospitals at Songkhla Province (Sujariyakul and Chongsuwiatwong 1999) found many factors relating to unaffordable health care costs. These factors were education, occupation and income levels of the households' heads or the breadwinners. Where level of education, occupation or income was low, the households were likely to be unable to pay health care costs when their members got ill. In some cases, people were denied treatment because of lack of insurance coverage, and in most cases, they reported disease complications and physical handicaps caused by delayed treatment (Siamwalla 2001).

In 1997, Pannarunothai and Mills reported health inequity in health financing in Thailand for the first time and they suggested that the poor are more likely to pay out-of-pocket fees than are the rich (Pannarunothai and Mills 1997). They reported an inequitable pattern of out-of-pocket health expenditure by income quintile and per capita. For underprivileged groups, the cost of health care formed a high proportion relative to their household income when compared to the privileged groups. This phenomenon is supported by other studies showing the regressivity of health financing systems to income⁴ by income quintile group (Makinen 2000), and Kakwani index⁵ (Pannarunothai 2000a). Pannarunothai et al (2000) found that out-of-pocket household payment is the most regressive system followed by indirect tax financing (Pannarunothai et al., 2000 quoted in Pannarunothai, 2000). Hence, the regressive financing system is a problem, and many conclude that a more desirable financing system is payment according to ability to pay (Wagstaff 1993b). Household health expenditure is a major source of health finance in

⁴ The regressive health care financing system refers to the extent to which payments for health care fall as a proportion of a person's income as his or her income rises (Van Doorslaer 1993).

⁵ Kakwani index is based on the extent to which a tax system departs from proportionality (Wagstaff 1993b).

Thailand. It was 44% of total health expenditure in 1994, but decreased to 41 and 33% of total health expenditure in 1996 and 1998 respectively (Pongpanich 2001). The reduction of household out-of-pocket payment with substitution by other progressive sources, thus, reflects the less regressive nature of the total health financing system (Pannarunothai 2000a).

Health care utilisation is affected by insurance coverage. Tangcharoensathien et al (2001) described utilisation and characteristics of the uninsured derived from several sources. Hospital admission rates of the uninsured were lower when compared to those who had insurance coverage, no matter what the scheme (see Table 1.1). The privately insured were the highest users of hospital inpatient care (1.5 times per year), three times higher than the uninsured (0.04 times per year), followed by those insured under other schemes.

Table 1.1 Annual hospital admission rate per capita by insurance coverage, 1996

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

Source: National Statistic Office 1996 cited in Tangcharoensathien et al 2001.

Under-utilisation is a problem among the uninsured and poor. One study found that the poor had inadequate access to antenatal care, and it was more common in urban areas than rural areas (Wongkongkathep 1999). The Provincial Health Survey (1996) provides characteristics of the uninsured by income, education and occupation. Twenty-eight percent of the poorest households (monthly household income less than 2,000 baht), who should have been covered by the Health Welfare Scheme, were actually uninsured. Uninsured rates were highest amongst taxi drivers and merchants.

Pannarunothai and Renburge (1998), analysing Thai data from the 1986 Health and Welfare Survey, measured equality in access to health care by concentration index⁶ from the point of view of horizontal equity (equal medical care received on equal health need). They found that when adjusting for the same level of illness, the rich had a higher health care utilisation rate than the poor. Another study using data from the 1991 Health and Welfare Survey (National Statistic Office, 1991) also confirmed that the percentage of those seeking care attending a hospital was higher in the rich quintile than the poor quintiles (Makinen 2000).

⁶ Concentration index for illness rate (or health care utilisation) is the twice of area between a curve which plots the cumulative proportion of illness rate (or utilisation of health care) against a curve which plots the cumulative proportion of population (Pannarunothai et al., 2000).

In summary, there were many problems of access to health care in Thailand. These were unaffordable payments by households, inequity in financing from out-of-pocket payment, the large number of uninsured people, and inequity in access to health care. These were the reasons why many called for health care reform and universal access as a means to improve the quality of the health system.

1.4.3 Context: social, political and economic

Thailand is a democratic, constitutional monarchy with a King as the Head of State. The population is estimated at 62 million of whom 35% are urban. It has never been colonised. In recent years Thai economy has grown at an average of 7.8% annually and Thailand is classified as a lower-middle-income country (Wibulpolprasert 2002). The development of the political system and the economy has highly influenced the policy decision-making. Recent important events were the promulgation of the 1997 Constitution and the 1997 economic crisis.

The Thai political system was transformed from absolute monarchy to constitutional monarchy in 1932. In reality, it was a military dictatorship and underwent a transition to democratic rule during the 1970s and 1980s. Three main groups had dominated the policy elite, namely aristocrats, bureaucrats and military soldiers, while businessmen were their financial support. After the fall of the military in 1973, business-based politicians increased their political power through the parliamentary system (Phongpaichit and Baker 1995). The early period was described as a 'bureaucratic polity' (Bowornwathana 2000) where power fluctuated between the elected government and the military, and the lack of democratic control allowed bureaucrats to hold the balance of policy decision-making (Green 2000). The latter period has seen the rise of 'business politics' in which corporate elites search for both capital and political authority (Phongpaichit and Baker 1995).

The close relationship between politicians and self-interest has led to vote-buying and electoral corruption (Callahan and Mccargo, 1996 quoted in Green, 2000). Such problems as power abuse for self-benefit, corruption, and a lack of political ethics led to the political reform movement during the 1990s (Wibulpolprasert 2002). Corruption scandals in 1991 led to a takeover by the military in order to clean up the regime, with support from the middle class. However, the middle class quickly became sensitive to the fact that their prosperity depended on the modern economy, and support for the military takeover did not last because of the impact of the coup on the modern economy. The middle class took to the streets in demonstrations during the event that came to be known as 'Bloody May' (Nelson 2001a), and overthrew the military regime in May 1992 (Phongpaichit and Baker 2001a). This event was followed by a political reform movement to fully democratize the country.

The government in 1995 appointed a committee to consider political reform and this led to the process of constitution drafting, public hearings, and the promulgation of the 1997 Constitution which was accelerated by the economic crisis in July 1997. The 1997 Constitution, called the 'People's Constitution', reduced the King's parliamentary control over the appointment of the senate; created direct election to the senate; and increased the political parties' power over the parliament by adding the election of MPs on a party-list basis. The election rules also changed to combat vote buying and other irregularities. The duty for inspecting political parties was transferred from the Ministry of the Interior to an independent election commission (Wibulpolprasert 2002).

The 1997 Constitution also increased civilian power in policy decision-making by eliminating the bureaucracy's monopoly over public policy formulation in favour of public participation. For example, civilians are eligible to propose laws regarding human rights. This led to a subsequent movement within civil society to propose new health laws.

The right of citizens to access health care and of free care for the poor was addressed in the 1991 constitution. The 1997 constitution confirmed the right by adding the principle of equity in health care access together with confirmation of the role of both private and public sectors in providing health services (Section 52 of the Constitution) (Council of State of Thailand 2003). The access to health services for all was also put in the five-year 8th Socio-economic Development Plan (1997-2001), but there was no action plan because of the economic downturn and a lack of political support.

Thailand's economy has developed from agrarian economy to industrial base economy (Green 2000). It grew rapidly after 1985 as Thailand opened up the market and welcomed foreign investment (Phongpaichit and Baker 1998). The economic growth period also increased demands for health care and private hospitals grew with the market support policy of the Bureau of Investment (Pitayarangsarit, Wibulpolprasert, and Tangcharoensathien 2000). However, in 1997, the Thai economy faced a crisis and economic contraction by 10.5% in 1998 (National Economic and Social Development Board 2002). Major determinants of the economic crisis included short-term foreign debts, private sector investments in non-productive businesses (in particular, in the real estate sector, automobile industries, petrochemical industries and private hospitals), weak production structures and foreign capital dependence, liberalized monetary policy without an effective monitoring and inspection system, and inefficiency of public sector management (Wibulpolprasert 2002). To maintain overall economic stability, Thailand adopted a managed float currency exchange system on 2 July 1997 and requested financial and technical assistance from the International Monetary Fund on 14 August 1997 (Wibulpolprasert 2002). The economic crisis had major social implications of unemployment, under employment, household income contraction, changing expenditure patterns, and child abandonment. The

crisis increased poverty incidence by 1 million, of whom 54% were the ultra-poor⁷. Household health expenditure reduced by 24% in real terms. Institutional care was forfeited, especially in poorer households, and replaced by self-medication. Private hospitals were clearly surplus to need and fell into debt (Tangcharoensathien et al. 2000).

Following the crisis, Thailand began to implement deep reform of the financial sector, corporate governance, a secured lending regime, and competition policy to strengthen the incentives for owners of banks and firms to move towards their competitive frontiers. The flexibility of the Thai economy facilitated a quick recovery of economic growth and the numbers in poverty began to fall. After contracting by 10.5% in 1998, Thailand's economy grew 4.4% in 1999 and 4.6% in 2000 – and stayed positive 1.9% in 2001 (National Economic and Social Development Board 2002), in spite of the global slowdown (The World Bank 2003; Wibulpolprasert 2002). In response to the crisis and to international reform trend, many reforms in the public sector were implemented before 2001, including those recommended by donors.

1.4.4 Coexisting reform policies before 2001

Thailand has followed the ideology of neo-liberal approaches by opening its doors to international finance, opening its capital accounts, and promoting free market including deregulation, privatisation and liberalisation (Phongpaichit and Baker 2000). For example, the master plan for State Enterprise Sector Reform Program was approved by the Royal Thai Government Cabinet on September 1, 1998 (The Royal Thai Government 1998) and several private enterprises have been privatized including those in the telecommunication sector, for instance. During the Chaun Leekphai administration (1998-2000), there were many Acts introducing reforms in different sectors. The Devolution Act 1999 set a strong pace to devolve MoPH services, such as health centre's, district and provincial hospital services, to local elected government by 2004. The MoPH will play a decreasing role in direct service provisions but maintain its role in financing, policy direction, monitoring and evaluation. Within the health sector, there were current reforms in other health themes such as the strengthening of the National Essential Drug Lists, the payment reform of the Civil Servant Medical Benefit Scheme, the introduction of the efficient use of drugs and supplies, and the transformation of public hospitals into autonomous hospitals.

In 2000, there was a health sector reform movement which used three strategies: generation and management of knowledge, involvement of civil society, and advocating for politicians' support. This movement was coordinated by the Office of Health Systems Reform funded by the Health

⁷ Ultra poor is defined as those with incomes below 80 percent of the poverty line and the poverty line in Thailand since 1998 was based on food consumption basket which varies according to age and sex (Rodriguez 1999). By 1998, the average poverty line for Thailand was at Thai Baht 878 per month per person equivalent to US 73 cents per day (The Office of the National Economic and Social Development Board 1999).

Systems Research Institute under the National Health Systems Research Committee. This movement was to get the involvement of the whole society in the development of a knowledge-based national health bill during 2000-2003, aiming to reform the whole health sector including health care. The goal of universal coverage of health care was a component of that draft bill. These coexisting reforms partly influenced the readiness for the implementation of the 2001 UC policy.

1.5 Overview of the 2001 Universal Coverage Policy (UC)

The landslide victory in the 2001 general election of the Thai Rak Thai Party (TRTP) was extremely important as it was the first fought on policies rather than on patronage (Phongpaichit 2001; Siamwalla 2002). The Party leader, Thaksin Shinawatra, became the Prime Minister of Thailand and, at a press conference on 6 January, Election Day, announced his intention to implement policies to which the Party was committed, that the party was entrusted with setting up the government, and the party's policies ought to be the government's policies: "If the Party cannot keep its promise, it would betray the electorate's trust⁸" (Shinawatra 2001). Since UC had been part of the TRTP's manifesto since 26 March 2000, and was promoted during the political campaign under the slogan 'Sam sib baht rak sa thuk rok' [30 Baht treats all diseases], the '30 Baht' policy became the government's policy after the election.

The government's policy declarations on health financing and health service delivery systems are presented in Box 1.1. The first was one of nine government priority policies: the Universal Coverage of Health Care Policy. The second was health systems reform under the social sector policy: declaring the intention to legislate for the National Health Security Act.

Box 1.1 Policy declaration to parliament by the Thaksin Shinawatra government on 26 February 2001

The Universal Coverage of Health Care Policy was one of nine high priority policies. The Universal Coverage of Health Care Policy aims to 'reduce the national health expenditures and household health expenditures with 30 Baht out-of-pocket per episode and provide accessible and equitable quality health services'.

Health policy under Social Sector Policy aims to implement the health systems reform by establishing a National Health Security Fund through the legislation of the National Health Security Act.

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

The provision of the Thaksin administration's health policy regarding health financing and health services in February 2001 can be summarized as follows.

- All Thai residents are entitled to accessible and equitable health services.

⁸ Translated from the Thairatch Newspaper, 7 January 2001, page 1.

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

In sum, Thailand chose to generate a large subsidised scheme which separated the purchaser role from the MoPH and to control cost with the methods of closed-end payment. The system is expected to have dual funds under a single system in the future. However, the policy was implemented rapidly from April 2001 under MoPH execution, with four progressive steps to expand insurance coverage. Table 1.2 shows the chronological events in the policy formulation and implementation during 2001-2002. Under the 30 Baht Scheme, health registration covered the whole country in April 2002, and that was before the legislation of the National Health Security Act (November 2002). This led to the country having high insurance coverage under three different management schemes. In 2002, the reform was still in a transition period with the development of the 30 Baht Scheme in its infancy in respect to the resource allocation formula, strengthening of primary care, and choice of providers.

Table 1.2 Chronological events in the policy formulation and implementation of the 30 Baht Scheme and the National Health Security Act

Periods	Events of Thailand regarding Universal Coverage policy
January 2001	Election of the Thaksin government
February 2001	Policy declaration in parliament on 26-27 February 2001: official announcement of UC policy – ‘the 30 Baht Scheme’
March 2001	Consultation meeting chaired by PM
April 2001	Implementation of first phase of UC in 6 provinces: extension of the Medical Welfare Scheme to cover uninsured
May 2001	Guidelines for implementation published
June-October 2001	Phase II. Private collaboration: expansion to 15 provinces with the collaboration of private

Periods	Events of Thailand regarding Universal Coverage policy
	providers and university hospitals
October 2001	Phase III. Nationwide implementation: expansion of coverage to all provinces except the inner Bangkok districts started from January 2002
April 2002	Phase IV. Achieving universal coverage: expanding coverage to the whole country including the inner Bangkok districts and achieved universal coverage
November 2001 - 2002	Parliamentary process of the National Health Security Act

1.6 Questions regarding UC policy

The 2001 UC policy ensures that all citizens have equal access to health care without financing barriers. While UC may decrease the severity of inequities, it may also raise new problems for the health system. These include cost escalation of the government budget, cream skimming by private hospitals, poorer quality and longer waiting time in public hospitals, and helping those of higher income more than lower income families. Thus system design is important but so is the implementation of the new policy, which may be changed by any of the participants at any step of the policy process.

Questions regarding the Thai UC policy include: what are the driving forces to this policy change? Why did this political party select Universal Coverage as the Party's health policy at this particular time? Academics and researchers had long been working on alternative solutions to the problem of access to health services, one of which was UC to health care. Why was it possible to introduce UC in 2001, when it had not been possible earlier? Why UC was accepted politically, promoted and implemented so rapidly is not clear. Understanding how UC was introduced will help to answer questions about implementation, and whether it will be successful and reach its goal. Only an in-depth policy study can understand the process of change.

The next chapter presents the framework of analysis, elaborated from a literature review of policy analysis, and specifies study objectives. It then goes on to describe the methods of data collection.

Chapter 2 - Research Framework and Methods

This chapter develops a policy analysis framework through a review of different disciplines relating to policy, to help explain the UC policy process. It goes on to specify the study objectives and research questions. Finally, it explains study methods used.

2.1 Framework of policy analysis: a review

In analysing public policy, frameworks are needed to organise ideas and concepts. This section starts with the description of policy analysis using the different views of policy scholars. It goes on to discuss why policy analysis is useful to understand a policy and in which other aspects it can be useful. Then it reviews how policy analysis is performed by discussing several approaches from different disciplines, and finally, it identifies approaches used in this study. The main argument of this section is that policy is not just an outcome of a rational process; it involves the interaction of actors who are influenced by the social, political, economic, and historical context in which policy is shaped and implemented; therefore, it needs a combination of concepts and tools to understand its process (Sutton 1999; Walt 1994), which is similar to the political economy approach⁹.

Policy scholars have different views on policy (Hill 1997; John 1998). It can be defined as many things from content (Hammer and Berman 1995) to a broad course of action (Barker 1996). While a traditional model of policy views policy as a rational process or based on causal-effect relationship, there are more explicit acknowledgements of the importance of the social, political, economic and historical context in which policy is shaped and implemented (Dunn 1994; Grindle and Thomas 1991; Keeley and Scoones 1999; Mooij and Vos 2003; Walt 1994; Walt and Gilson 1994). The traditional idea perceived policy as a product of a linear process; once it is decided, it is implemented accordingly and the implementation is dealt with by the management in the organization. This idea is based on a positivist view of the world, which searches for links between cause and effect. However, many authors argue that any form of absolute rationality is not realized in most policy-making settings (Dunn 1994). They suggest that policy-making is complex and involves a political process in which potent actors influence others in the making of policy (Grindle and Thomas 1991; Walt 1994), it involves interest groups, policy communities or networks, not just particular responsible persons within

⁹ Political economy approach offers tools with multidisciplinary for understanding the interrelationships between political and economic institutions and processes, 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 kinds of laws and policies that get made (Drazen 2001; Johnson 2000).

the government (Grindle and Thomas 1991; Kingdon 1995), and the policy is shaped through formulation and implementation (Gordon, Lewis, and Young 1977).

The approach to explore public policy – policy analysis – integrates and contextualizes models and research from several disciplines (Parsons 1995). It has been said that policy analysis “is an applied sub-field whose content cannot be determined by disciplinary boundaries but by whatever appears appropriate to the circumstances of the time and the nature of the problem” (Wildavsky, 1978: 15 quoted in Parsons 1995). The uncertainties of circumstances move the focus from policy description to the dimension of policy which acknowledges the courses of actions (process) and the context in shaping policy. This kind of analysis offers useful views into why and how policies came about, are formulated and implemented, and succeed or fail (Mooij and Vos 2003). Moreover, it is not limited to the analysis of policy¹⁰ (i.e. to understand policy determination and policy content), but it is able to evaluate implementation, so its results can inform future policy development. It also can be “a tool to help influence policy outcomes” (Walt, 1998: 379).

Several disciplines provide useful approaches to policy analysis including political science, sociology, anthropology, and management (Minogue 1983; Sutton 1999). Sutton (1999) reviews the main interest (often shared) in these disciplines:

- Political scientists are interested in what policy-making is. Various models have been developed to explain the decision-making process and identify diffusion of power in policy-making.
- Sociologists are interested in policy networks and policy communities to understand the role of interest groups in the policy process. Looking at policy networks can identify the dominant groups in policy-making and understand why policy is shaped in particular ways. Networks can be identified as corporatist, state-directed, collaborative and pluralist.
- Anthropologists focus on development discourses which explore a phenomenon through ideas, concepts and categories given to the phenomenon. Discourse analysis¹¹ provides a tool to understand and break down the perspectives in policy development.

¹⁰ Gordon et al (1977) define the varieties of policy analysis as analysis of policy, policy monitoring and evaluation, and analysis for policy. The analysis of policy includes: (1) analysis of policy determination, which is concerned with how policy is made, why, when and for whom, and (2) analysis of policy content which involves a description of a particular policy and how it is different in relation to other earlier policies. Policy monitoring and evaluation examines how policies have performed against policy goals and the impact of the policy. Analysis for policy includes policy advocacy and information for policy. Policy advocacy involves research and arguments, which is intended to influence the policy agenda. Information for policy is a form of analysis, which is intended to feed into policy-making activities (Gordon, Lewis, and Young 1977).

¹¹ Discourse analysis is an approach to analysing qualitative data that focuses on talk and texts as social practices and on the resources that are drawn on to enable those practices (Potter 1996).

- Management literature focuses on the complexity of implementation including organisation management, barriers to change, the skills required to manage change, and the importance of power and influence, for instance.

Contemporary approaches in policy analysis have combined several single disciplines and developed new theories or models to help explain policy process, which include four main themes: policy as process, political interests in the decision-making process, actor oriented approaches, and context concerns. Several review papers mention discourse analysis as an emerging tool among policy analysts (Keeley and Scoones 1999; Mooij and Vos 2003; Sutton 1999). Theories are discussed below under the four main themes in order to decide which are useful to help explain the UC policy.

2.1.1 Policy as process

Policy is complex and includes many courses of action. In explaining policy, several theories use metaphors to help explain how the process occurs. These include the stages heuristic, multiple-streams, punctuated-equilibrium, and interactive models.

The stages approach was originally defined by Lasswell (1951) in order to improve the quality of the use of information by government. The approach views the policy-making process as composed of a series of steps or sequences. Process in this approach usually begins with agenda-setting and concludes with policy evaluation and termination (deLeon 1999). The stages metaphor has been criticised for mistaking each stage as linear and giving a sense of a top-down process (Jenkins-Smith and Sabatier, 1993 cited in deLeon, 1999).

The multiple-streams framework by Kingdon (1984) focuses explicitly on differences between dynamic and static policy elements, giving an idea of how policy emerges once three independent factors come together (Kingdon 1995). This framework does not divide process into stages but it pays attention largely to agenda setting.

The punctuated-equilibrium framework by Baumgartner and Jones (1993) describes how events can result in policy change – that policies may remain relatively stable for long periods, and then, because of a particular event, undergo change. They call this process ‘punctuated equilibria’. This framework explains both stability and change; however, it emphasises only issue definition and agenda setting (True, Jones, and Baumgartner 1999).

The interactive model by Grindle and Thomas (1991) focuses on the uncertainty of policy change through the process of decision and implementation, and the way in which interested parties can exercise pressure for change at different points. These interests are those who are affected positively or negatively by the change of policy, including high level bureaucrats and managers in the implementation process (Grindle and Thomas 1991). The term ‘interactive’

gives a clear hint of how the policy process performs, and is also a feature of the multiple streams and the punctuated equilibrium framework.

Though the stages approach is contested, it is still widely used as a heuristic device to explain the whole range of public policy processes. This thesis will use four common stages as a framework to identify courses of action: (1) problem identification and issue recognition (agenda setting), (2) policy formulation, (3) policy implementation, and (4) policy evaluation. However, it recognised that the relationship of each stage is not in sequence as linear but rather it is interactive (Grindle and Thomas 1991; Walt 1994; White 1997). The multiple streams framework will be used to help explain the agenda setting and policy formulation process. The interactive model will be used to help explain the implementation process.

2.1.1.1 Kingdon's multiple streams model

Kingdon (1995) suggests the agenda setting process is composed of three separate and distinct streams: problems, policies and politics. He defined the word 'agenda' as "the list of subjects or problems to which governmental officials and people outside of government closely associated with those officials, are paying some serious attention at any given time" (Kingdon 1995: 3).

The problem stream

The problem stream is a condition which policy-makers perceive as a problem or something they think they should act on. It is composed of problems on which government policy-makers fix their attention, as opposed to those which they choose to ignore. Kingdon argues that there are three mechanisms which serve to bring problems to the attention of policy-makers:

- **Indicators:** measurements which are used to assess the scale and change in problems. Government data and reports feed into government a picture of the problem and thus have a significant role in shaping governmental attitudes and positions;
- **Events:** (i.e. focusing events) which serve to focus attention on problems: crises, disasters, personal experience and symbols;
- **Feedback:** gives information on current performance and indicates a failure to meet goals or points towards unanticipated consequences.

The policy stream

The policy stream is the way of selecting amongst problems and alternative policy solutions. Kingdon conceptualises the policy stream in terms of a 'primeval soup'. Ideas float around, confront one another and combine with one another in various ways (Kingdon 1995:117). The soup changes in a process of natural selection, survival, demise and recombination. In this soup stream some ideas float to the top of the agenda and others fall to the bottom. Those concerned with problems and solutions are policy communities – health specialists, politicians, academics

and consultants. Some communities are fragmented and some are closed and tight-knit. The fragmentation of a policy system affects the stability of the agenda within that system. Policy entrepreneurs are important actors in the policy stream. The policy solution being promoted has to satisfy a number of criteria if it is to survive and get to the top of the agenda. A number of criteria are:

- technical feasibility,
- congruence with existing values,
- anticipation of future constraints, and
- public acceptability and politicians' receptivity.

The end result of this struggle is a list of policy proposals, which constitute a set of alternatives to governing policies, and which may attract the attention of the policy-makers.

The political stream

The political stream operates quite independently from the other streams. It is composed of a number of elements:

- National mood: public opinion, climate of opinion;
- Organised political forces: parties, legislative politics, pressure groups;
- Government: election results – change in personnel and jurisdiction;
- Consensus building: bargaining, bandwagons and tipping¹².

These developments in the political stream can have a powerful effect on agendas, affecting which one becomes prominent. Politicians and policy specialists have different perceptions of national mood and the way they build consensus.

These separate streams – problems, policies, and political streams – come together at certain times. This is likely to occur when a policy window opens either by problems gaining attention or political opportunities arising. Under such conditions a particular issue has the opportunity to push an alternative. If the window is lost, then the policy launch has to wait for another time when conditions and alignments are appropriate. Therefore, timing is important for agenda setting (Glassman 1999; Kingdon 1995; Paul-Shaheen 1998).

2.1.1.2 Interactive model of policy implementation

Grindle and Thomas (1991) present a contrast to the linear model of policy implementation. They argue that their model is particularly useful for analysing the process of implementation,

¹² Tipping is used by Thomas Schelling to describe the process of change in racial mix in neighbourhoods. It presents the idea of the increasing of the minority (or the idea of few people) to become the majority (or the common idea of

and offers tools for anticipating reactions to change, considering the possibility of sustaining a policy, and assessing the adequacy of resources.

There are several views of the implementation process – put briefly, the top-down approach, the bottom-up approach, and the hybrid theory. The interactive model is in the third category, which argues that policy is not linear. The top-down model perceives the policy-making process as linear, normative and prescriptive, starting with the policy decision at central level. The government judges what ought to be done, gets officials to undertake what they are told, and keeps control over a sequence of stages in a system (Walt 1994; Pressman and Wildavsky 1973 cited in Parsons 1995). Behind this idea is the belief that 'perfect implementation' is necessary to achieve the policy objectives. Hogwood and Gunn (1984) suggest ten preconditions necessary to achieve a policy's objectives¹³.

But implementation in practice is difficult. Hogwood and Gunn's preconditions are not usually met. For example, it is difficult to eliminate the obstacles to implementation outside the control of the implementers, resources are seldom sufficient, and implementation always depends on other actors who are involved in execution of policy. Moreover, the precondition of perfect compliance is unacceptable and also unattainable in a pluralist democracy (Hogwood and Gunn 1984). Therefore, the top-down approach has limitations. The opposite idea – the bottom-up model – sees the implementation process as involving negotiation and consensus building. These involve two contexts or environments: the management skills and cultures of the organisation, and the political environment. In this model, the policy formulation process may be altered by policy implementation (Parsons, 1995). There may be chances for lower level actors to take decisions.

However, these two opposite models provide rather rigid approaches, understandable as linear either upwards or downwards. Many have the same view as Grindle and Thomas (1991) that

the community). See Thomas C. Schelling, *Micromotives and Macrobehavior* (New York: W.W. Norton, 1978), pp.99-102

¹³ Ten preconditions suggested by Hogwood and Gun (1984) include:

- (1) The circumstances external to the agenda do not impose crippling constraints.
- (2) Adequate time and sufficient resources are available.
- (3) The required combination of resources is available.
- (4) Policy is based on a valid theory of cause and effect.
- (5) The relationship between cause and effect is direct.
- (6) Dependency relationships are minimal.
- (7) There is an understanding of, and agreement on, objectives.
- (8) Tasks are fully specified in correct sequence.
- (9) Communication and coordination must be perfect.
- (10) Those in authority can demand and obtain perfect compliance.

policy making is interactive, with a continuous loop between formulation and implementation elements, and that political influence is as important at the implementation stage as at other stages (Grindle and Thomas 1991; Walt 1994; White 1997). For example, White's model, 'interactive policy analysis', connects local officials or implementers to policy-makers in considering alternatives (White 1997). These frameworks support the 'interactive' idea for implementation. The interactive approach can better explain implementation because it links the top-down and the bottom-up approaches and allows for actions of the various actors at different stages.

The interactive model of policy implementation suggested by Grindle and Thomas (1991) offers an assumption that a policy is set when it has reached a state of equilibrium. Efforts to alter existing policy may be resisted by those affected by the change. These reactions or responses move the decision and implementation to a new equilibrium. Thus nature, intensity, and location of those reactions all affect implementation. Moreover, they suggest that the characteristics of the policy have an important influence on the nature of the reaction. They group policy characteristics as the distribution of cost and benefit, technical complexity, administrative intensity, and its short- or long-term impact. From these policy characteristics, policy-makers and managers are able to anticipate where the reactions or responses to policy are likely to take place, in public arena and within bureaucracy. They suggest that the examination of the implementation activities needs to assess conflict, conflict resolution, and the development of strategic management capabilities.

2.1.2 Political interests in decision-making process and policy change

Many theories view decision-making in different political systems, which illuminate different actors who are prominent in policy-making. They are related to the views of how power is distributed in policy-making. Power is a highly contested concept, but put simply it has three dimensions: first, power can involve the ability to influence the making of decisions; second, it may be reflected in the capacity to shape the political agenda; and third, it may take the form of controlling people's thoughts by the manipulation of their needs and preferences (Lukes 1974). While power can be seen as negative (as in the third dimension), it can also be seen as positive. Two main ways of viewing decision-making power are the society-centered perspective and the state-centered perspective. The society-centered perspective argues that there are dispersions of power in society (i.e. civil society is important), while the state-centered argues that decision-making power is concentrated within state institutions. These perspectives are influenced by the political system (Grindle and Thomas 1991).

2.1.2.1 *Society-centered perspectives*

Under this perspective, decisions are seen to depend on the relationships of power and competition among individuals, groups or classes in society.

The structures of power are class, wealth, and knowledge, for example. There are at least five approaches of power relations in the political system: elitism, Marxism, pluralism, professionalism, and technocracy or public choice theories (Grindle and Thomas 1991; Parsons 1995; Walt 1994).

In *Elitist models* or *Class models* power is concentrated in the hands of a few groups and individuals, and that decision-making works to the advantage of these elites. This approach is close to the Marxist view. *Marxists* or instrumentalist approaches focus on decision-making in capitalist societies. The approaches are seen as a product of economic conflict, where the state plays a dominant role in safeguarding the long-term interests of a capitalist economy. *Pluralist* approaches suggest that different groups in society are able to compete to dominate decision-making and policy results from conflict, bargaining, and coalition. In the pluralists' view, the role of policy elites in the initiation, formulation, and implementation of change is limited as the activities of public officials are always determined by the way in which societal interests are expressed. In this view of society, the role of the media in highlighting the issues and political commitment becomes crucial. The *Professionalist* view is that professional elites have acquired power in decision-making and in the implementation of public policy in liberal democracies. *Technocracy* or *Public choice* ideas focus on bureaucratic power (the civil service) in decision-making processes. The idea is that the rationale and motivations of administrative agencies and government departments may result in policies which do not necessarily serve the public interest.

2.1.2.2 *State-centered perspectives*

The state-centered approach concentrates on the role of state in policy-making. Theories in this approach include rationality, bureaucratic politics, and state interest models.

In the *rational* approach, theorists have a common belief in the improvement of decision-making through changing the relationship of the political process to knowledge and information (Parsons 1995). The idea basically derived from the idea of economic rationality in economic theory and the bureaucratic rationality in sociological theories of organization and industrial society (Max Weber 1864-1920). The approaches in line with this idea are the perfectly rational actor model, bounded rationality (Simon, 1957), the incremental model (Lindblom 1959), and mixed-scanning (Etzioni 1967) (also see Grindle and Thomas, 1991: 27-28; Walt, 1994: 46-52; Dunn, 1994: 275-282).

The perfectly rational model views decisions as products of a rational process in which actors assess all possible alternatives on the basis of full information, and then choose an optimal way to reach a stated goal. The concept of ‘bounded rationality’ suggests that information seeking is costly and always incomplete; therefore, decision makers do not usually attempt to achieve optimal solutions but only find a solution that satisfies some basic criteria. The incremental model suggests that the uncertainty, conflict, and complexity affect decision-makers, so changes to policy are incremental over time. The mixed-scanning approach is suggested to overcome the unrealistic rational model and the limitations of the incremental model, which overlooks innovations. The model includes two levels of problem analysis: a broad examination and a detailed examination of some areas of problems.

The bureaucratic politics approach pays attention to policy-makers, in particular the role of bureaucratic players shaping policy by their positions within government through negotiation, bargaining, and power in hierarchical system.

State interest models view that state as having autonomy in making decisions in its own interest, for example, the maintenance of social peace and the national development. Thus, state action always benefits particular groups, for example, urban elites close to the seat of power.

Looking at the political system in policy-making can provide understanding of why some actors dominate policy-making and implementation. It can be argued that whether it is the state or society that dominates policy-making at central and sub-government level will depend on how strong the state is in that area, and this will differ between areas. Given the theories of political interests, it will be useful to explore how UC policy-making was shaped and in which political context the UC policy was shaped and implemented.

2.1.3 Actor-oriented policy explanation

Actors can be viewed as individuals, organisations, and members of policy communities or policy networks. In the literature on actors, there are three themes: first, how decision-makers interact with other actors in the production, implementation, evaluation, and revision of public policies (Grindle and Thomas 1991); second, how the characteristics of policy networks affect the policy process (Marsh 1998; Rhodes 1997); third, how important particular individuals in policy process are (Grindle and Thomas 1989; Kingdon 1995; Walt and Gilson 1994).

Many theories define actors in the policy process as elites. Policy elites are important as they are key actors in determining policy initiatives, choices, policy and organisation changes (Grindle and Thomas 1991). These decision-making elites make policy through at least four considerations: technical advice; bureaucratic implications; political stability and support; and international pressure. Technical advice is concerned with information, analyses, and options presented by technocrats, ministers, other high-level bureaucrats, and foreign advisers. The

impact of choices on bureaucratic interaction relates to individuals' concern about career objectives, budgets, compliance and responsiveness amongst ministers and other high-level bureaucrats, middle level bureaucrats, and international advisers. Political stability and support relates to political leadership, dominant economic elites, and leaders of class or interest groups. International pressure can influence aid, loans and trade relations. Grindle and Thomas (1991) suggest that there is space for manoeuvre by policy makers, which depends on the level of discretion of policy makers. Therefore, the perceptions, motivations, values, skills, and opportunities of decision-makers are important in shaping the policy process, including content, timing, sequences of reforms, and outcomes. These perceptions and motivations are framed by societal pressures and constraints, and historical, cultural, and international contexts (Grindle and Thomas 1991).

Network analysis is based on the idea that a policy is framed within a context of relationships and dependencies. Interactions between policy makers and bureaucrats may be described by different policy styles (Richardson 1982). The two main dimensions of policy style are (1) an anticipatory or reactionary style, and (2) a consensus-seeking or impositional style. These four policy styles reflect the way policy actors interact.

The notion of policy style is useful for comparing policy communities both within and between political systems and it offers an insight into the policy-making process (Parsons 1995). This study uses this approach to explain the interactions of policy maker and policy community.

Network analysis is interested in the increasing participation of other actors outside the government (Marsh 1998; Parsons 1995; Rhodes 1997) and the degree to which the state is influenced by such networks (Smith 1993, cited in Hill, 1997). The term 'network' is a metaphor to describe the relationship of participants in policy process (Peters 1998). Using Marsh and Rhodes's typology, it differentiates relationships between interest groups and government into three types: policy communities, policy networks and issue networks. The typology treats policy network as a generic term. Networks can vary along a continuum according to the closeness of the relationships within them. Policy community is at one end of the continuum.

“A policy community has the following characteristics: it has a limited number of participants with some groups consciously excluded; there is frequent and high quality interaction between all members of the community on all matters related to the policy issues; its membership, values and policy outcomes persist overtime; there is consensus, with the ideology, values and broad policy preferences shared by all participants; all members of the policy community have resources so the relationships between them are exchange relationships; the basic interaction thus is one involving bargaining between members with resources; there is a balance of power, not necessarily one in which all members equally benefit but one in which all members see themselves as involved in a positive-sum game; the structure of the participating groups is hierarchical so leaders can guarantee the compliance of their members. This model is an ideal

type. The actual relationship between government and interests in any policy area can be compared to it, but no policy area is likely to conform exactly to it.” (Marsh 1998:14)

In contrast to the tightly-knit policy network is the issue network, which involves a large number of participants who come together to promote a particular issue. They are characterised by unequal power relationships, few resources, and less stability (Marsh 1998). Policy network analysis helps to understand the relationships amongst actors and this can link to the analysis of political setting to identify who are the important actors in policy process (Peters 1998).

Two other types of policy networks which provide dynamism and predictive capacity are the advocacy coalition approach (Sabatier 1988; Jenkins-Smith and Sabatier 1993) and the epistemic community approach (Haas 1990; Adler and Haas 1992). The advocacy coalition approach views the behaviour of policy communities within networks as competing to pursue the change in rules based on each coalition’s belief. The capacity of the coalitions depend on how much they increase knowledge of problem identification and determinants, and feed information back to change their perceptions of the probable impacts of the alternative policies and advocate policy brokers or policy makers (Sabatier and Jenkins-Smith 1999). ‘Epistemic communities’ are groups of technical experts or professionals who “share a commitment of common causal model and a common set of political values” (Haas, 1990:41 cited in Parsons, 1995:173). The capacity of epistemic communities in getting their ideas adopted depends on the ability to bring the truth to be more persuasive to policy-makers and the ability to mobilise alliance with the dominant political coalition. This thesis will classify participants in policy-making by March and Rhodes’s category to explore how their relationships affect the policy.

Moving to focus on individuals (can be groups), there are many ways of describing individual actors, for example, as stakeholders (Brugha and Varvasovszky 2000), as 'hidden' or 'visible' actors (Kingdon 1995), as policy entrepreneurs (Kingdon 1995), or as policy elites (Grindle and Thomas 1991).

Stakeholders are defined as individuals or groups that have, or claim, ownership, rights, or interests in a policy, past, present, or future (adapted from Clarkson 1995 cited in Brugha and Varvasovszky, 2000), and also refers to the influential actors in the decision-making process. Kingdon (1995) categorised actors in the policy process as 'visible' and 'hidden' participants. The visible participants are the Prime Minister, the Minister of MOPH, political parties, media and the public. The hidden participants are the civil servants or bureaucrats, researchers, and academics. The visible participants play prominent roles in agenda setting and the hidden participants play prominent roles in policy formulation/alternative policy selection. Kingdon also recognises a special group of actors as policy entrepreneurs, "people who are willing to invest resources of various kinds in hopes of a future return in the form of policies they favour" (Kingdon 1995:143). They are crucial to the survival and success of an idea. They 'soften-up'

policy communities to gain acceptability for a policy. Paul-Shaheen (1998) also suggests that policy entrepreneurship is an essential condition for reform, as are interest group support, stakeholder commitment, and public support (Paul-Shaheen 1998).

This study uses the general term 'actors' to refer to participants in the processes of agenda setting, policy formulation and implementation. However, the analysis has explained actors based on several concepts of 'hidden', 'visible', entrepreneur, and policy elites. Amongst policy actors are academics, researchers, ministers, high- and middle-level bureaucrats, managers and health providers. Amongst interest groups are NGOs, private health provider associations, private insurance companies etc. The public is composed of individuals, groups and the media.

It is also useful to explore perceptions and motivation of policy makers and to link to context whether any factors were important in shaping their perceptions and actions.

2.1.4 Context explaining policy change

Grindle and Thomas (1991) suggest that perceptions, options and actions of policy makers are shaped by societal pressures and constraints, and historical, cultural, and international contexts. They group these contextual environments as crisis situations and 'politics as usual'. For the first condition, a response by policy makers is likely to be strong pressure to reform, and the stakes for the government are likely to be high. If there is no perception of crisis, the policy-making is usually in the hands of middle-level decision-makers and change is likely to be incremental.

The three streams approach of Kingdon (1995) also acknowledges the importance of context. When a focusing event draws attention to a particular issue, it opens the problem window. When political change or the political stream evolves to a point, it opens political window. At a critical time when three streams come together then a policy occurs.

There are many ways to categorize contextual factors (Collins, Green, and Hunter 1999; Leichter 1979). Leichter (1979) suggests four factors which affect the policy process:

- situational factors which are transient, impermanent or idiosyncratic conditions, such as one-off or unusual events including war and political instability or change in political leadership,
- structural factors which are the relatively unchanging elements of the society and polity, such as economic structure, political system, technological structure and demographic structure,
- cultural factors which are the value commitments of groups within communities or the society as a whole, such as language, the level of literacy, and values on issues such as religion, gender, participation and corruption, and

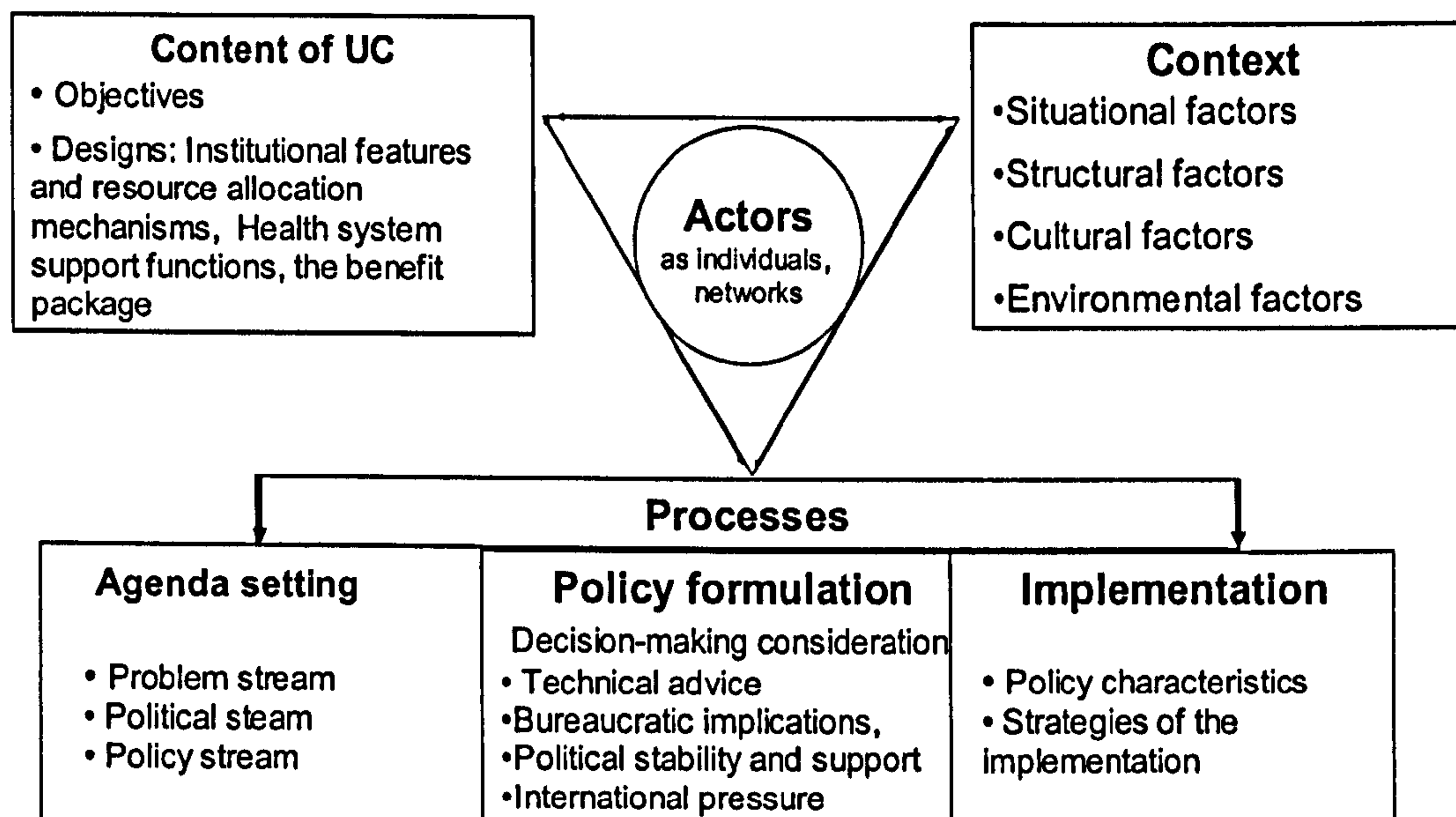
- environmental factors which are factors outside the boundaries of a political system such as the role of transnational companies and international agreements and events.

Grouping these factors by characteristic according to Leichter gives an idea of the contextual factor, whether it changes or is likely to be static. This provides power to explain a policy change. Therefore, this study used Leichter's categories to explain the UC policy.

2.2 Organised framework for investigating health policy processes

To organise several theories and ideas into a lens to investigate a health policy, this study uses a framework of policy analysis developed by Walt and Gilson (1994) because it provides a useful simple, heuristic device to explore the inter-relationship of different factors affecting policy. It is composed of four elements - content, context, actors, and processes, as shown in Figure 2.1. In its detail, it draws on some of the ideas from the theories above. In addition, a number of other concepts from the literature have been added to help explore the complexities of the policy process. These sources include Walt and Gilson (1994), Kingdon (1984), Grindle and Thomas (1991), Kutzin (1998), Collins (1999), Cleaves (1980), Hall (1975), and Sabatier (1986).

Figure 2.1 Conceptual framework for policy analysis of the UC policy in Thailand



2.2.1 Policy content

Policy content can be explained as an outcome of a set of conditions including ideologies, history, economic conditions, political feasibility, and decision-making process (Walt and Gilson 1994).

Policy content is what the policy aims to achieve and introduce to the system. Kutzin's framework, as mentioned in Chapter One, is useful for describing the content of universal coverage of health care policy. Content details should include three main elements: (1) sources

of funds, allocation of funds and associated institutional arrangements for health care; (2) broad health system support functions; and (3) the benefit package. The details in system design are important as they reflect government ideology and affect benefit distributions which can increase both support and resistance.

For its importance to process, policy design will be investigated. Benefit distribution, the principle or concepts of the policy, and its feasibility may be important in the agenda setting process. The technical complexity of issues may limit the participation of professionals or bureaucrats in policy formulation and implementation.

The concentration of cost and dispersion of benefit, technical complexity, its short- or long-term impact, the size of changes, facets of changes, and duration of changes will affect the ease of, and resistance to, policy implementation.

2.2.2 Policy context

The social, political, and economic context and other factors are important as preconditions of agenda setting, policy formulation and changes in health systems. This study looks at contextual factors which, according to Leichter (1979), include situational factors, structural factors, cultural factors, and environmental factors. The focus is on which conditions led to UC arriving on the political agenda, becoming government policy and being rapidly implemented. It also assesses the extent to which policy makers perceived the situation as a crisis and how this influenced the action of policy makers.

2.2.3 Policy actors

The influence of actors can change policy at any stage, depending on their position, power, and interests. This study looks at who played dominant roles and at which stages in Thailand's UC policy, and explains the interaction of actors, characteristics of actors and relationship of actors to other elements. Actors are viewed as individuals, policy communities, and networks. It also explores the power in decision-making, and whether the political context of UC policy was state dominated or society dominated. It uses network analysis to assess policy styles and types of policy network of the UC policy. Moreover, it observes the capacity and skills of policy analysts and explores whether policy-makers use them as instruments for decision-making.

Regarding the implementation process, the study explores the participation of different actors. It assesses the bureaucratic performance of both managers and street level bureaucrats¹⁴. It also explores their perceptions and responses to the policy.

¹⁴ The term 'street level bureaucrats' is coined by Michael Lipsky to describe the actors at the lowest end of the implementation chain, who implement policies at the point of contact with the policy's target population (Lipsky 1993).

2.2.4 Policy processes

This study focuses on three stages of policy process – agenda setting, policy formulation, and implementation – because it investigates the policy in the initial period and before outcomes can be evaluated.

The three-stream approach of Kingdon is used to explain how the UC policy got onto the policy agenda. Consideration of the policy elites' decision making of Grindle and Thomas is used to explain the policy formulation process. In the implementation process, the frameworks looking at policy characteristics, strategies, and interactions amongst several elements are used to investigate whether this policy is likely to be implemented as the policy intended.

2.2.4.1 *Agenda setting*

The three-stream framework of Kingdon (1995) is useful to help explaining the Thai situation. There are also other models such as the Hall model (Walt 1994), which identifies three conditions – legitimacy, feasibility and support – and suggests that only when an issue is high in relation to all three conditions does it become an agenda item. Legitimacy refers to those issues with which governments feel they should be concerned and in which they have a right to intervene. The level of legitimacy is different among countries according to their normative values. Feasibility refers to the potential for implementing the policy. This potential is defined by accepted technical and theoretical knowledge, financial and other resources, availability of skilled personnel, capability of administrative structures and existence of necessary infrastructure. Support refers to public support or public trust in government. The support groups may be general public or important interest groups. If there is no support, it is difficult for government to implement a policy. If the issue has high legitimacy, high feasibility and high support, then it may come to the policy agenda and be implemented.

This study uses the Kingdon model because the this model has more detail and is more nuanced than the Hall model, especially where the political stream is dominant and timing is important.

2.2.4.2 *Policy formulation process*

The Kingdon model can also help to highlight aspects of the policy formulation process, to show which actors have had dominant roles in content formation. The study focuses on the process by which the policy was designed and content decided. It analyses the interaction between policy-makers and policy communities or policy networks and assesses the extent to which policy-makers leaned on technical advice and other considerations such as bureaucratic constraints, political stability and support; and the international pressure. The prominence of a

particular factor may shift decisions in different ways. It can influence the decisions of policy makers in future policy development.

2.2.4.3 Implementation process

Implementation is often perceived as managerial or administrative (Walt 1994). It is judged by the extent to which objectives are achieved (Sabatier 1986 cited in Hongsamoot 2002). The process of implementation determines the nature and success of a policy initiative. However, there is evidence that outcomes frequently are quite different from policy intention (Grindle and Thomas 1991). This is shaped by implementers who respond according to the way they perceive the policy impacts on them. Therefore, strategies of implementation are important.

The interactive model of implementation of Grindle and Thomas (1991) is useful to explore policy characteristics, conflict, conflict resolution, and the development of strategic management capabilities. Other authors such as Cleaves (1980), Sabatier (1986), and Leighton and Wouters (1995) also suggest looking at characteristics of policy implementation.

Cleaves (1980) focuses on the characteristics of policy, arguing that certain characteristics make implementation easier (Cleaves 1980). These characteristics are: simple technical features, marginal change, implemented by one actor, clearly stated goals, one major objective, and short duration. Sabatier (1986) also suggests a set of six sufficient and necessary conditions for the effective implementation of policies (Sabatier, 1986 cited in Parsons, 1995). Leighton and Wouters (1995) report the obstacles to the implementation of health sector reform in Africa. They found that conflicting policy goals, political instability, weak institutional capacity, poor economic conditions, incomplete health sector development, and information constraints make implementation of reforms more difficult.

The various approaches described above support each other, so, synthesizing their similarities, this thesis builds an approach to analyse the implementation process. The following box is adapted from the sources above.

Table 2.1 Policy characteristics and situations which anticipate the success of implementation

Policy characteristics	<ul style="list-style-type: none"> • complex / simple technical features • big / marginal change • extensive/ limited participation (implemented by one actor) • conflicting /clear policy goals • many / one major objective • long / short duration • legitimacy enhancing the compliance of both implementers and targets; • weak institutional capacity / skilful implementers • resistance / support of interest groups (public and bureaucrats) • good / poor communication and coordination
Contextual factors	<ul style="list-style-type: none"> • Situation factors • Structural factors • Cultural factors • Environmental factors
Performance and capacity	<ul style="list-style-type: none"> • Good / poor resources - number of doctors and nurses • Good / poor skills • Independencies / dependencies in management • Incentives / disincentives

From the literature review it is clear that strategic implementation is essential, and it is useful to test which strategy the government has used. This list of strategies is suggested by Leighton and Wouters (1995):

- Build consensus among policy elites,
- Exercise and maintain Ministry of Health leadership of the effort,
- Strengthen institutional capacity and personnel skills,
- Adapt and update reforms to economic conditions,
- Develop health organisational and financing infrastructure,
- Collect, analyse, disseminate data and information.

This study explores the characteristics of the UC policy and the implementation, whether it created resistance in bureaucrats or in the public arena. Then it explores the government's implementation strategies and discusses whether the policy is likely to be successful. Table 2.2 summarises the details in the analytical framework used in this study.

Table 2.2 Analytical framework of factors important to policy process

	Agenda setting	Policy formulation	Implementation
Process	Processes of ideas meeting policy elite - Three streams: policy, problem, and political streams	Processes of decision-making of policy content - How research and knowledge was used	Processes of putting the ideas into action
Content	Characteristics of the issue influencing the agenda selection: - Benefit distribution - Congruent to social values and the political party's concept - Feasible	Characteristics of the policy: - Technical complexity	Characteristics of the policy: - Benefit distribution - Size of changes - Facets of changes - Duration of changes - Technical involvement
Context	Context support policy change: - Situational factors – political transition and economic crisis - Structural factors – economy - Cultural factors – commitment - Environmental factors	Contextual constraints: - Time constraints - Health infrastructure and resources	Context perceived as crisis or politics-as-usual
Actors	- Policy entrepreneurs - Government as agenda setter - Distribution of power between state, citizens, and technocrats - Level of participation in the different level of politics issues	- Policy styles and use of technical analysts - Level of participation in the different level of politics issues - Capacity and skill of policy analysts	- Discretion level of implementers - Professional involvement - Bureaucratic performance incentive and motivation - Institutional capacity - Political management skill of the government

2.3 Research objectives and methods

2.3.1 Main objective

To analyse the policy process of the Universal Coverage Policy in three stages: agenda setting, policy formulation, and implementation

2.3.2 Specific objectives

1. To analyse the design and characteristics of the policy

Research questions: What are the characteristics of UC policy in Thailand in terms of objectives, institutional arrangements and resource allocation mechanisms, health system support functions, and the benefit package? What aspects of the reform have been implemented in 2001-2002?

2. To analyse the extent to which contextual factors facilitated or delayed the UC policy

Research questions: What were contextual environments that facilitated or delayed the UC policy in each stage of the policy process?

3. To explore the influence, roles and powers of particular actors in the UC policy

Research questions: Who was involved in the policy process at the agenda setting stage and at formulation stage?

How far were decisions made by small policy elites?

Did non-government actors (e.g. civil society) participate in the policy formulation?

What role did the media play?

Who supported / resisted / was involved?

What were the policy styles?

Who was involved in the policy implementation process?

What are their positions, interests, and power on the policy, and the impact of the policy on them?

4. To explain how and why the notion of UC came onto the policy agenda, and was formulated into policy

Research questions: How did universal coverage policy get onto the policy agenda? How was the policy formulated?

How far did the problem, political and policy streams influence the policy processes?

5. To explore how the policy was executed / put into practice and analyse how far this policy is likely to be implemented as intended, by looking at characteristics of the UC policy, policy responses, and strategies

Research questions:

What methods of communication were used to transfer the policy from central to local levels?

What parts of the policy have or have not been implemented?

How did public and private providers negotiate their benefits? How did provinces negotiate with with MOPH?

What were the characteristics of the UC policy? What obstacles and difficulties have the implementers encountered during implementation?

What strategies did the MOPH use to overcome the obstacles?

2.3.3 Methodology

2.3.3.1 *Research process*

This study is based on qualitative research. After the research questions and objectives were defined, then key concepts suggesting possible explanations to explore were formulated as above. These concepts were derived from theory and experience from the literature, and helped to reformulate the specific research questions and to select methods of data collection as described in Appendix 1. The checklists for guided interview of each type of respondent are in Appendix 2. Data was collected at two levels: national and provincial. Most sources of data at national level provided understanding of the agenda setting process and policy formulation process, and implementation at national level. Information at provincial level explained largely the implementation process at local level and interaction with national level. Findings and interpretations were re-evaluated and reconfirmed whenever new information was accessed, by comparing the new information to the existing information.

There are two polar approaches of the steps in theory building: deductive and inductive approaches. The deductive approach confines the topic of interest within the theories and hypotheses that a study can test whereas the inductive approach moves from specific observations to formulate some tentative hypotheses that a study can explore, and finally end up developing some general conclusions or theories (Trochim 2000). As the policy process of UC was complex and there was no single theory that could well explain the whole processes, this study used the inductive approach to decompose this complex phenomenon into its component elements and formulate the hypotheses from the investigations in order to explain the phenomenon, and finally developed some general conclusions.

2.3.3.2 *Case-study approach*

The case study is a way of doing social science research. It has advantages and disadvantages depending upon three conditions: the type of research question, the control an investigator has over actual events, and the focus on contemporary phenomenon (Yin 1994). The case study has the ability to answer ‘how and why’ questions about a contemporary set of events over which the investigator has little control. However, this approach has several disadvantages. Firstly, it may allow biased views to influence the direction of the findings and conclusions. Secondly, it has little basis for population generalisation although some of the conceptual findings can be generalisable. Thirdly, it is sometimes criticised as resulting in unnecessarily massive and unreadable document. Finally, there is little way of testing an investigator’s ability to do good case studies (Yin 1994).

With the awareness of the advantages and the disadvantages of the case study above, the case-study approach was used in this study for two reasons. Firstly, the aims of this study were mainly to answer ‘how and why’ the UC policy came about, and to explore policy-making process which is contemporary. This approach was able to focus on an important event which was distinctive, not diffused and which had a set of circumstances. Secondly, the case-study methodology allowed going in-depth to investigate the inter-relationship between actors, design, and context.

To investigate intensively, two aspects were selected from two dimensions: the design content and the implementation unit. Six proxies of design content were selected to analyse the policy-making process. They are sources of finance, budget requirements for the program, methods of allocating resources to provinces, provider payment methods, primary care unit as a gatekeeper, and private provider collaboration. A province, Saraburi, was selected to investigate the implementation process.

Though the investigation of the implementation process of only one province limited the degree of variation in terms of design, management and context, it provided adequate information of the whole cycle of the management of an implementation unit and is in greater depth than would have been possible if more provinces had been studied. The explanation of the implementation process is likely to be generalisable to other provinces because many of the issues will be common to other provinces.

As this study uses several approaches to provide a detailed insightful and descriptive account of the policy process, it can be called ‘policy ethnography’. In *Interpreting Qualitative Data* Silverman (2001) uses ‘ethnography’ to refer to a general approach to social science writing about particular groups. Such studies may record interactions between people – although not always through observation - but may also work with cultural artifacts like written texts. This contemporary definition encompasses a much broader range of work than the original ethnographic works in nineteenth-century when anthropologists traveled to observe the different pre-industrial cultures (Silverman 2001). Ethnography is also a tool used in policy research. A clear definition of ‘policy ethnography’ is given by Beach (1999), who describes it as research about the processes of value dispute and material influence which underlie and invest the formation of policy discourses and which relate policy texts to practice. It does this by highlighting the process of mediation or re-contextualisation in policy making, including looking at the differences between intended policy and policy as implemented. This thesis thus can be called a policy ethnography as it looks at the processes of policymaking, the negotiation and mediation between different groups in that process, and the difficulties encompassed in implementing the policy as intended.

2.3.3.3 *Methods of data collection and data analysis*

Qualitative methods were used to collect data because the study aimed to investigate the phenomenon of UC policy in detail and to describe the interactions of participants; qualitative methods help identify facts and perspectives of participants (Flick 1998; Silverman 2001). However, a single method was not sufficient. Interviews, for example, gave information only of interviewees' views; texts did not explain themselves but relied on the writers' interpretations. On the other hand, observations did not give the reasons underlying activities. Thus, a combination of methods in both primary research and secondary research helped fill the gaps in data collection and analysis to answer the research questions. Most of the data which the study collected were derived from the primary research. Primary data sources included key informant interviews, government proceedings, and newspapers. Primary data collection methods included observation, interview, text analysis (some analysis of media), and focus group discussion. Where the secondary data collection including quantitative data was available to complement the data from primary sources, it was collected and analysed. The secondary data sources, for example, included:

- newspaper archives from the Matichon Newspaper's Library which provided the story of the phenomenon used for content analysis, and quantitative data of the news items used for a descriptive statistic analysis (frequency),
- the MOPH's evaluation report on the first six month period of UC which provided the situation of the provinces' decisions on budget allocation and difficulties in policy implementation,
- research reports by several research institutions on the first year evaluation of UC (Na Ranong and Na Ranong 2002a; Pannarunothai 2002) which provided the situation of the provinces' decisions on budget allocation, for example,
- database of the Health Insurance Office which provided the number of health facilities and registered population under the UC scheme for a descriptive statistic analysis (for example, percentage), and
- database of the Saraburi Provincial Health Office which provided financial information of providers in Saraburi and registered population under the UC scheme in the province for a descriptive statistic analysis (for example, ratio).

Analysis was conducted iteratively during data collection. New information brought other questions giving more clarification of the phenomenon, and led to new questions. In analysis, frameworks described in previous sections were used.

Observation

Observation gives information not only on what participants say but also what they do. This will fill the information gaps from interviews, which give information only of what the interviewee wants to say. Observation of MOPH meetings (the consultation meeting and/or the working group meeting) before interviewing took place helped to construct hypotheses and questions or checklists, increasing the reliability of research. Nine meetings about UC policy were observed at national level and five meetings at provincial level during fieldwork. To record observational data, the researcher used field notes. Broad descriptive categories were used as a framework of data recording (see an example of observation records in Appendix 3).

Interviews

This study used interviews to give narrative information (Grbich 1999) and explanations. Information from interviews provided the perspectives of respondents. In order to generate appropriate data from people who were involved in the policy, this study used the purposive sampling technique (Silverman 2001). Key informants were selected from two groups, actors at the national level and the provincial level. The sampling of key informants at the provincial level was bounded in a province, Saraburi. The typical case sampling (Green and Thorogood 2004) was used in selecting Saraburi to gain the information-rich case for in-depth study and Saraburi was selected for three reasons: both private and public providers in the province joined the program, the province faced budget constraint and requested extra money from the Contingency Fund, and data and health personnel were accessible. As there were 13 district-health services provided by two provider networks, two districts were selected with convenience from the districts which had providers in the Saraburi Hospital networks, and two districts from the districts which had providers in the Phabudhabaht Hospital networks.

For interview, the study started by selecting the visible actors who represented various groups involved in the policy process and followed on by using the 'snowball' sampling technique. New interviewees were included in the sampling until nothing new was being generated or the information came to the point called 'saturation' (Green and Thorogood 2004). However, access to interviewees was not always easy. Despite the researcher using an institution's letter to introduce her position, a few key informants refused to be interviewed. Finally, the sampling stopped when the time ran out. Nevertheless, 47 out of 53 approached informants were interviewed: 23 at the national level and 24 at the provincial level (with 2 refusals and 4 no responses). Lists of interviewees are given in Appendix 4.

The interview structure was a guided open-ended checklist of questions. The topic guide for interviews was developed from the research questions. It was improved iteratively all the time

it was used as the new answers created the new questions. However, the guide became stable after second or third times it was used with the same category of the key informants.

Face-to-face interviews were performed at respondents' offices, taking about 40 minutes. Tape recording was used with permission. Information from different perspectives helped triangulate the data. Interviews were transcribed and some were followed up with a second face-to-face interview. This served to verify the information.

Text analysis

There are many approaches to textual investigations of different types of documents. Publication, records, minutes and official proceedings were relevant to the way organisations account for their activities. Public opinion polls were relevant to how the public support the policy. This study treated these texts as description, telling the story of what had happened. Two main sources of minutes and official proceeding were the Bureau of Health Policy and Planning and the Office of Health Care Reform which acted as secretary office of the UC policy in 2001-2. Other documents were from key informants and related organisations.

For text analysis, inductive approach is useful for analysing complex data and massive documents through the development of summary themes or categories from the raw data (Thomas 2003). The categories or themes in this study were developed by both the research objectives (deductive) and multiple readings and interpretations of the raw data (inductive). The documents were read, analysed the linkage among them, and labelled for category by codes and short phrases of themes. Some categories were combined with other categories or splitted into several categories after revisions and refinements of category systems. Finally, report writing created 3-8 most important categories of findings in each issue or heading, and used detailed descriptions and quotations to illustrate the meaning of the categories developed.

The other form of analysis used was media analysis. Content analysis was used to investigate the public's interest in UC. A set of categories (the health insurance and service is a sub-category of health sciences) was established and then the number of instances that fall into each category (Silverman 2001). Only one category, health insurance and services, was counted, for comparison to the total news items in the health sciences category. The number of health policy stories that appeared before and after the UC policy was launched was observed in 20 newspapers¹⁵ during January 1999-December 2001, using the electronic database of the

¹⁵ Lists of 20 newspapers included Bangkok post (Eng), Banmuang, Dailinews, Khaosod, Krungtheptharakij, Loke-one-nee, Matichon, Naewnar, Phuchadkarnraiwan, Phujadkardraisabda, Prachachard Thurakij, Saimratch, SiamThurakij, Telecom Journal, Thai Post, Thairatch, Thansethakij, The Nation (Eng), Wattajak, Wikroa-Bammuang

Matichon Newspaper Library. The results of quantitative analysis of the media are shown in Chapter 3.

Focus group discussion

Focus group discussion is useful to draw perceptions of individuals and communities. Focus group discussions were used to gain information from villagers because it allowed a view of the community and it saved time (Morgan 1997). Four focus groups were conducted in four tambons (sub-districts) with an average six persons per group. The study selected four tambons in four study districts to relate the story of the implementation of the '30 Baht Scheme' (as the UC policy was popularity known) in Saraburi. Potential differences between urban and rural areas were observed by selecting two tambons within municipalities and two tambons outside municipalities. Co-ordinators at health centres selected participants with two criteria: the participants had expressible opinions about the 30 Baht Scheme and were available on the appointment date. Four main points of key informants' perceptions were investigated during the discussions:

1. Who gained and who lost from the 30 Baht Scheme,
2. Participation and communication,
3. Enrolment, and
4. Service delivery system.

The discussions took about an hour, and were all recorded with permission. A research assistant took notes, and transcribed the conversations.

2.3.4 Data collection at National level

The national level study included key informants from:

- MOPH: the Health Care Reform Office, the health Insurance Office, the Health Systems Research Institute, senior officers of the Permanent Secretary's Office, the Deputy Permanent Secretary, the Deputy Minister of MOPH,
- An academic from Narasuan University (little involvement from other universities),
- NGO representative,
- Political parties,
- Three informants were not interviewed: Private Hospital Association, Rural Doctor Society, Provincial Hospital Association

2.3.5 Data collection at provincial level

At provincial level, Saraburi was selected as a study case. Key informants were from Provincial Health Offices, Provincial Hospital, private hospitals, public hospitals, District Health Office, and Health Centre.

Documents examined at provincial level included plans, minutes, guidelines, budget allocation plan, financial reports, law and regulation documents etc. Local newspapers were not included in the study because they were not archived.

2.3.6 Scope of the study

This study looks at the UC policy process in 3 stages, at agenda setting, policy formulation, and implementation. For the agenda setting and policy formulation process, information was traced back before 2001, focussing discussion on the way supporters of reform in the MoPH interacted with the political party that became the government. For the implementation process, the study focussed on the precise changes that were introduced by UC at the national and provincial levels during January 2001 to September 2002 (fiscal year 2001-2002). The study design was initiated in 2001 and the fieldwork was carried out from November 2001 to September 2002. Data analysis and thesis writing started alongside the data collection and were completed in March 2004.

2.3.7 Limitations of the study

Deciding to investigate a contemporary policy has many advantages as the event is fresh, the public climate is observable, and documents are still available. However, information on the outcomes is limited. Therefore, the study cannot fully explain the outcomes of the policy process.

As this type of research requires iterative analysis alongside data collection, a researcher undertaking all the interviews and doing all observations can control internal validation, but this takes time and could be biased. Some informants were excluded because they did not respond to the invitation letters or first follow-up calls. However, information about these informants was derived from other sources such as media, documents, and third persons.

As this is mainly a single researcher study, the position of the researcher can be a source of bias for both the informants and the researcher. The fact that the researcher is a research fellow at the International Health Policy Program, MOPH, which supported research and knowledge for this policy, meant some informants assumed the researcher was not objective, and felt uncomfortable about expressing their opinions. Some refused to give an interview, which may have been for this reason.

As the time was limited, only one province was selected. Evidence from other studies show that there are variations between provinces; therefore, any generalizations from this one province must be made cautiously.

Another limitation is language. It was difficult to explain a story that occurred in Thailand using the English language. The research had to be collected, recorded in Thai, and then

translated into English. It was also not always easy to make direct translations. To avoid distortion, this thesis, in chapters three to seven, starts by telling the stories before jumping to the analysis.

2.3.8 Reliability and validity assurance

Comparing perspectives of key informants from interviews or different methods is a useful way of triangulation. This study used multiple methods, and sent data back to some respondents to validate the finding. As a single researcher, a uniform approach in collecting qualitative data was assumed, ensuring higher reliability and more internally valid cross-comparisons of data. The limitation of the single analyst is individual bias, which was tested by getting critical comments on data analysis throughout the study, from key policy-makers and academics in Thailand. Furthermore, the interim conclusion was presented to a support group to reveal unjustified assumptions.

2.4 Chapter summary

The main question this thesis asks is: how did the UC policy get onto the political agenda, and how was it formulated and implemented? To answer this question, a framework has been elaborated after a literature review of different policy approaches. As policy is complex, the framework chosen to organise the knowledge has been simplified, to include four interrelated elements: content, context, actors, and process (Walt and Gilson 1994). Literature suggests that policy is an interactive process including broad causes of interaction of several actors. The extent to which actors outside of the government are involved in the policy-making process depends on the political context which determines the distribution of power in policy-making. At different stages, different actors and different contexts are important in shaping policy. The policy characteristic and the strategies to execute the policy are important to the success of the policy. To understand the UC policy, and assess whether it is going to be sustained, needs exploration of all elements: content, actors, context, and process.

In order to explain the phenomenon well, qualitative methodology was used. Qualitative methods used in this study included four main methods of data collection: observation, interview, text analysis, and focus group discussion.

Chapter 3 - Agenda Setting Process

3.1 Introduction

This chapter focuses on the agenda setting process, aiming to answer how and why the UC policy became a priority on the government agenda. It also involves the policy formulation process before the government came to power. It begins with narration of the events in the Thai Rak Thai Party (TRTP), starting with the origin of the Party's health policy before its slogan became: '30 Baht treats all diseases'. The following sections explore the parallel role of bureaucrats and civil groups in promoting universal coverage.

Two points in the policy officially declared in February 2001 (see Chapter 1) were different from the TRTP's first policy announced in March 2000. Firstly, the source of finance was changed so that general tax revenues replaced a 100 Baht monthly contribution that had been suggested in 2000. The scheme's financial input will therefore depend on the government budget. This avoided public reaction to the payment and gained popularity by prompt implementation; however, the cost was concentrated on bureaucrats, who were resistant to change. Secondly, the '30 Baht treats all diseases' policy came under the MoPH, while the policy in 2000 had intended to establish a National Health Security Office under the National Health Security Act to manage the national scheme, aiming to create collaboration between several ministries and split purchaser from providers. The scheme which was put forward in 2001 had limited participation at the initial stage, and expanded to involve public hospitals in other ministries and private providers in the subsequent stages. However, the MoPH was able to provide resources for immediate implementation, although this had implications for regulation, because the MoPH plays both purchaser and provider roles (Interview K5).

The next section describes the agenda setting process in the TRTP and how UC became a TRTP issue, why the Party chose it for the election campaign, and why the content in the policy announced in February 2001 was different from the Party's first campaign.

3.2 Agenda setting in the Thai Rak Thai Party (TRTP)

The political agenda setting process was explained by a TRTP member interviewed in June 2002, who subsequently became the Deputy Health Minister. It has to be traced back to the time that the TRTP was set up in July 1998. According to this key informant, the leader of the Party - Mr.Thaksin Shinawatra - originally intended to establish a new political party to fight for popular policies. In order to do so, the Party's leader had met several people from many sectors including businessmen, well-respected village leaders, and civil organisations.

In addition, the Party set up a taskforce to monitor government performance in mid 1999. This taskforce used to meet every Thursday. Four members of the taskforce were designated to be a health team. All were medical doctors, two of whom were subsequently appointed as the advisor of the Health Minister and as Deputy Health Minister. The first was the President of the Thai Medical Council before joining the TRTP as the shadow Health Minister. This health team was responsible for evaluating the performance of the then current government on health and formulating a health policy for the TRTP's election campaign. The current Health Minister was not in the health team – her interest was in transport, as she had previously been a Deputy Transport and Communication Minister (1994).

While seeking a core health policy, in a taskforce meeting the party leader raised the issue of the inefficient utilisation of public and private health resources. The leader mentioned the case of Phayao Province to demonstrate the inefficient use of private hospitals. He told the meeting that when he visited Phayao province, the public hospital was crowded whereas the private hospital nearby was empty of patients. He said that situations like this should not happen, and then suggested to the health team that they address the question of collaboration between public and private facilities in the health care system to make the most efficient use of resources.

The health team at that time had discussed issues such as human resource development and the idea establishing the national health council, but these ideas were fragmented and would not be able to initiate system change. The desirable policy was explained by using a metaphor; the policy should be like a drop of water, able to make ripples. After several discussions, the group still could not come to a conclusion. In order to help decide the core policy, which would address the party leader's policy question, a team member personally contacted a health reformist, who was a Class 10 MoPH advisory officer¹⁶.

The first meeting between the member of the TRTP and the reformist was in 1999 (Interview 5, 20). The reformist was asked what his vision for public health was. Two issues were raised. The first issue was about health promotion. However, the then government had made some progress on this - the Health Promotion Office was already established as a public organization; the draft of the Health Promotion Bill was, at that time, in parliament. Therefore, this issue was not perceived as fresh for the policy agenda of new political party. The second issue was the universal coverage of health care (UC). At that time, only 69% of Thai people were covered by the health insurance system. The TRTP member's perception at that moment about UC was that "it was a good policy" and it was in line with the 1997 Constitution. However, he did not see how UC policy could be a crucial tool to initiate the health system reform as a whole and

¹⁶ Class 10 is the second top rank of Thai civil servant hierarchy. Class 10 civil servants include several positions such as Deputy Permanent Secretary, Director General, and Advisor of Permanent Secretary.

how this policy could promote collaboration between public and private providers. The TRTP member requested the reformist to prepare details of UC policy development to present to the party's leader in the near future.

Indeed, the Party leader had met this reformist and other senior health experts in some other meetings months before but the issue of UC had never been discussed (Interview K5, K22).

Additional to that meeting, the Thai-Rak-Thai health team sought other sources of information and consulted the Party's economic team, one of whom subsequently became the Minister of Finance. The question was how to implement UC if the TRTP selected this issue as party policy. The initial information (subsequently published as a small 24-pages booklet) from the reformist (Nitayarumphong 2000) did not define the details of the institutional arrangement and system management, i.e. provider payment methods and level of capitation rate. It just gave a crude assessment of the budget requirement being between 80-100 billion Baht. However, the experience of the capitation payment of the Social Security Scheme (SSS) convinced the TRTP health team that the UC could be achieved with an appropriate capitation rate. At that time, the TRTP health team was not convinced that the government budget could afford the UC scheme, until a member of the TRTP health team proposed the 100 Baht per month contribution (1,200 Baht per year). Additionally, it was suggested a nominal fee (of around 20 Baht) would be collected at the point of service to prevent the unnecessary use of services. The decision to ask for a monthly contribution of 100 Baht was abandoned over a ten-month period however.

In December 1999, the health reformist was invited to present his idea to the TRTP leader in a small group meeting. Participants were some members of the TRTP health and economic teams. At that meeting, the party leader raised many questions which suggested to participants that the party leader understood very well what the implications would be if UC was introduced, and what problems and obstacles the Party needed to be aware of (Interview K5, K20). At the end of the meeting, the Party leader accepted UC as a Party policy priority, and let the team proceed with the policy formulation. The party leader observed that the public might not understand the phrase "universal coverage of health care"; therefore, he suggested using the phrase '20 Baht treats all diseases'. Disagreement on the payment level led finally to acceptance of a 30 Baht payment, and the TRTP campaign promise of '30 Baht treats all diseases'.

UC was announced by the TRTP as part of the national agenda at the first convention of the TRTP, held at the Thammasart University gymnasium for about 10,000 members of the Party on 26 March 2000. The Party leader announced 11 national agenda priorities including the suspension of debt for farmers, changes in education, and health. The Party addressed “the new profile of the public health services” [Prick Chom Borigarn Satharanasuk] (see details in Box 3.1) although the term ‘UC’ did not appear. The first booklet on health issues – ‘the wall to which the poor have their backs’ [Gampaeng Ping Lung Khong Khon Jon] – was disseminated in the convention. It described the universal coverage policy including the 30 Baht payment per episode plus a 100 Baht monthly contribution, the provider payment system, the provision of hospitals, and the use of public and private facilities, for example.

Box 3.1 Health Policies of the Thai Rak Thai Party announced on 26 March 2000

1. To provide health insurance for 62 million people according to need and households contribute according to ability to pay.
2. To provide choices for people to register with a health care provider from both public and private sectors. The health care provider will receive an adequate budget according to the number of registered population in order to shift the health services authorities back to the citizens.
3. To provide quality hospitals with geographic accessibility.
4. To support health Promotion in children, adolescence, adults, and elderly as national priorities.
5. To provide disease prevention by health 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 health knowledge and health skills of people.

Source: TRTP (2000). The new profile of the public health services

This booklet was followed by a much shorter disseminated paper – ‘19 questions about the national health insurance policy’ [Sib Kao Kamtham Kamtob Karn Pra Kan Sukkaparphearnghart 30 Baht Tor Krang Raksa Dai Took Rok] – launched in July 2000. After that, the party set up a taskforce chaired by a TRTP member who subsequently became the Minister of Foreign Affairs, to translate the Party’s policies into tangible policies. The health policy draft was based on the first booklet. At this time in October 2000, the 100 Baht contribution was removed. The ‘19 questions’ paper was reduced to ‘17 questions about the national health insurance policy’.

According to a TRTP member (Interview in June 2001), the Party cut the direct contribution of 100 Baht from the Party’s policy paper just a few months before the election for two reasons. Firstly, they thought that premium collecting would be complicated. Secondly, they reviewed literature from several sources and estimated that the budget for UC need would not be higher than 100 billion Baht, and that would be affordable through the government budget. Although

he did not say explicitly, it may also be that the Party anticipated this would be unpopular. He suggested that some candidates for Member of Parliament expressed concern about the explanation of the 100 Baht contribution.

Three main sources of information on what UC might cost led to a change of mind. The first, a technical report by Management Sciences for Health and the Health Systems Research Institute (HSRI), supported by the Asian Development Bank, suggested a capitation rate of 1,040 Baht to achieve UC (Donaldson, Pannarunothai, and Tangcharoensathien 1999). The second source was the budget of the first autonomous hospital, Ban Phaew hospital. This hospital became a public organisation in October 1999 and received a budget of 782 Baht per capita per year (Pitayarangsarit et al. 2000). The third source was the rate of the SSS of about 1,400 Baht per year (1,200 Baht of capitation and 200 Baht of additional payment adjusted for high cost care). From these rates, the health team was able to estimate a crude budget need for about 60 million people in the range of 62–84 billion Baht. While the total government budget for health in 1999 was already 70 billion Baht (including budget for MoPH, CSMBS, and SSS), UC would be achieved with a small additional budget. Within the estimated budget range, the taskforce anticipated that the UC policy was affordable and feasible. This idea was similar to that of a group of researchers (Nitayarumphong and Pannarunothai 1998) studying the feasibility of achieving UC by adding additional budget. But, in view of the calculated budget change, system reforms would be required.

However, public notification of the deletion of the contribution issue lagged behind the change in Party policy (Interview K16) because the party did not change its statement on its WebPages, (Interview K20) and newspaper information in January 2001 still included the 100 Baht contribution (Wattajak Newspaper 2001).

On Election Day, 6 January 2001, the exit polls showed the possibility that the TRTP would win a majority of seats in parliament, providing political stability and unity. Thus, it was felt that UC was highly likely to be implemented. When media representatives asked the TRTP leader what issue the new government would push, the party leader said “the suspension of debt for farmers’ for three years, the village revolving loan fund of a million Baht each, the Citizen Bank, and the ‘30 Baht treats all diseases’ policy.

After the election, the health reformist suggested to the Party leader that it would be best to gradually move towards UC, starting in October 2001 with a few provinces. Implementation of UC would then take three years to achieve. However, at the first workday of the new Health Minister, on 19 February 2001, the Permanent Secretary announced that UC would start on 1 April 2001 in six pilot provinces with political support.

In the week before 26 February 2001, the government policy declaration day, a group of staff in TRTP preparing for policy declaration reviewed literature documents including recent academic papers from the Health Systems Research Institute (Siamwalla 2001) and Narasuan University (Pannarunothai 2000b). The Party then had much more detail and the confidence to raise UC as a high priority for urgent implementation. In the policy declaration, UC was one of the nine high priority policies (see Box 1.1 in section 1.5).

UC agenda setting can be summarized in four points. Firstly, the TRTP had a proactive process to formulate its health policy. The Party had consulted widely; not only meetings with one particular reformist, but also the Party leader had met other senior health experts. This process exposed the party to considerable information on health problems and critical health issues.

Secondly, information about UC had long existed, and had been discussed. The health reformist and other academics had studied UC issues; there were several national studies available to support information for the Party decision.

Thirdly, UC was picked up by TRTP because it had three dominant characteristics: legitimacy, congruency, and feasibility. Access to health care is stated in the Constitution as a right of Thai citizens; therefore, government saw UC as a legitimate move. UC was seen as a potential precursor to reform the health care system, and that was congruent with the Party's intention to reform the public services. Last but not least, the policy was seen as feasible under the existing government budget. The TRTP's economic team, which included the Minister of Finance, agreed with its feasibility and supported the idea. This is similar to the Hall model (1975) which suggests that when an issue is high in relation to three conditions – legitimacy, feasibility, and support – it is more likely to become an agenda item.

Fourthly, the policy content was changed in order to push the policy along. The monthly contribution was removed because the contribution collecting system was not available and it would take time to communicate with individuals. The MoPH was used as the management body of the scheme as it had staff capacity, organization, and experience; therefore, a new system could start up within a few months. These changes had some benefits. Rapid implementation can avoid organized resistance (Cleaves 1980); therefore, choosing the MoPH would ensure execution could proceed quickly. However, the rapid implementation might cause difficulties. Insufficient work on technical financing issues meant that there was over-optimism regarding the ability of the government budget to meet the costs of UC. While radical reform to amalgamate several schemes lagged behind the extension of health insurance coverage, the initial UC budget would be higher than the expected budget. Insufficient work on resource reallocation formula would delay the achievement of equitable resource allocation. These consequences will be discussed again under implementation in Chapter 5.

3.3 Floating the UC agenda amongst bureaucrats

Protection against the risk of medical bills has long been a concern in Thailand, as had geographic barriers to health care access. Health centres at all tambons (sub-districts) had reduced problems of access, but health insurance coverage, while gradually increasing, still did not cover all Thais in 2000. Several public health insurance schemes had been established at different times to cover four major population groups: government employees, private sector employees, the poor and underprivileged, and the self-employed. Coverage rose to 69% of the population in 2000. Increased coverage of health insurance had led to UC being perceived as the next step to achieve a national health insurance.

Health benefits for *government employees* have a long history. The government has paid for work-related injuries and illness as a fringe benefit for government employees since 1955 and this was extended to cover non-work related injuries and illness subsequently. In 1978 and 1980, the Civil Servant Medical Benefit Scheme (CSMBS) was launched by Royal Decrees, paying medical bills for current civil servants, employees, pensioners and their dependents (*Royal Decree for Civil Servant Medical Benefit Scheme. B.E.2523. 1980; Process to Propose a Bill by Electors Act 1999; Rojvanit 1993; Supachutikul 1996*)).

The idea of health insurance for *private sector employees* originated under the social security principle of the 1954 Social Security Act (Chantaravitul 1985). This Social Security Act was not implemented because of resistance from private insurance companies and enterprises including state enterprises. Chantaravitul (1985) discussed three reasons for this failure. First, the government did not undertake a situation analysis of the real need of workers on income security. Second, the first Social Security Act was too broad and did not define the workers' benefits. And lastly and most importantly, public communication of the value of social security was poor. In addition, there were inadequate health service facilities and personnel, and political instability (Tomornsak H, 1966 quoted in Supachutikul A, 1996). In spite of several attempts to implement the first Social Security Act, there was no decision from any government to start. The officials of the Labour Bureau and academics then shifted to an alternative, and successfully proposed the Workmen Compensation Fund in the second amendment of the Labour Law (1972). The Workmen Compensation Scheme (WCS) has been implemented since 1973. This scheme collects moneys from employers to protect employees and pays medical bills for work-related injuries and illness, invalidity and death compensation, including cash benefit for sickness absences. The WCS coverage was gradually expanded from Bangkok to other provinces and finally covered the whole country by 1988 (Nitayarumphong 1993). Since the WCS does not cover non-work related illness, the Social Security Act was reconsidered after General Prem Tinsulanond came to power in 1980 and announced an explicit social security policy on May Day 1980 with support from the National Labour Union. The formulation

process was a long and political process until the Act was approved by parliament. Students, labour unions, and NGOs together pushed this act by sending letters to all political party leaders. The Social Security Scheme (SSS) was then implemented in 1991 under the 1990 Social Security Act. This scheme supplements the WCS by providing comprehensive health benefit coverage on the basis of a tripartite contribution.

For people outside the formal working sector, fee exemption of health care for the poor came to be a major government policy for the first time in 1975, during the regime of Kuk-lit Pramote, and was administered by the MoPH. This scheme subsequently expanded coverage under the new name 'Medical Welfare Scheme' (MWS) to cover the elderly, children, handicapped, veteran families, monks, religious fraternities, community leaders, and health volunteers (Nitayarumphong 2000).

For the rest of the population, a community-financing project was established in 1983 and subsequently became the *national voluntary health insurance project*. At the beginning, the MoPH started this community-financing project as a pilot research project named 'Mother and Child Health Development Fund' to promote community health care. This project was then rapidly expanded under the name of the 'Health Card Project' to cover all districts in 1986 with government support, evidenced by the policy declaration on 27 August 1986 and also in the Sixth National Health Development Plan (1987-1991). In addition, the health card project was expected amongst academics, both in universities and the MoPH, to be expanded to achieve universal coverage (Boonyuen and Singhkaew 1986). However, the health card project did not continue expanding because of political instability and limited support from Permanent Secretaries in the MoPH. In addition, the project had community management problems and needed reform to improve the quality of management. After the pilot projects during 1984-1993, supported by the German Aid Agency, GTZ, the Health Card project was transformed into the Voluntary Health Card Scheme (VHCS) with an insurance basis at the national level, and gradually expanded coverage for the self-employed (Keeranund 1993). Since health insurance coverage had been increasing, UC was seen as a logical next step, provided a feasible policy could be designed.

UC was discussed again in 1993. That year, the National Economics and Social Development Board (NESDB) together with the MoPH and the World Bank (WB) held a national workshop, 'Health Financing in Thailand', in Petchaburi Province, Thailand. There were 47 participants, mostly Thais, from universities, the MoPH, the NESDB, the SSO, HSRI, Thailand Development Research Institute (TDRI), the Private Hospital Association, and the Nation Newspaper. Five participants were from international organisations (see list of participants in Appendix 5). Universal coverage was discussed at the workshop but there was no consensus on how to achieve it. For example, one group in the workshop focused on the process of reform

with incremental changes within 12 years coordinated by the National Health Security Coordinating Body. Another group wanted to set the National Health Security Purchasing Cooperative as a single fund manager for a major reform.

In January 1996, an international workshop on 'Health Care Reform: At the Frontier of Research and Policy Decisions' was held in Nakornrajsima Province Thailand, supported by the Commission of the European Union (EU) and the World Health Organisation (WHO) through the MoPH in cooperation with HSRI. There were 52 participants including 23 Thai participants (see participant lists in Appendix 5). In that workshop, the paper 'Thailand at the Crossroads: Challenges for Health Care Reform' (1996) discussed UC and raised the question of how to achieve it (Nitayarumphong and Pannarunothai 1997). In addition, the paper raised other aspects of the Thai health system, i.e. the health financing system and health delivery system, which needed to be reformed to achieve an equitable and efficient health system. This workshop highlighted the important contribution of research at all stages of the health care reform process and the necessity of involving civil society (Nitayarumphong 1997).

On 15-17 March 1998, Thailand held another international workshop 'Achieving Universal Coverage of Health Care: Experiences from Middle and Upper Income Countries' in Bangkok. This workshop was supported by the EU through the Thailand Health Care Reform Project, the MoPH in co-operation with the Institute of Tropical Medicine (Antwerp), the London School of Hygiene and Tropical Medicine (LSHTM), and Edinburgh University. There were 64 participants, 31 from Thailand and 33 from other countries and international agencies (see the list of participants in Appendix 5). UC was discussed thoroughly in the workshop, but Thai participants were unable to reach a consensus on how to achieve universal coverage, with disagreements especially on the timing.

The policy of achieving UC had thus been raised as an issue several times since 1996. The first draft of the National Health Security Act was from inside the MoPH, headed by the health reformist (the same person who met the TRTP member). This draft proceeded through the normal bureaucratic process and was submitted to the cabinet and consulted by several ministries, and then sent back to the MoPH for consideration. However, the MoPH officials, including the Permanent Secretary (PS) of the MoPH at that time, did not support the draft and delayed its consideration (Interview K5). In parallel, a second draft was presented via the parliamentary process by a health commission of which the reformist was a member. The health commission approved the draft, but did not actively push it for Parliamentary adoption (Jongudomsuk 2002), and Parliament was dissolved before the first draft returned to Parliament. The PS was reluctant to approve the draft because the administrative authority for the budget for health care would shift to an autonomous commission. The MoPH bureaucrats in the Health Insurance Office, who were responsible for reading the draft, also did not support the Bill

because they anticipated insecurity in their careers from the office transformation (Interview K5, K10).

UC was floated again in the 1997 Constitution and the 8th National Health Plan (1997-2001). The Constitution confirms the value of health care in Thai society, stating that health care is a right of Thai citizens. In addition, the 8th Plan aimed to achieve UC; however, due to the economic crisis in 1997 and a lack of political support, there was no definite implementation plan in the MoPH.

However, health-financing reform was still a major focus of attention amongst researchers in the MoPH. The Health Systems Research Institute (HSRI), an autonomous institution regulated by the Ministry of Health, collaborated with the Comptroller General's Department, Ministry of Finance to develop the method of provider payment in the Civil Servant Medical Benefit Scheme (CSMBS). The HSRI established a taskforce, including experts from universities and MoPH, to design the more desirable health financing system in Thailand and propose CSMBS reform. The HSRI intended that the CSMBS reform would be used as a pilot study for health financing reform of the whole health system with step-by-step changes. The CSMBS reform would start to develop the payment system using case-mix information (Diagnostic Related Groups weights - DRGs). The proposal for CSMBS reform was accepted by the Comptroller General's Department to test the new provider payment system in the fiscal year 2001. After finishing that proposal, the HSRI taskforce was re-appointed to design alternative models of the management system for achieving the universal coverage of health care. The HSRI released the proposal on Universal Coverage in March 2001 just after it had been declared policy by the new government. The process of that taskforce working facilitated understanding amongst experts and the details of the paper were helpful in the policy formulation process and implementation. For example, the paper suggested a set of concrete objectives for UC including equity, efficiency, choice, and good health. These objectives became guidelines for the current UC policy. The paper also discussed strengths and weaknesses of three alternatives to achieve UC: expansion of existing systems, a single system, and dual systems. It also suggested organisation and management arrangements including preparation plans for each alternative.

3.4 Roles of civil society

Interest groups changed their previous roles from external lobbying from the outside to being a part of the political process. NGOs and civil society groups were explicitly involved in the civil movement to support and propose the draft of the National Health Security Bill, while professional associations were not explicitly involved at this agenda setting stage (some members of the medical council were part of the TRTP agenda setting process). However, they

both were brought into the next stage of policy formulation as members of Health Commissions. The media had shown public interest in UC especially after the election.

The 1997 Constitution motivated civil groups to participate in the policy agenda setting, as the Constitution enhanced Thai law to allow 50,000 electors to propose a Bill regarding citizen rights and role of state (*Process to Propose a Bill by Electors Act 1999*). A group of civil society networks led by Jon Ungphakorn, a leader of the NGO 'People Living with AIDS network', with the support of more than 50,000 people, proposed a draft of the National Health Security Bill with technical support of health reformists. Mr. Jon, who subsequently became a senator by election, brought up the idea of UC among NGOs after meeting with the health reformist in 2000 (who failed to push the draft bill by the bureaucratic process and disseminated the idea of UC in a small booklet). Eleven NGO networks formed a united front to announce their intention to support UC in October 2000 in the campaign named 'Klong karn ronnarong pur luk pra gun sukthaparb tuanna' [Campaign Project for Universal Coverage] (NanUdon 2002). They were: consumer networks, children protection networks, handicap networks, People Living with AIDS network, labour network, elderly network, women network, alternative agriculture network, Southern Village Bank network, the Urban Community Welfare Fund, and the poor network. Their standpoints were equitable benefits for all groups of population, increasing people's participation in health management, and consumer protection. Their draft was submitted to the president of parliament in March 2001. While the parliament was auditing the list of 50,000 supporters, the government had completed its draft Bill. In November 2001, the government draft was submitted to parliament for consideration. Although the parliamentary process aborted the people's draft, five members of the NGO network were designated as members of the parliament commission for the National Health Security Bill of the House of Representatives, and three members to the Senate. The TRTP government facilitated and supported the Bill until the National Health Security Act was launched on 18 November 2002; just a year after the Bill was submitted to parliament.

Investigated in the Matchon Library Database, news items from 20 newspapers in Thailand over the period 1999-2001 illustrate how public interest in health and health insurance changed. The number of news items per year just related to health insurance increased from 42 and 53 in 1999 and 2000, to 433 in 2001. This was a dramatic increase when compared to the total number of news items under Medical Science & Public Health of which the number of news items were 893, 912, and 1,203 respectively. From January 2001, health insurance received a great deal of coverage and public interest, which peaked in March 2001 and remained at a high level. Interest in UC was clearly visible in October 2000 when NGOs (led by Mr. Jon and consumer groups) declared their support. Many public opinion surveys after government came

to power confirmed the policy's popularity (SuanDusit Polls 2001a; SuanDusit Polls 2001b; SuanDusit Polls 2001c).

In sum, UC had long been discussed in Thailand before the TRTP selected it as its priority. Although it was part of the 8th National Development Plan (1997-2001), it had not met political support and had been obstructed by the downturn in the economic situation. MoPH officers played both 'bureaucratic' roles and 'reformist' roles. The reformists were policy entrepreneurs, advocating UC through MoPH functions, social movements, and political processes. Bureaucratic roles were conservative, and led to stalemate in change. While democratization opened opportunities for people to participate in the policy process, reformists supported information for civil movement to raise the UC issue in the public's interest. Civil groups played pivotal roles in proposing a law in line with the TRTP's UC policy and subsequently integrated themselves in the political process to support UC as members of Health Commissions with the support of senators. These several factors facilitated the conditions for the UC issue becoming part of the government's agenda. The next section discusses factors influencing in the agenda setting process, explained by a framework of four elements: content, context, actors and process.

3.5 Factors influencing the agenda setting process: content, context, actors, and process

The characteristics of UC – legitimacy, feasibility, and congruence with the political party's policy – were important factors in its reaching the political agenda. Using the policy triangle framework, we can explain this by looking at four interrelated elements: content, context, actors, and process.

3.5.1 Policy content: legitimacy, radical, and popular

The content of UC reflects existing health problems, society's values, and government ideology. This policy was justified as it responded to problems in health care access, which were mentioned in Chapter One. These problems were suppressed under bureaucracy. It is clear that the trigger, which served to bring the problems to the attention of the TRTP, was the economic crisis which emphasised the suffering of people caused by medical expense. UC is in line with Thais' value that 'Health is a human right', which is in the 1997 Constitution. Therefore, the policy is supported by Thai people and consequently has political support. With the people's support, UC policy was able to bring about radical change in the Thai health system.

UC resulted in radical changes. Two major system changes resulted from the 2001 UC policy. Firstly, it extended health access eligibility to all Thais, with a tax-financed system in effect from April 2001, and consequently public hospitals received a controlled per-capita budget. Secondly, it increased participation, equity, and efficiency in health financing administration

through a structural change – the establishment of a single national body, the National Health Security Office, which will enforce the system three years after the National Health Security Act was launched (November 2002). It should be noted that UC did not affect the physician payment system.

The UC content was dominated by the TRTP favouring popularity. The UC concept suggested by reformists originated in principles of equity and solidarity, i.e. protecting all households but with households paying according to ability to pay. It was accepted that the benefit is distributed to all beneficiaries, but that those who could pay should bear the cost. While the government agreed that all Thais, regardless of economic status, were entitled as beneficiaries, it did not dare to collect money from households. Its decision was both political and technical. Firstly, government could start the implementation immediately and argue that the government budget would be enough to finance the scheme, thus gaining popularity. Secondly, it was not clear how the monthly contribution would be collected, and the Party had evidence from many sources that the cost could be met from general taxation. Initially, the TRTP's health team expected to take advantage of the health reform by amalgamating the administration of two other schemes, Social Security Scheme and Civil Servant Medical Benefit Scheme, into the National Health Security Scheme. UC would then have been achieved with a small additional budget. However, the amalgamation was difficult in reality. It is clear that the TRTP dominated the agenda and also the content. This differs to Kingdon's suggestion (1995:4) that presidents can dominate the policy agenda but they have much less control over the alternatives that members of Congress consider.

Monthly contribution was likely to be contested as the costs would have been borne by a large group of the population, and this dispersion of costs is an indication that the policy would generate reaction in the public arena (Grindle and Thomas 1991). In citizens' favour, government chose to burden the government budget, where the cost concentrated on public hospitals so that government was able to limit the budget. This was likely to create reaction in the bureaucratic arena. However, the government immediately created visible benefits resulting in public support, which was the countervailing force to opposition arising among the bureaucrats.

It can be concluded that UC was chosen because it was expected to be a popular, vote-winning policy.

3.5.2 Policy context

Several contextual factors affected UC agenda setting. Structural and cultural factors played a part but the situational factors were more crucial to create changes. The situational factors included the general election and economic crisis. The general election created political space

for change. At that time, Thai people demanded a new government as they had suffered from the economic recession. After the economic crisis in 1997, many government measures helped big business to recover. Rural farmers who also were affected from the economic recession felt that government should help rural people too. They protested increasingly during the then government. The TRTP offered many policies to relieve the poor (e.g. suspension of debt for farmers and village revolving loan fund) which gained support from rural people (Phongpaichit and Baker 2001b). Political change opens a window of opportunity for any new policy including reforms (Gilson et al. 2003), and in this case, UC was picked up.

3.5.3 Policy actors

There were a small number of important actors involved in identifying and facilitating UC. They were the Prime Minister and his team, health reformists in the MoPH, research institutions, and NGOs. The Prime Minister was the agenda setter while others looked for and supported information for his decision. There was a close linkage between the TRTP doctors and their peers in the MoPH. They had attended the same schools and some used to work together in the same office. The reformists not only had close link with politicians, but they also had links with NGOs and civil groups.

According to Kingdon (1995), the Prime Minister was a visible actor. His staff, health reformists, and other researchers were hidden actors. The following sections summarize their characteristics and power in setting health policy.

The Prime Minister

Major reform policies in the Thai health sector had not been seriously addressed at the political level (Green 2000) until the Thaksin Regime came to power. Thaksin Shinawatra was a billionaire businessman from a near-monopoly in the telecommunications industry. He entered politics for the first time in 1994, and clearly, needed political power for commercial survival (Phongpaichit and Baker 2001b). In 1998, he formed a new political party under the new constitution (1997) and reached his political dream in 2001 when 339 MPs (out of 500) from five out of seven parties voted for him to be the twenty-third prime minister of Thailand, with his party, the Thai Rak Thai Party [Thais love Thais], winning the majority of seats (248 seats) (Nelson 2001b). Two main reasons Thaksin was chosen by the electorate in January 2001 were that the middle class assumed he would be competent to run the Thai economy amidst globalization, and his electoral campaign appealed to rural voters on a platform of measures to spread wealth and help local economies (Phongpaichit and Baker 2001b). Universal coverage or 'cheap health care' was one among other popular policies – suspension of debt for farmers and village revolving loan fund. In contrast to other party leaders, he opened opportunities for

rural society to express its opinion and make its demands by simply asking what the rural people wanted and putting it on the platform.

Thailand has transformed from absolute monarchy to democracy. The power in policy decision making has shifted from aristocrats, bureaucrats, and military soldiers to business-based politicians (Phongpaichit and Baker 1995). The polity became pluralist. The election of Thaksin increased the business-based politician's power, but while his origin is from the metropolitan business elite, his platform also benefited provincial and small businesses and rural people who are the majority voters.

Many observers have asked whether UC is such a popular policy that it will guarantee the Prime Minister's premiership, to the end of his term and extend it (Pongpaichit 2001; Siamwala 2001). Will it generate real long-term benefit to all people, especially rural people? This thesis will discuss this further when we explore the policy content and its implementation.

Thaksin is rich and brought his entrepreneurial experience from business to lead the government. His rise led to a decline in the power of bureaucracy in health decision-making. To gain popularity, he suggested UC implementation as a priority which led to health system changes at the cost of bureaucrats in public hospitals and the MoPH's headquarters. This Prime Minister, therefore, appears to be a powerful change agent.

Bureaucrats

When professionals and bureaucrats are in unison, there is a less chance for major health reform. The Thai MoPH had long had the sole responsibility for writing acts and making decisions on public health. Its bureaucrats are dominated by medical doctors. UC, rational-based policy change was suppressed to maintain the bureaucrats' power over public health through the centralized hierarchical structure.

However, a few reformist bureaucrats played autonomous roles in health service and financing research, and formed a strong body of national researchers who had long studied problems and alternatives in the health sector. They had close relationships and strong capacity. Many graduated from the same medical school and most of them were trained in health 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 health financial structure and change the role of the MoPH in the control of the budget for health 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.

One particular health reformist 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 UC.

The policy, which generates costs to bureaucrats, would be expected to face strong reaction in implementation (Grindle and Thomas, 1991); therefore, we may anticipate seeing resistance in UC implementation (see in the implementation chapter). UC policy reflected a decline in the power of the bureaucracy, not just because of the rise in business politicians’ power but because of the greater participation of civil society organisations.

Civil groups

The 1997 Constitution has 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 organization representatives were elected as senators and voted in parliament for the public interest. Secondly, the constitution eliminates the bureaucracy’s monopoly over public policy formulation in favour of public participation. Moreover, civilians are eligible to propose a law regarding human rights. Thirdly, it transfers the bureaucracy’s role of election administration to an independent election commission.

Visible voices for civil society in Thailand include non-government organizations (NGOs). The development of NGOs started in the 1970s. The prototype was Munnithi Burana Chonnabot Haeng Prathet Thai [the Thailand Rural Reconstruction Foundation] founded by Dr Puey Ungphakorn in 1969. The foundation stood for development which benefits the rural people (Phongpaichit and Baker 1995). Over the 30 years of social and economic changes, and with networks of about 300 organizations, Thai NGOs have extended their interests to many aspects of social development including health, human rights, urban and rural development and politics (Thai Fund Foundation and Development Support Consortium 2003).

In the UC case, voices in support came from a communication network of those interested in UC who received information from reformist bureaucrats, not from independent technocrats as in other social movements.

3.5.4 Agenda setting process

Kingdon (1995) suggests that the processes by which agenda setting items come into prominence are composed of three separate streams – problems, politics and policies – and it is only when these three streams come together that an issue has a high probability of reaching the top of the decision agenda (Kingdon 1995).

As mentioned above, *problems* in health care access were well documented. Details on inequity in access to health care and inequity in health financing were available through a number of

different indicators. Some indicators were reported regularly by government institutions, for example, utilisation rates and patterns, and resource distribution (National Statistic Office, several years). Some indicators were not found in the routine reports, but were available in *ad hoc* studies, for example, issues about catastrophic illness payments (Sujariyakul and Chongsuwiatwong 1999). However, it appears that regular reports played little role in shaping policy-makers' attitudes and position - they provided facts but did not suggest the need for change. However, academic studies and evaluations used primary or secondary data from these sources, and made recommendations for change. In this UC case, formal mechanisms did not play a key role, but the personal experience of the TRTP leader was one of the factors to bring attention to health service problems. Economic crisis led the problems of health care expense to become more severe. The TRTP actively went out to meet people at the grass roots to find out their concerns about health and then discussed these with health specialists. Therefore, the Party knew there was support for its UC policy.

The *political stream* considers the interests of participants. It is composed of a number of elements: national mood, organised political forces, government change, and consensus building. The legislative process of the present constitution was widely participative. The constitution enacted in 1997 caused the new election in 2001 and changed the election system in many aspects; for example, the duty for inspecting political parties has been transferred from the Ministry of Interior to an independent election commission, as described in Chapter One. This forced political parties to find new ways to gain votes. The TRTP is the first party that registered after the new constitution was enacted. The Party competed with popular policies. TRTP manifestos deal with the problems of poverty, and the universal coverage policy was in the public interest and a popular policy.

The *policy stream* is where selection amongst problems and alternative policy solutions occurs. Policy-makers use a number of criteria to judge whether a policy should be on the agenda. The UC was picked up as it has technical feasibility and congruence with the existing values of the TRTP and Thai public (as stated in the 1997 Constitution). The criteria also included the anticipation of future constraints which some research had suggested beforehand, although the full extent of financial constraints only became apparent during implementation. Moreover, UC had public and political acceptability.

The window of opportunity for all three streams coming together was the election of 2001, when the TRTP won a majority.

3.6 Chapter summary

This chapter describes the agenda setting process and answers how the UC issue reached the TRTP, why the Party chose it for its election campaign, and why the content in the policy

announced in February 2001 was different from the Party's first campaign. It also describes the discussion and research on UC in Thai society before and parallel to UC policy development in TRTP. Finally, it discusses factors influencing the agenda setting process of the UC policy.

There were three key themes emerging from this study. Firstly, political support was important to form the issue into a political agenda. UC had long been discussed in Thailand but never received sufficient support to reach the political agenda. Two important sets of actors changed this: the new Prime Minister and bureaucrats who played the reformist roles. The general election provided the opportunity for them to come together. An influential factor that drew attention to UC was the Prime Minister's personal experience. Secondly, a situational factor, economic crisis was important as a focusing event emphasizing the problems of health care and brought the issue to get attention from policy makers. The TRTP was proactive and widely consultative, although the final decision was made by the Party leader. UC was picked up for three reasons: legitimacy, congruence with the Party's principles, and feasibility. Moreover, problems were apparent and solutions had already been developed; therefore, UC was ready to occur, just waiting for the political window and this window was opened by the TRTP. Thirdly, while UC was perceived as a good policy, some characteristics suggested that there would be difficulties in its implementation, especially among MoPH bureaucrats.

Chapter 4 - Policy Formulation Process

4.1 Introduction

This chapter focuses on the policy formulation process after the election once UC had been agreed. It explores how the UC policy was formulated and how the decision-making process shaped the policy content. As mentioned in Chapter 3, UC created two main themes of policy change in different processes. The rapid extension of insurance coverage in 2001 was implemented under MoPH regulation, while the structural change of the national health financing institution was implemented under parliamentary process (between November 2001 and November 2002). The timing of the latter process was outside the scope of this study (see Table 1.2 in Chapter 1 and section 2.3.6 in Chapter 2); therefore, the focus of this chapter is the decision-making with regard to the system design of the 30 Baht Scheme, to achieve universal coverage.

This chapter identifies actors and their relationships in the processes which generated the features of the 30 Baht Scheme. In addition, this chapter investigates six design issues of the UC policy that had most consequence on the health financing system and service delivery system.

4.2 Intent in policy

The intent of the UC policy is the benchmark for policy formulation and implementation. This section describes the design and implementation plan of UC, once it had been adopted by the new government and policy elites in March 2001.

Policy formulation developed through several communications amongst specific policy networks. In the initial period, the discussion of the policy design was amongst a small number of high-level civil servants, and elected officials. Since the formulation process overlapped with the implementation process, participation in decision-making expanded to cover other actors. Table 4.1 illustrates the increase of participation in UC decision-making.

Proposed by the Permanent Secretary (PS) for Health, the 30 Baht Scheme was implemented earlier than the initial plan, which intended to start a trial in October 2001, (Interview K20) and the pace was accelerated by private hospitals, Regional Health Offices and local politicians (interview K5, K7, K16). The PS took a leading role in responding to the government policy, consulted his officials and suggested starting the first trial phase of six provinces in April 2001 - earlier than the Thai-Rak-Thai Party expectation. His reasons were that these provinces had experienced the health financing reform, had developed a registration system and built staff

capacities on financial management under the 'Social Investment Project', financed by a World Bank loan during 1999-2001. While academics thought this was too rapid (Ammar Siamwalla in several newspapers), the media had reported a positive 'strong response to the pilot 30 Baht plan' (Khwankhom 2001). Private hospitals were also interested in the plan in joining the second trial in June, in the hope of recovering their financial status. Regional Health Offices and local politicians urged that the program be launched nationwide in October 2001, rather than go for gradual expansion. They argued that people in all provinces had equitable rights to entry to the 30 Baht Scheme (Interview K7). Other health providers under the Ministry of Defence also responded positively to the UC policy (Kaow Sod Newspaper 2001a). In contrast, university hospitals in Bangkok and health facilities of the Bangkok Metropolitan Authority (BMA) delayed joining the plan. University hospitals anticipated the budget would be lower than their costs (Thairath Newspaper 2001). The Governor of Bangkok was reluctant to support the Health Ministry, saying that the UC policy was not clear (Kaow Sod Newspaper 2001b; Matichon Newspaper 2001a). The extension of health registration covered the whole country by April 2002, and that was before the legislation of the National Health Security Act (November 2002).

Table 4.1 Participation in policy communications and decision-making of the 30 Baht Scheme design, January – May 2001

Periods and frequency	Participants and frequency of meeting	Issues of meetings
January–February 2001, every week	Seven high level MoPH staff, chaired by the Health Permanent Secretary	To design the model and the pace of the implementation
2–4 March 2001	60 MoPH officials	To seek opinions on system design chaired by the Health Permanent Secretary and to prepare the design details for the national workshop
March–May 2001, twice a month	About 30 MoPH's headquarters' officials (this group subsequently included university hospitals and functioned as the operational committee chaired by the Deputy Health Minister - September 2001 to August 2002)	Alternative formulation and discussion on UC designs for implementation
17 and 22 March 2001	111 members from eight ministries, providers both in public and private sectors, and representatives of consumers, chaired by the PM (on 17 March) and by the Health Minister (on 22 March)	Consultation with various stakeholders and making decisions on several details *
March–May 2001, on average twice per group	Ten working groups from several stakeholders including those participated in the 17 March meeting	To develop the operational guidelines for the policy implementation

Source: from several minutes of MoPH's meeting and MoPH's official letters

* from (Taskforce of the implementation of the Universal Coverage of Health Care 2001)

The next sections describe the policy intent including policy goals, the insurance system design, and the organisation and management design.

4.2.1 Policy goals

“The goal of the Universal Coverage of Health Care policy is to equally entitle Thai citizens to quality health care according to their needs, regardless of their socio-economic status.”(Ministry of Public Health 2002a)

The explicit objective of the UC policy is to expand health insurance coverage to protect all Thais from the burden of health care. Additional principles - equitable health care and sustainable health care - were adopted by policy elites in March 2001. Thus, UC policy has three main objectives (Jongudomsuk 2002):

- universal coverage,
- single standard in terms of benefits and care, and
- a sustainable system.

The sustainable system was defined in terms of financial, institutional and policy sustainability. For financial sustainability, the effective system addressed both allocative and technical efficiency as well as adequacy and stability of budget. For institutional sustainability, the system included personnel preparation, and to ensure sufficiency of the additional resources. Lastly, for policy sustainability, legislation was needed to ensure the stability of the policy.

4.2.2 System design to achieve the goals

The main characteristics of the new system were designed by the Thai Rak Thai Party (TRTP) and additional details were proposed by MoPH civil servants. The system design was the result of several discussions (see in Table 4.1).

To achieve the first goal, universal access, additional budget was required. The government decided to allocate more funds from general tax revenue as a main source of finance to insure population outside the formal employment sector.

To achieve the second goal, the equity aspect, the promotion of the use of primary care and a single system was proposed. The promotion of the use of primary care required an improvement of the quality of services at primary care units. This improvement would facilitate equal access to good quality services. The merging of existing insurance schemes would ensure equitable health care by leading to a single standard of the benefit and payment methods.

To achieve the third goal, a sustainable system, dividing the roles between purchasers and providers, and the decentralisation of the fund management to the Area Purchaser Board, were proposed to increase accountability of providers. The process of the Area Purchaser Board would provide participation in the regulatory role. This would balance the power in the health

care system to encourage quality. Hospital accreditation would be used for quality assurance. In order to achieve financial sustainability, the closed-end provider payment method¹⁷ and the contracting model¹⁸ were chosen. This would allow private providers to compete in the system. To increase allocative efficiency, population based budgeting was chosen to replace historical based budgeting. All these mechanisms supplemented each other to achieve the policy and sustain the system (Jongudomsuk 2002).

The expected characteristics of the system under the UC policy decided in March 2001 can be summarised as follows (Ministry of Public Health 2002a):

- 1) general tax-based finance with a user fee of 30 Baht per episode,
- 2) promotion of the use of primary care,
- 3) a single standard benefit package and payment method by merging of existing health insurance funds,
- 4) purchaser-provider split with a contract model,
- 5) decentralisation of fund management to the provinces and administration by the area purchaser board,
- 6) quality assurance by use of accreditation,
- 7) a closed-end provider payment method, and
- 8) private health providers collaboration.

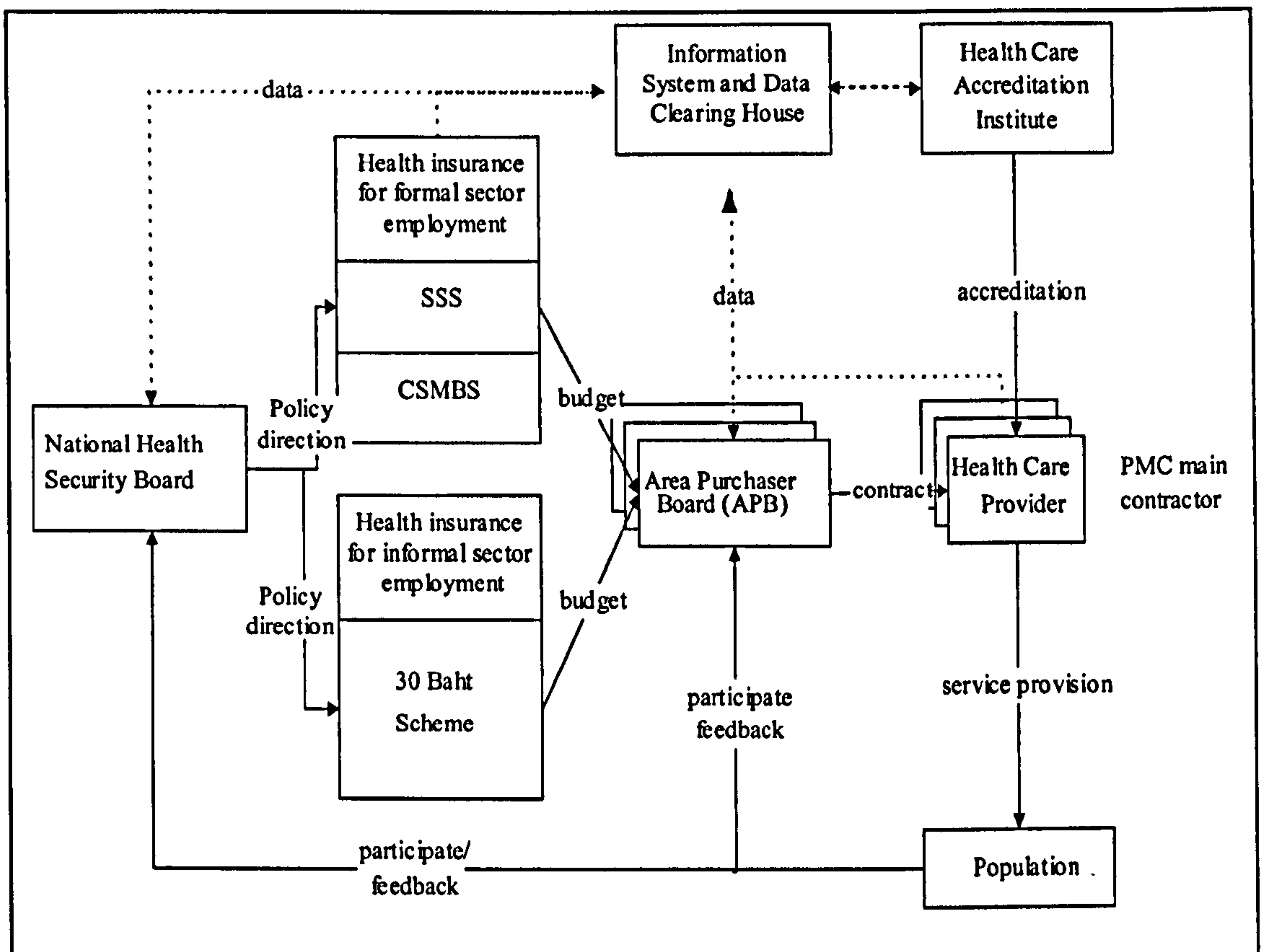
4.2.3 Organisation and management design

Dual management of public health insurance was chosen, although some may argue that the single management system is more desirable. For example, a single system can reduce the difference between benefits and care in the three main schemes, and single management can reduce the duplication of registration and benefit claims. However, there was no consensus on a single management system. Therefore, the proposed management system was a dual management system with formal sector employees coming under a managed scheme, informal sector employees under another management scheme. This is shown in Figure 4.1.

¹⁷ The closed-end provider payment method involves several payment methods, which have budget ceilings, for example, capitation and case-mix weight payment under a ceiling budget.

¹⁸ The contracting model involves relationships between providers and fundholders, which are based on commitment to provide services with an agreement payment.

Figure 4.1 The proposed system under UC Policy during the transitional period



Source: MoPH's Workforce on the Universal Coverage of Health Care Model (2001) and Jongudomsuk (2002)

A policy-making body, the National Health Security Board (NHSB), would be constituted to steer the design of the UC program, giving policy directions to the main scheme managers and ensuring a single standard of health care for all Thais in the future. For the health insurance for the formal sector employees, the current agencies (the Social Security Office, Ministry of Labour and Social Welfare, and the General Comptroller's Department, Ministry of Finance) would still administered the SSS and CSMBS respectively. In the long run, the CSMBS would be incorporated in the SSS. The National Health Security Office (NHSO) would be established as the secretariat for the NHSB and perform all supportive and coordination tasks. This NHSO would also manage the 30 Baht Scheme to cover people outside the formal employment sector. The Area Purchaser Board (APB) would be constituted in provinces to play the purchaser role by contracting with providers. This APB would coordinate all funds from the three main schemes and send data back and forth to the new-established Information System and Data Clearinghouse. Then, data and information would be transferred to the NHSB and the Health Care Accreditation Institute. All providers should be accredited by the Accreditation Institute.

In practice, the National Health Security Board could not be established before the implementation in 2001. Therefore, the MoPH took over the execution of the 30 Baht Scheme

and left the SSS and the CSMBS operating independently. While the Area Purchaser Board was being developed, the Provincial Health Offices were responsible for managing contracts with providers. Some of the decisions made were different from the content decided in March 2001. The actual system design for the implementation in October 2001 and the organization and management in 2001 are illustrated in the next section.

4.3 Policy formulation process of the 30 Baht Scheme

This section includes the actual system features, actors and their interaction in the policy formulation process, and the contextual factors related to the policy formation.

4.3.1 Actual system features

Regarding the health service and financing system, Kutzin's framework (1998) suggests looking at three main elements of the health financing functions: 1) institutional arrangement including source of finance, allocation institutions and methods, provider payment mechanisms, and providers; 2) broad health system support function including quality assurance; and 3) benefit packages and rules of access to care. Table 4.2 compares the health financing system in 2002 to the system before reform. The main features of change are summarized as follows:

1. Multiple fragmented schemes were grouped into three main schemes, namely the Civil Servant Medical Benefit Scheme (CSMBS), the Social Security Scheme (SSS), and the National Health Security Scheme (the 30 Baht Scheme). The latter scheme merged the Medical Welfare Scheme (MWS) and the Voluntary Health Card Scheme (VHCS) into the new scheme and expanded to cover all uninsured, but was still administered under the MoPH.
2. The National Health Security Scheme (the 30 Baht Scheme) was similar to the old MWS in terms of tax-based financing and benefit packages. The government subsidized the 30 Baht Scheme through the government budget allocated to the MoPH. The benefit packages included preventive care, health promotion, and curative care, which also included accidental injuries and high cost care. A big difference was that this benefit package excluded renal dialysis for end-stage renal disease patients and anti-retroviral drug treatment for HIV/AIDS patients, while the MWS did not clearly address these points. Anti-retroviral drugs and HIV/AIDS patient treatments were added into the benefit package in October 2002.
3. The major change was the pattern of provider payment, which shifted from a historically based budget to a per capita budget contracting with primary care. The capitation included staff salary, resulting in some resource reallocation amongst MoPH providers between provinces. The per capita budget was for all care in the package except accidental care and high cost care that could be additionally reimbursed from the Health Insurance Office, MoPH. Two choices of provider payment were suggested for provinces. The first was inclusive capitation paying directly to contracting

primary care networks. The second was to separate the inpatient care budget from the capitation to allocate by diagnostic relative group weight (DRG weight).

4. The 30 Baht Scheme introduced primary care units as gatekeepers and the primary care services were mainly provided by the MoPH public facilities. Private hospitals had a small share of the population.

Table 4.2 Functional features of health financing system, Thailand, years 2000 and 2002

	Pre-reform (Year 2000)	After the introduction of the 30 Baht Scheme (as of Fiscal year 2002 - Oct 2001 to Sep 2002)
1. Policy goal/objectives	Gradual expansion of insurance coverage	<ul style="list-style-type: none"> To reduce national health expenditure, reduce financial burden from health care and financial barrier to access to health care financing reform-more equitable resource allocation on demand side basis To improve efficiency of the provider payment To strengthen primary care and promote primary care as a gate keeper
2. Insurance coverage	CSMBS 11 % SSS 9% MWS 37% VHCS 12% Uninsured 31% (including private insured)	<ul style="list-style-type: none"> Universal coverage Incorporate MWS, VHCS beneficiaries and uninsured covered by the "30-Baht Scheme" 80% CSMBS and SSS similar to before reform
3. Source of finance	<ul style="list-style-type: none"> Tax revenue subsidize CSMBS, SSS, MWS, and VHCS with different rates per capita Employer & employee contributions in SSS Individuals pay partially in CSMBS, SSS, MWS, and VHCS for extra care out of benefit package. VHC holders pay 500 Baht per household. Uninsured and private insured pay full of hospital charge. 	<ul style="list-style-type: none"> Tax revenue subsidize CSMBS, SSS, '30 Baht Scheme' at different rates Employer & employee contributions in SSS Individuals pay partially in CSMBS, SSS, '30 Baht Scheme' for extra care out of benefit package.
4. Core package	<ul style="list-style-type: none"> CSMBS: curative care including physical check up and amenity services SSS: curative care MWS and VHCS: curative care and health promotion & disease prevention 	<ul style="list-style-type: none"> The 30 Baht Scheme: Comprehensive package: curative care plus personal/ family preventive & promotion services CSMBS and SSS similar to before 2001 reform
5. Allocation to purchasers i.e. budget from Central level to provincial level	Multiple systems 1. Gov. subsidy at actual expenses for CSMBS through the MOF (average 1,780 Baht per capita) 2. Tri-party contribution -employer, employee, and Gov.- each 1% of salary of private employee for SSS through the Ministry of Labour and Welfare (average each contribution 476 Baht per capita) 3. Per capita for MWS through MoPH (average 280 Baht per capita) 4. Community rate per household for VHCS through MoPH (Gov. subsidy 1,000 Baht per capita, households pay 500 Baht per household)	Multiple systems 1. CSMBS and SSS similar to before 2001 reform 2. 30 Baht Scheme: Per capita budget (1,202 Baht/capita in year 2002)
6. Allocating institutions (Purchasers)	Ministry of Finance-CSMBS Ministry of Labour-SSS MoPH managing MWS and VHCS	Ministry of Finance-CSMBS Ministry of Labour-SSS MoPH-Health Insurance Office – 30 Baht Scheme

	Pre-reform (Year 2000)	After the introduction of the 30 Baht Scheme (as of Fiscal year 2002 - Oct 2001 to Sep 2002)
7. Provider payment mechanisms	<ul style="list-style-type: none"> • CSMBS-fee for services reimbursement • SSS-per capita payment • MWS and VHCS-per capita formula under global budget 	<ul style="list-style-type: none"> • CSMBS and SSS similar to before reform • '30 Baht Scheme' has 2 options: 1. Inclusive capitation for OP, PP and IP care, or 2. capitation for OP& PP, and DRG weight for IP
8. Health registration at a PMC	<ul style="list-style-type: none"> • CSMBS- no registration, • SSS – registration at hospital, • MWS and VHCS: registration at a primary care network (a hospital and a health centre) 	<ul style="list-style-type: none"> • CSMBS and SSS similar to before reform • '30 Baht Scheme': registration at a primary medical care network (a hospital and a primary care unit-PCU) and must report at PCU first
9. Providers: private providers	<ul style="list-style-type: none"> • CSMBS-public providers (private providers are eligible only for emergency case) • SSS- public and private providers • HWS and VHCS-only MoPH providers 	<ul style="list-style-type: none"> • CSMBS and SSS similar to before reform, • '30 Baht Scheme' All public providers are eligible and private providers are eligible as managed collaboration (limit quota of registered population)
10. Quality assurance	Hospital accreditation mechanism (HA) was being developed	All hospitals were supposed to pass HA within September 2002.

As seen from the above, many policy details were formulated. The policy features are characterised as complicated, highly technical issues. The questions arising are: how research was used in design, were there alternatives, why were these choices made, and who had power to decide and shape policy content? This chapter explores the policy formulation process to answer these questions. In order to do so, the next sections look at actors and how they influenced the policy content.

4.3.2 Actors and their interactions in the policy formulation process

This section looks at actors at macro-level, meso-level, and micro-level. The macro-level emphasises how the state and policy elites were important, and looks at the government structures of policy execution. At the meso-level, the characteristics of the policy networks and policy styles are discussed. At the micro-level, this chapter looks at particular examples of how decisions were made.

4.3.2.1 Policy elites and steering structure

As with other public policies in the Thaksin government, the government played an important role in execution of UC policy. Decision-makers manoeuvred and influenced the content, timing, and sequence of reform initiatives, and their behaviour was influenced by their perceptions, values, skills, and opportunities to gain information (Grindle and Thomas 1991). This section explores the characteristics of the important individual elites and describes how they used 'policy space' for policy manoeuvre.

Policy elites are decision-makers who are 'formally charged with making authoritative decisions in government' (Grindle and Thomas, 1991:19). The policy elites of UC policy included the elected politicians and top civil servants. Elected politicians included the Prime Minister, the

Health Minister and Deputy, the Minister of Finance, the Minister of Labour and Social Welfare, the Minister of Commerce, the Minister of the Interior, the Minister of University Affairs. The top civil servants included the Permanent Secretary of the MoPH, the Secretary General of the National Economic and Social Development Board, the Director General of the Comptroller General Department, and the Secretary General of the Civil Service Commission. More details of these actors' positions are discussed in Chapter 5 (section 5.3.1).

Three important politicians were the PM, the Health Minister, and the Deputy Health Minister. The PM has been characterised as the agenda setter (see in Chapter 3). The Health Minister was more the policy ambassador, who acted in a public relations role promoting the work and policy of the MoPH, and the Deputy Health Minister can be characterised as the policy selector. He saw himself as a health expert and enjoyed choosing from alternative policy options. These elected politicians played their roles complementarily. The background of these elected politicians was business. They had skills and experience of management, and pro market economy values. Hence, they supported the collaboration of the private sector in the 30 Baht Scheme. However, the over-riding value according to the Party's commitment was to ensure citizens' entitlement to health care. This was evident in the rapid government response to the TRTP's policies.

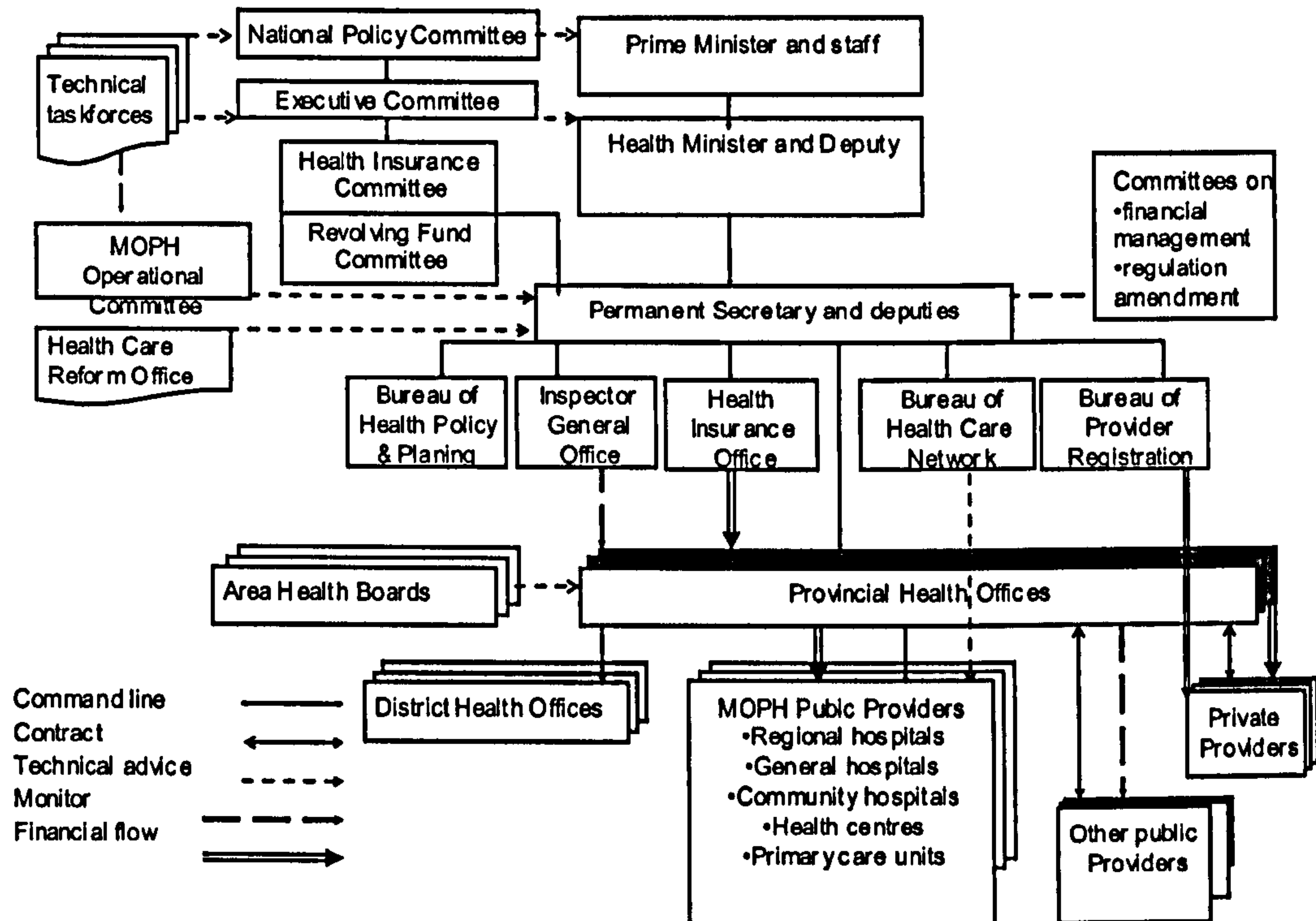
The top civil servants were also important in influencing decisions on timing and sequence of the reform as mentioned earlier (section 4.2). It is clear that the Permanent Secretary (PS), with his decisive and authoritative manner, took a strong leadership role and pushed the 30 Baht Scheme in 2001. Given his short term (9 months), he might have desired to 'make his mark' before he retired (Kingdon 1995). A subsequent change of PS changed the position of the MoPH civil servants, and led to a slowdown in financing reform.

It is clear from above that state and policy elites took dominant roles in the formulation of the UC policy. However, the policy elites sought for information and consultation to help them make better decisions. To gain information and promote direct participation, several committees were established. The most important included the MoPH Operational Centre Committees, the Executive Committee, and the National Policy Committee. Moreover, several taskforces were appointed, which were important in shaping the policy design. The members of each taskforce included representatives from stakeholders related to each issue.

The relationship of these organizations is illustrated in Figure 4.2. Within the MoPH, the 30 Baht Scheme mainly involved five offices under the Permanent Secretary, including the Health Insurance Office, the Bureau of Health Policy and Planning, the Bureau of Health Care Network Development, the Inspector General Office and the Bureau of Health Registration. The other two technical supportive offices were the Health Care Reform Office (an EU-supported research

program) and the Health Systems Research Institute (an independent research funding institution).

Figure 4.2 Organisations involved in the policy formulation and implementation process of the UC policy in fiscal year 2002



Source: developed by author from several MoPH meeting proceedings

Individual actors in the committees divided into five main groups, including the PM and his staff, bureaucrats, academics, health professionals, and consumers. The elected officials and top-level civil servants can be grouped as policy elites. Bureaucrats were civil servants from several ministries. Academics and some health professionals can be grouped into the research communities, and other actors outside government sectors can be grouped as interest groups. Bureaucrats included high-level and middle-level civil servants. In the MoPH, bureaucrats also can be divided into administrators and providers, some of whom were reform supporters while others were change resisters.

A comparison of the components of the Operational Committee, the Executive Committee and the National Policy Committee is shown in Table 4.3. The members of the Operational Centre Committee included most of the MoPH civil servants in the central MoPH's offices. In addition to the MoPH officials, the Executive Committee included the PM's staff, other ministry officials, insurance scheme holders, technical groups, health providers, and consumer groups. The

National Policy Committee was composed of the ministers and other members from the organisations in the Executive Committee and included the ministers who dealt with legislation and government budget allocation.

Table 4.3 Actors involved in committees of the Universal Coverage of Health Care Policy

Groups	Operation Centre Committee (33 members)	Executive Committee (32 members)	National Policy Committee (32 members)
Frequency of meeting	Every weeks from September 2001 to April 2002 and twice a month from May 2002 to August 2002	Meeting once in June 2002	First meeting in January 2002 Second meeting in March 2002 Third meeting in May 2002
Chairman	Deputy Minister of Public Health	Minister of Public Health	Prime Minister
Secretariat	Dr.Sanguan Nitayarumphong (MoPH)	Dr.Sanguan Nitayarumphong (MoPH)	The Permanent Secretary of the Ministry of Public Health
Prime Minister's staff		An official of the Secretariat Office of the Prime Minister	Deputy Prime Minister Minister of the Prime Minister Office and an official Minister of Justice The Secretary General of the Council of State of Thailand The Secretary General of the National Economic and Social Development Board The Director of the Bureau of the Budget
MoPH: policy makers, managers, and providers	Minister of Public Health (Advisor of the committee) The Permanent Secretary of the Ministry of Public Health Six Director Generals of Departments Six Deputy Permanent Secretaries Two Health Supervisors The Director of the Health Policy and Planning Bureau The Director of the Health Insurance Office The Director of the office of the Health Provider Network Development	Deputy Minister of Public Health Professor Arun Phaosawas-the minister's advisor The Permanent Secretary of the Ministry of Public Health and staff Two Deputy Permanent Secretaries The Director of the Health Insurance Office	Minister of Public Health Deputy Minister of Public Health Professor Arun Phaosawas Associate Professor Chusak Sirinil
Other bureaucrats (other insurance scheme holders)		The Director General of Comptroller General's Department The Director General of the Insurance Department The Secretary General of the Social Security Office	Minister of Finance The Permanent Secretary of the Ministry of Finance Minister of Commerce Minister of Labour and Social Welfare
Academic group		The Director of the Health Systems Research Institute and staff Professor Prawase Wase Professor Aree Walayasaewee Professor Wichan Panich Mr.Wutthipong Pongsuwan Professor Ammar Siamwala Professor Charus Suwanwela	The Director of the Health Systems Research Institute Professor Prawase Wase Professor Ammar Siamwala Professor Charus Suwanwela
Health professionals and providers	The Director of the autonomous hospital Ban-Praew University hospitals	The Director of the Department of Local Administration Deans of three faculties of medicine	Minister of University Affairs Minister of Interior President of the Private Hospital Association

Groups	Operation Centre Committee (33 members)	Executive Committee (32 members)	National Policy Committee (32 members)
	Other non-MoPH public hospitals Private hospitals	The Director of the Royal Thai Army Medical Department The Deputy Governor of Bangkok (public health) The President of the Private Hospital Association The President of the Local Administration Association The President of the Sub-district Administration Association	Professor Phirom Kamolratanakul
Consumers and beneficiaries		The Secretary General of the Consumer Protection Foundation The head of a campaign project to support the goal of the universal coverage of health care	The Secretary General of the Office of the Civil Service Commission The president of the Consumer Protection Foundation Senator John Ung-phakorn Senator Sophon Suphamong Dr. Phiroth Ningsanon Ms. Saree Ong-somwang

Source: (Ministry of Public Health 2001a), (National Policy Committee of the Universal Coverage of Health Care Policy 2001b), and (Office of the Prime Minister 2001)

The important taskforces were the groups that were involved in the development of the implementation guidelines (Ministry of Public Health 2001b). They included ten technical taskforces which were informally established and gradually expanded participation. The issues they were responsible for were:

- 1) benefit package and financial management,
- 2) quality of health services,
- 3) health registration system and information technology management,
- 4) public relations and complaint receiving,
- 5) provider relations and complaint receiving,
- 6) health infrastructure and organisation reform,
- 7) regulation, and purchasing system development,
- 8) human resource development,
- 9) knowledge building for system development, and
- 10) drafting the Health Insurance Act and public hearing.

After the establishment of the National Health Security Board, the Board (2003) also appointed seven technical taskforces to advise on these issues.

As seen from the above, the policy space had opened for the interplay of several actors, both inside and outside the government. They formed policy networks or communities. The next section will discuss the characteristics of the policy networks and the policy style.

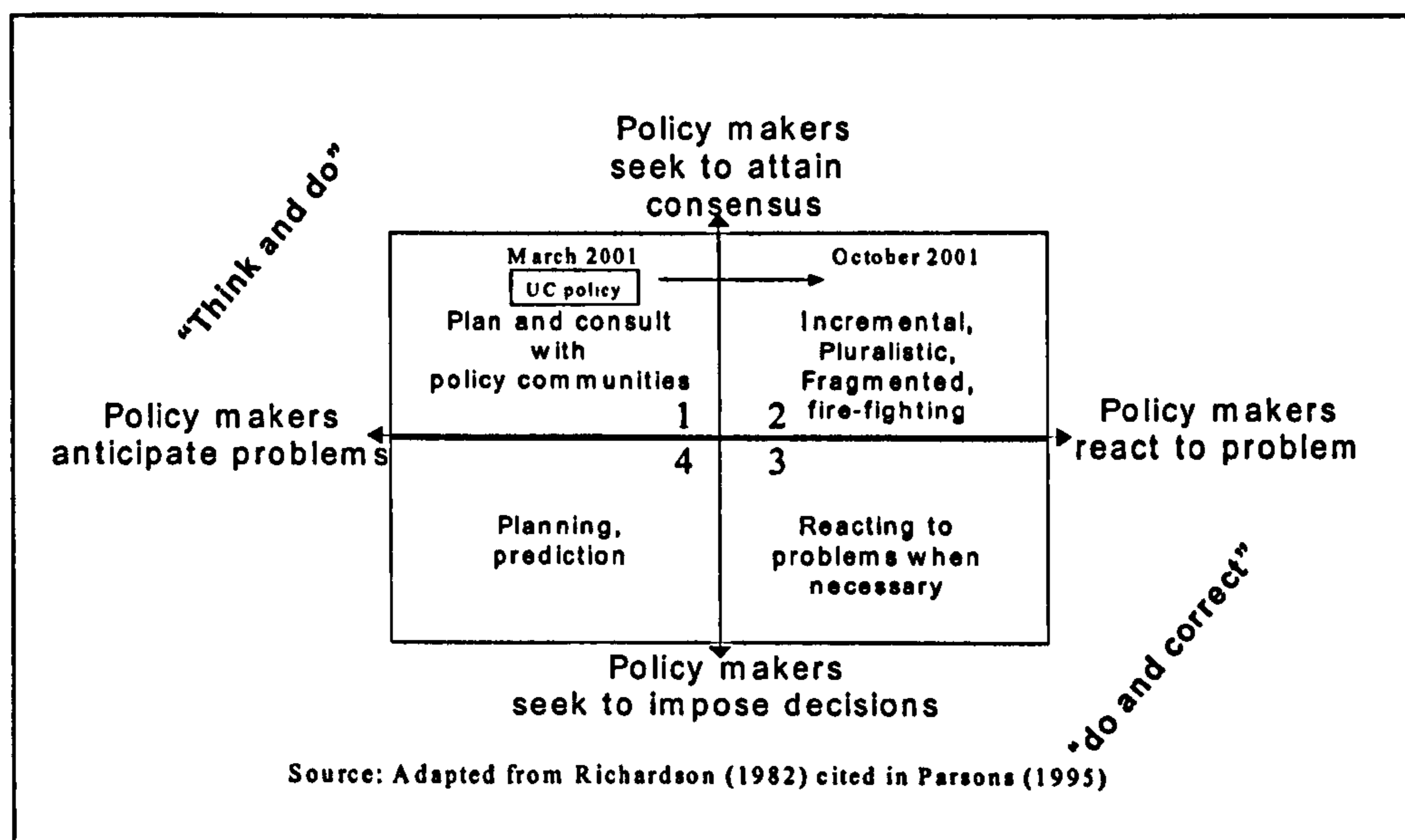
4.3.2.2 Policy networks and policy style

Policy networks can be seen as a generic name for interaction between different groups, inside and/or outside government (Hill 1997; Marsh 1998), while issue networks involve loose relationships between members, and policy communities involve close relationships (Marsh 1998).

In the UC case, the government established several issue networks (as several working groups) and policy communities essentially. The issue networks typically had a large number of participants, fluctuating interaction and access for the various members, and were essentially for policy consultation. In contrast, the Operating Centre Committee (War Room) was characterised as a tightly knit policy community, involved regular meetings and negotiation and bargaining. However, participants were limited to managers and health professionals (health providers), and excluded academics and consumers.

In looking at policy style, this thesis used Richardson's four-dimensional model to describe networks and dimensions made. Richardson suggests there are at least four policy styles: 1) plan and consult with the policy community, 2) fire-fighting, 3) planning and rationality, and 4) reacting to problems when necessary (see Figure 4.3).

Figure 4.3 Policy style of the Universal Coverage of Health Care Policy during 2001-2002



The analysis of UC policy suggests that there were different policy styles at different stages of the process of policy formulation. For example, in the trial phase the policy elites (the Permanent Secretary with support by the Health Ministry) imposed implementation of the first

trial phase and reacted to problems. During that time, the policy elites planned for, and sought participation and consensus for, the nationwide implementation. They asked the Health Insurance Committees to seek agreement and appointed ten technical taskforces to design policy content. They tried to anticipate problems and plan beforehand. However, they had only six months for this period. When the nationwide implementation started, the decision-making approach turned from a “think-and-do” approach to a “do-and-correct” approach, according to one economist (Siamwalla 2002). In order to resolve emerging problems from the nationwide implementation, the MoPH established a decision-making body – the UC Operation Centre (Ministry of Public Health 2001a). This was referred to as the “War Room”. The War Room, led by the Deputy Public Health Minister, acted as the fire-fighters within the MoPH, while another committee - the Executive Committee led by the Public Health Minister - coordinated other sectors including other ministries and private sectors (National Policy Committee of the Universal Coverage of Health Care Policy 2001b); (National Policy Committee of the Universal Coverage of Health Care Policy 2001a). Both committees worked under the guidance of the National Policy Committee led by the PM (Office of the Prime Minister 2001).

Before nationwide implementation (October 2001), the UC policy style was plan-and-consult (in quadrant 1). It became fire-fighting (in quadrant 2) after the nationwide implementation (see Figure 4.3) as operational problems arose and the War Room had to resolve problems every week. It could be anticipated that the implementation in the fiscal year 2003 would be more in the style of planning and seeking consensus again, as the seven technical committees had been appointed to give technical advice to the National Policy Committee (National Policy Committee of the Universal Coverage of Health Care Policy 2001c). In fact, subsequent Permanent Secretaries (fiscal years 2002 and 2003) did not move the reform forwards. Therefore, they did not take into account the technical committees’ advice. The MoPH successfully defended to retain the independent execution of the 30 Baht Scheme during 2003-2005 according to the National Health Security Act (2002).

In sum, the policy style of the UC policy was dynamic, and varied at different stages. Policy elites played a dominant role in decision-making, but could not always impose their decisions. Policy content was also shaped by other actors, for example, policy communities and bureaucrats. This will be illustrated by the interaction amongst actors in the next section.

4.3.2.3 Actors and potential power in influencing decision-making

This section moves to micro-level analysis of how decisions were made. It investigates six issues which had the greatest effect on the financial and service delivery systems. The issues relating to the finance system were: 1) source of finance, 2) budget requirement for the program, 3) allocation methods to provinces, and 4) provider payment methods. The other two issues

related to service delivery system were: 5) primary health care as a gatekeeper, and 6) private provider collaboration. Each of these is considered separately below. Each part of the policy had a different set of stakeholders, and they differed over-time. From this analysis it is suggested that there were four main factors that influenced the process: rational problem solving, impact on civil servants and bureaucrats, political stability and support, and external factors which included international influences. They are weighted to evaluate which factors were highly influential in decision-making.

Source of finance

Debates over the issue of whether the UC scheme should be financed mainly through general tax revenue occurred around three arguments. Firstly, would the government be able to afford UC? Secondly, if the program needed direct contribution, how would money be collected from self-employed households? Thirdly, would the government subsidise the rich more than the poor?

Until 2001, Thailand had used a mixed financing system; contributions for employees in formal sectors and general tax for a welfare scheme for the poor. The 30 Baht Scheme extended the tax-finance scheme to cover all populations outside formal sector employment.

Initially, the Thai-Rak-Thai Party stated that “households would be responsible for health expenses according to their ability to pay”. It had indicated a flat rate contribution of 100 Baht per month per capita and patients would pay a user fee of 30 Baht at the point of service (Thai-Rak-Thai Party 2000). The amount of the contribution was more or less similar to the cost of the Social Security Scheme, which was about 1,400 Baht per capita per year, but the money was deducted as a percentage of salary at the point of payment, while the money collection from people outside formal sector employment was problematic.

The Party decided to delete the flat rate contribution of 100 Baht per month per insured just a few months before the election following internal discussion within the Party, as mentioned in the Chapter 3. The reasons were that the collection of contributions was problematic and the contribution might be unacceptable to the public (Interview K20). The election campaign then became the “30 Baht treats all diseases” campaign, with the new UC scheme to be mostly financed by general tax revenue.

The different policy communities took different positions on the issue of the source of finance. The academic community viewed the contribution as a more sustainable source of finance, if the Scheme did not totally depend on the government budget. However, there was no good suggestion from this group as to how to collect the monthly contribution based on household ability to pay. Past experience showed that the attempt of the Medical Welfare Scheme to estimate household income from the large informal labour sector (about 80% of the population)

was not successful. In addition, the method of money collection from self-employed households was difficult to manage. The only way that the government was able to collect money from households was by tax revenue, either direct income tax or indirect tax such as value added tax (VAT) and excise tax. Other researchers disagreed with expanding insurance coverage by using tax, because the tax system in Thailand was regressive. Another argument was that the government would not be able to afford the scheme given the economic crisis. The Health Systems Research Institution suggested that given the scarcity of resources, other social investment, which gave indirect health benefits, should be invested in first (Interview K17). For example, some researchers argued that road safety would save more lives than health services. Perhaps because they had so many different views, they had little power to influence the policy.

Bureaucrats' feared that the UC program with tax-finance would become a burden on the government budget because the estimated expenditure would increase from 48 billion Baht in fiscal year 2002 to 52 billion Baht in fiscal year 2003. Then the increased budget would lead to increasing the public debt, which was high at about 56% of Gross Domestic Product (Thairat Newspaper 2001). The Director of the Bureau of Budget suggested the scheme should charge patients for private hospital room and board, additional treatments and services extra to the benefit package, and that hospitals should use this revenue to supplement the increased demand on the budget (the hospitals already practised in this way). Although, the Director of the Bureau of the Budget disagreed with the increased budget for the UC program, his concerns were overlooked, although the Bureau of the Budget still controlled the growth rate of the UC budget.

Opposition politicians opposed the tax-financed system, which they called a "welfare system", because it would create a burden on the government budget. The Deputy Leader of the Democrat Party urged the government many times to review this decision. He requested the government to accept that there was not enough money to run the program, and to seek another source either through extra tax or household contributions (Democrat Party 2002a). Another issue the opposition raised was inequity - arguing this project would use the government budget to help the rich (Democrat Party 2002b). However, opposition politicians had little power in Parliament.

Some members of the National Policy Committee were also concerned about creating a "welfare system", in which tax-financing subsidized all citizens. At one meeting of the National Health Policy Committee, a lively debate was observed. The PM suggested that the desirable model should not be a "welfare system", emphasising that the rich should pay more. To avoid the term "welfare system", the Deputy Health Minister suggested the words "social safety net" which guaranteed that everybody was able to access health care. A committee member criticised the committee over its problem with the definitions, saying that the rich should pay more than the poor even in a welfare system (National Policy Committee of the Universal

Coverage of Health Care Policy 2002). An interview respondent criticised the politicians saying that they did not clearly understand their policy, and the philosophy behind the issue. Therefore, they could not pitch a flag and communicate to all academics and implementers to serve their intention (Interview K17). The committee finally decided the program should be financed mainly by general tax revenue and sought ways for the rich to pay more.

From focus group discussion, villagers agreed that the scheme using government tax should protect all, not only the poor. However, some villagers regretted that the rich might have more opportunities to use public resources than the poor. Nevertheless, people did not express an opposite voice and the polls looking at government performance showed that the public supported the policy (3, 6, 12, and 15 months) (Manager Newspaper 2002; SuanDusit Polls 2001a; SuanDusit Polls 2001b; SuanDusit Polls 2001c).

In brief, the major policy determinant on the issue of source of finance was the concern with avoiding public opposition. Tax finance was chosen because there was no better alternative. Then minor amendments were made in response to the elites' suggestions, such as seeking ways for the rich to pay more. Academics did not have power to change government commitment to taxation because of a lack of alternative suggestions. At the same time, opposition parties were not strong enough to change the government's decision.

Budget requirement for the program

The government claimed that the national general tax revenue was enough to finance health services for all on the basis of several studies (see in Chapter 3). However, it needed to mobilise and merge sources from other insurance schemes in order to avoid duplicated registration and to increase efficiency.

There was resistance to merging funds with existing insurance schemes, particularly the SSS and the CSMBS. For example, the Ministry of Labour, which holds the SSS, protected employees' money by arguing that the money was a direct contribution for specific purposes for employees, with support from the Labour Union. The Civil Servants Commission explicitly protested on behalf of civil servants, who wanted to avoid the 30 Baht Scheme because they expected a lower quality of service as a consequence of merging. The Department of Insurance, Ministry of Commerce also insisted on holding on to the Traffic Accident Victims Protection Fund. Finally, only the internal MoPH budget was merged. Money available in the MoPH was about 35,966 million Baht. Then the question was, how much was the budget requirement for the UC Scheme.

Research proposed three estimations of the cost per capita. The first was based on the budget per capita calculated for the first autonomous hospital (Pitayarangsarit et al. 2000) plus the unit cost of health centres (Pitayarangsarit, Kantamara, and Tangcharoensathien 2001) with the rate

of 900 Baht. Then the overall budget would be 40,500 million Baht (900 Baht x 45 million people). At this rate the system would need very little extra money to implement the program. This figure was criticized, however, as too specific – arising from a special type of hospital. The second estimate was derived by the working group (Siamwalla 2001) commissioned by the HSRI, which adopted a figure of 1,500 Baht from a comprehensive study (Pannarunothai 2000b). However, the figure suggested was said to be an overestimation of the utilisation which did not consider the reality of government fiscal constraints (Tangcharoensathien et al. 2002a). As a result, the MoPH set up a study group to calculate the cost and ended up with a cost of 1,202 Baht (Tangcharoensathien 2001). This third estimation was accepted as a figure for the 2002 fiscal year budget. Nonetheless, the methodology behind this figure was criticized for not using age/sex adjusted illness rates and for not considering the cost at teaching hospitals (Pannarunothai 2001).

To seek acceptance, all stakeholders were invited to participate in a working group for the 2003 cost calculation. The calculation used updated databases and ended up with a higher rate of 1,414 Baht (Prakongsai et al. 2002). At this time, the MoPH decision-makers referred to another piece of research which stated that people using the 30 Baht Scheme had a lower compliance rate of 85%¹⁹ (Pannarunothai et al. 2002), so they reduced the per capita rate 15% to a rate of 1,303 Baht. The consequences were monitored and it is still unclear whether the system will be sustained without decreasing the quality of services and given the lower compliance rate of the UC cardholders.

In the 2003 calculation workshops, different actors expressed their different positions and influenced the calculation as described below:

- The Bureau of Budget wanted to control and cut the budget.
- The MoPH had conflicts of interest, acting as both purchaser and provider roles. They wanted the budget high enough to run the services.
- Private providers sought an opportunity to mobilise more money for private providers.
- University hospitals wanted the higher rate because their costs were higher than other hospitals' cost.
- Academics and researchers tried very hard to keep their concepts based on evidence, which were all different because of different assumptions.

¹⁹ An 85% compliance rate means that 85% of patients who were 30 Baht cardholders were using the 30 Baht Scheme and 15% chose to pay from their own pocket.

In summary, the government could not merge all insurance funds as it had intended because of resistance from several potential losers. Secondly, different actors influenced the decisions based on their interests and positions. Thirdly, this case shows how uncertainty of technical evidence created debate in decision-making.

Allocating resources to provinces

As the campaign promised, the new government decided to move the budget allocation method from a health service base to a population-based allocation. This change turned the resource allocation method of the MoPH from a supply-side basis to a demand-side basis. As noted in the literature, the previous budget for public hospitals depended on the number of beds, personnel, and high technology equipment, rather than the population within the hospitals' responsibility (Krilas 2000; Lao-ratanasai 1995). Therefore, this budget payment reform was a radical change. While there were disagreements, the Ministry of Public Health decided to use the flat rate of budget per capita to allocate money to provinces in the fiscal year 2002 (Ministry of Public Health 2001b). Three questions were raised. First, was the flat rate allocation method the ultimate model or a transitional model? Second, would the rate in the first year include salaries or not? Third, should the allocation criteria for general hospitals and regional hospitals be different from the allocation for community hospitals? Actors influencing these issues were senior health officers, academics, operational health officers, Permanent Secretaries, the Deputy Health Minister, the Rural Doctor Society, and the Provincial Hospital Society.

The first question regarded the concept of the flat rate allocation method. Using an egalitarian concept (Wagstaff 1993b), a technical working group proposed a model which adjusted capitation to the different health needs. However, policy-makers rejected the proposal and decided to use flat rate capitation for allocating the fiscal year 2002 budget for two reasons (interview K5). First, the initial model did not respond to the policy-makers' concern about the risk to providers due to the size of the population - the technical working group had considered only the risk to providers due to the burden of diseases. Secondly, after the model was adjusted for the population size, it was too complicated to explain to providers and the public within the short period before the implementation. But the failure to adjust the capitation budget resulted in a real lack of money in several provinces. Though it was rectified by the Contingency Fund²⁰ (Ministry of Public Health 2002b), budget constraints pressured the MoPH to shift the budget allocation method back to the supply-side basis allocation a year later and to maintain the unequal distribution of resources. The flat rate model was definitely just a transition model. A

²⁰ The Contingency Fund was established in the face of concerns about budgets not being sufficient, personnel concerns about salaries and security, and lack of clarity as to what system each province would choose. This was the way of the MoPH re-assuring provinces, but also ensuring that UC implementation stayed on track, and was not diverted or slowed down. However, this fund was available only in 2002 and did not continue in 2003.

working group proposed a new formula once for the 2003 fiscal year budget, but because of political pressure from bureaucrats (in big hospitals) to protect staff salaries, the new adjusted formula was not reconsidered.

The second argument regarded the inclusion of salary in the 30 Baht Scheme budget. Senior health officers anticipated that the per capita budget which included salary would worry health professionals and health workers at health facilities. There were attempts to exclude salary from the program budget and let health civil servants enjoy permanent salaries. An alternative was that the program would reallocate only the material budgets in the initial stage. The material budget per capita would be on top of the salary budget. The advantage of this model was that the program would need less extra budget than the included-salary model and there would be reserve budget for motivating providers to improve efficiency by transforming to be autonomous hospitals, which would receive a high amount of inclusive capitation for efficiency improvement. The Director of the Rural Health Division and the Director of the Provincial Hospitals at that time rejected this alternative because of the difficulty of the dual system management between the full capitation system and the capitation plus salary system for the autonomous hospitals and other majority hospitals respectively (Interview K5, K16). To resolve the question, the Health Permanent Secretary at that time, with support from health economists and the Health Minister, decided to include salary costs in the program budget to accelerate the health financing system reform. There were few complaints, not strong, since the Health Permanent Secretary's leadership was strong and he had the support of the Health Minister. Indeed, most MoPH officers at health facilities in the study province reported the disagreement with the salary inclusion (Sirisomboon, Wongsathit, and Pitayarangsarit 2002). As civil servants, they had been secured of their positions for their whole working life. This form of budget made their salary dependent on hospital efficiency. Hospital inefficiency could result from management inefficiency or mal-distribution of health facilities. Many high-level MoPH officials argued that the majority of the inefficiency was due to the latter problem, which was out of the control of health providers; therefore the MoPH should protect them. In order to secure staff morale the MoPH decided to guarantee staff salaries in the health facilities (Ministry of Public Health 2001b). This operated by allocating an additional budget from the Contingency Fund to hospitals that were deficient. As a result, resistance to the salary inclusion decreased. However, the Contingency Fund was used only in 2002 and did not continued as the MoPH changed the budget allocation system to the capitation on top of the salary budget in fiscal year 2003.

The third argument regarded the allocation criteria for general and regional hospitals, and whether it should be different from that of the community hospitals. The Provincial Hospital Society expressed their concerns to the next Permanent Secretary (October 2001 to September

2002). This Permanent Secretary suggested the budget for secondary and tertiary care should be separated from the capitation budget. He proposed to turn the budget system back to the previous supply-side based system. This caused a conflict between the Permanent Secretary and the Deputy Health Minister (Matichon Newspaper 2001b). The Deputy Minister did not favour the budget system being revised. In the Thai-Rak-Thai campaign, system responsiveness was an objective for allocation of funds. The campaign had said it would “shift the health services authorities back to the citizens” (Thai-Rak-Thai Party 2000). In fact, it was a strong intention of the government to use the method to achieve equitable resource allocation, in order to reform the whole health service system; i.e. financing system, manpower distribution, infrastructure distribution, and service delivery system. As this budget management reform benefited community hospitals, the Rural Doctor Society supported the reform direction (Botaphiboon 2001). After the Deputy Health Minister moved to other Ministry (August 2002), the budget system was revised.

In sum, with strong top political support, the MoPH decided to reform the budget management despite resisters within the MoPH. In this case, strong leadership and legitimacy of politicians were influential.

Provider payment method: inclusive capitation versus exclusive capitation

The MoPH ended up with two choices for provincial committees to choose from for purchasing services in the fiscal year 2002. The first choice was *inclusive capitation* based on experience with the Social Security Scheme. The rate covers disease prevention, health promotion and primary care to tertiary care. As a result, the burden would fall totally on contracting unit providers. The second choice was *exclusive capitation*, separated into two portions.

The first portion was the capitation for disease prevention, health promotion and primary care by the contracting unit providers. The second portion, a collecting fund managed at the province, paid hospitals for inpatient care including secondary and tertiary care by the relative weight allocations under a global budget (weighted by Diagnostic Related Groups-DRGs). Both choices had advantages and disadvantages.

The supporters of the inclusive capitation were senior health officers, private hospitals, community hospitals, and some academics. They had several reasons to support this method: low cost of administration (senior health officials); it was familiar and led to the expected hospitals' revenue (private providers); and anticipation of treatment cost-saving by emphasizing health promotion (community hospitals). Some academics agreed that this method would increase system efficiency because inclusive capitation allows the health manager to mobilize resources to the most cost-effective intervention, which would save on health service costs. However, some academics opposed this idea. They argued that the inclusive capitation payment

was a disincentive for providers to treat a severe case needing costly drugs and treatments. Second, community hospitals might delay referral of patients to higher level hospitals which could affect quality of care. In addition, some community hospitals, with a small population size, might not be able to bear the cost of referring patients. These might lead to an unsustainable system.

The *exclusive capitation* was the capitation payment plus case payment. Regional hospitals, general hospitals, some provincial chief officers, and some academics supported this choice because the case payment is an incentive to hospitals to admit a patient. However, an officer of the Health Insurance Office pointed out that the DRG system was still incomplete and might lead to unfair budget allocation. In this respect, some provinces had low confidence in it, though MoPH had used DRGs for allocating the high-cost care budget in the Medical Welfare Scheme since 1999. Furthermore, the case payment needs well-trained computer officers, but only some pilot provinces had trained their officers to use the computer software to allocate money to inpatient care.

In conclusion, there was no consensus on which method suited the Thai health system because of little evidence available for a decision, so the MoPH passed this decision to provincial committees. The decision in provinces depended on the negotiation power of each stakeholder in the provinces. The number of provinces selecting each choice was nearly equal. This allowed supporters of both sides to debate the evidence in the next budget round for the fiscal year 2003.

Service delivery system: primary care unit as a gatekeeper

The UC policy indicated that people have to register with a provider in order to allocate the budget according to the registered population. The MoPH introduced a new model of the primary care unit (PCU) as a gatekeeper of the service delivery system to achieve the universal coverage of health care (Ministry of Public Health 2001b). In fact, the Thai-Rak-Thai Party policy did not mention the primary care unit as a register unit (Thai-Rak-Thai Party 2000) but the MoPH researchers sought an opportunity to develop the primary health care service and referral system, and the Health Minister became a strong supporter of the concept of the primary care unit.

Though the MoPH has established health centres over the whole country, people's satisfaction with the services at health centres was low, evidenced by a large number of patients bypassing health centres to hospitals (Jongudomsuk 2002). The MoPH wanted to improve primary care services with a new model of the primary care unit. The new PCU model had a standard of service quality, which required a standard set of health personnel. This kind of PCU was expected to provide continuity of care and comprehensive care with a holistic approach to

people in a catchment area. It could be upgraded from a health centre located in a hospital or located in a new place. An area with a population up to 10,000 should have a PCU. Using PCUs, the health service delivery system would have a higher cost-effectiveness than using hospitals to deliver primary care. Many stakeholders agreed with the MoPH but some disagreed. Largely these were private hospitals, some public providers including general hospitals, regional hospitals, and health officers at community hospitals and health centres.

The Private Hospital Association (2001) preferred contracting units to have at least 100 beds, similar to the SSS (Private Hospital Association 2001). However, elites in the MoPH wanted the health services to be accessible and not to be bound to big hospitals. Several new primary care models had been tried in many places, for example in Ayuthaya, Song Khla, and Khon Kaen provinces. Consequently, there was enough knowledge and development of the primary care models for implementation. Furthermore, the academics thought that the UC reform was the last opportunity to construct the primary care services in the provider-contract model. To do so, the service delivery system designers indicated that the smallest contracting unit was the PCU. Hospitals in both the private and public sectors were also allowed to be the contracting units but they had to provide primary care reaching the MoPH-standard of a PCU. Private providers tried to remove the gatekeeper regulation because they wanted to use the reputation of high technology hospitals to attract patients, but the MoPH was strict in enforcing the regulation.

In general, public providers agreed with this aspect of the UC policy, and some general and regional hospitals thought that this was an opportunity to refer patients to a PCU, relieving hospitals' outpatient departments. Front line health officers agreed with the policy, because they wanted to strengthen the health promotion services rather than the curative health services. However, the existing situation was far from the PCU standard, for example in the number of doctors. Where the number of doctors was low, there was a low probability of allocating doctors to a PCU. On the other hand, where the number of doctors was high, most of the doctors were trained as specialists. Consequently, in both situations, providers could not fill positions in PCUs. The PCU standard was criticised as unrealistic. However, the designers argued that the spirit of the PCU was desirable and the system might take time to be achieved (Interview K11). Therefore, the program allowed many transitional models to develop in the primary care service; at least 3 models were suggested.

In brief, researchers saw the UC policy as an opportunity to develop the primary care system after accumulating knowledge for several years. This issue was theoretically acceptable. However, the limitation of the existing resources, i.e. number of family doctors, and the rough implementation plan caused some concerns.

Private providers collaboration

Initially, the MoPH planned to incorporate private providers after the health registration system covered the whole population, probably after October 2001; however, private providers were interested in joining the program from the beginning in April 2001 (Krungthep Thurakij Newspaper 2001).

The concept of private collaboration was accepted amongst all because the collaboration would encourage competition amongst public and private providers and result in greater efficiency in the system. A reason supporting the delay of the private provider collaboration was that the quality assurance system was still underdeveloped (Director of Food and Drug Administration 2001). The Health Minister declared on 26 February 2001 that the first phase of implementation would be to establish the registration system and arrange the allocation of the capitation budget. Then, the second phase would be to allow people to choose and register amongst public providers, and then only in the third phase would the private providers join. Private providers were not happy because the third phase might be delayed till fiscal year 2003. As a result, several attempts were made by private providers to influence this decision. On 16 March 2001, the MoPH revised this, to allow private providers to join the 30 Baht Scheme earlier in October 2001. However, the private providers were still not happy. Ultimately, private providers were allowed to start 3 months earlier in the second trial in June 2001. Actors involved in this issue had different views. They were the private hospitals, the MoPH, the Rural Doctor Society, and the PM.

The private providers wanted to join the 30 Baht Scheme as soon as possible. The private hospitals (many of which were under-utilized) were eager to join the program at the beginning because the size of the market of about 80 billion Baht interested them. They believed that the 30 Baht Scheme would be similar to the Social Security Scheme - a major source of income. Furthermore, many private hospitals needed this money to improve their financial status (Prachachart Thurakij Newspaper 2001). They responded to the MoPH and the public via the media every time a decision was made to postpone their entry to the program (Krungthep Thurakij Newspaper 2001; Prachachart Thurakij Newspaper 2001; Private Hospital Association 2001).

The MoPH had the role of regulator as well as the role of provider. The MoPH agreed to delay the entry of the private providers because the scheme started rapidly and there was no preparation for a quality assurance system (Director of Food and Drug Administration 2001). As provider, the MoPH wanted to protect its hospitals' financial status because they anticipated the low competitive capacity of the public providers. In the end, although the private providers were allowed to join the scheme, the MoPH limited the population size for private providers and

prohibited the entry of new private providers established after 1 April 2001 to avoid new opportunistic investors (The first taskforce of the Universal Coverage of Health Care Scheme 2001).

The Rural Doctor Society disagreed with the government's decision to allow the private sector to join as a main contractor. It suggested that the MoPH might allow private providers to be sub-contractors at the beginning, because public providers needed to improve their competitive capacities (Rural Doctor Society 2001).

The PM explicitly suggested incorporating private resources in the public health scheme. Indeed, this suggestion was based on an original idea of this current health system reform. The Party supported the policy that could turn the unused resources to promote system efficiency. It was clear that the PM supported the private sector.

In sum, this case clearly showed stakeholders influencing policy, especially the private sector. The MoPH as the program owner tried to protect public providers, whereas private providers influenced the policy through politicians and were strongly supported by government leaders.

Analysis of potential factors in decision-making

The six study cases of policy content show different networks of actors influencing decision-making processes. Positions and attempts of actors to influence the decision-making process in each issue changed depending on their policy involvement and the impact of the policy on them. All actors protect their interests. There was no single stakeholder having absolute power to dominate every decision, but each issue had a number of influential actors. Therefore, it is clear that there was a space for policy networks to contribute to the decision-making process.

Grindle and Thomas (1989) suggest that decision-makers are frequently influenced by at least four criteria: "the technical advice they receive; the impact of their choices on bureaucratic interactions; the meaning of change for political stability and political support; and their relationships with international actors" (Grindle and Thomas, 1989: 223). It is clear that the issue of source of finance was decided mainly based on the political stability and support, whereas the decision on the primary care service followed the MoPH researchers' technical advice. The decisions on the budget requirement, the allocation methods of resources to provinces, and the provider payment methods were decided mainly based on the technical advice and also took consideration of the bureaucratic implications into account. The issue of private collaboration balanced considerations of the impact on public providers and the influence of private providers

It seems that the decision-makers looked for technical evidence to justify their decisions; however, there was uncertainty about technical evidence. Other factors also affected final

decisions where policy elites sought acceptance from various networks and tried to avoid social and economic fallout.

4.3.3 Context of the decision-making process

In contrast to the agenda setting process, structural rather than situational factors highly influenced the policy formation process. Structural factors are defined as the 'relatively unchanging elements of the society and polity' (Leichter, 1979:39). These contexts included the existing health system and economic base. Also, the values and ideology of the public sector were important. External factors (international influence) were not evident.

4.3.3.1 *Health system structural development*

The existing structure of the health system, including infrastructure, the development of the insurance coverage, and human resources in the public health sector, provided the contextual feasibility, financial feasibility, and technical feasibility of the policy. The distribution of health infrastructures and health personnel provided the primary care services accessible for all rural people. The development of health insurance coverage (69% before 2001) provided an affordable additional budget to achieve universal coverage.

4.3.3.2 *Knowledge building*

The experience of the Social Security Scheme provided lessons for the capitation payment which effectively controlled health expenditure. Research knowledge in health systems has built up in the last decade, although there was considerable disagreement between researchers on what the evidence illustrated, i.e. a dynamic, lively, policy-learning environment. Several institutions carrying out research projects contributed to health sector reform, for example,

- The Health Care Reform Office carried out Research and Development (R&D) on models of health care financing and primary care system.
- The Center for Health Equity Monitoring, Narasuan University created the health equity index for Thailand and monitored the changes regarding equity in health.
- The Health Systems Research Institute (HSRI) studied the CSMBS financing and proposed a reform strategy to the Ministry of Finance (MOF). The institution also appointed a taskforce to develop a proposal of the design of the universal coverage of health care which was useful in the UC policy formulation process.
- The International Health Policy Program (IHPP), a capacity building program under collaboration between HSRI and MoPH, strengthens young researchers especially in health financing and economics. These human resources contributed to cost studies and produced a manual for analysis of hospital financial status and performances.

- The research communities and networks expanded with many more health policy and health system researchers. Amongst the research communities was the network of the rural doctor movement which was a crucial drive to the health sector reform (Wase 1997).

4.3.3.3 *Economic base*

The development of the health service delivery system and private sector growth increased in capital investment in infrastructure and the distribution of health facilities in Thailand. This resulted from the economic growth of the last two decades before the economic crisis. The MoPH has established health centres in all sub-districts to decrease geographic barriers to health care access. Community hospitals (10-120 beds) were also established in more than 90% of the districts. This infrastructure is ready for people to access, but the system needs to go a step further to improve accessibility to quality services.

The private health sector growth was a result of the rapid economic growth during 1988-1997. Government incentives through the mechanism of the Board of Investment (BOI), and access to low interest capital, coupled with increasing demand from rising urban incomes, led to a rapid growth of the private sector. After the economic crisis in 1997, the private hospitals were in a situation of 300% oversupply due to decreasing ability to pay. These resources were under utilised; therefore, this allowed the public scheme to use these existing resources to make the system more efficient.

4.3.3.4 *Ideology, public policy and public sector*

The state's ideologies have been mixed and the Thaksin government sought a middle stance to suit Thailand. In the context of democratic development, the new constitution in 1997 stated that access to health care is a right of the citizen. This government responded to the constitution with the health system reform of the UC policy. It differed from previous governments, which used incremental approaches and focused on the poor and underprivileged groups. The UC policy accepted the egalitarian approach at the level of equal access by reducing financial barriers to health care and promoting primary care units to reduce geographic barriers.

This government used the general tax to fund the UC scheme, similar to models supporting a "welfare state" ideology. However, to avoid the word "welfare", the National Policy Committee used the term "social safety net" which the committee defined as aiming to protect the risk to the people from health expenditure. While this public scheme was funded by the general taxation, the scheme accepted the notion of competition within the concept of the "new public management", contracting to both public and private providers. At the same time, there was a space for the profit-making hospitals in the free market. Some are in the stock exchange, a consequence of the liberalization policy of the state during economic growth.

4.3.3.5 *External factors*

External factors did not directly influence UC policy. In the policy formulation process, international agencies were hardly involved in UC policy. However, the World Bank's Social Investment Project loans in the period of the previous government partially influenced the design of the UC scheme. Another implicit factor, but most crucial for the sustainability of the reform policy, was the involvement of external institutions through the development of networks of personal and institutional links. The European Union funded the health care reform project under the Office of the Health Care Reform, and technical and research skills were strengthened through the training of Thais at schools in developed countries, for example, Antwerp University and the London School of Hygiene and Tropical Medicine.

4.4 Chapter summary

The analysis of this chapter clearly shows how actors influenced the policy formulation, what considerations the policy elites used, and the context which limited and allowed opportunity to change the health system.

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

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

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

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

Chapter 5 - Policy implementation: National level

5.1 Introduction

The analysis of the implementation process is divided into three chapters. This chapter explores arrangements at national level. Chapter 6 looks at provincial arrangements, and provincial-to-district execution in one province, Saraburi. Finally, Chapter 7 explores local level implementation and villagers' perceptions.

This chapter starts by analysing the arrangements at the central level and changes in health insurance coverage and other aspects of health care reform. This includes discussion on the gap between policy intent and the reality of implementation. It goes on to analyse actors' involvement, their position, interests, and perceptions of the content and process of reform, as well as the impact of the policy on them. Finally, the chapter explores change management strategies of the MoPH towards the UC policy and how it tried to overcome obstacles.

5.2 UC implementation: central arrangements and changes

UC implementation in 2001-2 included policy execution to achieve universal coverage and healthcare reform. The extension of health insurance coverage was rapid, within a year, with four phases: implementation in six provinces, in fifteen provinces, nationwide, and in Bangkok. The implementation of health care reform encompassed several aspects including: public-private mix, autonomous hospitals, primary medical care, hospital care, resource redistribution, manpower redistribution, payment methods for doctors, financing of the health care system, hospital financing, patients' rights, organisation of health care and decentralisation, and quality accreditation. While a radical shift of finance from big hospitals to primary care was introduced, other elements were underdeveloped.

5.2.1 Policy executions to achieve universal coverage

Phasing was a strategy in the UC implementation to build system capacity and readiness. There were at least two dimensions of phasing, extension of areas and level of complexity. The analysis below focuses on four aspects: objectives, insurance systems, organisation and management, and enrolment.

5.2.1.1 Objectives

Phase I. Extension of coverage in six pilot flagship provinces

To start off the 30 Baht Scheme in April 2001, insurance coverage had expanded in six provinces (Payao, Pratumthani, Yasothon, Samuthsakorn, Nakornsawan, and Yala) which were

already involved in the Social Investment Project – SIP (see section 4.2). This involved relatively little change and implementation in this phase was quite smooth.

Phase II. Private providers collaboration

The second phase of implementation, in 15 provinces in June 2001, aimed to include providers outside the MoPH. This phase also tested the new capitation budget mechanism, which included salaries. Its timing was influenced by private providers, and the number of provinces was influenced by the Health Inspector Generals (12 regional offices). Each Health Inspector General wanted at least one province in his control. Furthermore, there was pressure from local politicians, pushing their provinces for inclusion in this phase (Interview K7).

Phase III. Nationwide implementation

The nationwide implementation started in October 2001, the beginning of the fiscal year, and the best time for provinces to run a new system. The objective was to entitle all citizens to health insurance as well as to change the budgeting system to a full population basis. The timing to expand the scheme nationwide was influenced by bureaucrats (Interview K5) and local politicians (Interview K7) aiming for equal benefit distribution.

Phase IV. Implementation in Bangkok Metropolitan area

The objective of this phase (April 2002) was to complete total coverage. From October 2001, people in some outer districts of Bangkok had been entitled to the 30 Baht Scheme because the providers in these areas, mainly MoPH hospitals, were ready to respond to the scheme. In contrast, the hospitals in the inner districts of Bangkok, mainly university hospitals, needed to wait until April 2002. Moreover, the Bangkok Metropolitan Administration (BMA), responsible for local administration, refused to play the purchasing role for the 30 Baht Scheme in Bangkok. Therefore, the Medical Service Department of the MoPH became responsible for purchasing services and management in Bangkok.

5.2.1.2 Design of insurance systems

The insurance system features changed progressively during 2001-2002. The insurance system of the first phase of UC implementation was developed from the SIP financing model in the Medical Welfare Scheme (MWS), which allocated budgets to provinces according to the number of registered population and paid providers for inpatient care according to workload (Srithamrongsawat 2002). The benefit package was the same as that of the Voluntary Health Card Scheme (VHCS), including curative care and drugs on the National Essential Drugs list. Providers in this phase included only MoPH facilities, as in the MWS and the VHCS. A hospital and a health centre were identified to be gatekeepers for each beneficiary.

The budget for implementation in the first phase was limited to about 399.8 million Baht or 7.5 USD millions (45 Baht/USD in April 2001) for all newly registered population. Ten percent of the total budget was allocated for change management and 5% for primary care network development. The rest was for health care services with a capitation rate of 477 Baht per year (or 238.5 Baht per 6 months – this rate excluded salary budget). From the total 477 Baht, 2.5 and 1.25% was administered at the Central MoPH for high cost care and administration. Ten percent was administered at PHOs for referred and accident patients across provinces. From this 10%, less than 1% could be used for health promotion and disease prevention because government had already allocated budget for those purposes at the beginning of the fiscal year. The rest of the budget was divided into two parts: 45% and 55% for outpatient and inpatient care respectively (Figure 5.1). The budgets were allocated to providers according to the size of the registered population and the performance measured by the Diagnostic Relative Groups (DRGs) weights respectively.

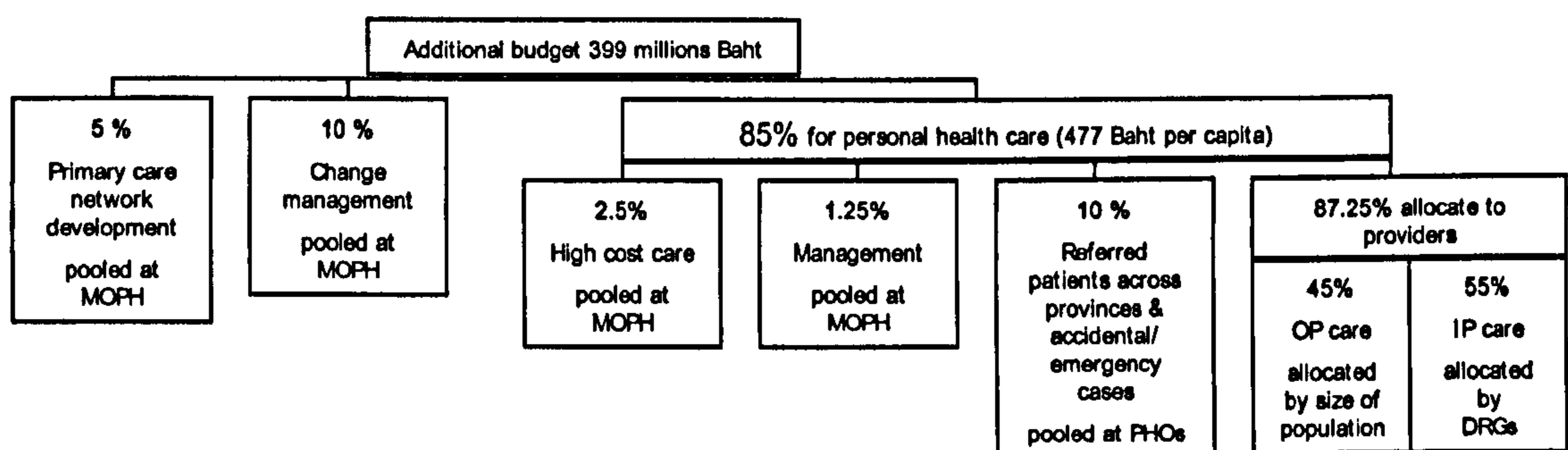


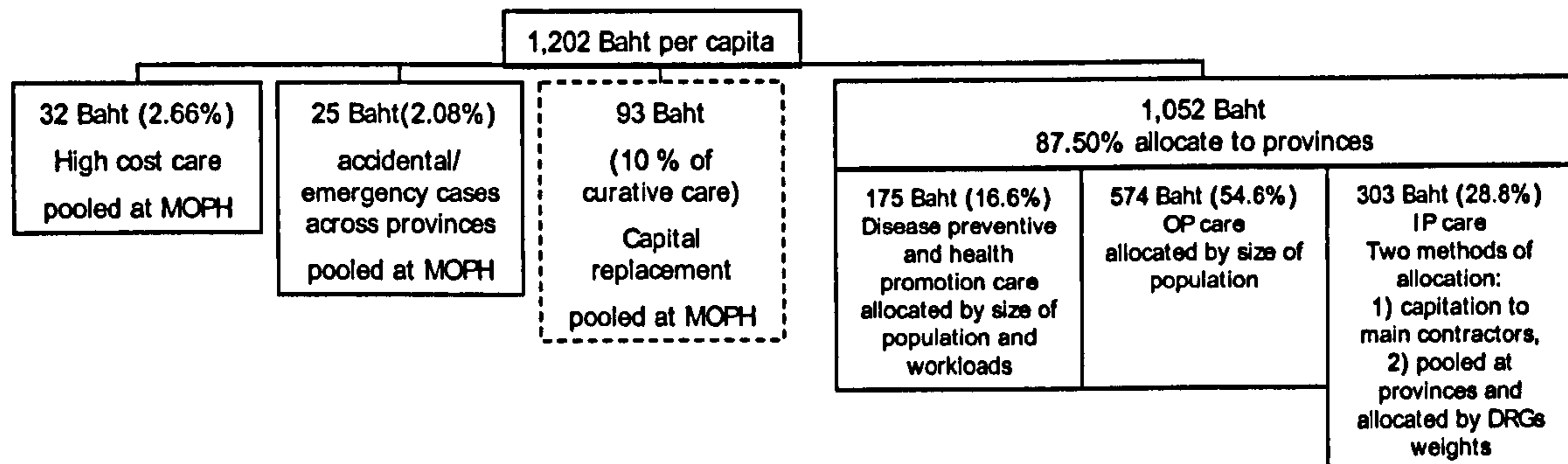
Figure 5.1 Budget allocation of the 30 Baht Scheme in phase I

Source: Paper proceeding in the taskforce meeting for implementation in six provinces on 13 March 2001 at MoPH

In the second phase, the main differences from phase I were the amount of budget (budget for preventive care and health promotion was added) and the provider payment methods. The additional budget for four months implementation in 15 provinces was about four times higher than the first phase, 1,510 million Baht (34 USD millions), of which 1,100 million Baht came from the VHCS Revolving Fund (there was 1,237 million Baht left in 2001). It is clear that the reserved money of the VHCS made implementation in the second phase possible. The capitation rate in this phase was 1,202 Baht (27 USD) per year for a more comprehensive benefit package, which included curative care, disease prevention and health promotion care, and drugs in the National Essential Drugs list (Tangcharoensathien 2001). This cost was also used in the third phase (see the cost structure in Figure 5.2). The cost structure components were:

- Budget for curative care, composed of 574 Baht (61.5%) for outpatient care, 303 Baht (32.4%) for inpatient care, 32 Baht (3.4%) for high cost care, and 25 Baht (2.7%) for accident and emergency patients,
- 175 Baht for disease prevention and health promotion,
- 93.4 Baht (10% of curative care) for capital replacement.

Figure 5.2 Budget allocation of the 30 Baht Scheme in phases II and III



Source: Tangcharoensathien et al (2001)

The budgets for public facilities to enrol new insured excluded budgets for salaries, capital replacement, and other high cost and accident care. The figure was about 262 Baht per capita per four months. The non-MoPH public hospitals received the same budget rate as the MoPH providers although they had already received a higher proportion of salary budgets, as a result of an argument about equal additional benefit (Health Insurance Revolving Fund Committee 2001). PHOs managed the 262-Baht budget by authorising the Provincial Insurance Committee to decide on the provider payment methods. The budget for outpatient care and promotion & preventive care was mostly allocated to providers according to the size of the registered population plus incentives measured by workload. There were two alternative provider payment methods for inpatient care: inclusive and exclusive capitation. In inclusive capitation, inpatient care was included in the capitation budget, as per outpatient and promotion & preventive care. In exclusive capitation, the budget for inpatient care was separated from the capitation budget, pooled at the PHOs and reallocated according to case-mix loads. Eight provinces selected exclusive capitation while seven provinces selected inclusive capitation (The evaluation committee of the UC implementation in the transition period in fifteen provinces 2001).

In the nationwide phase (phase III), there were a lot of changes. The MWS was merged with the 30 Baht Scheme but the beneficiaries of the MWS were exempted from the 30 Baht co-payment. No new VHCS card was issued in the fiscal year 2002, but a number of cardholders could still use the cards until September 2002. The CSMBS introduced a central information system of individual medical records in order to implement the provider payment with DRGs

weight in October 2001. The SSS increased its coverage to all employees in all firms that had at least one employee from 1 April 2002.

The budget for the 30 Baht Scheme in fiscal year 2002 was about 47,000 million Baht (1,044 USD million) for a total of 45 million people, including those who were covered by the MWS. This budget replaced all MoPH budgets for health services (about 33,400 million Baht in 2001). Thus, this was an increase of 40% in expenditure for health services; in reality, however, the expenditure was lower because the approved size of the registered population was less than the target for several months.

The capitation rate was the same as phase II. The budget for capital replacement, high cost care, and accident and emergency care continued to be managed at central level. Private providers received a budget of about 1,052 Baht per capita per year (after deduction of 150 Baht for high cost care, emergency care, and capital investment to be managed at central level). For public facilities, salary budgets followed the health personnel according to the Government Salary Act; therefore, the capitation budget had to be subtracted from the salary budget before transferring the budget to PHOs. The subtraction in this phase was different from the second phase, because each province had to be responsible for its staff salaries. In other words, the population-based budget allocation in this phase included salaries in the allocation. Non-MoPH hospitals received the salary-excluded budget 578.6 Baht per capita per year (labour costs were 55% of total cost: 1,052 Baht). For MoPH facilities, PHOs managed the rest of the budget after subtracting the salary budget by authorising the Provincial Insurance Committee to decide on the provider payment methods. The Provincial Insurance Committee had to decide two main issues before transferring budget to providers; firstly, whether the salary subtraction should be at provincial or at Contracting Unit for Primary Care (CUP) level, and secondly, whether to choose the inclusive or exclusive capitation. The budget for outpatient care, promotion & prevention was mostly allocated to providers according to the size of the registered population, plus incentives measured by workloads. Forty provinces chose exclusive capitation while 28 provinces chose the inclusive capitation and others chose a mixed system. Thirty-six provinces chose to subtract salaries at provincial level while 34 provinces chose the salary subtraction at CUP level and others chose a mixed system (Na Ranong and Na Ranong 2002a).

The Primary Care Units (PCUs) were strengthened in this phase, to play a gatekeeper function. Any health facility that was overseen by a medical doctor providing primary medical care could be a PCU. The doctor to population ratio should be less than 10,000 head of population per doctor. Health centres were improved to play the PCU roles. People were requested to first contact PCUs in the registered provider network, and hospital services were only covered if referrals came from PCUs.

In the fourth phase, the insurance system in Bangkok was unique. Bangkok was divided into 14 zones of provider networks according to tertiary hospital locations. Tertiary hospitals were invited to be chief providers in each zone. There were three university hospitals, four BMA hospitals, a police hospital, three hospitals of the Ministry of Defence (one is a teaching hospital), and three MoPH hospitals. Private hospitals and other public hospitals were main contractors responsible for population at an agreed-quota number. BMA health centres, health centres of the Signal Department, Ministry of Defence, and private clinics were subcontractors of those hospitals. On 1 April 2002, there were 128 PCUs, of which 92 PCUs were public and 36 PCUs were private. They were provided by 21 public hospitals, 61 BMA health centres, 2 Red Cross health centres, 8 health centres of the Signal Department, Ministry of Defense, 30 private hospitals, 5 private polyclinics and a private clinic. Private hospitals acting as main contractor received a budget of 1,052 Baht per capita per year. The budget for public providers in Bangkok was a supplement to government salaries and allocated as a capitation payment including inpatient-care cost (salary exclusion and inclusive capitation). Therefore, all public hospitals acting as main contractors received a budget of 578.6 Baht per capita per year (55% of total capitation cost, 1,052 Baht) to allocate money for inpatient care, ambulatory care, preventive care and health promotion, and drugs in the National Essential Drugs List. A beneficiary could access a hospital directly and a health centre or a private clinic indicated on the health card with only a 30 Baht co-payment. The public health centres were reimbursed from the main contractors at the rate of 100 Baht per visit, excluding labour costs (this rate is about the unit cost of health centres but much less than the unit cost of hospitals) because health centre staff received government salaries. Private clinics were reimbursed at the rate of 150 Baht per visit (Interview K25). Referral rates to higher level care used the same criteria as the national agreement, which was the differentiated rate according to the sophistication of the level of care.

For public hospitals in Bangkok, this budget was an additional budget supplement to their salary budgets, logistic budgets, and capital budgets in the previous system. There was little change in the financing system and low negative impact on their hospital finances. No hospital requested money from the Contingency Fund.

As seen from the above, the complexity and changes were greater in the later phases.

5.2.1.3 Organisation and management

UC needed the National Health Security Office (NHSO) to be established by law to legitimise implementation, but the legislative process was not as fast as the MoPH implementation. Although implementation started rapidly, it was not underpinned by legislation until November 2002. It was only in May 2002 that the House of Representatives passed the National Health

Security Act, with 376 votes out of 500. During the consultative process public hearings were made four times in four geographical areas of Thailand (Northern, Eastern, Southern, and Central). The bill had four main principles:

- The NHSO, the health care purchaser, should be an autonomous body separated from the MoPH, congruent with the concept of the purchaser-provider split.
- The right for health care protected by this law is for the whole population, not just for any particular group.
- People have rights of access to health care, choice to register with a provider, rights to participate in the insurance management, rights to be compensated under defined circumstances, and rights to be protected from the health care cost of accidents and emergency illness.
- All health care providers of private, public and other sectors are eligible to register to provide services under the National Health Security Scheme.

The principles of the Bill were widely accepted but some points were debated:

- Incorporation of the management of health care expenses of the CSMBS and SSS;
- Transferring the indemnity from private health insurers or the compensation from responsible agencies to the National Health Security Fund;
- Whether to establish a Compensation fund for people who suffered due to health services and reimbursement from mal-practitioners; and
- The authority of the committee on standards and quality control.

The Senate agreed in August 2001 to remove NHSO authority over indemnity and compensation claims against private agencies, and the dissemination of information on malpractice cases to the public. However, the House of Representatives finally agreed to remove only the latter issue and the law was promulgated in November 2002. Both the House of Representatives and the Senate, with influence from the government, seemed to pass this Bill as a matter of urgency, despite lack of consensus on a lot of points.

As the legislative process behind the implementation (the National Social Security Bill got into the Parliamentary process in November 2001), the MoPH executed the implementation. The organisation and management in 2001-2 was briefly described in Chapter 4 (see section 4.4.2.1). It was not static. There were at least three aspects of transition: from inside to outside the MoPH, narrow to wide participation, and from informal to formal appointees. The organisation and management was composed of three parts: policy design and planning committees, management authorities, and the technical and management preparation within the MoPH. Figures 5.3–6 illustrate the wider participation of organisations in the UC policy from phase I to Phase IV. Figure 5.7 illustrates the organisation and management structure intended in the National Health Security Act (2002).

At the beginning, the MoPH was solely in charge of UC management. Two taskforces within the MoPH were constituted to oversee separately the general implementation of the 30 Baht Scheme and the specific implementation in the six pilot provinces. The management was carried out under MoPH regulations. The management authorities included the Insurance Committee and the UC Budget Management Committee. However, the structure of these managerial committees was composed of several ministries' representatives, chaired by the MoPH Permanent Secretary and with the Director of the HIO as committee secretary – the same committee structure as the MWS.

In the full-blown implementation, the roles of policy design and planning were transferred from inner MoPH committees to multi-ministerial committees. The former MoPH committee for guideline development was changed to the Operational Centre Committee dealing with problems occurring during implementation. The National Health Security Policy Committee was commissioned to oversee the whole system preparations for the national Health Security Office under the new law. The National Executive/Administrative Committee was commissioned to co-ordinate and to involve top civil servants from other ministries in the UC policy execution. However, the MoPH had a dominant role in the 30 Baht Scheme execution and this committee played a minor role. The Health Insurance Committee and the Health Budget Management Committee (also named the Health Insurance Revolving Fund Committee) continued as the main management authorities. (See the lists of important committees in Chapter 4, section 4.3.1).

The main responsible organisations in the MoPH dealing with provinces included the Health Insurance Office (HIO), the Rural Hospitals Division and the Rural Health Division (the latter two offices merged into the Bureau of Health Care Network Development in the second phase). The HIO developed the information technology system for registration and was responsible for budget transfer. The Rural Hospitals Division and the Rural Health Division were responsible for skill support. The Bureau of Health Policy and Planning (BHPP) and the Health Care Reform Office (HCRO) facilitated technical support as members of taskforces. The Inspector General Office was involved in the second phase. Each Regional Inspector General Office (from 12 Regional Offices) was assigned to support and monitor the implementation in their region.

In April 2002, a set of arrangements for Bangkok was established (see in Figure 5.6). The Medical Services Department was stripped of its purchasing power and only coordinated the implementation. There was wide involvement from all stakeholders from providers but none from consumers. The National Health Security Policy Community appointed a Committee for Implementation in Bangkok in August 2001. In October 2001, this committee appointed two subcommittees: a committee for provider network development, chaired by the Deputy

Governor of Bangkok, and a committee for implementation coordination, chaired by the Director General of the Medical Services Department. The latter committee was labelled ‘the Bangkok War Room’, and its meetings were political arenas for negotiation and participation.

Figure 5.3 Organisation and management in phase I

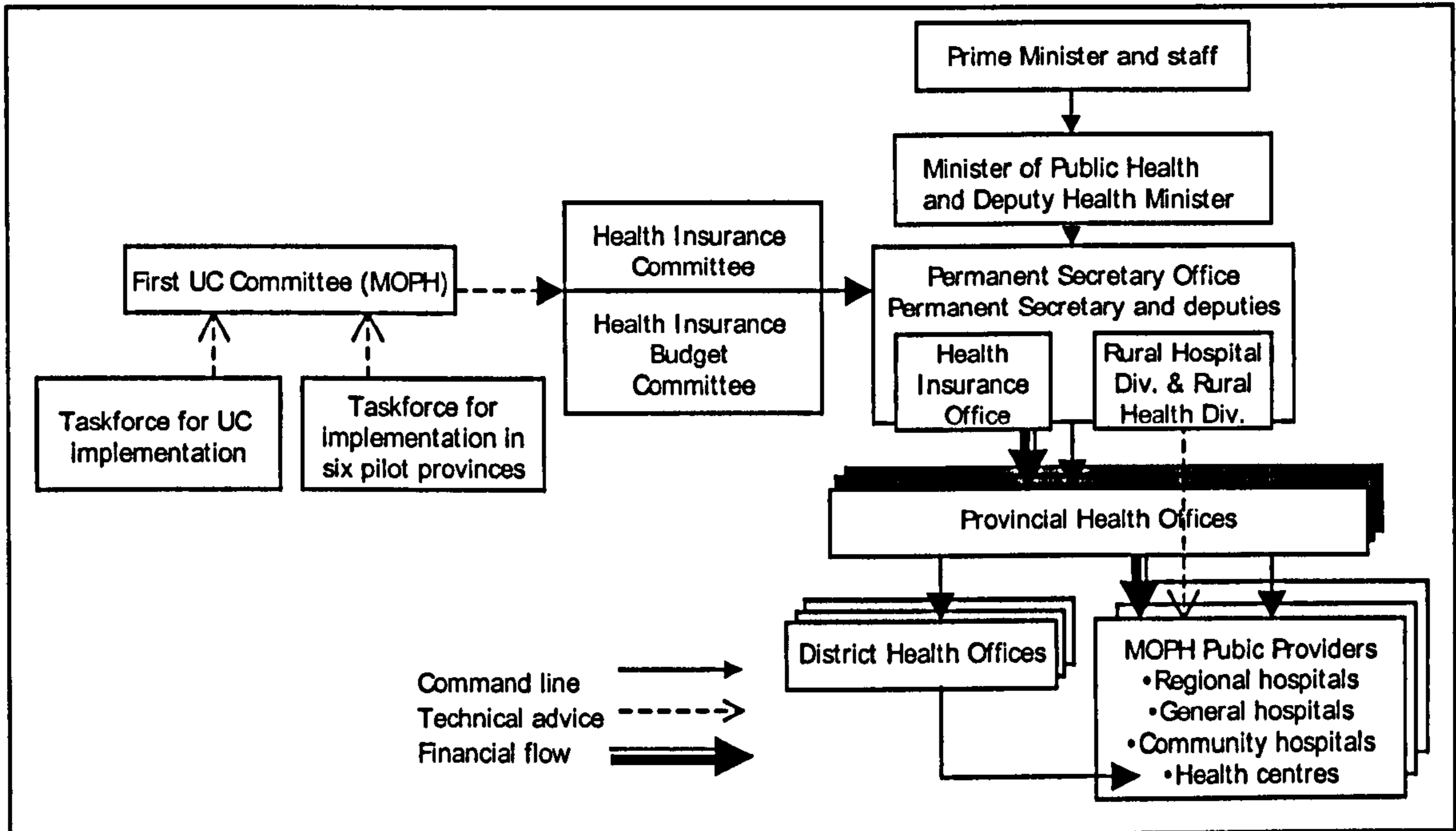


Figure 5.4 Organisation and management in phase II

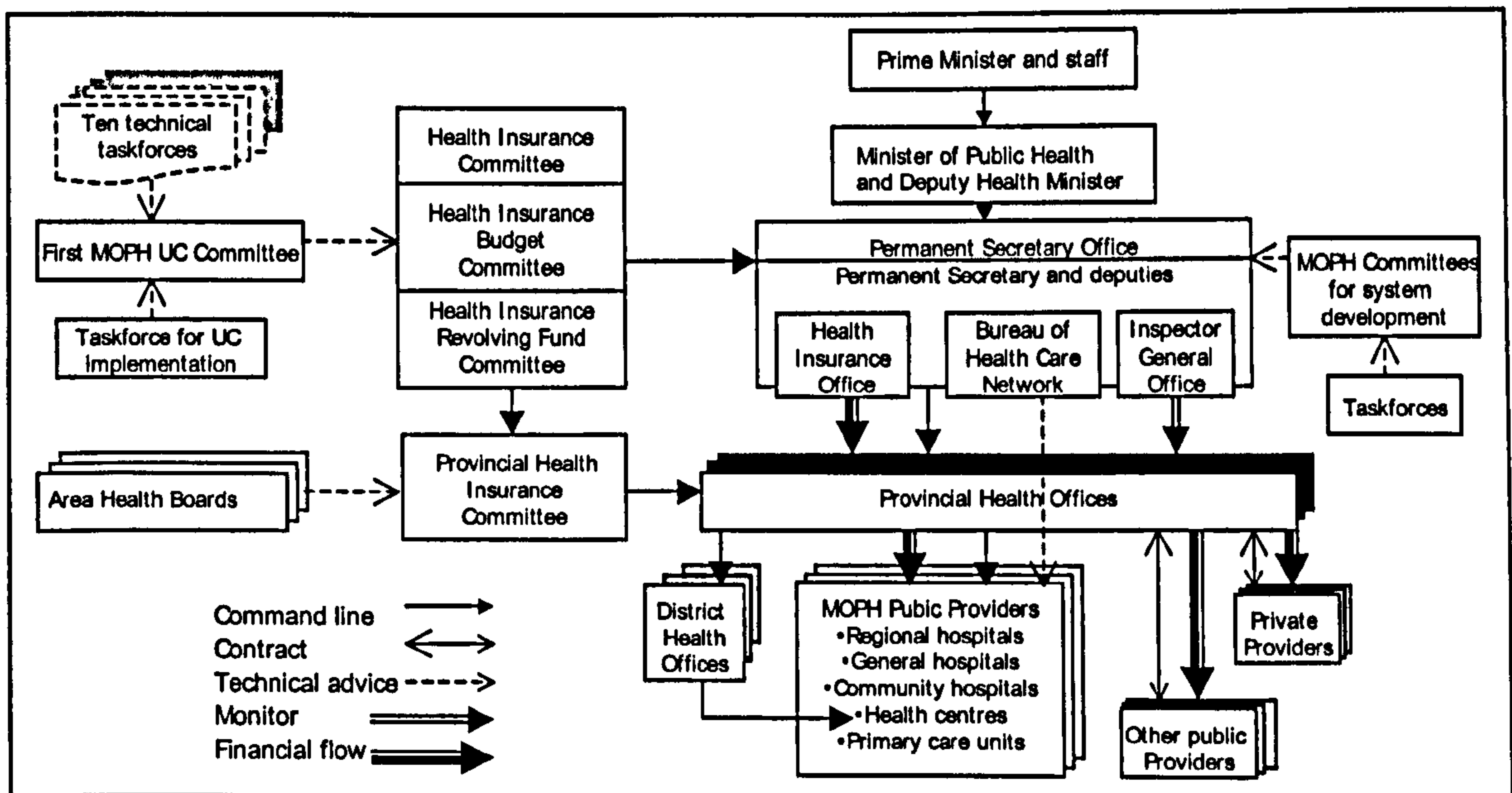


Figure 5.5 Organisation and management in phase III

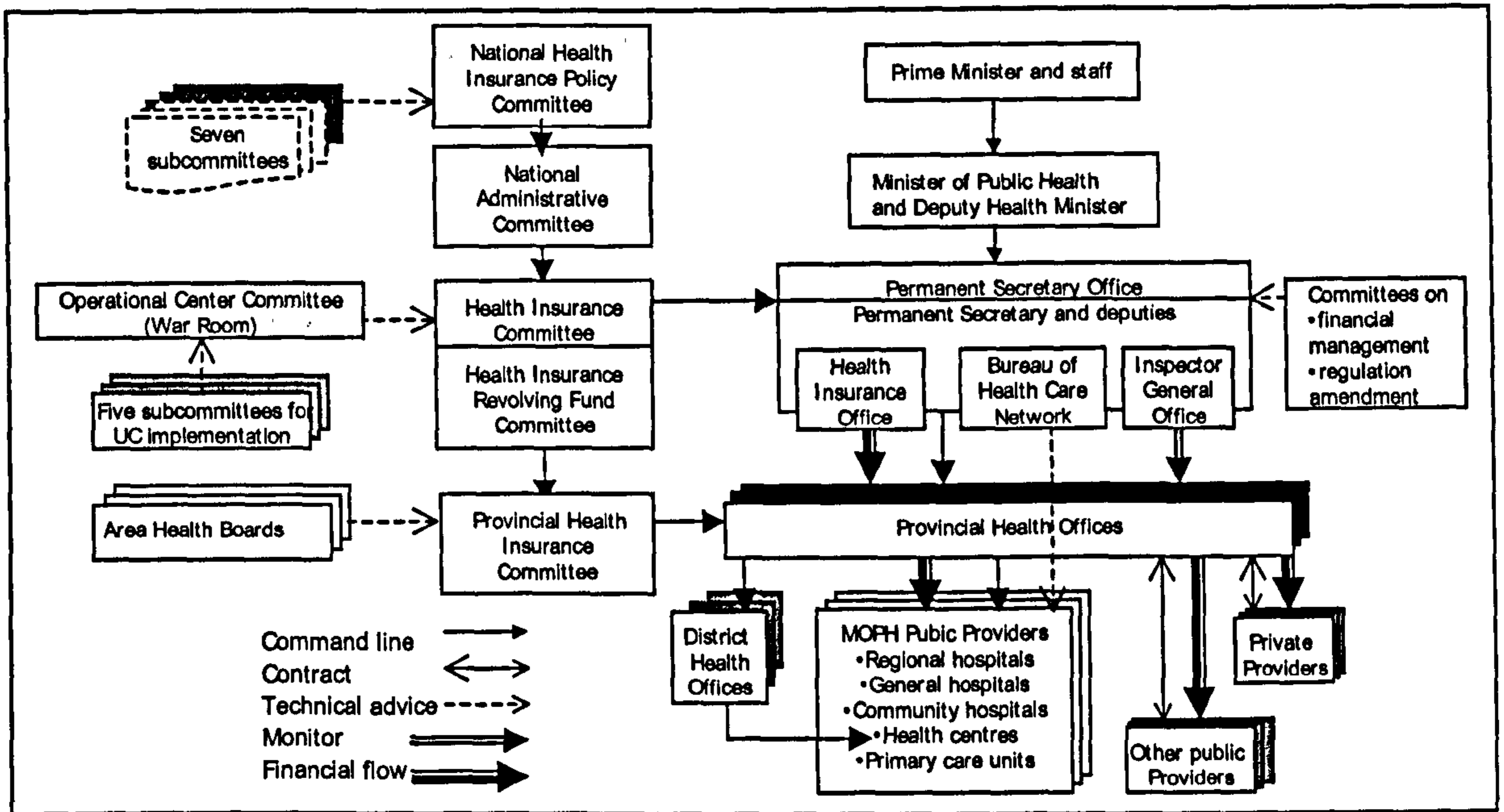


Figure 5.6 Organisation and management in Bangkok

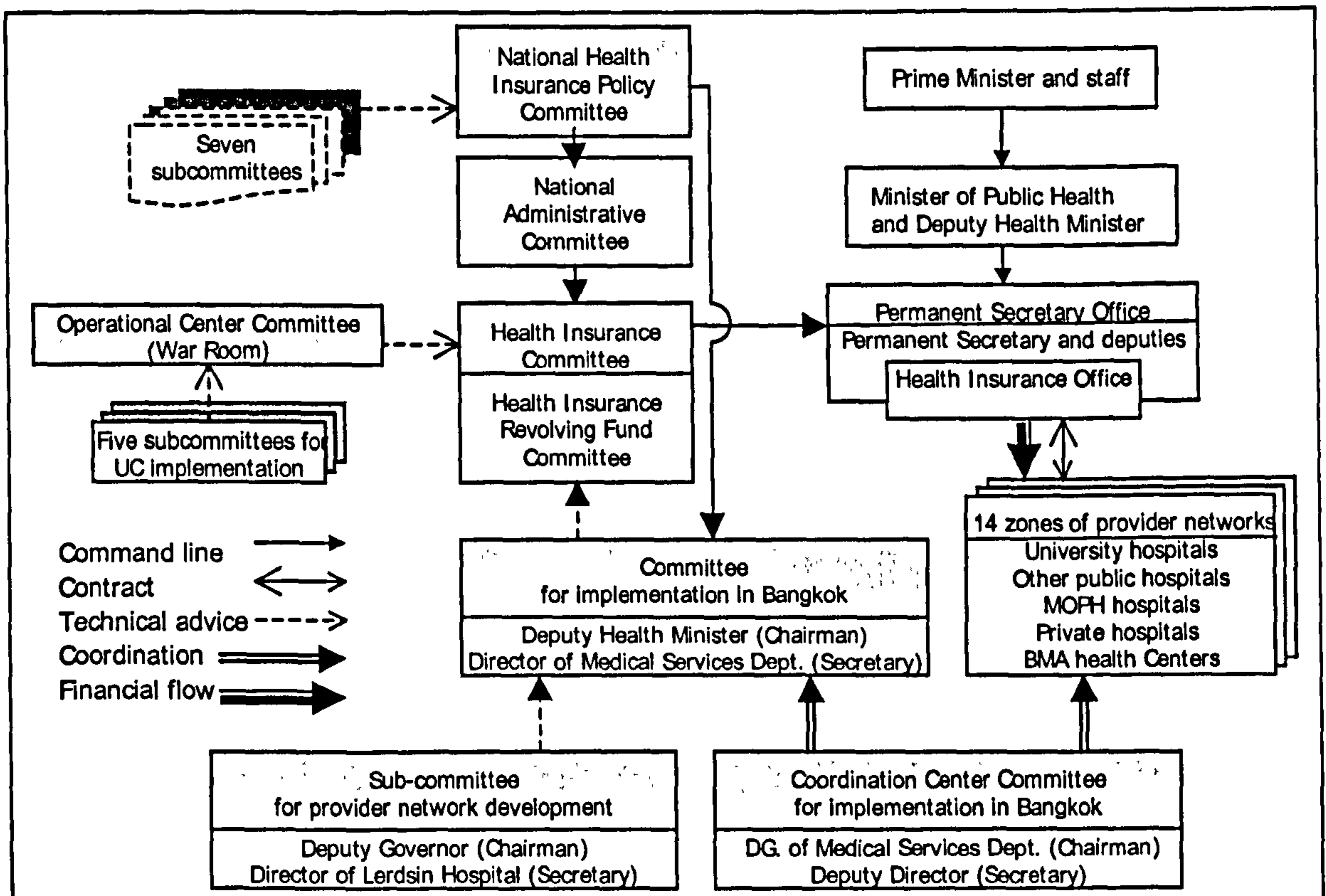
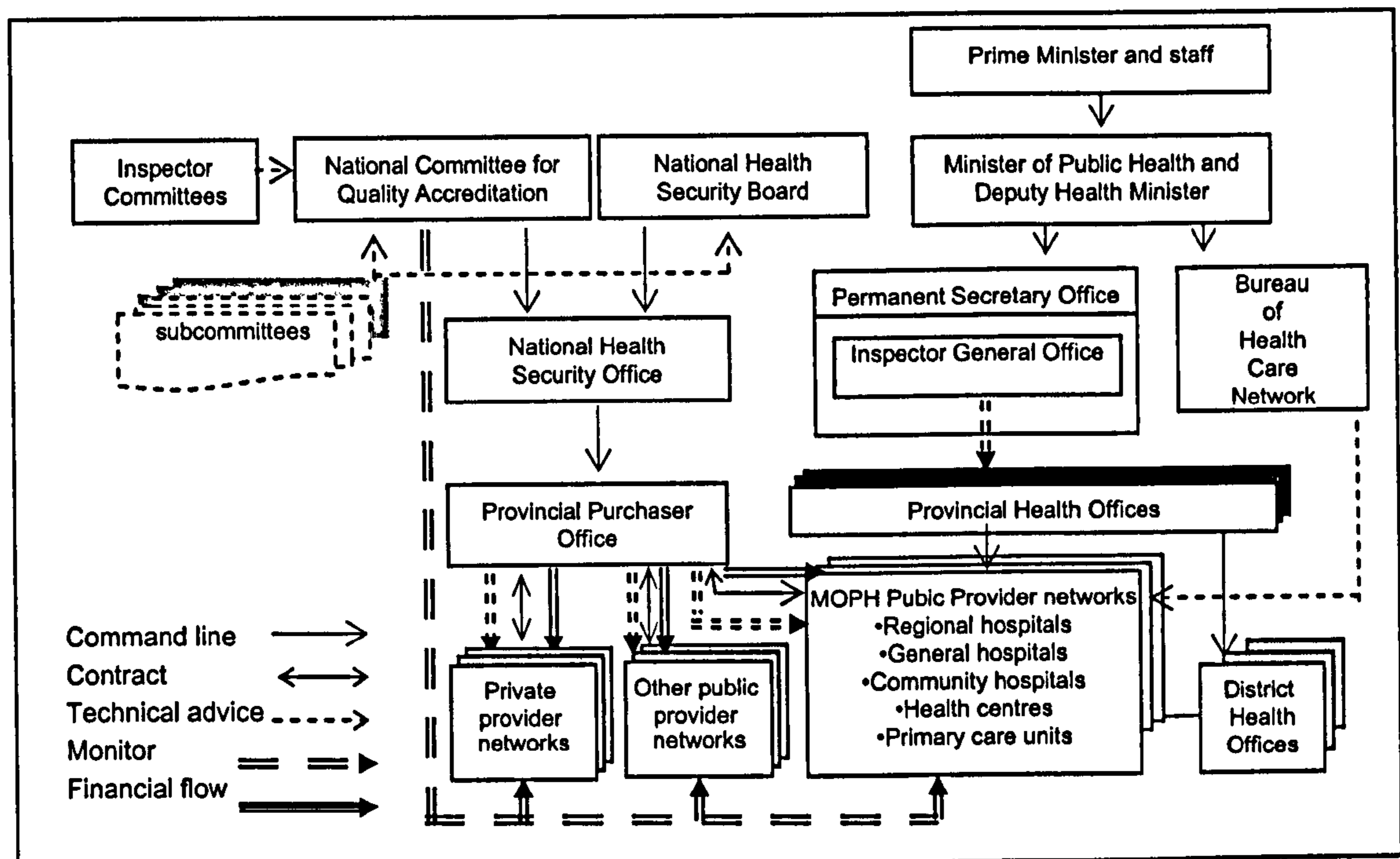


Figure 5.7 Organisation and management structure intended in the National Health Security Act (2002)



Source: Interpreted from the National Health Security Act (2002) by Pitayarangsarit (2004)

Figure 5.7 shows the organisation and management structure in the National Health Security Act (2002), which should be in full operation in December 2005, three years after the Act's promulgation. The National Health Security Board (NHSB) was constituted to steer the design of the UC program, giving policy directions to the UC scheme manager and ensuring a single standard of health care for all Thais in the future, and the National Health Security Office (NHSO) was established as the secretariat for the NHSB and will take charge the 30 Baht Scheme in 2006. The NHSB would appoint several sub-committees for technical advices. Provincial Purchaser Offices are being established in provinces to play the purchaser role by contracting with providers. The National Committee for Quality Accreditation was constituted to deal with the quality assurance, under which several inspector committees would be established to investigate the grievances. While these organisations and committees are being developed, the MoPH is responsible for the management of the 30 Baht Scheme (2001-2005).

For policy communication and provincial management preparation, the Health Minister had met MoPH provincial staff at four meetings in April and May 2001, one for each geographical area (Northern, North Eastern, Southern, and Central Regions of Thailand). Senior MoPH officers (the Permanent Secretary and Deputies, and the Director General of MoPH Departments) were divided into 7 teams to support and supervise the implementation in the 12 administrative areas

and Bangkok. These senior officers worked with the Inspector Generals in the 12 areas and visited the target provinces at least twice before June 2001. At this time, the role of the Inspector General was prominent. It seemed that each implementation team competed in their positive responses (Interview K16).

5.2.1.4 Enrolment

The 30 Baht Scheme expanded the coverage of the newly registered population from 1.4 million people in six provinces in the first phase (April 2001) to 4.9 million people in 15 provinces in the second phase (June 2001) and to 21.3 million people of the population nationwide in the last two phases (April 2002). The third and fourth phases achieved the target of 45 million people, of which 24 million people were from the MWS. Thus the total health insurance coverage (of all schemes) had risen to 91.9% of the whole population in the Kingdom (Table 5.1). The uninsured made up about 8.1% of the population. Some of the uninsured were unreachable by either health insurance or any other social welfare because they could not show their identification numbers (13 digits). These people included the elderly, the handicapped, prisoners, hill tribes, beggars, and orphans. However, the social welfare system in public hospitals could still be used to exempt them from the 30 Baht fee, but the burden fell on providers as the exemption was not counted for in the capitation budget. Hospitals complained and requested extra budget to cover this group.

In the developing phases, migrant workers had been excluded from the program until October 2001 and there might have been some people covered by multiple insurance schemes. This was because of the incomplete information system. The CSMBS did not have the beneficiary lists and the MoPH had not linked the data with the SSS and the house registration database. Before the registration database of the Ministry of Interior was able to be used as reference, the MoPH had to set up the database receiving data from provinces. The MoPH electronic database was only up and running in March 2002 (Srithamrongsawat 2002).

At provinces, since the budget for the second phase was to be determined by the size of registered population, the provinces had to establish the database of health registration within a few months. Officials from health centres, hospitals and Provincial Health Offices were allocated to carry out household surveys for individual records. House registration was used as a reference. There were many mistakes in data entry and data validity. Problems with hardware availability, software errors and computer using skills were reported (The evaluation committee of the UC implementation in the transition period in fifteen provinces 2001). Provinces starting in October 2001 had the same problems as the forerunners. The weakness of the information system caused conflict between beneficiaries and providers, and between providers and Provincial Health Offices (Interview S2).

Table 5.1 Populations covered by the UC Policy in the transition phases until September 2002

Insurance types	6 provinces*		15 province*		Whole country	
	Millions	%	Millions	%	Millions	%
30 Baht Scheme	1.39	38.31	4.92	35.06	21.30	34.8
Medical Welfare Scheme (incorporated in the UC Scheme after October 2001)	1.52	41.85	5.99	42.69	24.03	39.3
Voluntary Health Card Scheme	0.03	0.81	0.24	1.72	0.01	0.0
Civil Servant Medical Benefit Scheme & Public enterprises	0.06	1.78	0.25	1.80	3.93	6.4
Social Security Scheme	0.40	11.07	1.42	10.11	6.94	11.3
Total insured	3.40	93.83	12.82	91.39	56.19	91.9
Population	3.63	100.00	14.03	100.00	61.2	100

Source:

*1. Total population was used data in December 2000. Registration Division, Administration Department, Ministry of Interior

*2. Registered population in the 30 Baht Scheme was in September 2001. Health Insurance Office (2002)

*3. Populations in other scheme were in March 2002 from the electronic database of the Health Insurance Office <http://203.157.2.238/workxeon/NumberCardHospProvinceR.jsp>

** Health Insurance Office (in September 2002), <http://203.157.2.238/workxeon/NumberCardHospProvinceR.jsp>

5.2.2 Implementation of health care reform

5.2.2.1 Public-private mix in providing services

Private providers, including hospitals and private clinics, had played roles in public schemes since the instigation of the Social Security Scheme (SSS) in 1991. At the initial stage, the proportion of employees registered with private providers was low but it increased and became higher than the proportion of employees registered with public providers, illustrating the competitive edge of private providers. Though the 30 Baht Scheme allowed private providers to provide any service in the benefit package, thus private provider function depended on how many private Contracting Units for Primary Care (CUPs) had registered. The MoPH has the biggest market share and de facto it protects MoPH hospitals from competition by managed collaboration with private providers. Because of the incomplete information given to private providers and the limited number of allocated population, only 96 private hospitals joined the 30 Baht Scheme in September 2002 (with a small number of private clinics joining the program), comparing to that 132 hospitals joined the SSS (Social Security Office 2002), out of 456 private hospitals in Thailand. In addition, the quota of registered population for a private CUP outside Bangkok was only about 10,000 population per hospital. As a result, the proportion of population registered with private providers was only 3% while the proportion of private providers acting as CUPs was about 9% of total CUPs (see Table 5.2 for number of health facilities and registered population in the program). While there are many problems with public hospitals' incomes in provinces outside Bangkok, development of the public-private mix in

these provinces was a low priority. At the same time, public-private mix development in Bangkok has just started.

Table 5.2 Number of health facilities and registered population by type of providers in 2002

Type of providers	Health facilities (main contractors)	Registered populations
MoPH facilities	840 (83%)	52,264,637 (93%)
Non-MoPH public facilities	76 (8%)	2,134,651 (4%)
Private hospitals	96 (9%)	1,822,196 (3%)
Total	1,012 (100%)	56,221,484 (100%)

Source: Health Insurance Office, September 2002, searched from <http://www.hinso.MoPH.go.th/cgi-bin/Hospitalmain/CountHtype.asp>

5.2.2.2 *Autonomous hospitals*

Hospital autonomy was a proposed strategy at the initial stage of the UC implementation planning to increase MoPH hospitals' efficiency. Experience from the first autonomous hospital convinced policy makers of the feasibility of this reform. However, there was limited interest among MoPH hospitals (Interview 20). Resistance within MoPH civil servants has been high, as the transformation would change their working status.

5.2.2.3 *Primary medical care*

Primary care was identified as a key mechanism for providing health care in UC policy, with the slogan "*Krai Ban Krai Jai*" (literally 'close to the home, close to the heart') (Interview K11), and to increase quality of care (Interview K20).

During the last decade, there had been continuous efforts to strengthen primary care in Thailand. In 1992, the first demonstration model of primary care was established in Ayutthaya province (Pongsuparb 1996) and it became a successful model (Interview K5) (Jongudomsuk 2002). The concept and management of primary medical care had gradually expanded in many provinces with the introduction of Primary Care Units (PCU), coordinated by the Office of Health Care Reform. The Consortium of the Deans of Medical Schools organized a national conference on medical education in April 2001 and reached a consensus that changing medical curriculum to serve primary care was a priority issue (Jongudomsuk 2002).

Primary medical care was defined as a holistic, continuous, and comprehensive care using the family medicine concept. Due to the UC policy, a set of standards for Primary Care Units (PCUs) was developed and the primary medical care providers are designated as:

- main contractors holding funds for primary medical care services for the registered population, and
- gatekeepers to provide primary medical care and refer patients to hospitals.

However, the number of qualified primary care providers was small. This allowed any hospital that could arrange primary medical care services to make contracts as a Contracting Unit for

Primary Care (CUP). Therefore, any provider with at least a medical doctor and a PCU is eligible to be a CUP. Consequently, many hospitals established PCUs inside and outside the hospital. Health centres were improved to reach the PCU standard, but the PCU standard was criticized as being impossible to achieve given the limited number of doctors. Later, the MoPH graded PCUs according to three development levels, to increase flexibility and allow opportunities for development.

5.2.2.4 Hospital care

The focus for investment in hospital care changed from the number of hospital beds to the establishment of centres of excellence - high technology treatment in regions, for example, cardiac surgery, organ transplant, emergency service and cancer treatment. Moreover, more attention was paid to the quality of hospital care, resulting from the capitation payment system. The procedure of accreditation was implemented from 2002 in all public and private hospitals in the 30 Baht Scheme and is ongoing.

5.2.2.5 Resource redistribution

Budgets for material expenses and salaries were redistributed to match the population. One quarter of hospitals were expected to have a negative balance of finance (Na Ranong and Na Ranong 2002a). The MoPH used the Contingency Fund to subsidise these hospitals using a set of criteria; therefore, no hospital was bankrupted, although some suffered from increased insecurity. Some providers, however, had a budget surplus because of the redistribution. This imbalance was caused by the poor distribution of health facilities and personnel, especially medical doctors. There had been resistance to including salaries within the redistribution budget, and there were attempts to separate provincial hospitals from the redistribution, but they did not succeed. In October 2002, attention shifted to the separation of total salaries from the reallocated budget, and this succeeded in fiscal year 2003.

5.2.2.6 Human resource redistribution

Budget reallocation was expected to initiate a more equal human resource reallocation. However, this did not happen because of several factors. Firstly, implementation documents rarely addressed the issues of human resources; therefore, MoPH staff were not sure whether they would be forced to move and felt panic for a while until the MoPH recommended that movement should be voluntary (in August 2001). Secondly, there was unclear authority regarding manpower within the MoPH, since there was no main organisation responsible for overseeing the whole process of human resource development. The Bureau of Health Policy and Planning was responsible for planning manpower size, the Bureau of Health Care Network

(BHCN) was responsible for distributing new personnel, and the Institute of Manpower Development took responsibility for undergraduate education, producing community health officers, dental nurses, community pharmaceutical officers, and technical nurses. These were fragmented and under the separate control of Deputy Permanent Secretaries. When the BHCN proposed a plan for medical doctor redistribution to the War Room, the plan was put to one side and referred to a Deputy PS who was from the provincial hospital faction and did not support the human resource reform (Interview K7). Consequently there was no master plan in human resource mobilisation. Thirdly, there was a fight for leadership between two groups of bureaucrats: reformists and conservative bureaucrats. When the new PS of fiscal year 2002 started, the BHCN changed hands.

The distribution of new personnel in April 2002 followed the old pattern. However, many provinces refused to accept new graduates. It is clear that the MoPH passed the responsibility for decision on manpower to provinces by changing the financial incentive rules to be more flexible and generous, and letting provinces decide on their own requirements. Moreover, there was a commitment on salary security for all civil servants. This meant that some hospitals that had high numbers of health personnel had less incentive to reduce salary costs. Consequently, big city hospitals could continually attract medical doctors, causing congestion in the cities at the expense of rural areas.

5.2.2.7 Payment methods for doctors

The 30 Baht Scheme did not define payment methods for doctors. Public facilities normally pay doctors by salary plus some payment for out-of-hours work or surgical operations. The MoPH tried to increase flexibility by using hospital budgets as incentives for doctors and staff according to workloads. However, some hospitals with budget constraints could not pay more, even though some staff had higher workloads than previously. For private hospitals, a low salary rate was offered to medical doctors practising in the PCU; therefore, only new graduates with little experience accepted this job, while other experienced doctors worked in the normal OPD. This seemed to encourage a two-tier standard of quality of services.

5.2.2.8 Financing of the health care system

The UC policy also aimed to control national health expenditure and reduce household health expenditure. The implementation of the UC policy could have replaced household out-of-pocket spending with the expenditure of the prepayment risk-pooling public scheme. Empirical data shows an increase of about 20% in public spending in 2002 (the MoPH was the biggest share with 13.5 Billion) but there was no evidence to show any decrease in household out-of-pocket spending (from the report of the Socio-Economic Survey (SES), likely to be

disseminated in 2003). However, Tangcharoensathien et al estimated a reduction in household out-of-pocket spending from 55 Billion Baht to 47 Billion Baht (14% reduction). This estimation was based on the latest 2001 SES figure by assuming that the 30 Baht scheme would affect only the 30% previously uninsured, with the compliance rate for ambulatory and inpatient care as reported by Pannarunothai et al, namely 59% and 69% respectively (Pannarunothai et al. 2002). Consequently, private health spending in 2002, which includes private insurance premiums and out-of-pocket spending, decreased 12% from 2001. Table 5.3 shows the health system expenditure and financing in Thailand during 2001 to 2002.

Table 5.3 Health System Expenditure & Financing in Thailand, 2001-2002 (Millions Baht)

Measured Financing Agents	2001	2002	Sources
1. Public spending on health	83,487	100,266	
The 30 Baht Scheme	36,866	50,464	BHPP, MoPH
...of which MoPH	33,402	47,000	BHPP, MoPH
...of which other ministries	3,464	*3,464	BHPP, MoPH
CSMBS	19,131	*20,635	Comptroller's General Department, Ministry of Finance
SSS	9,810	*11,480	Social Security Office
Non personal care (MoPH only)	17,681	17,687	BHPP, MoPH
2. Private expenditure on health	65,699	57,872	
...of which private health insurance premiums	10,475	10,475	Department of Insurance, Ministry of Commerce
...of which out-of-pocket spending on health	55,224	*47,397	National Statistic Office
3. Total health expenditure	149,187	158,138	
4. Public expenditure on health (%)	56	63	
5. public expenditure increase (%)		20	
6. private expenditure change (%)		-12	
7. General Government budget on health (%)			
8. Total expenditure on health % GDP	2.93	2.94	
GDP (Bil.Baht/year)	5,091	5,371	NESDB
Total government spending (Bil.Baht/year)	910	1,023	BOB, Prime Minister Office

Source: Several sources excluded public health spending in other ministries and traffic accident insurance

* Data estimated based on assumptions by Tangcharoendathien, Vasavit, Pitayarangsarit (2002)

The proportion of the public expenditure increased from 56% to 63% and was expected to gradually increase after 2002. However, household spending on health depends very much on how healthcare providers behave. Tangcharoensathien et al (2002) suggest that if a decent quality of care is provided with a strong referral backup, there is no reason why households would not comply with services at designated providers. This would accelerate compliance to the 30 Baht Scheme. In contrast, a lack of MoPH leadership could send a wrong signal about the reform, and lead to MoPH healthcare providers offering bad and discriminatory services, resulting in low compliance. This would result in the failure to implement good policy and intentions (Tangcharoensathien, Vasavit, and Pitayarangsarit 2002). One discouraging factor would be budget constraint, if the government pays providers less than the actual cost, resulting in public providers fulfilling a lower compliance rate and not improving the quality of services.

5.2.2.9 Hospital financing

The UC policy altered hospitals' income, hospitals' expenditure and the financing patterns of hospitals. Hospitals that are contracting units for primary care (CUPs) received health care budgets according to the registered population and were responsible for the expenses of their network PCUs and referred patients based on contracts. Their income from out-of-pocket spending should be replaced by the 30 Baht Scheme budget. Table 5.4 shows possible patterns of financial flows of the MoPH hospitals.

Table 5.4 Possible financial patterns of MoPH hospitals after the 30 Baht Scheme implementation

	Types	Situations
Income types	Permanent salaries	Same as previous
	UC budget (after subtracted salaries)	Changed from MWS and VHCS - increase if salaries budget is less than 50% of capitation budget - decrease if salaries budget is more than 50% of capitation budget
	SSS	Same as previous
	CSMBS	Same as previous
	Out-of-pocket	Decrease or little decrease
	Referral cases (in)	Increase if capable to receive import cases
	Total income	increase
	Net revenue	Decrease if low efficiency, increase if high efficiency
Expense types	Permanent salaries	Same as previous
	Temporary wages	Increase or decrease depends on workloads
	Medicine	Likely to decrease
	Materials and other expenses	Likely to decrease
	Subcontractor	Increase as new type of expenditure
	Referral cases (out)	Increase if incapable to provide complicated care
	Total expenses	increase
Total net revenue		Decrease

Source: analysed from the guideline for hospital financial assessment and management improvement, MoPH, 2001

Twenty-four percent of community hospitals and 46% of general/regional hospital were expected to have financial problems (Na Ranong and Na Ranong 2002a). Some hospitals coped with the reform by establishing the new cost accounting system and some provinces improved the payment for referred cases based on cost per DRGs.

5.2.2.10 Patients' rights

The rights of patients were extended by the Medical Council's statement²¹. The 30 Baht scheme also paid attention to grievance procedures by establishing a hotline telephone number to receive complaints, and at the same time introducing systems to deal with complainants.

Patient rights were incorporated into the National Health Security Act (2002).

²¹ Issued on 16 April 1998, joint signed by the Council for Registration of Medical Practice, Ministry of Public Health,

the Medical Council, the Nursing Council, the Pharmacy Council, and the Dental Council (The Medical Council of Thailand 2000).

5.2.2.11 Organisation of the health care system

The Thai Bureaucracy Reform Act was launched on 2 October 2002 in order to change the Thai bureaucracy structure to one of more horizontal hierarchy. This also increased the facility for ministers by establishing the Minister Office. All Departments report directly to the Minister and also to the PS. Changes in the MoPH created two new departments: the Department of Health Care Promotion and the Department of Traditional and Alternative Medicine. The National Health Security Office (NHSO) will be established according to the National Health Security Act. Health care providers will be transferred to the authority of local government according to the Decentralization Plan Act. Area Health Boards will belong to local government with multi-segmented participation. Please see Figures 5.8 and 5.9.

Comparing the new and the old organisation pattern of the MoPH, it is clear that the old vertical, centralised structure under the control of the Permanent Secretary was changed to become flatter with the increasing direct authority of the elected officials to command departments outside the Permanent Secretary Office. The Minister Office became a more helpful assistant for the elected officials' activities.

Figure 5.8 Organisation structure of the MoPH before reform (September 2002)

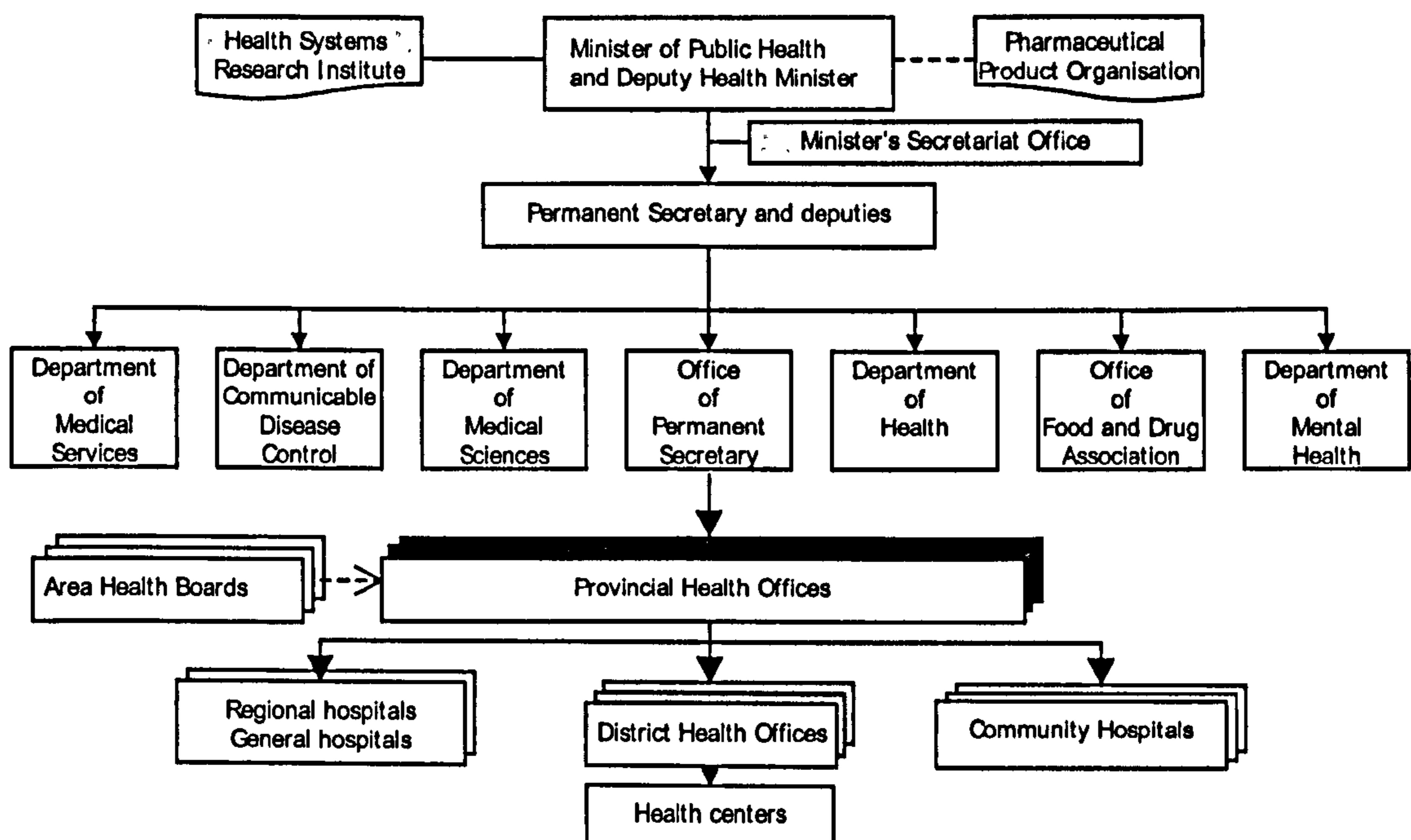
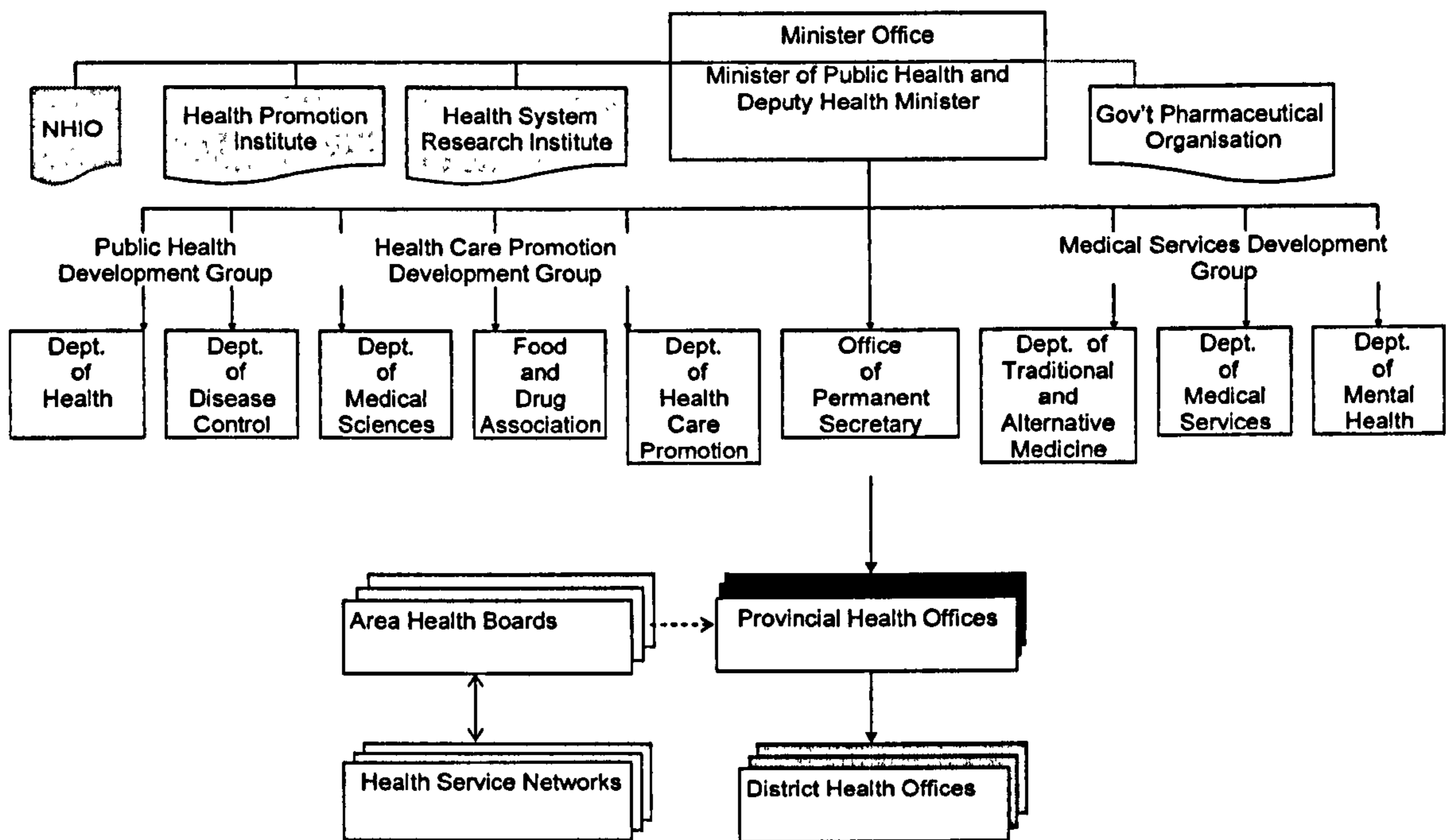


Figure 5.9 The new organisation structure of the MoPH after reform (October 2002)



5.2.2.12 Quality assurance and accreditation system

The Institute of Hospital Quality Improvement and Accreditation was established under the HSRI in 1998. This institution is expected to be an autonomous organisation under law in the near future. Until 2002, only 23 hospitals had been accredited. At the initial stages of the hospital accreditation program, the institution had to encourage hospitals to join the program. The number of hospitals joining the program was slow, and only increased with capacity building of the institution. Under the 30 Baht Scheme criteria, all hospitals should be accredited, increasing the demands for accreditation. There were some problems arising from the rapid increase in demand; for example, hospital directors pushed staff without building bottom-up agreement, resulting in unsustainable development. In contrast, some hospitals directors did not allocate enough resources for their staff's activities.

5.2.3 Summary: gaps between policy intent and implementation in reality

Compared to the policy intent discussed in Chapter Four, implementation was in line with the policy intent, but many goals had to be realised. Three main goals were assessed: universal coverage, equitable benefits and care, and sustainable system (see section 4.2 in Chapter 4).

The expansion of insurance coverage was very fast. It increased from about 69% to 92% of the total population within one year; however, about 8% of the population were left uninsured.

Coverage of this uninsured population was difficult to increase, as there were other factors involved, for example, migration and deprivation. The development of information and technology mainly contributed to the development of the health registration models, and the delay in their development led to problems in the transition period.

Equity in health benefit and care was improved through policy implementation, but a large gap remained. Three groups of people in the previous system, namely the Voluntary Health Card holders, the Medical Welfare Scheme beneficiaries, and the uninsured, became able to access the same quality and variety of health services. They were about 74% of the total population. The attempt to adjust the benefit package and cost subsidization of the other schemes for formal sector employment has been postponed for more than three years. Moreover, the actual benefit distribution between urban and rural areas was still questionable, as there was no a long-term human resource re-allocation plan. Only the promotion of the use of primary care was in progress.

Institutional change has been implemented and will be sustained under the National Health Security Act. However, financial sustainability cannot be ensured as the adequacy and the stability of the government budget was questionable. Moreover, the system will not move to be more effective if resource allocation does not continue improving.

5.3 Actors: their roles, position and power in the UC implementation

In Chapter Four, the actors influencing in the UC policy formulation process were shown to have had a significant role in shaping the policy. This section describes the key actors influencing the implementation process and assesses their roles, positions and powers. The information in this section is mainly derived from in-depth interviews of key informants, direct observation, public documents and newspapers. Actors involved in the UC policy implementation can be divided by roles: service providers, regulators, and consumers. Health services were provided by agencies in two sectors: the government sector, and the non-governmental and private sector. Regulators were government authorities and professional councils. Some agencies in the government sector played both provider roles and regulator roles. Consumers included consumer representatives and NGOs. There were several issues involved in the UC policy implementation as described in the previous section. This assessment attempts to specifically address actors' positions in relation to the three significant changes: the health financing reform, the changing role of the MoPH, and the establishment of the NHSO granted by legislation.

5.3.1 The government sector

5.3.1.1 *Thaksin regime*

Prime Minister Thaksin Shinawatra had a high stake in government performance, which would have an effect on the next election. The early phase of the government was the best time to implement a good policy, and he strongly supported UC policy, which was in line with the TRTP policy. Furthermore, the UC policy had shown itself to be highly popular, more so than all other policies. He had a very high level of power in this era since the TRTP captured the majority of seats in Parliament.

5.3.1.2 *Ministry of Public Health*

The Ministry of Public Health was the sole responsible agent for UC implementation in the transitional period. The MoPH performed purchaser / regulator and provider roles, and this led to conflicts of interest in performing these roles (Jongudomsuk 2002). However, the purchaser role will be transferred to a quasi-governmental body, the NHSO, three years after the Law has been promulgated. The lag period of three years was a result of the negotiation by the MoPH, as some civil servant leaders had resisted the transfer of the power to the new NHSO (Interview K10).

The Health Minister, Sudarat Kayuraphan, clearly stated the MoPH's mission as achieving universal coverage of health care and establishing the NHSO by law. She also strongly supported the financing reform changing the historically based budgeting to population based budgeting. She is a core TRTP administrative committee member and highly trusted by the Prime Minister. She graduated from the Faculty of Commerce and holds a Master's degree in Business Management from Chulalongkorn University. She is good at strategic management but has less technical knowledge in health sciences (Interview K16). However, the medical doctor who formulated the UC policy for the TRTP, Dr. Suraphong Suebwonglee, was appointed as the Deputy Health Minister. He steered the changes in the transition period ensuring progress of the reform. His strong attempt to reform the health financing system successfully raised the 2002 per capital allocations including the salary budget. His leaving to be the Minister of the Ministry of Information and Technology in October 2002 was a significant factor, resulting in a step back of the budget allocation reform to the 'per capita allocations excluding salary budget'. The new Deputy Health Minister was a police general. His main health interest was in drug addiction prevention and care, and he had not been involved in the UC policy.

The positive response of the first Permanent Secretary (PS), Mongkol NaSongkhla, led to rapid UC implementation initiation in April 2001. He successfully merged the Rural Hospital and the

Rural Health Division, which had separately monitored and supported provincial hospitals and community hospitals respectively, into the Bureau of Health Care Network, aiming to bring equitable support to and unity among MoPH hospitals. He strongly supported the per capita allocation including salary budget, which was a radical financing reform, and which will affect the balance of many inefficient hospitals. However, he retired in September 2001, only a few months after UC was introduced. The next Permanent Secretary did not support the financing reform. This second PS suggested that hospitals should keep quality of services without excessive concern with medical costs. He agreed with the idea to protect provincial hospitals from the capitation system and to provide sufficient budget for these hospitals. The third PS, who came to the position in October 2002, also did not support the financing reform and succeeded in protecting salaries from the per capita allocations in fiscal year 2003.

The Health Insurance Office, which acted as fund manager of the 30 Baht Scheme, prepared itself to be transformed into an autonomous organisation (Interview K10). This office responded positively to the UC policy.

The Bureau of Health Care Network had a close relationship with providers in the provinces with regard to resource distribution. It had been responsible for the allocation of health personnel, capital investment, and contingency fund during implementation in the transition period. The first director of this Bureau supported the reform but the second PS appointed another doctor to replace him. The personnel allocation under the control of the new director in 2001-2002 was conservative, following the old pattern, not that of the reform. This Bureau became the Department of Health Care Promotion and was proposed to oversee autonomous providers according to the government's changes to the bureaucratic structure. In fact, its new role is one of technical support to hospitals without allocation powers, as a result of the internal politics in the MoPH. The Permanent Secretary's Office, with the PS in charge, still maintains the power to oversee provincial health offices, district health offices, provincial hospitals, community hospitals, and health centres.

Provincial Health Offices (PHO) were assigned to perform as purchasers in the transition period; however, they could only be passive purchasers because of inadequate preparation. Some Provincial Chief Medical Officers felt they were losing the power to manipulate the budget because funds were assigned directly to health care providers. They shared their experience in their assembly and came up with a proposal (date 17 September 2001) asking for more flexibility in the insurance model, and to allow provinces to select an appropriate system to fit the local situation.

MoPH staff can be characterised on a continuum from reform activists to conservative bureaucrats. All agreed to extend the insurance coverage but some disagreed with some

elements of system reforms that affected their lives. Medical doctors represent the most powerful professional group in the MoPH from both provincial hospitals and community hospitals. The community hospital group supported the financing reform while the provincial hospital group seemed to resist the reform. Both groups competed for influence in the MoPH. Many MoPH staff played independent professional roles as representatives of their professional societies and some also worked in the private sector. This also led to various conflicts of interest.

5.3.1.3 Other government departments and ministries

Other than MoPH hospitals, there are some public hospitals operated by universities, the Ministry of Defence, and local administrations. The UC program intended to include these hospitals to complete the referral system. Moreover, the participation of the educational sector is essential in relation to the review of the medical education system. All of them received a UC budget as a supplement to their own budget, so they gained from the reform.

Other ministries involved in the policy, including the ministries of Finance, Labour and Welfare, and Commerce, did not play major roles in implementation in 2001-2.

5.3.2 Non-governmental and private sector

Physicians represent the most powerful professional group in the health sector. Doctors and other health professionals are permitted to work simultaneously for government and private sectors. The MoPH has encouraged non-private practice by giving an incentive 10,000 Baht per month for doctors and dentists, and 5,000 Baht per month for pharmacists who work full-time in the public sector. However, this strategy is effective only in areas of low private demand. In urban areas, most medical doctors in provincial hospitals and university hospitals run private practices. Full-time private practitioners open private clinics or work in private hospitals. In rural areas, most medical doctors work in community hospitals only and receive the compensation for foregoing private practice.

At the initial stage of UC implementation, private practitioners safeguarded their position because they could maintain their patients in their clinics. When the National Health Security Bill came to Parliament some private practitioners and hospital owners joined together to oppose the Bill, especially the section regarding liability. A medical doctors' club, 'Phate phur wichacheep Phate' (literally 'Doctors for the medical professional'), protested the bill, reasoning that the law would increase litigation in medicine. However, Parliament passed the Bill establishing the authority of the NHSO. The Health Minister met the worries of the private sector by promising to change the content of the liability section whenever possible.

Some private hospital owners saw the UC policy as an opportunity to increase bed occupancy. However, many private hospital owners saw the policy as competing with the private market. The latter group labelled the 30 Baht Scheme services as low quality with an inadequate budget. Most private providers opposed the National Health Security Bill because it will authorise the NHSO to regulate and control the quality of health services.

In favourable economic and business environment it is likely that the UC scheme will have little impact on private insurance companies (Interview K20). The UC scheme was not attractive to the customers of private insurance. Data from the Department of Insurance shows that the health premiums during January to June 2002 compared to the same period of the previous year saw 11.88% growth (Department of Insurance 2002), illustrating that private health insurance growth is elastic to income (Pitayarangsarit and Tangcharoensathien 2002).

The Pharmaceutical Producers Association (PPA) represents multi- or trans-national drug companies. As the UC policy limits drug use to the National Essential Drugs List, this affects drugs outside the National Essential Drugs List. The PPA has exerted influence through physicians to extend the benefit package beyond the National Essential Drugs List, but this has not been successful (Interview K4).

5.3.3 Professional councils

Professional councils had a low profile in UC, except for the Medical Council. The Medical Council is a regulator for market entry and ethical control of the medical profession. The Medical Council of Thailand has been criticised as non-transparent and unreliable in solving grievances (from a circular letter in 2002 of a network of people suffering from health services). In this regard, the Health Ministry appointed two committees from the Medical Council and the Health Registration Division, MoPH to clear all remaining grievances and develop the grievance system. The Council announced its disagreement with the National Health Security Bill regarding the NHSO's authority on consumer protection, which the Council felt that the NHSO could undermine the authority of the Medical Council. However, this concern was overlooked.

5.3.4 Consumer representatives and committees

Consumer representatives played a part in the health commissions of the House of Representatives and the Senate to review the content of the National Health Security Bill, but they were not involved in implementation in 2001-2002. The mass media played major roles in reflecting people's satisfaction and problems with the implementation.

5.3.5 International Donor Community

International donors or organisations, for example, the WHO, ILO and the World Bank, did not influence the UC implementation, but where they were involved – for example the Health Minister requested the WHO and the ILO to run a technical seminar – they gave positive support.

5.4 Assessment of change management

Two levels of managing change regarding UC implementation are considered in this section: national and the MoPH.

5.4.1 Change management at national level: action outside the MoPH

UC policy was supported very widely outside the MOPH. How well was this support managed?

5.4.1.1 *Understanding the culture and values of Thai people towards health and health services*

Passive values around ill health had been typical of the Thai health system for a long time. Many people have suffered from illness and also the cost of care. Some Thais perceive sickness is “Khroa Krum” (laterally ‘Karma’ or ‘unlucky’) so everyone risks ill health. The subsidy for health care costs for those unable to afford care had been constructed in public facilities as ‘welfare’ and perceived by patients as giving with kindness, based on a patron-client relationship. Few grievances were brought to court because of low expectations.

Changing the Thai political system to democracy generally was reflected in the 1997 Constitution. The public were empowered to participate and move on political issues. Health care was legitimated as a human right, and people had rights to propose laws and demote ministers. Politicians are more responsive to their voters and public issues affect their interest, and people, through networks, have gradually become more demanding.

5.4.1.2 *Action in mobilising support*

The arrival of the UC issue onto the national policy agenda reflected a successful step in mobilising political support. Health issues are of public concern; i.e. benefits from the policy can be dispersed to the whole population. UC had great legitimacy, and therefore, gained votes for the government party. Research results on feasibility in terms of affordability, technical knowledge, and resources available supplemented political support. Implementation at a time of high political support and leadership was seen as a major opportunity.

Mobilisation of public support occurred in many ways. The process of the ‘National Health System Reform Movement’ was one platform for communication about health issues. Another

route, encouraged by the Health Care Reform Office, was through beneficiaries and NGO groups over a few years. These groups of beneficiaries declared their support for the Universal Coverage concept. Their 2000 campaign presented explicit support, through for example, the slogan ‘Health rights are for all, not only for the poor’. The dispersion of the benefits to a wide population, raised public interest and the negotiation powers of beneficiaries.

Slogans to capture the interest and attention of the public were important in getting support for UC. For example, instead of ‘financing according to pay’, the motto “*Dee chouy puey Ruey chouy joun*” (literally ‘the healthy help the sick and the rich help the poor’) was an active symbol reflecting the quality of solidarity in the Thai culture.

The slogan ‘30 Baht treats all diseases’, though it was successful in the election campaign, was criticised, as it mentions disease rather than health and could increase health care expenses. The new value “*Sang (sukkaparp) Nam Som (sukkaparp)*” (literally ‘build health prior to repairing health’) was used to communicate to both providers and people as an inherent goal of UC.

For other stakeholders, private employees and university hospitals, for instance, the initial attempt to create new arenas of decision-making to enable participation was not a success. The National Health Security Policy Committee and the National Administrative Committee were constituted later in August 2001, so the implementation in the transition period was led by the MoPH. Much of this was because UC was highly technical and therefore depended on competence and support in the bureaucracy (Grindle and Thomas 1989).

5.4.2 Managing change in the MoPH: changing organisational culture

5.4.2.1 Understanding the culture and values of the organisation and staff

The MoPH of Thailand is a hierarchical and centralised top-down decision-making government organisation. However, staff at each level have some autonomy in thinking, problem solving, and managing their own authorised resources. MoPH staff are highly competent as the Ministry has recruited well-educated medical professionals. Medical doctors dominate the organisation and have considerable power. Health staff still listened to their boss rather than to patients, although customer-orientation was increasingly respected after UC introduction. Nevertheless, the criteria of rewards and promotions are not clear so staff often feel they have to satisfy their boss in order to be promoted. Most MoPH officials were civil servants, with secure permanent salaries, and therefore, there was little incentive to change the status quo. Above all, health officials had a strong public service ethic which stressed the value of helping people and alleviating suffering. Many of them cooperated in setting and achieving the MoPH goals, displayed high loyalty and willingness to go beyond what was officially set.

A long history of ‘culture clash’ (Whiteley 1995) divides medical doctors into two groupings: medical services and community health services. The medical doctors who concentrate on medical services usually work in general/regional hospitals and often in the private sector. The medical doctors who concentrate on community health services usually work in community hospitals and rise to become community hospital directors and then provincial medical chief officers. They have separate interests and support systems. Health care reform was proactively supported by the group in the stream of community health services. Reformers tended to ignore (intentionally or not) the other group’s values.

5.4.2.2 *Action for change*

UC implementation started rapidly because of the strong support and leadership from the Permanent Secretary. It was a quick decision with limited consultation. In addition there was no explicit disagreement when the leader consulted about 60 MoPH senior staff in a workshop held in March 2001. The decision-making process sought consensus (in the formal meeting) based on evidence. However, some argued that the core group listened to whom they wanted to and did not hear the oppositions’ ideas. Some argued that the core group could pursue the decision as they had better evidence but it did not mean they were right. That was not a real consensus. When the new PS replaced the retired PS, reform was supported inconsistently.

At the initial implementation stages, communication of the UC policy to health staff was explicitly directed through broadcasting of the Tele-medicine network²². As the information was dynamic, health staff were confused by the rapidly changing decisions, a result of the ‘do and correct’ approach. However, they had learnt the expectations of the PS. For example, ‘*Sang nam Som*’ [building prior to repairing health] was the symbolic message they widely accepted.

Pilot testing was a good learning process to shape the policy for implementation, and also build up staff capacity. The War Room was established to keep abreast of implementation. It was a new way of enabling implementers to participate in decision-making, so that changes could be made iteratively.

UC implementation was rigid at the beginning, but allowed some degree of flexibility later with policy-makers adjusting to reality. For example, the capitation budget was fixed at a flat rate and hospitals financial constraints were met from the contingency fund. This strategy labelled many hospitals as ‘inefficient’ and needing improvement. Money from the contingency fund could solve hospitals’ financial problems but could not wipe out the stigma of inefficiency.

²² Tele-medicine network was the tele-communication network established in 17 general/regional hospitals for medical training.

Another example was the adjustments to the standard of the Primary Care Units, which turned out to be unfeasible. Three levels of PCU standard were therefore set, to facilitate primary care development.

The period after the termination of the War Room (August 2002) led to a vacuum in decision making. The MoPH led by the Health Minister and the new PS maintained the status quo, but there was little progress. This may have been because after such radical reform, a period of consolidation was necessary to ensure UC was implemented effectively.

5.5 Chapter summary

Five key themes emerged. Firstly, UC implementation in Thailand was characterised by rapid, radical, and top-down change, creating some consequences such as administrative problems. However, introducing it so rapidly means that opposition did not have time to consolidate and grow.

Secondly, this rapid implementation encouraged a ‘do and correct’ approach, which provided some flexibility into what otherwise appeared to be a top-down process. Flexibility allowed easier implementation. Policy implementation was top-down in a hierarchical institution (MoPH) and was mainly dominated by MoPH actors; other influencing factors for MoPH responses were capacity and the bureaucratic culture. Consensus was achieved only part of the time, and a lot of conflicts occurred. The ‘do and correct’ approach led to a balance in the policy continuum which was dominated by the policy elites.

Thirdly, the 30 Baht Scheme induced a radical change in health care finance, one of several other proposed health reforms. In October 2001, the scheme shifted the historically based finance to population-based finance. It was radical, and found resonance with a small group within the MoPH, but was essentially from outside. In contrast, health reforms came from within the MoPH and were contested within, by different groups - because those reforms directly affected people involved in the health sector at all levels. The change was not linear. Reform directions were subject to push-and-pull by different stakeholders.

Fourthly, factors enabling the easy implementation of UC were: clear policy goals with strong leadership, strong institutional capacity and skilful implementers, and flexibility and discretion level of implementers.

Fifthly, factors hindering the introduction of the UC were: resistance of bureaucrats and medical professionals and budget constraints.

Chapter 6 - Implementation: Provincial arrangements

6.1 Introduction

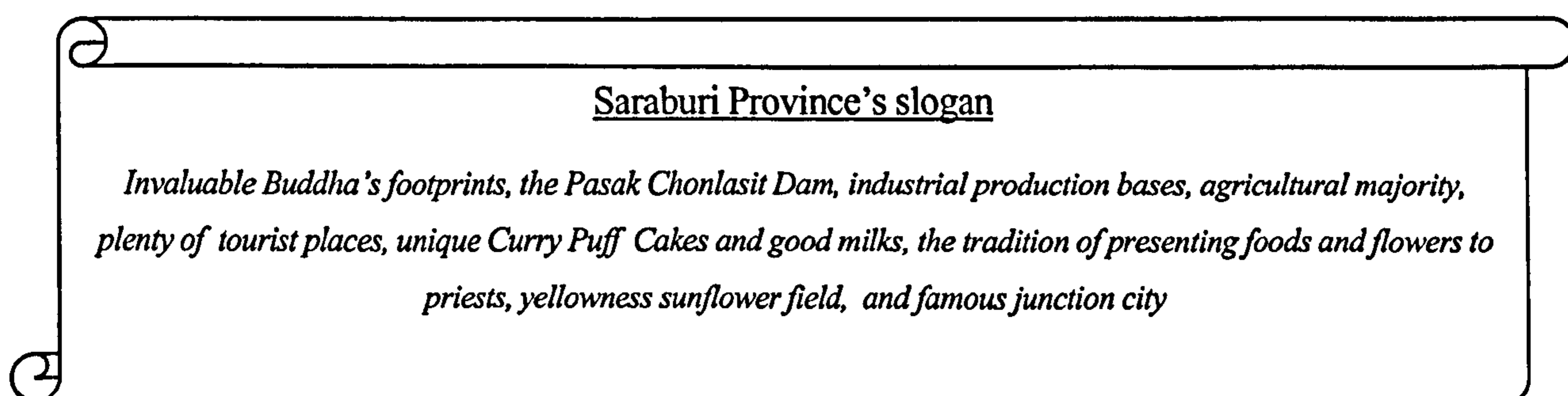
This chapter looks at the UC implementation at provincial level connecting to the management at central level. Implementation at provincial level is a crucial management stage affecting operations and outcome results. To understand the processes of management and interactions of actors in the implementation of UC policy at provincial level, this study employed qualitative data collection in a province, Saraburi. Data were retrieved using key informant Interview, document analysis, and participatory observation during February to April 2002. The province was selected for three reasons:

- both private and public providers in the province have joined the program,
- the province faced budget constraint and requested extra money from the Contingency Fund, and
- data and health personnel were accessible.

The chapter starts by introducing the Saraburi context and then goes on to the UC implementation in Saraburi, exploring the organisation and management, policy communications and perceptions of implementers at provincial level. Next, it goes on to analyse the decision-making process on particular issues: the enrolment process and population coverage. It assesses the impact of the policy on implementers and highlights their responses.

6.2 Profile of Saraburi Province

Figure 6.1 The slogan of the Saraburi



Source: Translated from the Department of Local Administration: <http://www.dola.go.th/>

Saraburi is a province in Central Thailand, 107 kilometres from Bangkok. It has the reputation of being rich in natural resources and culture (see the province's slogan above). It is composed of 13 districts with a total population of 607,600 in 168,979 households in December 2000 (Department of Local Administration 2000). Table 6.1 shows general information on Saraburi compared to national figures. The household size and income characteristics of Saraburi are similar to other provinces in the Central Region, although per capita Gross Provincial Product is higher than the average. In other respects, the province is fairly average, although a little smaller in household size and more densely populated than average.

Table 6.1. General Information on Saraburi Province

	Saraburi (December 2000)	Average province (December 2000)
Area (Sq.km2)	3,576	6,752
Districts	13	12
Households	168,979	217,320
Populations	607,600	814,194
Household size	3.6	3.7
Pop.density (persons/Sq.km2)	169.89	120.59
Per capita GPP.(Baht) 1999 **	115,539	74,675

Source: Department of Local Administration: <http://www.dola.go.th/>

** NESDB. Gross Provincial Product of Thailand 1999 edition: www.NESDB.go.th (National Economic and Social Development Board 2000)

Table 6.2 Health resources per 10,000 population in 1999

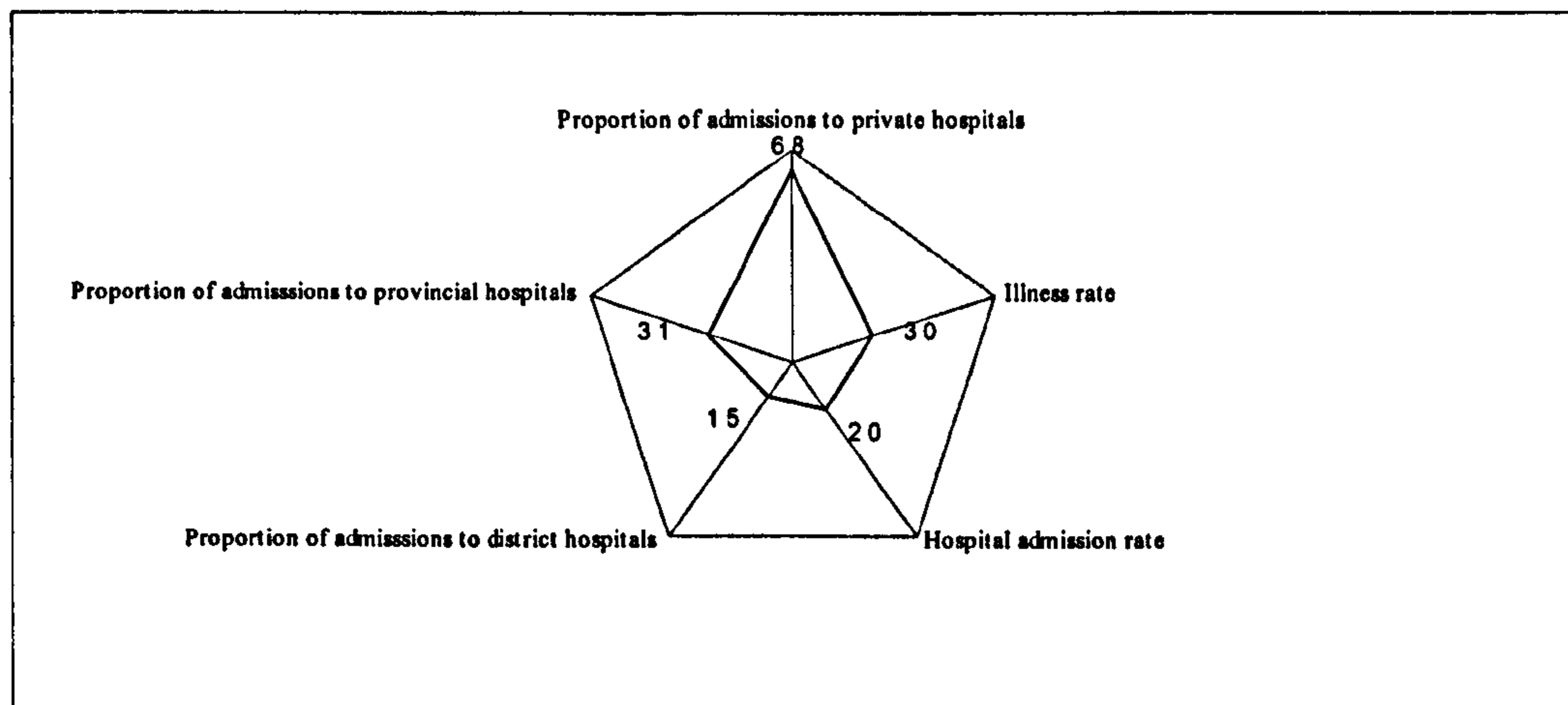
	Saraburi Province	Whole Kingdom	Compared to Kingdom average (times)
Public beds	23.1	16.9	1.4
Private beds	8.8	5.1	1.7
Doctors	3.7	2.9	1.3
Dentists	0.7	0.7	1.0
Pharmacists	1.1	1.0	1.2
Nurses	24.4	16.2	1.5
Health workers	4.1	1.7	2.4

Source: Bureau of Health Policy and Planning, MOPH. Health Resource Survey 1999

In 1999, Saraburi had more health resources per person than the country average except in number of dentists (see in Table 6.2). On comparison with national figures, the greatest difference is in the ratio of health workers, followed by the difference in the ratio of private beds, nurses, public beds, doctors, and pharmacists respectively. Resources have been invested in Saraburi because it is the centre of the patient referral system in the second zone of the Central Region. There are two big public hospitals, a general hospital (400 beds) in Phabudhabaht District and a regional hospital (634 beds) in Muang District (Saraburi City). In addition, there is also a college of nursing in this province. Furthermore, two big private hospitals (200 beds or more) are located along the main road in this province as a result of the demand in health care arising from both geographic and

economic factors (Saraburi is at a junction of the roads from the Northeast and North to Bangkok). There are also three small private hospitals which are located outside Saraburi city.

Figure 6.2 Illness and hospital utilisation rates in Saraburi Province in 1996, rank out of 75 provinces from lowest to highest rates



Source: National Statistics Office, Thailand. The 1996 Health Welfare Survey.

The average illness rate of Saraburi residents was 3.975 episodes per capita per year in 1996 (National Statistics Office 1996), close to the national average figure (3.978). Despite the large number of health resources, the hospital admission rate was only 0.05 admissions per capita per year in 1996, rather low with a ranking of 20 among 75 provinces when ranked from lowest to highest (see the ranks in Figure 6.2). Of all admissions, 46% were to regional hospitals and general hospitals, 38% to private hospitals, and 17% to community hospitals. Saraburi residents used private hospitals more than the national average, with a ranking of 68 from 75 provinces when ranked from lowest to highest, perhaps because of their greater income and therefore their greater ability to pay. Data in Table 6.2 and Figure 6.2 imply that the health resources in Saraburi were not totally consumed by Saraburians. This is supported by a study of the net inpatient flow ratio in 2000 by Pannarunothai (2002). He found that 2,564 Saraburian patients were admitted in hospitals in other provinces, while 13,596 patients from other provinces were admitted in hospitals in Saraburi (Pannarunothai 2002). Thus, the population-based budget reform worried public providers in Saraburi because the allocated budget would be less than their historical incremental budget and the revenues from reimbursable referral cases might be uncertain.

Table 6.3 Distribution of health resources in Saraburi Province, June 2001

District	Populations	Hospitals	Resources per 10,000 populations					
			Public beds	Private beds	Doctors	Dentists	Pharmacists	Nurses
Saraburi City and Chalemprakiat	143,355	5	50.5	33.5	7.3	0.9	2.0	44.8
Gaeng Khoy	87,180	2	6.9	1.4	0.6	0.2	0.3	6.1
Nong Kae	84,617	2	7.1	5.9	0.7	0.2	0.5	7.7
Wihamdang	36,677	1	8.2	0.0	0.3	0.3	0.5	9.8
Nongsang	15,858	1	6.3	0.0	1.3	0.6	0.6	18.3
Ban Mo	42,401	2	28.3	0.0	1.4	0.5	0.5	14.4
Don Phud	7,535	1	39.8	0.0	2.7	1.3	1.3	38.5
Nong Don	14,686	1	6.8	0.0	1.4	0.7	1.4	12.9
PraBudhabaht	76,568	1	52.2	0.0	3.7	0.8	1.8	43.9
Sao-hai	29,032	1	3.4	0.0	0.7	0.3	0.7	9.3
Muag-leg	49,865	1	6.0	0.0	0.6	0.4	0.4	7.4
Wang-muong	21,473	1	14.0	0.0	0.9	0.9	0.5	14.4
Total	609,247	19	24.2	8.9	2.7	0.6	1.0	22.4

Source: Saraburi Provincial Health Office Annual Report, 2001

Table 6.3 shows the unequal distribution of health resources amongst districts in 2001. The distribution of health personnel was not proportional to population size. The boundary setting of districts is under the Ministry of Interior, which is out of MoPH control. In Saraburi, every district has at least one hospital, except the new district created from a division of the city of Saraburi, Chalemprakiat, population 27,961. Community hospitals start from 10 beds and rise to 30, 60, 90 and 120 beds according to the district's population size and the incremental investment plan of the MoPH. However, political factors can also lead to upgrading a hospital from 10 to 30 beds. For example, in Don Phud, a very small district which has about 7,500 people, the previous 10-bed hospital was upgraded to a 30-bed hospital due to political lobbying of local politicians. Once the number of beds increased, other resources such as doctors, nurses, budget, and equipment followed. That is a characteristic of supply-side budgeting. Other highly resourced districts, such as Ban Mo, Phabudhabaht, and Saraburi City, have specific backgrounds to their extra high numbers of beds. Ban Mo has a community hospital (30 beds) and a Mother and Child Hospital (60 beds) which is mainly for technical purposes. Phabudhabaht has a general hospital of 400 beds – Phabudhabaht Hospital. This hospital was first established in 1954 (100 beds at that time), a year after the establishment of the Saraburi Hospital in Saraburi City, with a commitment of the Prime Minister in that era, General Por Phibulsongkram. Saraburi City has a regional hospital (the Saraburi Hospital, 634 beds), a military hospital (90 beds) and three private hospitals (250 beds, 200 beds, and 30 beds).

In sum, Saraburi is a province rich in resources. It is a centre for referral of patients and can be labelled as a patient-importing province. The study of Saraburi province cannot therefore perfectly represent all provinces but it helps to explain the system. The characteristics of Saraburi clearly reflect the design of the infrastructure of the Thai health system and the influence of the health care

market. These are contextual factors that facilitated the implementation of the UC policy but which also limited system change in some aspects.

6.3 Implementation of the UC policy in Saraburi Province

Saraburi is one of the 15 provinces which came into UC implementation in the second phase in June 2001. At the initial stage the communication from central level confused the provincial staff (Interview S2 and unpublished report). The MoPH Permanent Secretary selected the province and communicated directly via telephone with the Saraburi Provincial Chief Medical Officer (PCMO) in March 2001. Then, the Saraburi staff requested the support of the Health Insurance Office (HIO) for household databases and guidelines, but the HIO refused to support the province because the province was not on its list. Therefore, the province started the preparation without HIO support; however, the HIO subsequently changed its decision within a few weeks and supported the province. It seems that implementation in the province started relatively chaotically. This section starts with the organisation and management of the Provincial Health Office, the policy communication and the perceptions of the health staff on the UC policy content and process.

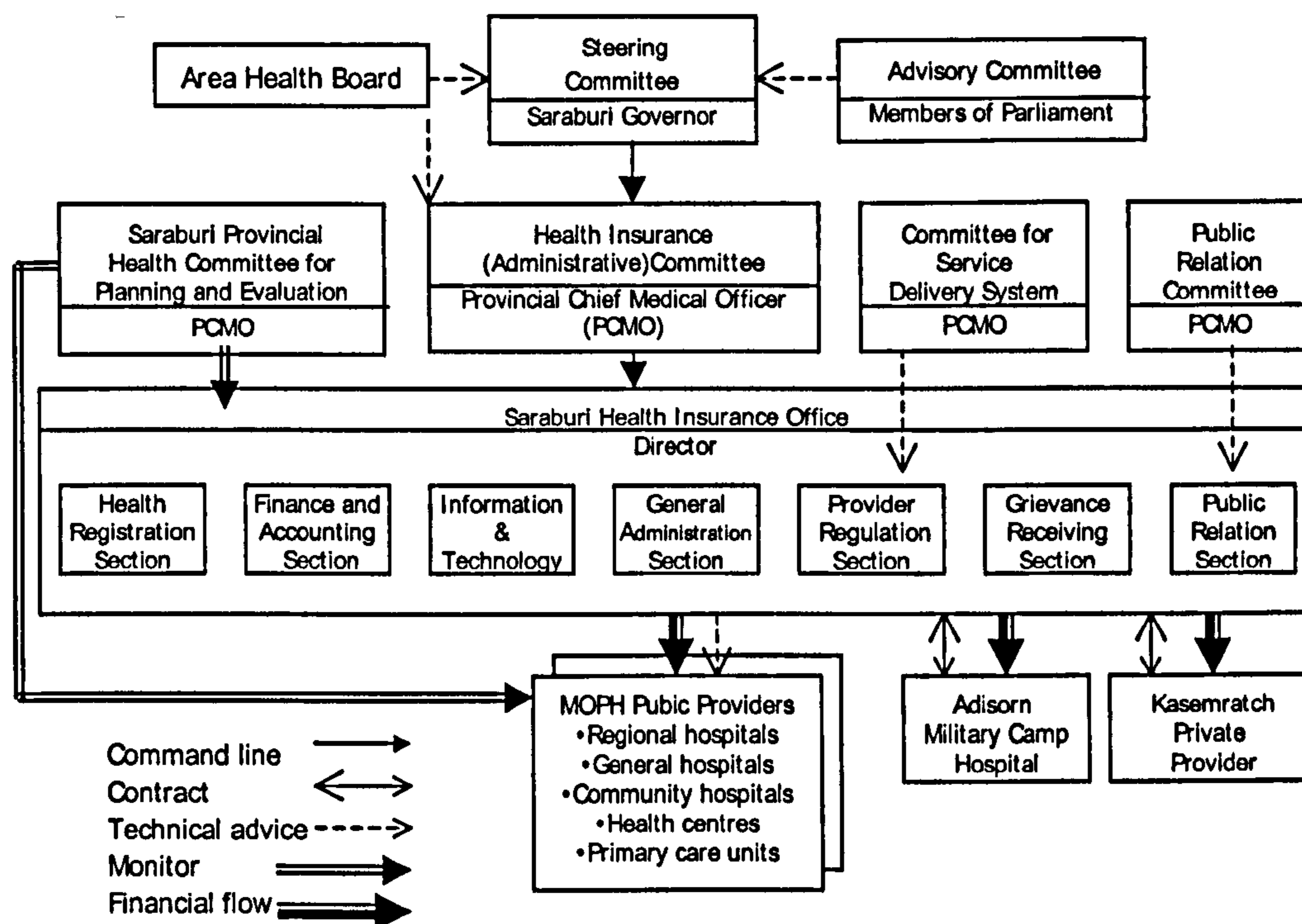
6.3.1 Organisation and implementing management

Saraburi PHO managed seven functions of the UC implementation through the Provincial Health Insurance Office. These functions were health registration, financial management and accounting, information and technology system development, provider regulation and network development, management of grievances, public relations, and evaluation. In order to invite collaboration, an administrative committee was appointed in April 2001 (Saraburi Provincial Health Office 2001). Later, participation expanded to cover five committees to include other government sectors and MPs (elected from Saraburi) (Health Minister's Secretariat Office 2001). Figure 6.3 demonstrates the relationship between organisations and committees.

The five committees were the Advisory Committee, the Steering Committee, the Administrative Committee, the Service Delivery System Committee, and Public Relations Committee. In respect of the insurance system, the five committees and the PHO were the purchasers in the province. However, the decision-making and management processes were concentrated in the Administrative Committee and an existing committee - the Provincial Health Planning and Evaluation Committee. Sections in the PHO were responsible for monitoring and evaluating the program. An Area Health Board acted in an advisory capacity. This Board was appointed in September 2001 according to a suggestion from the MoPH in response to the Decentralisation Act. However, the Board's actual

role was unclear, and it was never activated. The roles, capacities, and relationships of organisations in the province are discussed below.

Figure 6.3 Organisation and management structure in Saraburi, 2001-2002



Source: The 2001 Saraburi PHO Annual Health Report

6.3.1.1 Provincial committees for the implementation of the UC Policy in Saraburi

The five committees appointed by the Saraburi governor were broadly participative, and included MPs and village volunteers. The wide participation led to public support and smooth implementation. The committees' members, roles, and relationships to others were as follows (Saraburi Governor Office 2001).

The Advisory Committee included two senators and four Members of Parliament. This committee advised other committees on the implementation of the policy.

The Steering Committee chaired by the Saraburi Governor, with the PCMO acting as secretary, included 29 members from the Governor's Office, local administrative offices at all levels, Provincial Social Welfare Office, Provincial Social Security Office, Provincial Insurance Office, five MoPH hospitals, two private hospitals, two District Health Offices and two health centres. The committee was responsible for health-care purchasing.

The Administrative Committee was chaired by the Saraburi PCMO, had a deputy PCMO (a medical doctor) as secretary, and included 17 members. The committee members were composed of five PHO officials, five Saraburi hospital officials, three officials from Phabudhabaht Hospital, a community hospital director, a District Health Officer, a health centre head, and a private hospital director. The committee was responsible as a coordination committee and providing technical support to the Steering committee.

The Service Delivery System Committee was chaired by the PCMO and had the deputy PCMO as secretary (the same person as the above committee). It included representatives from all providers in the 30 Baht Scheme in Saraburi (13 public hospital directors, a private hospital director, 13 District Health Officers, and four Municipal Councillors). In addition, the committee members included a director from a private hospital who had qualified to join the program but finally did not. This committee was responsible for providing services and communication to the public and communities.

The Public Relations Committee was chaired by the Saraburi PCMO and its secretary was the head of the Health Education and Public Relations Section. This committee was composed of representatives from several public institutions and all mass media in Saraburi, both public and private. Members in the public sector were the Director of the Adisorn Military Camp Radio Broadcast Station, the Provincial Agricultural Officer, the Provincial Public Relations Officer, the President and members of the Saraburi Administrative Organisation, District Officers, Presidents of Municipal Councillors, and Chairmen of Sub-district Administrative Organisations. Members in the private sector were all media representatives from television channels, local newspapers, national newspapers, village radio stations, village volunteers for public relations, and village health volunteers. This committee was responsible for public relations.

The last four committees took actions concerned with implementation and all were led by the PCMO.

Provincial Structure

6.3.1.2 The Provincial Health Committee for Planning and Evaluation

Like other provinces, the Saraburi PHO had a Provincial Health Planning and Evaluation Committee. This committee was responsible for regular management of health care in the province. It was composed of staff heads of all sections in the PHO, directors of all community hospitals, the Director of the Saraburi Hospital, the Director of the Phabudhabaht Hospital, and all District Health Officers in Saraburi. They held monthly meetings to coordinate the health plan and to monitor

outcomes of public health activities. All health issues were discussed in the meeting including the health insurance issue. This committee was a core structure affecting any public health program implemented in Saraburi.

6.3.1.3 *The Saraburi Provincial Health Insurance Office and other sections in the PHO*

The Health Insurance Section in any provincial health office is an informal unit without an official structure certified by the Civil Service Commission or the Bureaucratic Structure law. In Saraburi as well as in some other provinces, jobs regarding health insurance issues are separated from jobs of the Health Planning Section and allocated to a new small unit, the Health Insurance Section. The Health Insurance Section in Saraburi was established in the PHO and headed by a nurse under supervision of a deputy PCMO before the UC policy was launched, to take responsibility for the MWS, VHCS, and other health insurance schemes.

Incidentally, the then PCMO restructured the PHO in order to improve performance in April 2001; he adopted a matrix organisation to prepare for the reform of Bureaucratic Structure, the law subsequently enacted in October 2002 (see PHO structure in Table 6.4). The former organisation of the PHO included eleven sections with a staff head in each section, two deputy PCMOs (a medical doctor and a nurse), and the PCMO, the provincial health authority. The new grouping was based on five duties: administration support for public health, health insurance, provider regulation, disease control and risk factor control, and health promotion including consumer protection. In response to the UC policy, the PCMO appointed a medical doctor from the Saraburi Hospital, who was keen on the Social Security Fund management, to direct the Provincial Health Insurance Office; consequently the office moved into and used facilities of the Saraburi Hospital.

Table 6.4 Matrix organisation in transition to the new PHO structure

Former Sections for	New PHO's structure according to duty grouping				
	Office for Administrative Support for Public Health	Provincial Health Insurance Office	Office to regulate providers	Office to control diseases and risk factors	Office for Health Promotion and Consumer Protection
1. Administration					
2. Planning					
3. Human resource and primary health care development					
4. Community pharmacy					
5. Dental health					
6. Health promotion and health care					
7. Communicable disease control					
8. AIDS control and prevention					
9. Sanitation and environment					
10. Public relations					
11. Health insurance					

Source: Saraburi Provincial Health Office (dark colour means some degree of involvement)

The Saraburi Provincial Health Insurance Office (2001) had seven sections responsible for seven roles and coordinated all health insurance schemes in Saraburi. There were only ten people in this office. The director and two officers were from the Saraburi Hospital. The director had experience in the management of the SSS fund of the Saraburi Hospital. Two officers were from the Public Relations Section of the PHO and the rest were from the former Health Insurance Office in the PHO, which had years of experience in the bill clearing system. The office had a good reputation for its performance.

There was a good relationship between the Health Insurance Office and the hospital; the first worked as a purchaser and the latter acted as a provider (Interview S2). However, this close relationship was seen as negative because the office might have conflicts of interest between its roles of regulator and regulatee, and therefore the office was removed in July 2002 and relocated at the PHO under supervision of a deputy PCMO. The director of the Saraburi Health Insurance Office then resigned and moved to oversee a community hospital in the network of the Saraburi Hospital.

From July 2002, a deputy PCMO was in charge of the Health Insurance Office and transferred some of its tasks to other sections in the PHO. For example, the provider regulation and licensing roles were transferred to the Pharmaceutical and Consumer Protection Section. The Human Development and Primary Health Care Development Section was responsible for the health care network development and primary care unit development. The UC policy then became the whole PHO's responsibility rather than a responsibility of only the Health Insurance Office.

As can be seen from the above, the PHO structure in 2001 and 2002 was in transition. In October 2002, the PHO regrouped sections and divided the organisation into five sections due to the new Bureaucratic Structure Act (BE 2545). The new sections were: 1) General Administration, 2) Strategy Development, 3) Technical Support, 4) Consumer Protection, and 5) Health Insurance. These new five sections were close to the five sections in the matrix organisation proposed by the former PCMO with which the PHO staff was familiar.

In summary, the implementation of the UC policy in Saraburi had wide participation. The PCMO provided a strong leadership to start off the program. The program management in this province was flexible and adjusted according to new situations. Health officers had skills and experience in insurance management. All health officers had experience of several past reforms and could adjust themselves well to the new situation.

6.3.2 Policy communication and perceptions of the implementers

6.3.2.1 Policy communication

Figure 6.4 Communications in implementing the UC policy: Saraburi

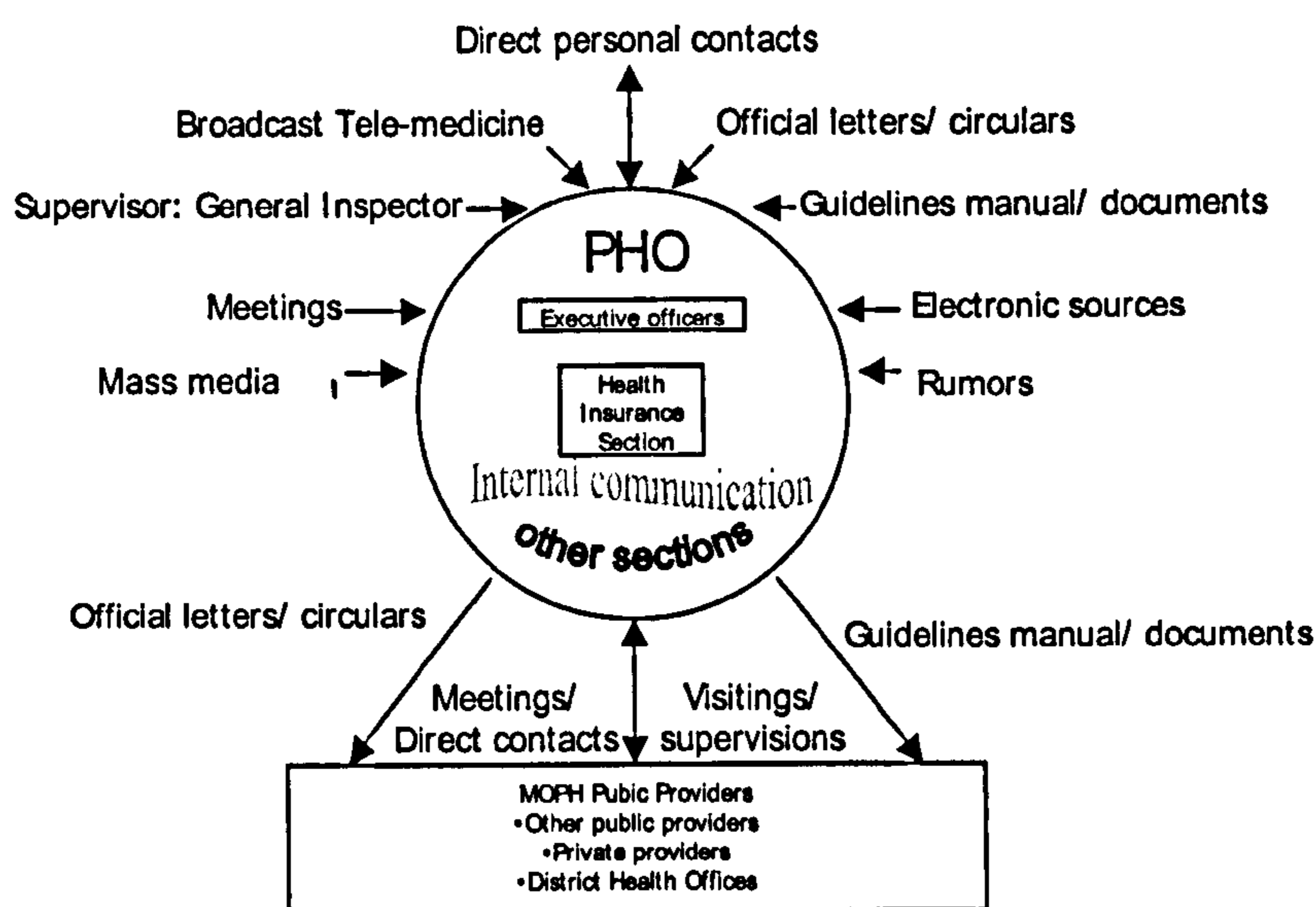


Figure 6.4 is a summary of the communication flows. The information on the UC policy came to the province from several sources, and affected staff perceptions in various degrees. This discussion divides the communication pathways into three groups; first is the pathway of information inflow, second is the internal communication within the PHO, and third is the communication between the PHO and operational implementers.

Communication from the MoPH to the province

The PCMO received informal messages when the province was consulted about joining the second phase in direct communication with the PS (Interview S1, S2, S4.1). Province staff learned about the UC policy from informal sources such as mass media before the PHO received formal messages, i.e. through letters, circular guideline manuals and documents or MoPH electronic sources. Other sources of information were from broadcast tele-conferences and from the Inspector General from the 2nd administrative zone health office, who was charged with supervision and monitoring in Saraburi.

The mass media, i.e. newspapers, played major roles in transferring messages from the central MoPH to staff in Saraburi. It was a fast messenger but included a lot of rumours. Newspapers delivered messages the next day while the tele-medicine conference system helped to present on-

line broadcast (only 17 big hospitals had a tele-medicine system). With the tele-conference broadcast, people in various provinces participated in MoPH meetings; therefore, they could clearly perceive the desires of the MoPH leaders. For example, providers in Saraburi had an initial agreement to divide providers into two networks, but they changed the decision to choose the inclusive capitation system (13 networks) due to the PS's position supporting inclusive capitation in a meeting broadcast via tele-conference (Interview S2, S3).

The communication from central level to the provinces was rather one-way. Policy content was decided with some choices at central level and then distributed to provinces for implementation with a time lag following guidelines. The participation in meetings seemed to encourage two-way communication; however, there was little space for voices from local level. For example, several provincial representatives were invited to join a meeting - the coordination meeting with 15 provinces - but were given no opportunity to voice their opinions. "They invited us to join the meeting to listen to them, not to listen to us", a hospital director said (Interview S3).

Another source of information linking the central MoPH and provinces was Inspector Generals. The Inspector General in charge of zone II visited staff in Saraburi and influenced the decision on the salary subtraction (Interview S2). The warning of hospital bankruptcies and negative impact of salary-including budgets had led to rumours that worried health officials who worked in health facilities, and caused a loss of morale (Interview S1, S2). However, the Inspector General played an important role in countering anxieties, and encouraging the progress of policy implementation in Saraburi.

A source of formal information was the book of guidelines for implementing the UC policy. It was published twice, with the second version in January 2002 (Ministry of Public Health 2002a) being a bit different from the first version in May 2001 (Ministry of Public Health 2001b). It focused on the concepts of solidarity, equity and sustainability. Most of the principles in the first version were retained; i.e. people's participation, strengthening of primary care, decentralisation and purchaser-provider split, cost containment system and performance-related payment, consumer protection and choices, and single fund. However, some issues were deleted due to low urgency and priority, for example, hospital accreditation, provider networks and public-private mixes, and gatekeepers. The change in the principles in the documents had little effect on provincial staff because they were not relevant to provincial actions.

The real impact on actions was from the resolutions of the War Room, released twice a month. While the resolutions could solve problems in implementing the policy, they led to a vacillation in the rules between providers and the purchaser in the province (Interview S2, S13). Another impact

was from the sub-programs of many divisions in the MoPH. Each division had its own program to support the policy but there was little coordination between divisions; therefore, the province was invaded with similar orders, different targets and no cohesion. For example, the Bureau of Health Care Network allocated money to support the model development of primary health care, which the provinces agreed to develop in 13 selected PCUs depending on staff capacities and locations. However, the Nursing Division instructed the province to select only big health centres called “Chalermprakiat” (means royal honour commemoration) (Interview S4.1).

The most important message from central level to get the system started was from the position of the Permanent Secretary in 2001. He expressed a strong commitment to implement the policy in several meetings broadcast via telemedicine and was perceived to have a radical reform mind (Interview S2), and he got along well with the Deputy Minister. This facilitated the implementation.

The information from central level had been interpreted in Saraburi in several brainstorming meetings (Interview S1, S2, S4.1) and communication processes within the PHO.

Internal communication within PHO

The internal communication within Saraburi PHO was unique during the early phases as it set up the Health Insurance Section outside the PHO and this office was a focal point of the UC policy information. As the office’s location was at Saraburi Hospital, two kilometres from the PHO, staff participation in the policy implementation was concentrated amongst the staff of the Health Insurance Section and its executive officers; i.e. PCMO and his deputies. However, other sections were finally included according to the related tasks. Internal communication within the PHO included meetings of head of sections twice a month, circular letters, and the monthly meeting of the Health Planning and Monitoring Committee (participated in by hospital directors, district health officers, and head of PHO sections).

Communication between PHO and other operational implementers

The communications between the PHO and other operational implementers were similar to other provinces, with official letters and circulars, guideline manuals and documents, meetings, and supervision. In order to clarify the policy with operational staff, preparation in the province started with a brainstorming discussion with wide participation of about 80 health staff from all levels of the province in April 2001. It was followed by two rounds of visits from the PHO. Other consultations were held in the monthly meeting of the Health Planning and Monitoring Committee.

In summary, the communication within the province was more two-way communication than was the communication from the central level to the province. Messages from the central level were

perceived as ‘commands’; the PHO had to transfer the messages and facilitate collaboration in implementing the policy. The statement “it is a policy, we must do it” usually followed the information (Interview S1, S3, S4.1, S17). The communication within the PHO was initially concentrated in one section and finally spread to other sections, resulting in more participation in regulation and consumer protection roles. The quasi-autonomous authority of the Provincial Health Insurance Office was able to respond very well as a focal point of the policy communication and management.

6.3.2.2 Perceptions of implementers in Saraburi

In this section, perceptions of implementers are divided into perceptions about the policy goals, and perceptions about change management and impact of the policy.

Perceptions towards the policy goals

In general, the PCMO (Interview in April 2002) and his staff agreed with the concepts of the UC policy. The general goal that everyone perceived was to improve equity of access for health care. However, there were multiple perceptions of other goals. One PHO officer summarised the goals of the UC policy as good health for all in order to decrease curative expenditures as the health care costs have been increasing; therefore, health promotion must be implemented. The policy would change the service delivery approach from ‘walk in patients’ to ‘home visits’ (Interview S2). The following are opinions on each issue.

- Equity in rights to health care – Although health staff agreed with this objective, one key informant said: “it is very difficult to find the rest of the people who are uninsured. Why should we invest a lot of resources to register them when the province would get just a small additional budget?”(Interview S17).
- Tax subsidisation for all – Some providers perceived the similarity between the 30 Baht Scheme and the MWS. A hospital director said: “why don’t we just extend the Medical Welfare Scheme without system reform?” (Interview S3). Others asked: “why does the government give free care to those who are able to pay? They used to pay without complaint” (Interview S2).
- Thirty Baht Co-payment – “This deduction at the point of service aims to prevent unnecessary seeking of care and brings co-responsibility in self-care” (Interview S1).
- Health promotion – “This objective is congruent to what I was taught in school” (Interview S2).
- Primary care development – “To promote primary care is a good policy; however, general practitioners in tertiary care hospitals are scarce and specialists would have

to be forced to practice in PCUs. This is not an efficient way of human resource management.” (Interview S4.1)

- Decentralisation – “As the money follows people, the money then was directly paid to CUPs [Contracting Units for Primary Care]. Therefore, the management power was delegated from the PHO to CUPs” (Interview S4.1). “Much information was passed over PHO to providers and now district level operations do not listen to the PHO” (Interview S17). “The inclusive capitation let community hospitals independently hold money; therefore, it is difficult to bring unity in management in our province” (Interview S3).

In summary, the existing values of health civil servants dominated their perceptions. These values were built up by their experience and education. Equity in health care, health promotion and the primary care approach were widely accepted as a good direction of reform. Nevertheless, other changes in the health system were debated.

Perceptions towards change management and impact of the policy on them

According to one PHO staff member, there was no voice from health civil servants in Saraburi because the then PCMO showed a strong commitment to implement the policy; therefore, all staff kept quiet and acted as “Lai Tarm Nam” (means all staff acted according to the leaders’ wishes). According to a key informant, the then PCMO announced that: “you should follow the policy to survive in the system” (Interview S1). The change within the PHO included the restructuring of the organisation and roles. The change in hospitals included establishment of PCUs and the structure of hospital finance. The change in health centres included primary care service strengthening and the relationship to community hospitals and District Health Office. The latter change also affected the roles of the District Health Office. However, there was little staff movement. These changes were facilitated by several factors, as a PHO staff member said: “we cannot say the 30 Baht Policy solely made the PHO change. The changes in Saraburi PHO were caused by the leadership of the PCMO and other changes in the government’s bureaucracy. Health officials were aware that they needed to improve their performance to survive, because the plan aimed to reduce staff numbers in the PHO” (Interview S1).

The issue of rapid implementation was perceived differently by different staff. Many people felt the policy implementation was too rushed. Health registration had to be done within a few months, causing many errors and conflicts. However, some argued that no matter whether they started in June or October the staff would still not be ready as bureaucrats were perceived to usually wait until the due time (Interview S1). Though the extension of the health insurance coverage could be implemented immediately, some felt salaries should not be included instantly in the per capita

budget (Interview S2, S3). However, the change in hospital payment was perceived as unavoidable because the system was needed to cope with the limited resources (Interview S1).

The PHO staff member also pointed out that government showed only positive results and did not mention the problems in service providers (Interview S1). Providers worried about salary inclusion; they perceived that the numbers of staff were a big burden on the hospital budget. They were concerned about the adequacy of the budget, and did only the necessary jobs such as curative services. However, some staff felt that the government would not let any public hospital go bankrupt (Interview S2).

The inclusion of salary at Contracting Units for Primary Care (CUPs) showed an impact on physician's retention in Saraburi. Tertiary care hospitals had to calculate staff efficiency, and in Saraburi it became clear that no more specialists were needed. Many young physicians who were waiting for the opportunity for specialized training resigned. Therefore the tertiary hospital requested new graduates to replace the positions and some community hospitals were left without a physician.

In summary, the perception of health officials at local level clearly reflected the bureaucratic culture with an awareness of hierarchy, top-down obligation, and some reluctance to change. The consultation process did not seek consensus but assumed implementation would occur. Resisters were hidden and only slowly responded to the policy. However, leadership of the top-level civil servant of each organisation was crucial in ensuring decisions and changes.

6.3.3 Saraburi insurance system and decision-making process

The decision-making processes were concentrated in the Administrative Committee. Their decisions were based on the existing Saraburi situation and the negotiations amongst them. Some decisions were decided at central level and some were influenced by the Inspector General. The characteristics of the insurance system and service delivery system in Saraburi from June 2001 to October 2002 were as presented below.

6.3.3.1 Eligible beneficiaries

Residents with a certificate of house registration in Saraburi were eligible to register at health providers in Saraburi in June 2001. In 2002, registration was more flexible, covering all residents who could provide evidence of a living place in Saraburi, i.e. letters from house owners in Saraburi to certify their present dwellings. The decision to extend the criteria of the beneficiaries came from

the central level, and it delayed as it waited for the information technology support from the Central Health Insurance Office.

6.3.3.2 *Provider networks*

There were only two public provider networks (Saraburi Hospital Network, Phabudhabaht Hospital Network) in the first few months. Then the providers were split into 13 networks of Contracting Units for Primary Care (CUP) following suggestions from central level. A private provider - the Kasemratch Hospital - joined the Scheme from October 2001. Therefore, there were 14 CUPs including 12 MoPH provider networks (hospitals as main contractors), a military hospital (the Adisorn Hospital), and a private hospital.

The two provider networks at the beginning were similar to the provider networks under the SSS in Saraburi. Public hospitals in Saraburi were used to the SSS system, in which two big hospitals were the main contractors since the SSS indicated that the main contractors should have more than 100 beds. The two big hospitals did not only hold the SSS fund but also provided services without a gatekeeper. As community hospitals and health centres were subcontractors of the Saraburi Hospital and the Phabudhabaht Hospital, they could provide services to the SSS beneficiaries and get reimbursement from these two big hospitals at a negotiated rate per visit.

This existing experience led the Administrative Committee to opt to follow the SSS. In fact, the SSS concept was different to the concept of the UC policy, which aimed to strengthen primary care. The UC Scheme allowed any providers (no limitation on the number of hospital beds) to be a Contracting Unit for Primary Care (CUP) and used direct financial incentive payments to CUPs. The change of the provider network model in Saraburi was a consequence of the changing of the payment method from 'capitation excluding budget for inpatient care' to 'capitation including budget for inpatient care'.

6.3.3.3 *Registration choices and population size allocation*

In 2001 and 2002, there was no choice of provider in health registration, but a pilot model of choices of registered providers in municipal areas in Saraburi City will start in fiscal year 2003²³. People had to register at the allocated primary care providers in their district; i.e. people in a tambon could go to the health centre in their tambon and the community hospital in their district to gain the

²³ The fiscal year 2003 began 1 October 2002.

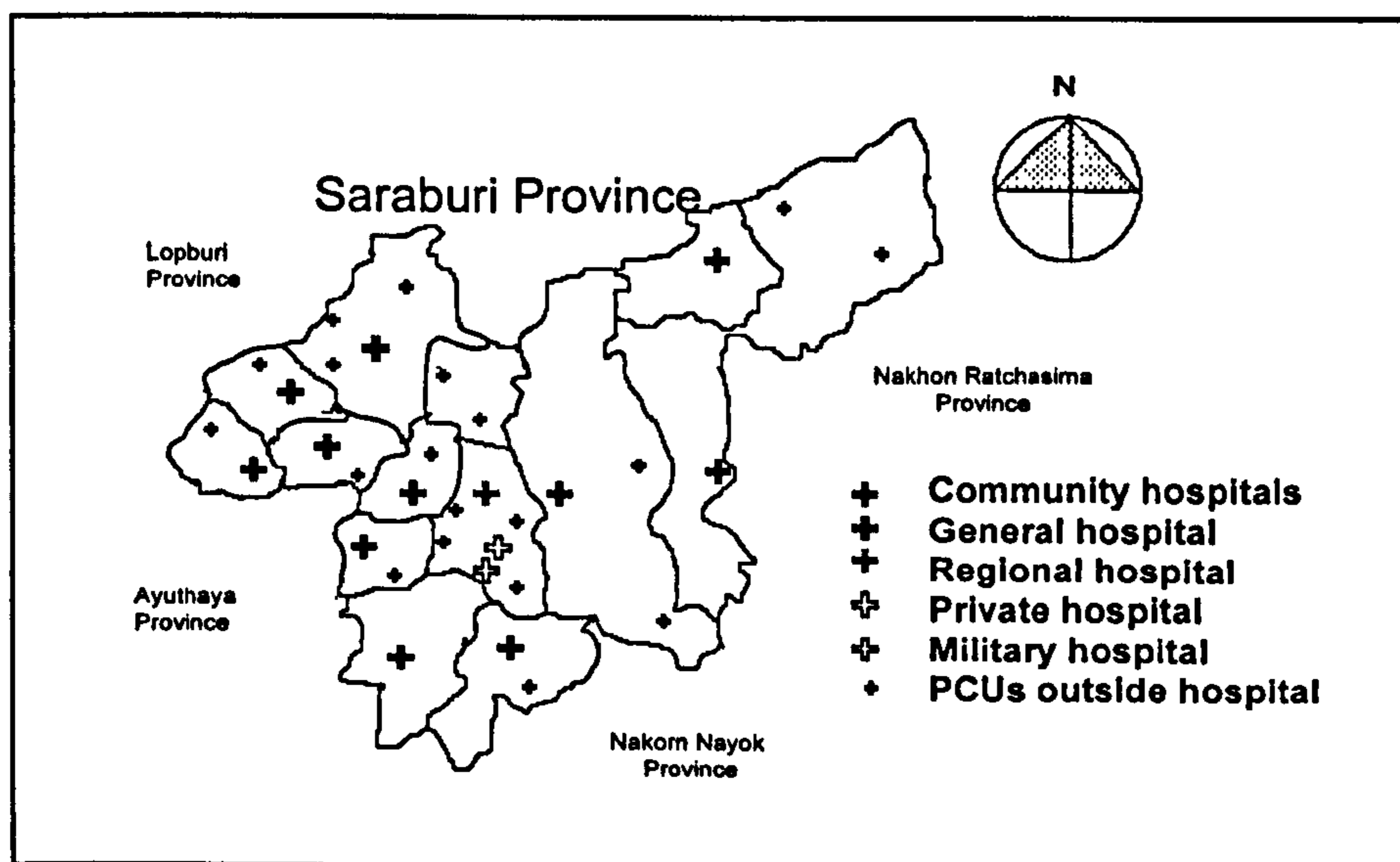
benefits from the 30 Baht Scheme. Exceptionally, people in villages close to borderlines between districts had the choice to register with a closer hospital.

The size of the registered population of each CUP related to the population in the district in which the CUP was located, except for the CUPs in Saraburi City. The district population size range from 9,000 to 150,000 people. In rural districts, only one public CUP was located in a district, while there were three CUPs in Muang District (Saraburi City) – Saraburi Hospital, Adisorn Military Hospital, and Kasemratch Private Hospital. The Saraburi Hospital held the biggest share of about 90,000 people, followed by 9,000 registered people at Kasemratch Hospital and 2,300 at Adisorn Hospital (2001 figures). The size of population allocated to the private hospital and the non-MoPH hospital was rather small, resulting from the low negotiation power of the private hospital and the non-MoPH hospital (Interview S4.2, S2).

In summary, registration choice was expected to encourage competition, but public hospitals and the PHO were reluctant to compete and used their authority to protect the hospitals' income. The higher the number of population allocated to the private sector, the less budget there was for public health providers. The conflict between public sector and private sector did not last long because they were the same professionals and their relationship was of collaboration rather than competition. Moreover, arguments in Thai culture usually end up with compromise.

6.3.3.4 Service delivery system with primary care units as gatekeepers

Figure 6.5 The distribution of the primary care units in Saraburi, March 2002



Source: Sirisomboon, Wongsathit, and Pitayarangsarit (2002)

The MoPH suggested that Contracting Units for Primary Care provide primary care through PCUs or health care networks which were able to provide comprehensive care, from preventive to curative care and rehabilitation. A PCU should have a medical doctor and the doctor to population ratio should not be more than 10,000 people per doctor. The PHO authorised the CUPs to develop health centres to be PCUs with their own capacities. In March 2002, there were 29 PCUs within 14 CUPs. Twenty-three PCUs were developed from health centres and six PCUs were located in hospitals (Sirisomboon, Wongsathit, and Pitayarangsarit 2002). There was a five-year plan to upgrade health centres to be PCUs in the province. However, in the first year establishment of the PCUs was poorly distributed, as can be seen in Figure 6.5. The establishment of the PCUs depended on the location and capacities of hospitals rather than the size of population. This did not contribute to the equity objective.

6.3.3.5 Preventive care and health promotion

The personal care of disease prevention and health promotion was in the benefit package and should be provided by the CUPs or PCUs. However, there is no clear difference between the effectiveness of community care and personal care regarding disease prevention and health promotion. Therefore, the Saraburi PHO set disease prevention and health promotion in both community care and personal care as priorities for all health centres to achieve people's good health and to save costs of treatment. The incentive of this strategy was to spend less money on curative care and then secure staff salaries.

Overall, activities were still the same as previously; i.e. antenatal care, well baby care, school-based health care, and the campaign for larva elimination, for example. Some models of proactive home health care were developed and were still in their infancy. The aim to achieve holistic care was largely unreachd in 2002 as the health officers in the province were only trained in the holistic approach in 2001/2. It seemed that health centres in Saraburi had long been neglected. Two explanations were, firstly, people had easy access to hospitals, as there were few geographic barriers, and secondly, many health centre officers did private practice either in private hospital or private business (Interview S2), and therefore had little incentive in performing proactively at health centres.

6.3.3.6 Salary subtraction

In 2001, all staff received salaries as previously and the capitation budget excluded salaries. Salaries were subtracted from the UC budget in fiscal year 2002. In 2002, the total health care

budget was per capita health care cost multiplied by the registered population (1,052 Baht x 403,000 people = 424 million Baht). Since the province received its budget for salaries directly from the Ministry of Finance, the 30 Baht Scheme would pay only the difference between the budget for salaries and the total cost of health care. Unfortunately, the budget for salaries was about 463.4 million Baht and was higher than the calculated capitation. This meant the province might not receive any money from the 30 Baht Scheme. This shocked many staff and demonstrated the necessity to request extra money from the Contingency Fund.

In order to highlight the financial problem, the Administrative Committee chose to subtract salaries at CUP level following the suggestion of the Inspector General. A criterion for extra support was that the estimated hospital revenue in 2002 was less than 1.5 times labour cost. The average hospital revenue of the province was 1.4 times labour cost, which was close to the cut-off point. With the salary subtraction at CUP level, the province could show the obviously low score of some CUPs from 0.9 to 1.4 (see Table A6.1 in appendix 6), and therefore requested an extra 215.3 million Baht for six CUPs from the MoPH. However, the Contingency Fund Committee, with its criteria, approved an additional budget of only 85.5 million Baht for five CUPs in the first round of its considerations in December 2001.

The salary-inclusive budget troubled Saraburi's providers. Consequently, the providers sought ways to survive by selecting the salary subtraction at the CUP level. Community hospitals agreed with this decision because they felt this kind of budget allocation would mobilise resources from big hospitals to small hospitals; i.e. community hospitals would have money to purchase medical equipment and attract health personnel. However, this was not totally true. In fact, only 40% of the total budget of the province was distributed to community hospitals because 60% of the total budget was salaries, of which most belonged to Saraburi Hospital staff and the Phabudhabaht Hospital staff. The debit accounts were established as the big hospitals borrowed the community hospitals' money. Therefore, community hospitals did not have enough money to develop. Moreover, after clearing the referred patient costs, there was no money returned to community hospitals as the costs of referred patients were high. This decision to subtract salary at CUP level was a condition leading to the selection of the inclusive capitation payment methods.

6.3.3.7 Provider payment methods

The payment methods for private providers and non-MoPH providers were inclusive capitation with direct payment from the HIO. For their own hospitals, the MoPH suggested two choices: inclusive capitation and exclusive capitation. In the fiscal year 2001, the Administrative Committee of

Saraburi selected exclusive capitation with three inpatient-care fundholders before the two choices were addressed in Saraburi. After receiving clear messages from the central level, the committee changed to inclusive capitation a few months later and continued with the inclusive capitation in the fiscal year 2002. However, in the last quarter of fiscal year 2002, the committee proposed a new model to the MoPH and requested permission to test the model in two public networks, each with inpatient-care budget pooling.

In the discussions on the advantages and disadvantages of the two systems, the Inspector General of Zone II had a critical role in influencing the selection of inclusive capitation. His reason was that the province would have a budget deficit; therefore, the province should request extra money from the Contingency Fund. In order to get the fund, the province should subtract salaries at CUP level and the budget deficit could be emphasised under the inclusive capitation system. Therefore, the Administrative Committee selected the inclusive capitation although the relationship between the big hospitals and the small hospitals would change from financial and management support to only technical support and referral support (Interview S2, S3).

6.3.3.8 Payment systems within CUPs and payment for referred patients

Payment systems within a CUP and payment for referred patients included payments for preventive care and health promotion, payments for outpatient care, and payments for inpatient care. Saraburi models of payment mechanisms can be divided into four models (see Table 6.5).

Table 6.5 Four models of financing and payment systems in Saraburi, 2001 to 2002

	First model in 2001 (I)	Final model in 2001 (II)	Official model in 2002 (III)	Proposed model for pilot study in late 2002 (IV)
1. Salary subtraction level (only MOPH hospitals)	At national level	At national level	At CUP level	At network level: Saraburi and Phabudhabaht Hospital networks
2. Allocated budget from MOPH	-For MOPH providers: 261 Baht per capita for 4 months (not included salary cost) -For private and non- MOPH public hospitals: 350 Baht per capita for 4 months	Same as I	-For MOPH providers: 1,052 Baht per capita per year (including Salary) -For private hospitals: 1,052 Baht per capita year -For non-MOPH public hospitals: 578.6 Baht per capita per year on top salary (55% of 1,052)	Same as III
3. Payment method for private hospitals	Inclusive capitation (350 Baht) for Kasemratch Hospital	Same as I	Inclusive capitation (1,052Baht) for Kasemratch Hospital	Same as III

	First model in 2001 (I)	Final model in 2001 (II)	Official model in 2002 (III)	Proposed model for pilot study in late 2002 (IV)
4. Payment method for non-MOPH public hospitals	Inclusive capitation (350 Baht) for Adisorn Military Camp Hospital. The hospital was a member of the Saraburi Hospital Network	Same as I	Inclusive capitation (578.6 Baht) on top salary budget for Adisorn Military Camp Hospital	Same as III
4. Payment methods for MOPH provider networks	Exclusive capitation with two networks (Budgets for outpatient care budgets, preventive care, and health promotion were paid to 12 main contractors according to the size of registered population. The budgets for inpatient care were pooled at two main providers.	Inclusive capitation for 12 CUPs	Inclusive capitation for 12 CUPs (1,052 baht per capita), subtraction salary at CUP level	Exclusive capitation with two networks (inpatient care budget pooled at two main providers for two networks), subtraction salary at network level
5. Payment system inner CUPs: Preventive and promotion care budget	From 43 Baht per capita (17% of total capitation budget), 40% was paid to health centres and PCU on capitation basis, 40% was paid on workload basis, and 20% was paid as bonus.	Same as I	Per capita budget for preventive care and health promotion was 175 Baht (17% of total capitation budget). The difference between this amount and the budget for salaries of staff at health centre was allocated with the same methods in I.	Same as III
6. Payment system inner CUPs: Outpatient budget	From 142 Baht per capita (55% of total capitation budget), hospitals held the fund and responsible to support medicine to health centres and paid 12 Baht per visit to health centres on top the medicines (sub-contractors). Hospitals paid to supra contractor for referred patients based on fee-for-service at the price rate of Saraburi Hospital.	Same as I	From 574 Baht per capita (55% of total capitation budget), hospitals held the fund and responsible to support medicine and staff to health centres and paid 12 Baht per visit to health centres on top the medicines. Another payment system was based on workloads with the rate 45 Baht/visit and 120 Baht/visit in the case provided by physicians. Hospitals paid to supra contractor for referred patients based on fee-for-service at the price rate of Health Insurance Office with ceilings.	Same as III
7. Payment system inner CUPs: Inpatient budget	From 75 Baht per capita (29% of total capitation budget), two big providers, Saraburi Hospital and Phabudhabaht Hospital held the funds of their members and allocated to their members with DRGs weight. The referred-patient charge rate within public providers in the province was 4,000 Baht per DRG weight and the rate for private hospitals and	The main contractor held the IP budgets and paid other hospitals based on DRG weight of the referred cases. The referred-patient charge rate within public providers in the province was 4,000 Baht per DRG weight and the rate for private hospitals and public providers in other provinces was 10,000 Baht per DRG weight.	The main contractor held the IP budgets (303 Baht as 29% of total capitation budget) and paid other hospitals based on DRG weight of the referred cases. The referred-patient charge rate was 10,000 Baht per one unit of DRG weight.	Similar to I. From 303 Baht per capita (29% of total capitation budget), two big providers, Saraburi Hospital and Phabudhabaht Hospital held the funds of their members and allocated to their members with case-mix basis (DRGs weight). The referred-patient charge rate across networks was 10,000 Baht per one unit of

	First model in 2001 (I)	Final model in 2001 (II)	Official model in 2002 (III)	Proposed model for pilot study in late 2002 (IV)
	public providers in other provinces was 10,000 Baht per DRG weight.			DRG weight.
8. reimburse- ment for emergency and accidental cases	-Reimburse from the MOPH Health Insurance Office for expenses in first 72 hours or insurers according to the Traffic Accident Victim Protection Act - The registered provider of the patient is responsible for the expenses after first 72 hours.	Same as I	Same as I	Same as I

Source: Saraburi Provincial Health Office, 2001-2002

Model I from 'Health Insurance Report during 1 June to 31 July 2001 in Saraburi' (August 2001)

Model II from 'the 2001 Saraburi Annual Health Report' (24 September 2001)

Model III from 'the Saraburi PHO performance' paper presented to the Inspector General of zone II (March 2002)

Model IV from Interviews

The first model originated from the agreement amongst providers at the initial stage in 2001. The second model was the final model in 2001 influenced by suggestions from the central level, changing the exclusive capitation payment of two public networks to inclusive capitation payment of 12 MoPH CUPs. The third model was the model implemented in 2002, similar to the second model as the payment model continued from 2001. The last model was a model proposed for a pilot study in late 2002, which changed the inclusive capitation back to the two-network exclusive capitation.

In summary, the changing back and forth of the provider payment models in Saraburi showed the low effectiveness of decisions that were influenced by the central level messages. However, it can be argued that the decision-making and the system in Saraburi had high flexibility and authority as they followed the 'do and correct' approach. The two choices were limited to fit the situation in Saraburi; therefore, the province needed its own model. The messages from central level were restricted to means rather than concept. The concept of primary care strengthening was not recognised as the aim of the health registration and the capitation payment.

6.3.4 Enrolment and insurance coverage

This province had experience and capacity to develop its own information system with support from IT expertise in community hospitals and the Saraburi regional hospital. Staff at health facilities made household surveys and validated the data, using the information of the MWS as a reference. Then data were transferred to the PHO. The individual records, of those who were uninsured or were not covered by other public health insurance schemes, were printed on the 30 Baht Scheme

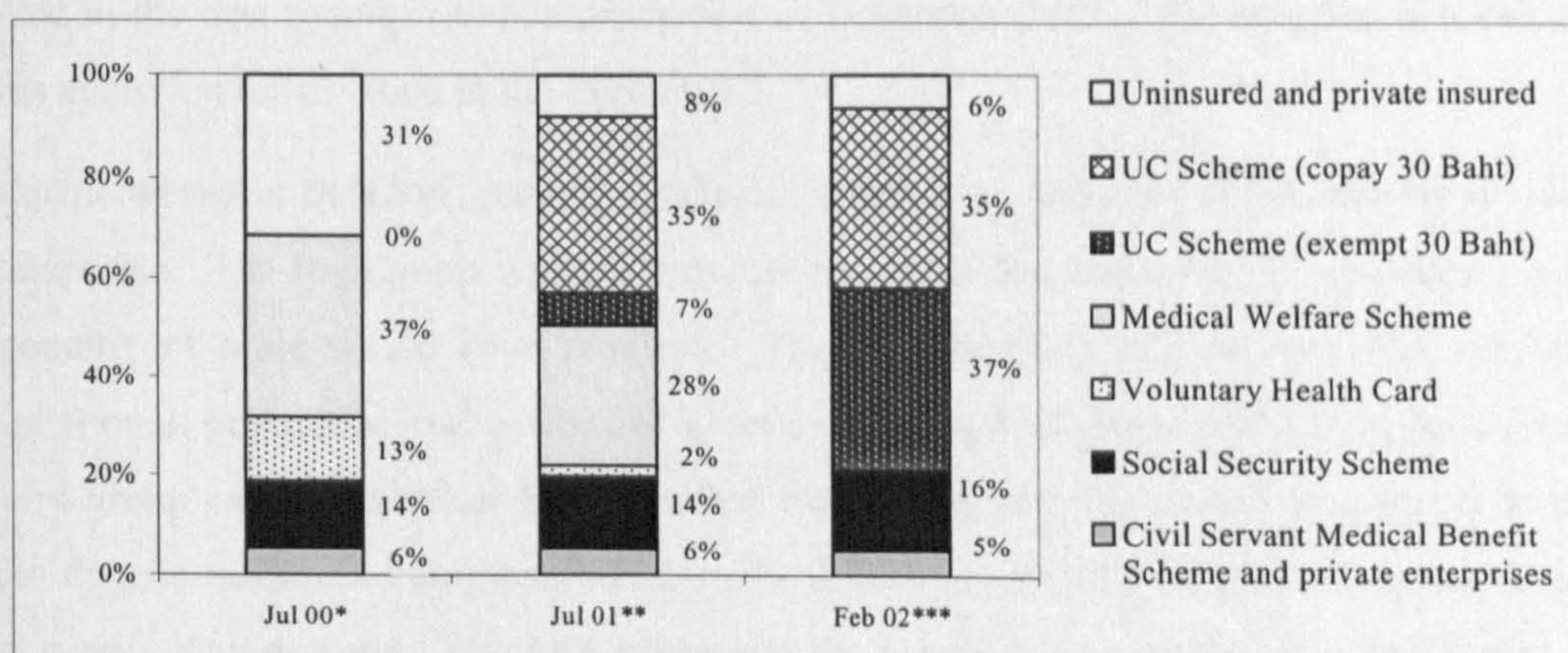
cards and distributed to health facilities to deliver to people nearby. The PHO was able to distribute the first card five days before the program launched.

Until August 2001, the Central HIO was able to validate the data from Saraburi and changed the amount of the budget to Saraburi arising from the change of the population size. There were several mistakes, for example, many people had wrong identification numbers, some people did not have house registration in Saraburi province, and some had other insurance schemes. The delayed response of the HIO created conflicts between cardholders and hospitals since some cards had to be cancelled and the hospitals called the cards back while the cardholders claimed for their rights. The province had addressed this problem by putting up the announcement of the card cancellation in public places and hospitals. However, there still were many conflicts between providers and cardholders.

Another problem arose over the deficiencies in the database in municipal areas. The Saraburi Municipality Administration could not present data of people in areas which were allocated to private hospitals. That caused entry data errors and delayed card production.

Despite many technical problems, insurance coverage in the province increased from 69% in 2000 to 92% in 2001 and 94% in 2002 (see Figure 6.6 and details in Table A6.2 in Appendix 6). This was higher than the national average (92% in September 2002; see Chapter 5).

Figure 6.6 Health Insurance Coverage in Saraburi: Before and After the UC Scheme Implementation



Source: Saraburi Provincial Health Office 2000-2002

6.3.5 Impact of the policy on implementers and their responses

The impact of the policy on implementers in Saraburi was mainly on hospital finances and PCU management. The issue of hospital finance is discussed below and the issue of PCU management will be discussed in the next chapter on the operational arrangements.

The UC policy changed the pattern of hospital revenues and hospital expenses. The main sources of hospital revenues were from patients' out-of-pocket payments, insurers, the reimbursement of import-cases, and government budget. Expenses were in-house expenses and export-case expenses. The UC policy intended to replace the hospital income from patients' out-of-pocket payments with the government tax revenues. However, it was recognised that this might lead to hospitals having budget deficits. This was caused by several factors. The leading factor was the change of MoPH budget from an historical-expense base to a population base; i.e. changing from the budget for salaries plus other costs to a capitation including salaries. In this respect, the hospitals with a high proportion of total budget taken by salaries might have had a budget deficit. Therefore, the MoPH used the proportion of the total budget spent on salaries as a criterion to support extra moneys from the Contingency Fund. However, looking in detail, any factor causing high in-house expenses (including salaries), high export-case expenses, low import-case revenues, or low out-of-pocket revenues would have affected deficit financing. The financial data of the public provider networks between October 2001 and March 2002 suggested that ten out of twelve provider networks in Saraburi needed a budget of more than 1,052 Baht per capita (see Table A6.3 in Appendix6). However, only six networks were approved for extra moneys from the Contingency Fund in 2002. The Don Phud, the Nong Saeng, the Sao Hai, the PraBudhabaht, and the Saraburi networks were approved in the first round of the consideration in December 2001. The Ban Mo network applied and was approved for the fund in the third round.

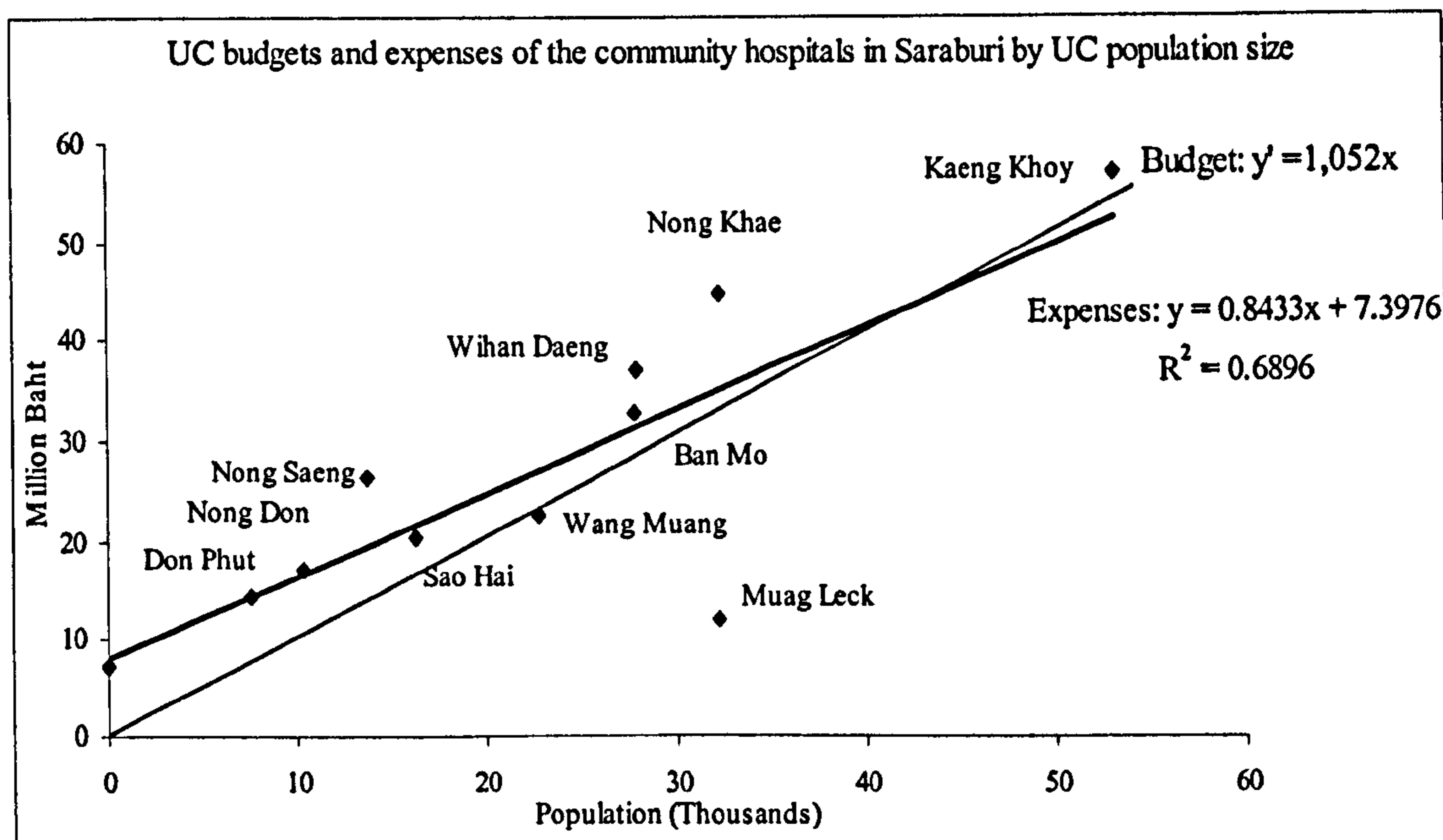
Provider networks in Saraburi, judged by factors concerning financial status, can be divided into five categories. The first group was the provider networks that had a small population - less than the economy of scale would have required. The second group was the provider network that covered enough population and performed at an average cost of about 1,052 Baht per beneficiary. The third group was the provider networks that were inefficient due to lack of capacity to provide services despite resources being available. The fourth group was the provider network that had greater supply than demand. The fifth group was the provider network that had rich resources and capability to import patients. The next section looks at how the system coped with these situations.

6.3.5.1 The first group: smaller population size than the scale of economy

“The capitation budget for the Nong Don District (population of 10,000 people) was 3 million baht (about 30%) lower than the hospital expenses. ... The 10-bed hospital was over supplied for the 10,000 population and it was not necessary to be located here as people could seek secondary care in another hospital within 10-kilometre distance.... Though the hospital was donated by villagers, the maintainance and operating costs burdened the government budget. ... We have cut the public utility expenses and generated revenues from other services, for example, Thai traditional massages to survive” (Interview: Director of the Nong Don Hospital).

Three hospitals were located in the districts that had populations of less than 20,000 (see Table 6.3). They were the Don Phud Hospital, Nong Don Hospital, and Nong Saeng Hospital. No matter how efficiently they performed; they had to face a budget deficiency due to the flat rate capitation. In the relationship between hospitals’ costs and population sizes, Figure 6.7 shows that hospitals had average fixed costs of 7.4 million Baht and an average marginal cost of 843.3 Baht per capita. Therefore, hospitals with a small population had high average unit costs of services and certainly were not able to cope with the flat-rate capitation. All requested extra moneys from the Contingency Fund.

Figure 6.7 Expenses of the community hospitals in Saraburi in 2002



Source: The Saraburi’s letter of intent to request support from the Contingency Fund, second round (March 2002)

Note: Expenses were deducted by hospital revenues from sources other than UC budget. Data from provider networks expenses during October 2001 to March 2002 were multiplied by two to represent for a year and showed in the graph as spots.

The Contingency Fund Committee approved the budget for the Don Phud Hospital and the Nong Saeng Hospital but not for the Nong Don Hospital. The Nong Don Hospital had requested an extra 2 million Baht and had revenues 1.4 times salaries. The taskforce of the Contingency Fund Committee suggested that this hospital did not need extra money if it could reduce its expenses by 10% (Interview: Director of the Nong Don Hospital). Therefore, this hospital did not get support from the Contingency Fund.

In 2002, the Committee suggested criteria for the budget allocation in 2003 that the hospitals with these two criteria should receive more allocated budget even without a formal request to the Contingency Fund. These criteria were: 1) population coverage of less than 25,000 people, and 2) far from other hospitals (more than 15 kilometres) or in the frontier or remote areas. Small-scale hospitals that are close to other hospitals should be incorporated into a bigger hospital. Therefore, the Saraburi PHO had to find another resolution for the Nong Don Hospital's deficit. In the fiscal year 2003, the Nong Don Hospital and another two community hospitals were incorporated as members of the Phabudhabaht Provider Network, and the other seven community hospitals were incorporated as members of the Saraburi Provider Network. This solution should eliminate the problem of lack of economy of scale, but other inefficiency problems might still occur.

The other case of a hospital with a small population was Sao Hai. This hospital is located in a district of 29,000 people but the number of UC beneficiaries registered was only 16,000. The rest of the population were civil servants and employees in the formal sector. Since this district is only 13 kilometres from Saraburi City, it had high levels of health personnel. The Sao Hai Hospital network had salaries of about 16.6 million Baht per year, close to the salaries of Nong Khae Hospital which had 90 beds but Sao Hai had only 30 beds. The Sao Hai Hospital network was supported by the Contingency Fund for about 5.7 million Baht because of the high proportion of revenue spent on salaries. However, the Sao Hai Hospital produced more revenue from other sources, and performed well to keep its costs under the province average. Therefore, it had a surplus and was expected to increase the hospital's reserves by about 2.1 million Baht. As this hospital would not get support in the fiscal year 2003, it had to decrease the burden of staff salaries, or compete in the market to gain more revenue from the Civil Servant Medical Benefit Scheme and the Social Security Scheme.

6.3.5.2 *The second group: sufficient population and efficient performance*

“The new budget allocation was based on the population size. ... There were only 4-5 districts in this province (of which the population sizes were bigger than 20,000 people) that had enough budget to run the hospitals and there were 4-5 districts that had budget deficit after deducting the salary budget” (Interview: Deputy Provincial Chief Medical Officer).

All the other hospitals had enough population to share the hospitals’ fixed costs. Among these hospitals, four seemed to have no financial problems. They were Wang Muang, Ban Mo, Muag Leck and Gaeng Khoy, of which the number of beneficiaries were 22.7, 27.8, 32.0, and 53.18 million people respectively. They had lower unit costs than the provincial average (the average cost of community hospital networks was 256 Baht per OP visit). Muag Leck and Wang Muang hospital networks had the lowest cost, caused by low in-house expenses and a high number of services provided at health centres (see Table A6.4 in Appendix 6). The Gaeng Khoy Hospital network earned a lot of money from the UC Scheme as it covered 50 million people. It was enough to run a 60-bed hospital and its networks. The Ban Mo Hospital network was also able to survive during the first half of fiscal year 2002. However, the Ban Mo Hospital reached a zero-doctor situation in April 2002. Young doctors moved to other provinces, where specialist training opportunities were available. Although the PCMO asked the Phabudhabaht Hospital to send rotating doctors to cover at the Ban Mo Hospital, there was still a shortage of medical doctors, causing the director of the Ban Mo hospital to eventually resign. Ban Mo Hospital network rapidly deteriorated in its performance, and increased the number of referred patients, incurring costs to the network. This network applied for, and was approved, extra money from the Contingency Fund in the third round. This network thus later fell into the third category - networks which were inefficient due to a lack of capacity to provide proper services.

6.3.5.3 *The third group: inefficiency due to lack of capacity*

“The adequate size of the population in Vihandaen District (about 30,000 people) resulted in a sufficient budget for a 30-bed hospital to survive ... but the referral expenses charged from the provincial hospital were about 20 millions (about 60% of total budget). ... If the Vihandaeng Hospital pays out the referral charges, the hospital’s reserved money has to be run out. ... After the Vihandaeng Hospital was incorporated into the Saraburi Hospital, it has been supported for both human resources and moneys by the Saraburi Hospital” (Interview: Director of Vihandaeng Hospital).

There were another two hospital networks clearly incapable of providing proper services, evidenced by the high numbers of referrals. They were the Wihandaeng Hospital Network and the Nong Khae Hospital Network. Referrals made up about 53 and 31% of the in-house expenses, respectively. This was caused by the low proportion of doctors. Despite resources being available for operations

and hospital admission, there were not enough doctors to undertake those services. The doctor-nurse ratio was a good proxy to present the poor proportion. The Wihandaeng Hospital Network and the Nong Khae Hospital Network had two and three doctors respectively, while they had 19 and 28 registered nurses respectively. The doctor-nurse ratios were 9.5 and 9.3 nurses per doctor. This was higher than those of other hospital networks (see in Table A6.5 in appendix6). While the average number of nurses per doctor in the province was 5.7, doctors concentrated in the Saraburi Hospital Network with a doctor-nurse ratio of 4.6 nurses per doctor.

The poor-distribution of physicians in Saraburi had long existed and some were improved by support from the Saraburi Hospital and the Phabudhabaht Hospital. For example, in 2001, the Saraburi Hospital supported the Wihan Deang Hospital by sending its deputy director to direct the Hospital. The Saraburi Hospital Director planned to use the Wihandaeng as its training centre for medical students in 2003. “This could be achieved only if we direct the Wihandaeng Hospital”, the Saraburi Hospital’s director said. However, collaboration or negotiation between hospitals was not sufficient to deal with the resource problem. “There was no trust between the big and small hospitals; therefore, the Saraburi Hospital had to control small hospitals to manage the system more efficiently”, the director said. It seemed that the small hospital could not resolve its own problems.

The case of Nong Khae Hospital was still unsolved by September 2002. This hospital increased its bed numbers from 60 to 90 beds through donations but was unable to increase the number of personnel. With high workloads in this hospital, physicians resigned or moved elsewhere. In April 2002, the director of the Nong Khae hospital threatened the PCMO to get more support of physicians or he would resign. There was no positive response from the PCMO (this PCMO was in charge since October 2001). Data from Interviews suggested that the PCMO was hoping that if the director resigned, the Nong Khae would be merged into the Saraburi Hospital Network. However, the director of the Nong Khae Hospital did not carry out his threat, and at the end of this research (September 2002) the situation continued. Actually, the costs of referred patients did not burden these two hospitals - the Wihandaeng and the Nong Khae - specifically because the Saraburi Hospital and the Phabudhabaht Hospital could not get real reimbursement from all the community hospitals in Saraburi. It was a debit-credit account with ceilings. In other words, the Saraburi Hospital and the Phabudhabaht Hospital borrowed the money from community hospitals for staff salaries and repaid by clearing the debts with charges for referrals. However, the community hospital would not pay if the referral charges were higher than the borrowed money. Many complained that this was unfair to other community hospitals, which had good performance and put effort into treating their patients before sending them to other hospitals. Moreover, community

hospitals needed money to improve their services rather than to deposit the money with the big hospitals. This argument was unsupported.

In fiscal year 2003, there will be only two big networks – the Saraburi Hospital Network and the Phabudhabaht Hospital Network. The burden of salaries will be shared within each network. All hospitals within a network will receive budget for inpatient care by cases with DRG weights. Therefore, they have to compete for the budget on top of their salaries. It is not clear that this solution will be able to improve these hospitals' efficiency.

Another example of collaboration was impressive and should be mentioned, between the Saraburi Hospital and the Gaeng Khoy Hospital. The Saraburi Hospital sent doctors in four specialised areas to rotate in the Gaeng Khoy Hospital in order to increase the Gaeng Khoy Hospital's reputation, and to decrease the congestion in the outpatient department of the Saraburi Hospital (Interview S3). However, at the time of research there was no data to show how congestion in the OPD in Saraburi Hospital decreased. The resource mobilisation occurred because of the trust and good relationship between two hospital directors (Interview S3). The relationship between hospitals in this example may improve service system and community hospital efficiency.

6.3.5.4 The fourth group: inefficiency due to higher supply over demand

“The money allocation should have been adjusted. ... It should have depended on the level of care provided by the hospital. For example, there should have been additional budget for the hospital which provided special treatments by specialists or teaching facility to medical students. ... This hospital is a general hospital but is located in a district. ... The financing system in the 30 Baht Scheme limited the number of refer-in patients from other neighbour provinces, although there was an abundant supply of specialised treatments in this hospital. ... Meanwhile, this hospital froze the number of medical specialists” (Interview: Director of the Phabudhabaht Hospital).

One hospital which had greater supply than demand was the Phabudhabaht Hospital. With a population of about 76,000 people, a 400-bed hospital was in excess of the population's demand. This general hospital is supposed to serve tertiary health care to imported patients from community hospitals and should earn money from the referral system. However, it was difficult for the Phabudhabaht Hospital in the new referral system because the community hospitals had a choice of sending patients to the Saraburi hospital, which could deliver more sophisticated services, or to private hospitals which had lower costs. While the resources were available but less used, the hospital's unit cost was increasing, and therefore it was inefficient. This hospital got support from the Contingency Fund but could not improve its efficiency. The new territory network of the Saraburi system in the fiscal year 2003 allocated three community hospitals as members of the

Phabudhabaht Hospital Network. These hospitals have to refer their patients to the Phabudhabaht Hospital before sending patients to a specialist hospital. However, it seemed that this solution could not cure the Phabudhabaht Hospital's problems because the whole network was inefficient due to over-supply and community hospitals could not pay for referral cases. This network includes the Ban Mo Hospital, Nong Don Hospital, and Don Put Hospital. The MoPH needs a long-term plan for these kinds of hospitals which are located in many provinces. The MoPH has not decided any solution for this kind of problem because it dares not touch on issues which may arouse personnel resistance.

6.3.5.5 The fifth group: rich resources and capability to import patients

"In the finance account, the hospital could survive if we got money from all referral charges. In fact, not all referral charges were paid. For example, the municipality authority refused to pay for two referral cases of about 100,000 Baht each. ... The hospital reported to the MoPH that there were no-income cases of about 100 million Baht provided by the hospital in the last year. ... We requested money from the Contingency Fund" (Interview: Director of the Saraburi Hospital).

The one hospital able to import many patients was Saraburi Hospital. Initially, this hospital was expected to have a budget deficit because of a high number of health personnel. The calculation in the request for extra moneys from the Contingency Fund suggested that the hospital had revenues of 1.4 times salaries and needed an extra 117.6 million Baht. The committee of the Contingency Fund approved an extra budget of 56.4 million Baht.

Actually, this hospital did not perform badly. Its unit cost was lower than the Phabudhabaht Hospital, it provided sophisticated services, and should have received charges for imported patient of about 105 millions Baht during October 2001 to March 2002, but there were few actual payments. If the referral system works well, this hospital might not need any more money from the Contingency Fund.

In summary, there were five situations which needed different solutions. The MoPH had some remedies but left provinces alone to deal with the problems of hospital networks which might not be effective in the long run. Several hospitals with financial problems had coping strategies including cutting the hospital expenses, generating incomes from other services, incorporating into a big hospital to share risk, and requesting for Contingency Fund.

6.4 Chapter summary

The chapter concludes that the implementation was rapid, complex, and top-down, with little consultation from the central level to the province, but more consultation within the provincial level.

Leadership was important in policy implementation, as well as staff capacity. Medical professionals were dominant actors in the managerial process at provincial level. The financing reform clearly affects hospitals' finance and staff morale. Nevertheless, health officials had a positive response to increasing the health insurance coverage to achieve the policy goal.

Provincial level authorities had some degree of autonomy in decisions and implementation. In Saraburi, the then Provincial Chief Medical Officer integrated all reforms, both in the UC policy and other aspects of the government sector reform, into the PHO plan. This province also had capacity in IT systems and management, which was able to cope with change better than the central level. These were results of social capital investment in the rural development plan, which distributed medical doctors to all provinces and developed capacity in health systems in each province.

The policy transfer process between central level and local level was largely top-down. There was little consultation but allowance was made for flexibility, and it was given to the province to manage the process. At provincial level, the decision-making process was more interactive and it seemed to manage conflict partly due to the Thai culture, which resulted in compromises. The health authorities exercised their power on some issues, such as hospital income protection from the private sector, and sought consultation on financing models. The latter strongly affected hospitals' finance and staff morale. Because the Contingency Fund helped to deal with the problem, low staff morale was alleviated by guaranteeing staff salaries. The Inspector General played an important brokerage role between central and provincial level.

The implementation in Saraburi was as rapid as in other provinces, but changed continuously. It can be characterised as having high adaptive capacity for survival.

Chapter 7 - Implementation: Operational arrangements

7.1 Introduction

This chapter focuses on operational arrangements at district level dealing with health enrolment, service delivery and quality of services. The 30 Baht Scheme introduced four main changes which affected districts, and meant they had to change their organisation and management of services. First, the budget for health services was allocated to the Contracting Units for Primary Care (CUPs) which were usually community hospitals. This meant the role of the District Health Office in service support was diminished and replaced by the role of monitoring and regulation. Second, district population size would affect providers' budgets – i.e. the more people who registered in the district, the greater the providers' budget. In the districts where the budget lowered their resources, they had to rearrange their services. Third, what they offered as part of the primary health services had to expand, as part of the 30 Baht Scheme. This meant hospitals and health centres had to extend their ranges of services to include home visits and medical consultation. Fourth, because of the way networks were established, the referral system had to be re-organised. This chapter illustrates variations in the perceptions and responses of health professionals and health workers in four districts.

Data were mainly retrieved by qualitative methods including document review, interview of health staff and villagers' focus group discussion, in four districts in Saraburi. Two districts, Gaeng Khoy and Wihandaeng were selected because they had providers in the network of the Saraburi Hospital (634 beds). The other districts, Nong Don and Ban Mo, were selected because they had providers in the network of the Phabudhabaht Hospital (400 beds)²⁴. The information was complemented by the views of the directors of the Saraburi Hospital and the Phabudhabaht Hospital.

7.2 Responding to the 30 Baht Scheme: perceptions of health professionals and health workers involved in the implementation

The Ministry of Public Health of Thailand had long played both health financing management and service provision roles. Although private providers had increased in the economic boom era, they were concentrated in big cities, and were uncommon at district level. The national management structure of the MOPH was represented by sub-national, provincial and district health offices.

²⁴ Provider networks of Saraburi Hospital included public providers in 8 districts and led by a regional hospital. Provider networks of Phabudhabaht Hospital included public providers in 5 districts and led by a general hospital.

Services were like a pyramid, consisting of regional hospitals, general hospitals, community hospitals in all districts, and health centres in all sub-districts, with referral relationships and loose supervisory relationships. The relationships amongst providers was characterised by peer groups, with no top-down relationship; i.e. the provincial doctors did not have greater status than their ‘peers’ in districts because district hospitals received budget and equipment support directly from the MoPH through the Provincial Health Offices. Authority for regional/general and community hospitals was delegated from the Provincial Chief Medical Officers to the hospitals themselves; therefore, they had certain levels of autonomy: for example, they were able to provide financial incentives for their own personnel, and set their own priorities in health spending. In contrast, health centres were closely controlled by District Health Officers in terms of financial management and position promotion. The 30 Baht Scheme led to four main changes:

- separating the role of regulation from service provision,
- changes to the budgetary system and provider payment mechanisms,
- expanding the range of services for the frontier providers, and
- reorganising the provider network and referral systems.

The perceptions in this section were derived from health professionals and health workers in four districts which have particular contexts. Given the different contexts, health staff might perceive and respond in different ways. Therefore, Table 7.1 gives a summary of the important features of the providers in the four districts to help to explain their perceptions and responses.

There are four main differences between the districts. First, the size of population varies from less than 30,000 in Nong Don District to three times that in Gaeng Khoy District. Second, human resources (medical doctors) and infrastructures (beds) were distributed unequally, health centres being the exception. Third, the proportion of 30 Baht Scheme beneficiaries was about three-quarters of the total population in each district, but the proportion of those exempted from co-payment dropped in Wihandaeng District. This was likely due to the perceptions of the health workers in this district, who limited the number of exemptions (see more details in section 7.4.2). Fourth, these four districts had diverse primary care development and financing arrangements and two districts suffered budget constraints.

Table 7.1 General information and descriptions of providers in four districts in Saraburi

Districts	1. Gaeng Khoy	2. Wihandaeng	3. Nong Don	4. Ban Mo
Contexts				
Number of population	83,000	36,000	15,000	42,000
Health Providers located in the District	-Gaeng Khoy Hospital (60 beds) -20 Health centres -1 private hospital (12 beds) -9 private clinics	-Wihandaeng Hospital (30 beds) -7 Health centres -1 private clinic	-Nong Don Hospital (10 beds) -4 Health centres	-Ban Mo Hospital (30 beds) -Mother and Child Hospital -8 Health centres -3 private clinic
Beds per 10000 pops (only community hospitals)	6.9	8.2	6.8	7.1
Doctor per 10000 pops (only in community hospital)	0.6	0.3	1.4	0.7
Health centre per 10000 pops	1.9	2.0	2.0	1.7
Responses				
Enrolment of 30 Baht Scheme beneficiaries (and % of those who were exempted from the 30 Baht co-payment)	75% (54%)	76% (48%)	71% (59%)	71% (53%)
Features of developed PCU in 2002	At 2 health centres	At the hospital and a health centre	At a health centre	At the hospital and a health centre
Budget allocated to health centres in the Contracting Units for Primary Care (CUPs)	Salaries plus medical supplies as needed and 3,000 Baht per month Additional budget for health promotion and disease prevention according to proposed activities	Salaries plus budget for workloads A capitation budget for health promotion and disease prevention (3-5,000 Baht per month)	Salaries plus budget for workloads A capitation budget for health promotion and disease prevention (a minimum guarantee at 3000 Baht per month)	Salaries plus medical supplies as needed and 3,000 Baht per month
Proposal to the Contingency Fund	No	No	Yes. but was rejected	Yes. Accepted in the 3rd round

Note: Situations as of March 2002

7.2.1 Separating the role of regulation from service provision

In law, the District Health Office was in overall charge of all health centres and the management of public health activities. The District Health Officer (DHO) was the top health authority responsible

for all health centre workers. However, the UC policy shifted the budget flow for health care from the District Health Office to the Contracting Units for Primary Care, which were usually hospitals, and hence reduced the budget allocation function of the DHOs. Some DHOs accepted this change passively but others were active in establishing new collaborations with other local authorities, such as the Tambon Local Administration Office, to secure funds for public health functions.

DHOs felt that the shift of the budget reduced their financial authority (Interview: Gaeng Khoy DHO, Wihandaeng DHO). Although all DHOs sat on the District Health Coordination Committee, and had a voice equal to that of hospital representatives, they had little information (interview: Wihandaeng DHO), so hospital directors dominated the decisions in budget allocation (Interview: Wihandaeng DHO, Director of Nong Don Hospital):

‘Though, there were debates about the Wihandaeng Hospital’s proposal on budget allocation criteria (e.g. the rate of budget allocation per case – 29 Baht including medical supplies), the Director of the Wihandaeng Hospital did not allow any change to the proposal. ... it was the style of the director, who had more information than other members and therefore influenced the committee decision (Wihandaeng DHO).’

DHOs found themselves with limited resources for public health activities as most of the MOPH budget was mobilised for health care. The Ban Mo District Health Officer managed this situation by coordinating local authorities to fund some health activities, for example the larva reduction campaign. However, he expressed disappointed in his career:

‘The district health office has a limited budget. There are some jobs which the district health office needs to coordinate, for example, in an outbreak of disease, health centres need support for disease investigations. ... The district health office looks after the whole community ... but there is little support for equipment, personnel, budgets, and other instruments. ... The budget for non-UC activities was about 58,000 Baht per year. It was inadequate and just enough for gasoline. ... The development of the health centres needs a coordinator to negotiate with local government. ... In Saraburi, I do not see any hospital that focuses on community health (Interview: Ban Mo DHO).’

It is clear that the budgets were concentrated with the service providers and district health authorities (regulators) were kept at a distance from the financial management of the services. Consequently, it reduced the power of the districts in favour of the providers. It is still questionable as to how these district agencies will be able to exercise their regulatory role, in view of financial constraints, and indeed whether they will be capable of doing this job. At the time of interview, there was no instrument to strengthen the regulatory role of the DHOs.

7.2.2 Changes of budgetary system and provider payment mechanisms

As the budget for health services allocated from the centre to provinces depended on population size, this also effected the budget allocated to districts. Some districts had budget constraints and negative consequences. On the other hand, the capitation approach created flexibility in priority setting of health spending at local level.

Nong Don, a very small district with 15,000 people and 10 kilometres from a general hospital (the Phabudhabaht Hospital), expected a very small budget from the 30 Baht Scheme. The provider in this district faced financial constraints. Although, it could survive for a short period while the MOPH guaranteed all staff salaries, this could not last because the hospital's request for an additional budget from the MOPH Contingency Fund was rejected. Therefore, the Phabudhabaht Hospital, finally, took charge of the 10-bed Nong Don hospital, and sustained the hospital activities under its support. The problem of the Nong Don hospital was caused by the absence of economy of scale. The hospital director observed:

“It is possible to reduce the inpatient wards of any small community hospital but the hospital should keep the emergency department and the observation ward. The reduction of cost would be outweighed by many disadvantages. For example, the people around there might be inconvenienced, reducing their rights. Secondly, it will reduce the development of hospital capacities. Thirdly, the donors of these hospitals will wonder why the hospitals are reducing their services and fourthly, the economy of these districts would turn down” (the Director of the Nong Don Hospital).

Financial constraints did not only affect the pattern of services, it affected staff motivation. The Nong Do District Health Officer said:

“There were some rumours of problems. For example, how the inadequate budget would affect the quality of services, quality of medicines would be low, and some health offices might be abolished. These worried the public and also our staff. ... The messages about the budgets alarmed us. The message was that the budget for this year (2002) would be one third of the last year. It made our staff frightened. The payments for staff allowances were delayed because there was not enough money to pay. Health officers including me felt oppressed. ... I think the policy would not be sustained. The program will end when there is no more money. This is because the implementation guidelines are not comprehensive. If the government wants to continue the program, there should be no impact on staff and citizens. The policy should not touch on salaries, fringe benefits, positions, roles and authorities of health staff (Interview: Nong Don District Health Officer).

Another negative consequence was from the way providers allocated the registered population. Ban Mo district had to allocate a number of the registered population in a suburban tambon (Sangsok Tambon) to register at the Mother and Child Hospital, as this hospital needed revenue from the 30

Baht Scheme. Sangsok was selected because it is close to the hospital. However, the transportation from Sangsok to the Mother and Child Hospital was inconvenient. The Mother and Child Hospital was established a few years ago for academic purposes and located in the same municipal area as the Ban Mo Hospital. However, the Ban Mo Hospital protected its revenues by registering all people in the municipality.

In a larger district, such as Gaeng Khoy, the providers would have a large portion of the 30 Baht Scheme budget. They did not have financial problems; therefore, they responded to the needs of consumers. The allocation of registered population was based on consumers' convenience. For example, people in some villages were allocated to register at Saraburi Hospital (638 beds) and Phabudhabaht Hospital (400 beds), according to their location. Though this allocation of the population already existed, it was formalised because of the financing system of the 30 Baht Scheme, which indicated that the money follow the registered population. It can be seen that districts were affected in different ways.

A clearly positive impact from the per capita allocation method was that it increased the flexibility of health centres to prioritise health promotion programmes. Together, the guaranteed salaries and the collection of 30 Baht co-payment allowed health centres sufficient funds for health centre expenses and staff allowances (Interview: Health centre workers in Wihandaeng), and it allowed flexibility to the health workers to implement many community programs based on local problems.

7.2.3 Expanding the range of services of frontier providers

The UC policy suggested that providers should provide a PCU, where patients could consult a medical doctor, for every 10,000 residents, and start with a model development. Therefore the Saraburi Provincial Health Office suggested each district should develop a PCU model in a hospital, and a PCU model in a health centre in 2002. To respond to the policy, Gaeng Khoy District started with two health centres as Primary Care Units (PCU), whereas Wihandaeng and Ban Mo Districts developed a PCU at a health centre and a PCU at the hospital. Nong Don District developed a PCU at a health centre, although as it is a small district, the hospital could have been an effective PCU for the whole population. It did not allocate its PCU to the hospital because the director thought that the MOPH preferred a PCU developed outside. He explained:

“This district does not have to invest in a PCU outside the hospital; however, the MOPH ordered us to do so. Moreover, patients would get benefit from a shorter travel distance” (The Director of the Nong Don Hospital).

Services provided by health centres already included mother and child care - ante-natal care (ANC) and post-natal care - and minor illness treatments. Community programmes by health centres included health promotion, health education, and disease prevention. There were three main professionals working interchangeably in health centres. They were midwives, MOPH trained health workers²⁵, and nurses. After the introduction of the PCU initiative, health centres still continued routine services and some designated PCUs were expected to provide a wider range of services and service loads.

Services provided in PCUs in hospitals (both in Wihandaeng and Ban Mo District) were basically provided by nurses with a holistic care approach derived from the family medicine concept. Doctors were on standby in the Outpatient Department (OPD) and came to the PCU on request for consultations. The PCU team usually included the staff from the Health Promotion Section and the Sanitation and Disease Control Section. They provided physical examinations and consultations mainly for mothers and children in the morning, and visited chronic patients at home in the afternoon. In Wihandaeng, there seemed to be little change. In contrast, the PCU in Ban Mo Hospital was highly active. The former director of the Ban Mo Hospital fully supported the family medicine approach. He refurbished a small building beside the OPD as an office of the PCU. Nine people – three nurses, three sanitation officers, and three health promotion officers – were recruited from several departments in hospitals. The staff were divided into three teams responsible for continuous care at home in three areas. They worked actively and had presented their findings from communities in several meetings. For example, they said they could provide mental support for chronically ill patients who were hospital-phobic and encouraged them to accept medical treatment at hospital.

Services provided in health centres designated as PCUs included routine physical examinations and consultations (including drug dispensing) by nurses (usually working permanently at health centres). If not available, a nurse from the hospital came to the PCU health centre. An average number of permanent staff in a PCU health centre was five, including a nurse (and a dental nurse in some PCUs). A hospital team of about five people, including a physician and a pharmacist, came to each PCU once a week (except in Ban Mo District there was no visit from a hospital team) and staff from other health centres came to assist in healthcare provision on appointed days (especially in Wihandaeng). The number of patients on such days was double that (60-80) on normal days (30-40 patients). After UC was introduced, the health centre services in the PCUs (except in Ban Mo

²⁵ The health worker trained by MoPH is a type of medical auxiliaries. The present curriculum of MoPH health worker combined the curriculums of sanitarians and midwives.

District) included chronic illness follow-up with support from hospitals. Staff claimed this caused a greater workload as they had to fill in medical records in family folders (Interview: health workers in Wihandaeng District, Nong Don District). In Ban Mo District, the PCU health centre did not emphasise illness care, but strengthened its computerised health information system.

Apart from the health care which was concentrated in the PCU health centre, every health centre was encouraged to create health promotion programmes, through flexible budget allocated by capitation that was not fixed to a specific program. For example, the PCU in Wihandaeng introduced many programs: Pap smear screening for cancer, malnutrition surveillance, hygiene education in communities and schools, haemorrhagic fever prevention and larvae control, handicap rehabilitation, and Thalasemia control and prevention in pregnant women. In health centres in Gaeng Khoy District, the programmes included exercise promotion, larvae control, and drug addict prevention. In Ban Mo District, some community programmes had been continued even though there was no budget indicated. Only in Nong Don, community programmes were not emphasised because the budget deficit was so serious. The head of the PCU health centre said that the CUP focused on illness; the health centre workers had too high a workload and were not able to allocate time for home visits or community programmes for disease prevention (Interview: Head of Ban Krab Health Centre, Nong Don District).

7.2.4 Provider network and referral system

Services provided by the hospital did not improve as a result of reforms, and possibly decreased in quality in some districts because of increased patient loads. Providers adapted themselves in responding to the service loads and financial constraints by grouping into two networks where some small hospitals were merged into two large hospitals.

Before the introduction of the 30 Baht Scheme, the provider network in Saraburi had been divided into two loose networks in response to the Social Security Scheme. In the initial response to the 30 Baht Scheme, all district hospitals acted as Contracting Units for Primary Care (CUPs) and independently managed their capitation budget. However, there were many constraints, both in service capacity and financing, and finally, the province grouped hospitals into two networks at the end of 2002. It was expected this would decrease financial risk and increase efficiency of resources used within each network.

The Gaeng Khoy Hospital was an example of a community hospital that had a good relationship with the Saraburi Hospital. It received support from the Saraburi Hospital, through specialist

doctors visiting Gaeng Khoy Hospital once a week. This hospital had been in the process of hospital accreditation and had no financial constraints.

The Wihandaeng Hospital had a problem of high turnover of physicians and was perceived to be decreasing in quality. In 2002 the resident doctor at the Wihandaeng Hospital felt himself to be overloaded, and therefore moved to another community hospital in April 2002 (Interview: Wihandaeng DHO). Although the Saraburi Hospital had sent a doctor to take charge as hospital director from October 2001, he came only in the evening to run the administration and service loads were not decreased. Another doctor came part-time for the morning clinic. This situation could not last as the services could not be provided properly. The Saraburi Hospital finally took over the Wihandaeng Hospital and sent a team to take charge permanently.

The Nong Don Hospital faced two big problems; financial constraints and a deficiency of doctors. To cope with the financial constraints, the hospital made a plan to increase hospital revenues, to decrease expenses, and to increase efficiency. However, it could not solve the problem of doctor deficiency. The Nong Don Hospital had a high turnover of physicians because it was small and could offer no financial incentive to stay. The hospital director said:

“The problem of discontinuous working of doctors at primary care level, I think comes from the lack of incentives. Many doctors at community hospitals have private clinics. Therefore, doctors will not stay long in districts where they cannot generate income from their private clinics. The government incentive at the present is not enough” (The Director of the Nong Don Hospital).

As the hospital could not provide services at full capacity, it needed strong support from the supervisory hospital. This hospital director requested the improvement of the referral system. He suggested that:

“I agree with the policy to develop a provider network; however, there are problems in the network management. The big hospital must cooperate. They should provide both information transfer and staff mobilisation. For example, the staff in the big hospital should send back the information from the laboratory investigation of a referred patient; then, I can further treat the patient. Without the information, how can I act? For the staff mobilization, it will be very helpful to villagers if specialists come to this community hospital once a week” (The Director of the Nong Don Hospital).

He expressed the conflict between the small and the large hospital as follows:

“Though the MOPH system is changing, the separation between the community hospitals and the group of general hospitals and regional hospitals still exists. The backgrounds of the directors of the community hospitals are different from the backgrounds of the directors of the big hospitals; therefore, their status is

different. The director of a big hospital must have prestige and standing with his colleagues. While the director of a community hospital does not necessarily have prestige amongst colleagues but he would be accepted by villagers. The problem of the difference between the directors of the small hospitals and the directors of the big hospitals has long existed. ... The big hospitals emphasise secondary care while the community hospitals emphasise community health. ... If the directors of community hospitals are asked to approach the big hospitals, they will agree to do so. In contrast, the big hospitals will be reluctant. In other words, the big hospitals do not have a unit which is responsible for community health. Most of physicians are specialists and specialised doctors usually are disinterested in primary care” (the Director of the Nong Don Hospital).

However, the Director of the large hospital did not agree with this viewpoint:

“Previously, I could not send any staff to community hospitals. Each hospital had its own director. The directors of community hospitals have their clans. The big hospitals do not want resources from the smaller hospitals but we do need cooperation to refer patients in good condition, not too late. There have been many arguments between nurses regarding the conditions of referred patients” (Director of the Phabudhabaht Hospital).

In May 2002, the Nong Don Hospital director left for specialist training. As with the experience of the Wihandaeng Hospital, a large hospital - the Phabudhabaht Hospital - took it over and sent a senior doctor to direct.

The Ban Mo Hospital had a high turnover rate of physicians, as with other community hospitals. As a result, patients were transferred to other big hospitals, increasing expenditures. The inadequate support of the Provincial Health Office and the Phabudhabaht Hospital led to a crisis situation, and the former director of the Ban Mo Hospital resigned from the hospital. He said that “it was risky if you are the only doctor who is responsible for all patients of the 30-bed hospital. Mistakes might occur and the government might not protect you. Moreover, the UC policy raised people’s expectations. Patients might sue doctors any time. The new insurance bill is going to impose the liability on doctors”. The overall quality of services of the Ban Mo Hospital had been developing as the hospital was in the process of hospital accreditation. After the former director resigned, the Phabudhabaht Hospital sent a senior doctor to direct the Ban Mo Hospital. As the Ban Mo Hospital team was strong and could maintain the primary care model development, the quality of hospital services, and its reputation did not diminish as it did in the case of Wihandaeng.

7.3 Villagers’ perceptions of the 30 Baht Scheme

Villagers’ perceptions reflect health sector performance in policy implementation. The study selected each tambon (sub-district) in the four study districts to connect the story of the implementation of the 30 Baht Scheme. The study investigated the difference between urban areas

and rural areas by selecting two municipal and two rural tambons. Coordinators at health centres selected participants using two criteria: the participants should be key respondents with opinions about the 30 Baht Scheme and be available on the appointment date. Table 7.2 shows the dates and the characteristics of the study sites and participants in the focus group discussions. Each focus group discussion took about 60 minutes.

Table 7.2 Participants in the focus group interviews in four districts in Saraburi, 3-10 April 2002

Group	1. Ban Mo	2. Wihandaeng	3. Nong Don	4. Gaeng Khoy
Places	Ban Krua Tambon, Ban Mo District	Nongsuang Tambon, Wihandaeng District	Ban Krub Tambon, Nong Don District	Huay Haeng Tambon, Gaeng Khoy District
Area	Municipal area	Municipal area	Rural area	Rural area
Dates	3 April 2002	5 April 2002	9 April 2002	10 April 2002
Participants	Five people: two males and three females.	Six people: four males and two females.	Six people: five males and a female.	Seven people: two males and five females.

The number of participants in the four groups was 24 people, 13 males and 11 females, including a village leader, an officer of a local administration, a member of a sub-district council, and eleven health volunteers, and ten lay people. Within these groups, three and two people were CSMBS and SSS beneficiaries respectively. Nineteen people were covered by the 30-Baht Scheme, of which 14 people were exempted from the 30 Baht co-payment (an elderly person and others who were members of health volunteers' families).

Four main points of people's perceptions were investigated during the discussions:

- Who gained and who lost through the introduction of the 30 Baht Scheme;
- Participation and communication;
- Enrolment; and
- Service delivery system.

7.3.1 Who gained and who lost

7.3.1.1 *The gainers: Rural people and the poor*

The Scheme ensured that people could seek care when they needed, and could alleviate catastrophic illness. According to a village leader (in Wihandaeng):

“Lay people get benefits from this scheme. It is very useful for poor families because they used to be in debt when they got sick, but not any more with the 30 Baht card.”

Besides the elderly and children, the beneficiaries of the 30 Baht Scheme in these four tambons included farmers, unskilled labourers, and shopkeepers. These people were the majority in the rural

areas and the minority in the municipal areas. Therefore, the scheme benefited more people in the rural than in the urban areas.

The 30 Baht Scheme should have benefited farmers, unskilled labourers or daily waged labours. Some of them had not been able to afford the 500 Baht for the Voluntary Health Card, and were not poor enough to meet the criteria of the means test of the MWS. However, some were identified as poor by the focus group participants because “they had no land and lived from hand to mouth with big families” (Nong Don group). The participants suggested that the cost of 30 Baht was less than the daily wage (140 Baht per day); therefore, the daily-wage workers could afford the cost of 30 Baht (Ban Mo group, Wihandaeng group, and Kaeng Khoy group).

The shopkeepers in the focus groups used private facilities rather than public facilities. The reason they gave for refusing public facilities was the long waiting time (the Ban Mo group). Therefore, they had little benefit from the 30 Baht Scheme. However, the scheme protected them when they needed services in cases of emergency and severity. A health volunteer described the population in his municipality, showing the low importance of the 30 Baht Scheme in his particular municipality, as follows:

“Most of people in this area are the employees of the Thai Cement Public Enterprise. They and their families access a health facility inside the factory and the health facility refers the severe cases to a private hospital (which contracts to provide services for the public enterprise’s employees). Others are private sector employees who have Social Security Scheme cards. There are not many farmers and merchants in this tambon.”

Though the scheme could protect patients from health care costs, some families were in debt from transportation costs. However, the loans from the Village Fund Program²⁶, which had just been introduced by the government, was perceived as helpful in protecting villagers from the high interest rates. This was observed by villagers in two rural groups (Nong Don group and Kaeng Khoy group). In the case of the poor elderly living alone, they could receive a pension fund of 300 Baht per month from government welfare. The criteria to receive this welfare included poverty, disability, and no support from their families. Though the 300 Baht was very little, it seemed that the society had its safety nets. The following is a conversation in the group of Nong Don District about the Village Fund.

²⁶ The Village Fund Program was introduced by the Thaksin regime. The government allocated a million Baht to every village as a revolving fund for loans in each village.

Researcher: “Did anybody borrow money from others to seek care when they were sick?”

Villager2: “Yes, there were some families.”

Researcher: “What were the expenses for?”

Health volunteer11: “They borrowed money from others for the transportation costs of the patients and their families to look after the patients at the hospital”.

Health volunteer10: “However, the number of borrowers decreased because families could request money from the Village Fund to invest to earn a living. Therefore, they should have cash available. Moreover, there are many earners in a family; hence, they can help each other in the family.”

In summary, the uninsured non-skilled labourers should have got the highest benefit from the scheme because they suffered from more poverty than others, following by other uninsured. In addition, the scheme benefited people in rural areas more than those in the urban areas as informal sector workforces were the majority in rural areas.

7.3.1.2 The losers: some MWS cardholders, chronic illness patients and people with minor sickness

The issue of the taxpayers’ burdens was raised with regard to fee exemption. The conversations were as follows:

Researcher: What do you think if everybody is exempted for the charge of 30 Baht?

Health volunteer8: “It will be very good but I wonder where the doctors could earn money from?”

Health volunteer9: “Thus, how the government can afford the cost? The government just gets income from taxpayers.”

According to the focus group participants’ perceptions, the SSS and the CSMBS beneficiaries were not affected by the 30 Baht Scheme. They perceived that these people had the advantage of choice. The SSS beneficiaries could go to private clinics and hospitals, and villagers believed the private facilities were better than the public facilities, at least in respect of waiting time. The CSMBS beneficiaries could go to a general hospital, bypassing a small community hospital. In the participants’ views, both the SSS and CSMBS beneficiaries were not losers.

Three population groups were mentioned during the discussions as potential losers because they got fewer benefits than previously. The first group was the MWS cardholders who received the card of the 30 Baht co-payment instead of the exemption card. In theory, the MWS beneficiaries should have received the 30-Baht exemption card with a clear statement ‘exemption of the nominal fee’ and the rest should have received the 30 Baht co-payment card. However, it was evident in three

groups (see below) that the cards with the 30 Baht co-payment replaced the MWS cards instead of the card exempting them from co-payment (Ban Mo group, Wihandaeng group, and Gaeng Khoy group).

Therefore, some poor families might have actually lost from the introduction of the policy. The conversation of the Wihandaeng:

Health volunteer8: “Before the 30 Baht card was issued, there had been no support to 14 million people but they had paid very little at health centres and the ‘Free’ cardholders (MWS cardholders) had never paid. Presently, all of them have to pay a charge of 30 Baht for a visit.

Researcher: “Are the Free cardholders exempted for the charge of 30 Baht?”

Health volunteer8: “No. Everybody has to pay the charge of 30 Baht”.

Health volunteer7: “No one can be exempted now.”

Another case was given by a villager in the Gaeng Khoy group. She said “The 30 Baht Scheme was bad because I had to pay the charge of 30 Baht. I was a MWS cardholder and had never paid for health care costs. Perhaps, people think I am rich now, although they thought before I was poor.”

Health volunteers in the Wihandaeng group argued that people could afford the 30 Baht co-payment. They felt uncomfortable distinguishing those eligible for exemption from those who were not, in spite of the fact that they could recognize some villagers as ‘the poor’. Their discussion was:

Researcher: “Is there anybody particularly poor and exempted?”

Village leader: “Though they are poor, they still do not receive the exemption.”

Researcher: “How many people are particularly poor?”

Village leader: “There are at least 10 to 20 poor families in a village. A village has 100 families. Some villages may have about 200 families.”

Researcher: “So, the poor are about ten percent of the population. They might not be able to afford the charge of 30 Baht.”

Village leader: “They might not be able to afford but they have to pay because the cards had been launched.”

Health volunteer6: “Most of them are unskilled labourers living from hand to mouth. However, if they can afford a tonic, they must be able to afford 30 Baht.”

Researcher: “Besides elderly and children, should anybody be exempted for the charge of 30 Baht?”

Village leader: “Yes. Some people need the exemption but we do not know where they are.”

Health volunteer6: “I think some people should be exempted.”

Health volunteer8: “If you (researcher) account in this way, then, many people want to be the poor asking for the exemption.”

Village leader: “It should be accounted by the family’s status, people do know who are actually poor.”

Health volunteer6: “Thus, the people who are responsible to issue the card must be in trouble.”

The second group who lost were patients with chronic conditions, as they paid the charge of 30 Baht many times. The third group was those with minor illness, as they paid higher than the actual cost. Comments were as follows:

“People use the 30 Baht Scheme in the case of diabetes and bone diseases. Both the 500 Baht card in the past government and the 30 Baht card in this government are good for the poor. However, the chronic illness patients have to pay 30 Baht many times, which is different from the previous 500 Baht card scheme which had no payment at the time of service” (Ban Mo group).

“When I had the MWS card, I used to receive headache relieving drugs at this health centre. After the 30 Baht card replaced my expired MWS card, I had to pay the charge of 30 Baht. Therefore, I bought the drugs from a drugstore where costs were only 5 Baht for a dose. So, I could buy a box of that drugs and it cost me only 15 Baht” (a villager in Gaeng Khoy group).

In summary, participants in the focus group discussions noted a change in cost sharing with the introduction of the 30 Baht co-payment, which was disadvantageous for some groups but others gained.

7.3.2 Participation and communication

Participants in the focus group discussions had different experiences in the process of registration, card delivery, and communication. Health volunteers were an important group who conveyed messages about the health services and health events to communities. Health volunteers also took part in the household survey for health registration as they were allocated responsibility for 10 families. Village leaders did not have any role in the registration process of the 30 Baht Scheme, although they had been involved in identifying the poor for the MWS. For the 30 Baht Scheme, the lists of the poor came from health volunteers and health workers. Local administrative organisations also had no role in the 30 Baht Scheme. Posters and press releases giving information on the 30 Baht Scheme were on the noticeboard at health centres but not disseminated to villages. The following are points made in the group discussions.

“In the survey for card registration, health workers came to health volunteers’ houses for the information of villagers” (Villager4 of the Nong Don group).

Health volunteer5: “Health workers asked health volunteers to make a survey first. A health volunteer was responsible for 10 households. ... We often explain how to use the card and sometimes we delivered the 30 Baht card to villagers.”

Researcher: “Was the process of enrolment complicated?”

Villager9: “No. It was not complicated. The health workers had villager lists from the family records. They completed everything by October (2001). Health volunteers helped them. The village leader was not involved in the registration process in this time. Health workers did a survey by themselves”.

Local administrative officer: “The local government also had no role in the registration process of the 30 Baht Scheme. The health workers had named who are the poor” (Gaeng Khoy group).

However, during the discussions, it could be observed that villagers still had many questions about the 30 Baht Scheme:

Villager9: “Are the services for the 30 Baht cardholders separate from the services for patients paying by cash? ... If we have severe illness, will the hospital reject us?”

Villager8: “There should be lists of services saying whether the services are included in the benefit package or not.”

Villager6: “What does it mean? If we have an accident and go to a hospital, do we have to pay total costs? Or should we pay only 30 Baht?”

Villager8: “Does the package include all diseases? Is there any exception?” (Gaeng Khoy group)

Because of inadequate communication, some villagers faced problems when they went to hospitals, as this example shows:

“The big hospital did not give information on the drugs outside the benefit package before giving drugs and bills; then, I had to pay a lot” (Wihandaeng group).

7.3.3 Enrolment

As described in the previous section, health providers managed the registration of the 30 Baht Scheme based on family records with the assistance of health volunteers. However, a few remained un-enrolled because they could not show evidence of Thai citizenship²⁷. The data at national level supports that 8% of the total population in 2002 were uninsured (Chapter 5). The following were the characteristics of the uninsured observed by participants of the focus group discussions:

²⁷ Evidence of Thai citizenship includes the identification card and the house registration documents which indicated identification number of each citizen.

“There is an elderly person having registered as a citizen at a district outside this province but he has no copy (of the household registration documents) with him; therefore, we (health volunteers) could not help him to register with a health provider” (Nong Don group).

“There is a blind elderly person. She does not have a copy of the household registration documents. I (health volunteer) went to find her name in the family records at this district office but I failed. She has forgotten in which district she registered. I have reported to the district office for years but nothing progresses. She also failed to get a pension from the social welfare” (Ban Mo group).

“Yes. A man aged more than 40 and a man aged nearly 100 years have never been registered as Thai citizens and have no identification card. Although there were witnesses to prove their ethnic origin, the district officer did not dare to register them. This was because he feared to be fired if there was a mistake as there was a deputy officer who was fired after making a mistake in registering a foreigner” (Nong Don group).

“Yes. An 80-year-old female divorced from her husband many years ago and her ex-husband has held the house registration. She has no copy of the household registration documents. Another lady aged more than 60, she does not have a copy of her household registration documents” (Gaeng Khoy group).

During a visit to the blind elderly person, the researcher found a girl, aged 11, who was reported to have no birth certificate and therefore, her name was not registered in her family records. In this case, it was easier to register her because there were documents proving her origin at her primary school and also people as witnesses. Unfortunately, her father had made insufficient effort to deal with the district office. His excuse was the income loss from being absent from work and, he had failed to deal with this matter many times.

In summary, there was a loophole in the whole social system, the root of which was poverty.

7.3.4 Service delivery system

The discussions regarding the service delivery system under the 30 Baht Scheme included four aspects; access roles, care delivery, quality of care and people’s self-care. The following were people’s perceptions derived from the focus group discussions.

7.3.4.1 Access roles: Troublesome rules of the gatekeeper function and the referral system

There were some changes in the access rules when the MWS’s beneficiaries and the VHCS’s beneficiaries became the beneficiaries of the 30 Baht Scheme. Criticism was voiced about some aspects:

“The 30 Baht card is worse than the MWS card. For example, one of my neighbours was in an accident in Nonthaburi Province and was able to use the MWS card in a nearby hospital. When the 30 Baht card was launched, replacing the MWS card, that hospital denied the 30 Baht card. In my case, if I am moving to Bangkok, I have to register for the 30 Baht card in Bangkok. Why doesn’t the government make a card that is eligible for using health services anywhere in the country?” (Wihandaeng group).

“I wonder why a patient had to come back to the registered hospital when the patient went for a hospital admission at the Saraburi Hospital despite the patient being nearly dead” (Wihandaeng group).

“Have you ever heard nurses asked why did you come to this hospital after official hours? (Wihandaeng group)”

“People have to start at a health centre before going to a hospital. It seems a weakness of the 30 Baht Scheme” (Ban Mo group).

The reason why people did not comply with the gatekeeper rule was because of perceived quality. They perceived that the service quality of their registered hospitals was lower than at other larger hospitals. Moreover, they said the 30 Baht card was meant to be for use at any hospital in case of emergency, but this was not always complied with, and there was no explicit definition of an emergency case. Therefore, there were a lot of misinterpretations and quarrels between providers and patients:

“If not severe, we agree to start at the registered hospital. If severe, we disagree. For example in the case of an accident, we went directly to a bigger hospital though a community hospital is closer. That was because doctors, who were in charge of the on-call services at the community hospital, were not in the hospital but they were at their private clinics in the market nearby. In that case, the hospital would provide an ambulance but it might not be in time and the patient might be dead before arriving at a bigger hospital. The 30 Baht program does not encourage the hospital to improve the services at all. This hospital has a bad reputation for quality of services” (Wihandaeng group).

7.3.4.2 *Care deliveries: New services reaching homes*

Villagers noticed new services at some health centres provided by health team from hospitals, especially services by doctors. They noted that chronic disease patients could receive drugs and follow-up for symptoms at several health centres; sometimes health teams visited elderly and chronic disease patients at home:

“The number of health personnel in this health centre increased. The hospital sent a health team to provide services at the health centre three times a week. People have more confidence in the services at this health centre” (Ban Mo group).

“Home health care is good for elderly” (Wihandaeng group).

“Health promotion activities are the same as previous, for example, vaccination and pregnant care” (Wihandaeng group).

It was clear that demands in health care increased, as these examples indicate:

“Doctors should come to provide services here at this health centre” (Gaeng Khoy group).

“We need dental services provided at this health centre. The queue at the hospital is too long. If we go there a bit late, we will not get a service” (Gaeng Khoy group).

7.3.4.3 *Quality of care: in doubt due to systems’ uncertainties*

Quality improvement could not be observed because the UC system was in a transition period.

Indeed, people expressed concern that the quality had not improved:

“There was no change. People do not express opinions on the service because the program is just launched and still not stable” (Nong Don group).

“The news about the resignation of the hospital director made people concerned about the quality of hospital services” (Ban Mo group).

“This community hospital has new doctors every three months, just like a training period. ... This hospital should have permanent doctors, we do not want new doctors all the time.” ... “This hospital has long waiting times for services and few doctors.” ... “Waiting for a long time was so disappointing” (Nong Don group).

“If the case is severe, we might go to a private hospital. Even in the public hospital, doctors send patients to have x-ray checks at this private hospital” (Nong Don group).

“After the economic crisis, people saved their money and went to public hospitals. Therefore, the public hospitals have more patients than previously. I think the problems are the limitations of the hospital budget and human resources” (Ban Mo group).

“Long queue, there were more than 100 patients while there were only two doctors. That is why people want to bypass this community hospital” (Wihandaeng group).

In addition, there were concerns about the differences in quality of services received according to the different payment schemes or social status:

“There were many complaints that the drugs of the 30 Baht Scheme were different from the drugs for patients who paid from their pockets. The hospital should improve this problem” (Wihandaeng group).

“Someone can get special services if doctors recognise them; however, this was true before the 30 Baht Scheme was launched. For example, lay people might not be able to get access to a private room. In contrast, when you know someone working inside the hospital, you can book the room with a short time of waiting” (Wihandaeng group).

“I (health volunteer) think that the policy of this government is to provide equally health care services and hospitality to all because these are our rights. Therefore, civil service officers should not exploit us. Though, as a tradition, civil servants are respected as our bosses, indeed, they are our employees earning from our taxes through government tax revenues” (Wihandaeng group).

7.3.4.4 *People's self-care: Seeking care from drugstores and village drug fund*

For minor illness, villagers avoided paying 30 Baht at health centres. They had many choices for self-care, for example, going to drugstores and going to villages' drug funds:

“Only the poor (who have MWS card) and the elderly (who have MWS card) come to this health centre. The 30 Baht cardholders go to drugstores instead (Ban Mo group).”

“People still buy drugs from drugstores. They still use the combination drug sets, which are cheaper than 30 Baht. There is a new pharmacy, which provides advice free of charge. I (villager) did not pay at all in a case where the symptoms do not need any drug (Ban Mo group).”

“There is a drug fund project. The health centre provides medicines for the village health centres at cheap prices. Therefore, people have choices to buy medicines, which cost lower than 30 Baht at these village health centres (Wihandaeng group).”

7.4 Performance in reform implementation and capacity strengthening strategies

This section analyses the Thai health system performance in the reform implementation in four aspects of change at operational level. The assessment of performance in this chapter is not linked to outcomes but rather focuses on the process of management and service delivery by using skills, incentives, and motivations to help explain performance in the implementation of the 30 Baht Scheme.

In brief, the Thai health system suffered from inappropriate staff distribution, which was a structural problem limiting the system from providing more equitable access to health care. The introduction of the 30 Baht Scheme urged system changes at operational level in four aspects: 1) increasing accountability and responsiveness by paying providers directly and separating the roles of regulation from service provision, 2) increasing equity in health care access by enrolling all citizens and changing budgetary and financing systems, 3) expanding the range of services in primary care provision, and 4) strengthening the provider network and referral system. However, problems associated with implementation existed and are still challenging the system. The following section explores strategies and incentives of the system and how these factors affected policy responses.

7.4.1 Increasing accountability and responsiveness

Separating the regulation role from the service provision role was expected to lead to greater accountability of the health providers. However, at the beginning of the UC policy, the Health Insurance Office at the central MOPH was dominant in the purchaser role, and centralised decision-making. It was too overwhelmed by operational management and fire fighting for it to fulfil its strategic role as regulator effectively. Some decisions such as provider payment methods were

delegated to Provincial Health Offices but no task was delegated to District Health Offices. This meant that the sub-national bodies at district level were not trusted to make decisions, and were not encouraged to take on the regulator tasks. This also reflected the sub-national bodies at provincial level – the provincial health offices or Area Health Boards. No sanction was provided by the DHOs for non-compliance in practice. This was also because the Thai culture prefers giving incentives more than punishments. Therefore, a regulator which does not have authority to control resources has little power in regulation. However, the District Health Offices still had authority for deciding on staff promotion, and were co-chairs with the hospital directors in the District Health Coordinating Committees.

For DHOs, there was no incentive or specific training for skills in regulation tasks. For the committees, members were limited to bureaucrats and there was no place for private providers, representatives of consumers or local communities. Responsiveness was therefore limited.

7.4.2 Increasing equity in health care access and management of budget reallocation

There are several points discussed in this section. First, the health staff at operational level had strong data management and data analysis skills, resulting in high coverage of health enrolment in Saraburi (as well as in other provinces). Health workers were capable of making surveys and using existing information to enrol people in districts, though there were some difficulties during the initial period.

Second, the skills were developed from past experience in the former scheme management and with support from the MOPH and the Saraburi Provincial Health Office by technology transfer, i.e. training and software distributions. However, the information system was still incomplete as a result of a limitation of the information technology for online access and identifying patients, which was developed at national level. This prevented flexibility for health care access across borders.

Third, the revenue according to the number of registered population was an incentive to enrol as many people as possible. In Thailand, health providers enjoyed relative financial autonomy, which stemmed from their control over revenues, for example, to pay for staff workload. The higher the registered population, the more allowances they could receive. Moreover, they had an incentive to charge the 30 Baht co-payment since health providers saw the user charge as a source of revenues. This incentive may have led the health workers to refuse the exemption card to some. From observation by the researcher in the field, it seemed that there was no particular effort to protect the poor, with little participation from other third parties (or communities) to prevent any health workers' bias.

Fourth, financial data management depended on the existing capacity of each provider network. The Saraburi hospital had developed a computerised financial management system and provided training of computer skills to accountants from community hospitals in its networks. The accounting development was optional; therefore, the other hospital network, the Phabudhabaht network with fewer resources, had limited incentives to change the accounting system.

Fifth, the capitation budgeting system allowed the local level greater power in prioritising resource allocation. Hence, providers increased autonomy and could respond better to local problems. It was expected that this might lead to more participation for local communities or consumers in priority setting. At the stage of this research, customers could express their views only through hospital directors, central MOPH, and their local politicians - there was no direct channel for their voices in decision-making.

7.4.3 Expanding the range of services in primary care provision

The Primary Care Unit development aimed to expand the range of services and improve quality of care for peripheral providers. However, there were limitations in the number of physicians who were willing to work at small community hospitals and at PCUs. In practice, people in rural tambons had a low probability of a consultation with a doctor, with services provided by nurses.

The MOPH gave time to develop the PCU and test systems, train staff and generate experience. Resource mobilisation to primary care was optional. Some hospitals supported both manpower (nurses) and training (of medical skills) to health centres which were designated as PCUs. For example, the Gaeng Khoy Hospital offered health centre workers a rotation at the Emergency Department or child-delivery room. Although the idea was not new, it was activated in order to respond to the policy which aimed to strengthen provider networks.

The MOPH gave incentives to staff by increasing the allowance rate (Interview: Health centre workers). Moreover, the Saraburi Provincial Health Office suggested all districts allocate at least 3,000 Baht per month for public utilities and other expenses to each health centre. That suggestion was intended to force the CUPs to find resources for health centres (Gaeng Khoy Hospital Director). In some health centres which had high workloads and could generate revenues, the increase of resources was an incentive. However, some small health centres, which could not generate revenue to pay all staff allowances, closed the evening clinics and moved to working part-time (Interview: DHO). It seemed they managed this way, but people in the small tambons lost the opportunity to attend clinics in the evening.

7.4.4 Strengthening the provider network and referral system

It was capacity and financial constraints that pushed providers to rearrange their networks. The UC policy to strengthen primary care at PCUs made slow progress because of the scarcity of physicians. The burden of case loads was on community hospitals, the smallest unit where patients could meet physicians regardless of an appointment. The 30 Baht Scheme brought patients back to the district level. An incentive to develop the provider network was to share resources between health centres, community hospitals, and general/regional hospitals. However, until the present time there has been no concrete strategy from the MOPH to reallocate health personnel, especially physicians, equitably.

In sum, the system introduced by the 30 Baht Scheme was relatively adaptive. The new scheme tackled issues such as the mal-distribution of beds and physicians between cities and districts, and low pay for government physicians working in primary care in some rural areas, where they were not able to earn from private clinics. The situation was much improved as the MOPH adjusted additional payments many times, but the high turnover of physicians continues. The effect of economy of scale of small hospitals was explicit when districts chose to manage capitation budget inclusively. However, the inclusive capitation benefited those community hospitals which had optimal size of registered population, and was detrimental to others.

Although the Thai health system is hierarchical, there was considerable flexibility for local levels to adapt the system according to constraints. The system at district level faced high workload volumes and financial constraints, and the reforms tried to meet this by:

- greater autonomy of budget management in priority setting,
- increased budget at peripheral level,
- increasing allowance rates and flexibility management such as paying by workload,
- logistic support from larger providers,
- manpower support from larger providers (mobilisation from hospitals),
- training support in computer skills and medical care skills.

The extent to which there was a gap between core policy and implementation was questionable, however. The policy did not establish a reward system for compliance and good performance, and rather many providers suffered from the policy change. The cultural clash between the community hospitals (good health approach) and regional/general hospitals (illness approach) was still a constraint for primary care development. Community participation did not appear to increase.

7.5 Chapter summary

This chapter is based on key informants' views of the 30 Baht Scheme, which provides fascinating insights into the process of implementation; but is clearly limited because of potential bias of responses in a small study.

It suggests that people involved in the implementation at local level observed four main changes: separating the role of regulations from service provisions, changes of budgetary system and provider payment mechanisms, expanding ranges of services at the frontier providers, and reorganising the provider network and referral system. The UC policy brought a high volume of work and financial constraints. However, many expressed positive responses as there was also pressure from the public. There were also incentives such as higher rates of allowance, payment according to workloads, and resource mobilisation to support primary care services. However, many constraints acted as disincentives - such as uncertainty of salary income (at the initial stage) and scarcity of health personnel.

In the views of villagers, they accepted that this program was useful, especially for the poor. It was largely people who had chronic diseases or minor illnesses who were perceived to lose. The new rules implemented under the 30 Baht Scheme were a bit different from the previous practices of the VHCS and the MWS, and people were confused about these rules. There were a small number of poor people who were unregistered as they could not prove their citizenship; however, they could be exempted from any health fees in practice as they were known to be underprivileged.

With regard to quality of services, villagers saw not much change as the program had been implemented for less than a year. They felt that the health facilities which used to be good, were still good, and the health facilities which used to be bad, were still bad. Complaints were about long waiting times, the few doctors in community hospitals, and discrimination due to patronage. They appreciated two new services. Firstly, doctors came to provide services at health centres and chronic patients could receive medicines at health centres instead of at hospitals. Secondly, health workers came to see people at home, which was helpful for elderly and chronic patients. The strengths and weaknesses of care provided in the 30 Baht Scheme in the consumer perspectives are summarised below.

Strength:

-Majority of the population get more equal benefits than ever as the 30 Baht Scheme covers everyone except people who already have health insurance under the formal sector employment (about 20% of the population).

-Medical services are available at health centres which are located in every sub-district and special cares for the elderly and handicapped were delivered at home.

-The scheme expands range of services provided at health centres (for example, chronic care, dental services).

Weakness:

-A small number of chronic patients have to pay more i.e. paying 30 Baht many times more than the previous scheme- Voluntary Health Card Scheme.

-There are troublesome rules of gate keeper function i.e. paying full costs when a patient visits a hospital without any referral note from the registered Primary Care Units either a community hospital or a health centre.

-Some hospitals limit the service opening hours for outpatient care for those who are the 30 Baht card holders to discourage people to visit the hospitals in the first place.

-The 30 Baht copayment may discourage patients to visit health providers at an early stage of illness.

-There is no incentive to improve quality of hospitals' services (sometimes longer waiting time and lack of physicians).

-The process of health registration depends strictly on citizenship documents that are likely to rule out underprivileged.

The implementation was top-down and rapid; however, there was a lot of space for local implementers to manoeuvre. Providers at the district level had autonomy in financial management and could adapt themselves to secure their staff income and service provision. As there was less participation in the direction of adaptation from communities, it was questionable whether the system became more responsive.

Chapter 8 - Discussion and conclusions

8.1 Introduction

In Chapter 1, the aims of this thesis were established: (1) to analyse the process of the UC policy in agenda setting, policy formulation, and implementation; (2) to explore how the process influenced the design of the policy and how far the design affected implementation; and (3) to explore the extent to which the policy is likely to achieve its goals. To meet these aims, the specific objectives of this thesis were:

1. to analyse the design and characteristics of the UC policy;
2. to analyse the extent to which contextual factors facilitated or delayed the UC policy;
3. to explore the influence, roles and powers of particular actors in the UC policy;
4. to explain how and why the notion of UC came onto the policy agenda, and was formulated into policy;
5. to explain how the policy was executed and to analyse how far this policy is likely to be implemented as intended, by looking at characteristics of the UC policy, policy responses, and strategies.

This chapter synthesizes what has been presented in the preceding seven chapters and compares the findings with the lessons from theoretical and empirical information in other studies and other countries.

The analysis proceeds according to the conceptual framework developed in Chapter 2. This framework was elaborated by drawing on a review of literature relating to the policy process: agenda setting, policy formulation and decision-making, and implementation. Models explaining the policy process draw on many theoretical disciplines, including political science, sociology, economics, and organisational management. Political theory provides decision-making models, to which power is central. Sociology focuses on the relationship of members in society, in which the concepts of policy community and policy network are central. Economic theory provides concepts of welfare and equity. In financing reforms, allocation of resources is central to economics. Management theories focus on capacity and management in implementation. This thesis drew on approaches from all these disciplines. The justification for this combination is that policy in practice is complex and involves interaction of actors influenced by the social, political, economic,

and historical context in which policy is shaped and implemented. Policy analysis thus uses concepts from the different disciplines to help to understand highly complex interactions. But policy analysis is not only a retrospective tool for understanding the constraining and facilitating factors in a particular policy; it can also be used prospectively, as a tool for policy-makers to improve and change policy for more effective decision-making.

This chapter follows the analytical framework outlined in Chapter 2 in Table 2.2. It looks at content, context, actors and process, along the continuum of agenda setting, policy formulation, and implementation, recognizing that boundaries between these concepts are not clear, and that such divisions are to some extent merely a heuristic device to help in untangling complexity.

8.2 UC policy design and characteristics of the policy

As mentioned in Chapter 1, reform proposals in most developing countries were driven by neo-liberal ideology and attempted to achieve better health care systems by increasing the contribution of private sources of finance. Thailand, by contrast, introduced a tax-based finance scheme to achieve universal coverage. Factors which affected the outcome of the policy-making process and will determine the success of the implementation included: the ideology which drove the UC debate; the design which affected the financial sustainability and technical complexity, implementation and support for the policy.

8.2.1 Ideology

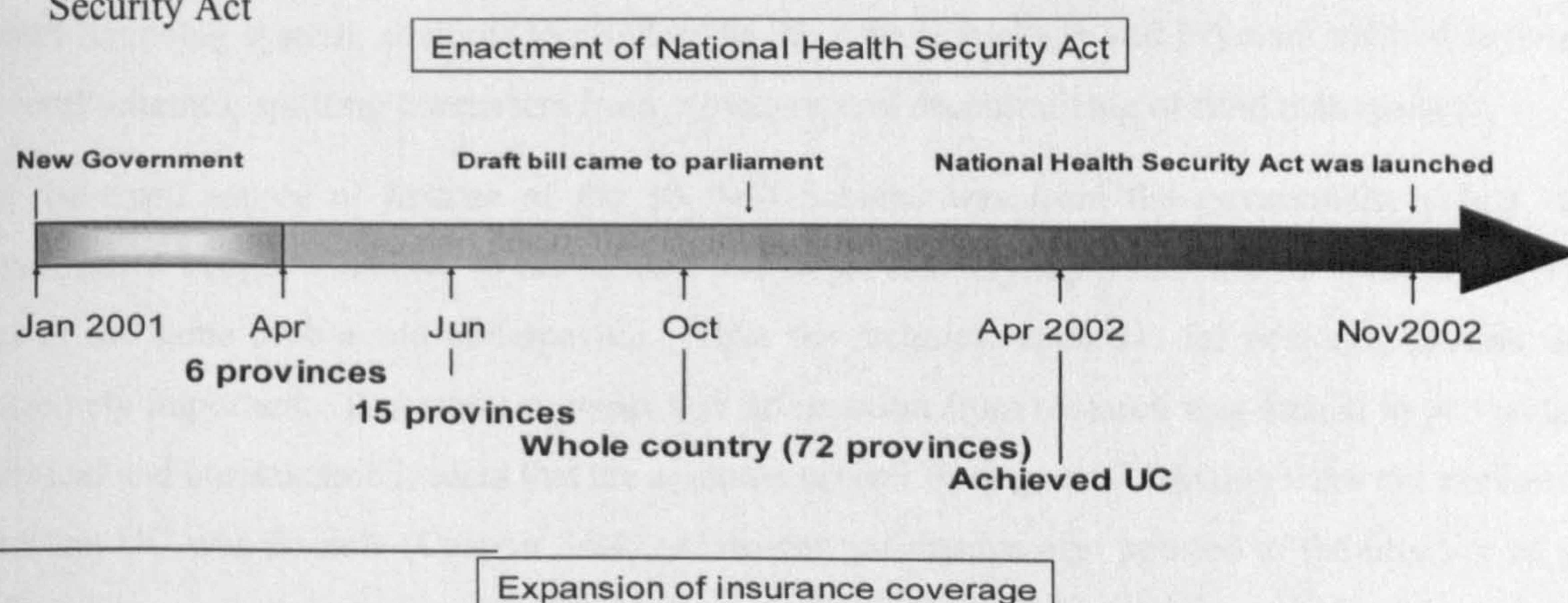
Most developed countries achieved universal coverage before the world economic crisis in the 1980s. UC policies in these countries were driven by diverse factors, including the ideology of human rights and challenges from the working class (Chapter 1). In Thailand, the ideology of human rights in health care, together with the concept of primary care for all and reforms emanating from neo-liberal concerns, drove UC policy. This mix of ideas came from national and international experience, although this study suggests that international institutions did not directly influence policy development in Thailand. Reform ideas were transferred by interaction between policy communities in training programmes, workshops, and through international collaboration (Chapter 4). It seems that UC was a strongly felt Thai initiative, and indeed in some ways flew in the face of international health reforms which emphasised the growth of the private sector; UC focused on improving coverage and co-opting the private sector.

UC policy development was unique, as it was continuously pursued by a group of researchers, of which one particular member played an entrepreneurial role (Chapter 3). This study suggests that UC policy development had been occurring over a long period, supported by a national policy

community of researchers and bureaucrats in the MoPH, already involved in health reforms. They had been garnering information and doing research which was important in helping to define the design and content of policy. In particular, one of the members of this policy community acted as a policy entrepreneur, going between the political party (both before it was in office and when it came to office) and members in the research community and MoPH. The idea of UC transferred to politicians and civil societies by processes of policy advocacy (Chapter 3).

UC was simply adopted by both politicians and civil societies because the issue of rights in health care access was in line with the new Thai constitution, established in 1997. The study shows that the Thai Rak Thai Party recognized the legitimacy of the UC policy, picked it up as a priority to gain public support before the election, and so were confident to implement it before legitimizing it by law (see Figure 8.1 of the timeline). Universal coverage policy in Taiwan was also introduced by the government to gain popularity to maintain political power (Cheng 2003). The commitment of the Thaksin government to universal coverage was a key factor in bringing the issue onto the political agenda, and then to rapid implementation. Moreover, the government enacted the National Health Security Act in 2002 to ensure policy sustainability. In contrast, the 'Health System Reform Bill'²⁸ was formulated by the previous government, did not have support of the new Prime Minister and failed to go to Parliament. This might have been due to the broad aspects of the 'health system reform', which brought too few obvious short-term benefits, so public support was lacking. It might also be partly because the ideology of this bill attempted to control the for-profit private health care market, which would have been extremely unpopular with many business and political groups.

Figure 8.1 Timeline of the UC policy implementation and the enactment of the national Health Security Act



²⁸ It was part of the process of thinking about health sector reforms, which aimed to reform the whole health system in Thailand including other aspects outside the health service sector by law. Although it generated the 'health system reform movement' to mobilise support for a 'Health System Reform Bill', the bill was suspended, and never went through the parliament process.

8.2.2 System design: technical aspects

International experts suggested developing countries should establish social health insurance, but there was little evidence in the literature to show how to extend such insurance to the large informal employment sector (Chapter 1).

In Thailand, several schemes had been established incrementally so that about 69% out of a population of 62 million was insured by 2000. These schemes included the Civil Servant Medical Benefit Scheme, CSMBS (1955), the Medical Welfare Scheme for the poor and socially disadvantaged, MWS (1975), the Voluntary Health Card Scheme, VHCS (1983), and the Social Security Scheme, SSS (1991), but universal coverage was not achieved. Hence, a new attempt to entitle all citizens by law was seen as reasonable and feasible, but there had been no political support for this until 2001. The introduction in 2001 of the 30 Baht Scheme (merged scheme) was thus based on incremental experience in managing insurance schemes of about 25 years (1975-2000) of the Ministry of Public Health initiatives and many operational research projects during 1991-2000.

The UC policy created a big change in terms of timing – a rapid increase of coverage (extending coverage to the 18.5 million people who were previously uninsured) – and a radical shift in funding away from major city hospitals to rural provinces and district hospitals in order to build up primary care. This also involved changes in budgeting, regulation, and management rules and systems, resulting from the adoption of the contract model. Other aspects of the new system were developed incrementally from the existing system. These included the benefit package, the use of primary care services, the patient-referral system, the quality assurance system, and private provider collaboration. The most challenging aspects of the UC system design were the shift towards a tax-based financing system, attempts to standardize the benefit package and payment method between several schemes, splitting purchasers from providers, and decentralizing of fund management.

As the main source of finance of the 30 Baht Scheme was from the government budget, the government budget allocation to the scheme had to prevent any rapid increase of financial burden, but at the same time avoid underpaying. Thus the technical expertise for cost calculations was extremely important. This study suggests that information from research was crucial in persuading political and bureaucratic leaders that the amounts needed from general taxation were not excessive, and that UC was feasible (Chapter 3&4). However, informants also pointed to the fragility of the calculations, and that there were differences in opinion about the amounts needed. It seems that government acted opportunistically, using the numbers that best supported its position (Chapter 4).

The attempt to standardize the benefit package and provider payment was impeded, partly due to the uncertainty of evidence to support what was considered to be the affordable cost in the long run for the comprehensive benefit package, and the different views of the effectiveness of the provider payment methods; the payment designs were always contested. Nonetheless, the main factor that made it impossible to merge all three insurance schemes into a new system at the beginning was the strong resistance from other government departments which acted as fund-holders – the Social Security Office and the Comptroller General's Office, Ministry of Finance – and from civil servants and trade unionists benefiting from the two employment-based schemes. This conflict was reflected in the amendment process of the draft law during 2002, and when it was finally passed, it compromised on merging by allowing negotiations every year to merge all schemes if it became politically acceptable to these fund-holders and these schemes' beneficiaries.

Splitting purchasers from providers involved a power shift from central MoPH bureaucrats to a decentralised network of independent organisations in which, at least in theory, consumers, managers and professionals participated, now the National Health Security Office. This was highly resisted by the MoPH bureaucrats, and although legally there should be a split between purchasers and providers, MoPH bureaucrats have successfully negotiated for at least a three-year phasing out period (the split should be effective in 2006).

The establishment of a single purchaser for the 30 Baht Scheme unified the main system design and moved implementation forward rapidly. The attempt to decentralise the management to the provincial level was slowed and in the first two years (2001-2) the management was centralised through the MoPH and the Health Insurance Office. As this study showed, in Saraburi there was no clear plan to decentralise and no training support. These activities were strengthened after the establishment of the National Health Security Office in 2003, and the operational function of purchasers should be decentralised over the next few years. However, Thai policy makers will no doubt be looking closely at neighbouring countries' experience in devolving or decentralising management of health services. Where Vietnam has reported positive experiences in the centralised policy but decentralised management, the Philippines found its devolved structure could not support the implementation of universal coverage (Phua and Chew 2002).

It is clear that major attention was on the financing system and structures, and one of the great gaps in system design was the apparent neglect of human resource issues. This study found little evidence that the UC policy paid attention to human resource re-allocation. This may have been because if it did, it would induce resistance from bureaucrats to the manpower mobilisation, but

manpower is important in distributing primary care services and strengthening capacity for the design and implementation of policy change.

As seen from the above, UC policy design was very complex, and was resisted by some groups, which managed to delay or amend the policy. Moreover, the UC was not just a vertical program; it incorporated many innovative features which related to and supported health system development. In this complex system, there was no one blueprint to fit all. It required the insiders who understood the whole functioning of the health system to adjust the design during the course of implementation, and also it required legal power to regulate change. Even then, lags in implementation occurred, and some issues, such as human resource planning, were neglected because of a lack of political leadership to confront them.

8.2.3 Policy design: factors influencing the outcome of implementation

Content of UC policy was also influenced by the concentration of cost, the dispersion of benefit, short and long-term impact, and the size and pace of change. These factors, according to Grindle and Thomas (1991), were likely to influence both the content of the policy and how well it fared in implementation.

This study found that MoPH providers bore the cost of policy change, arousing opposition in the bureaucratic ranks. However, UC had benefits that could be seen in both the long and the short term. The benefits of system reform, i.e. resource reallocation and the separation of providers and purchasers, for example, would become visible only in the long term and would not induce public appreciation for the UC policy, although it had a lot of support from key policy communities in health. But the extension of the insurance coverage in the earlier stage could effectively bring visible benefits to the poor and general population, so UC policy generated a lot of general support from the public. The government recognised this, so it wanted to get the 30 Baht Scheme implemented as quickly as possible, to carry out its promise to the electorate and also possibly to head off resistance. Because of public pressure, the MoPH bureaucrats' responses avoided any negative impact on consumers. However, they attempted to maintain power through financial management, and to delay the reform by switching the salary-inclusive per capita allocations in fiscal year 2002 to the salary-exclusive per capita allocations in fiscal year 2003. Outside the MoPH, medical professionals influenced the law amendment by lobbying senators, but failed to secure the deletion of some articles regarding malpractice liability, and subsequently negotiated with the Health Minister to amend the law when feasible. An explicit strategy the government used was to maintain political leadership, but there was no other explicit strategy to manage the cooperation.

In other countries, such as South Korea (Kwon 2003), professionals displayed strong powers to stop the separation between prescribing and dispensing, and delay the introduction of the prospective payment system based on DRGs (Diagnostic Related Groups). In Thailand, the law regarding the separation is not yet launched because of the strong resistance of medical professionals, although it has been drafted since 1999-2000. The content of this law was again contested and largely protested by medical professionals during the new government thinking to create this law in 2003. The response of medical professionals to UC policy was a bit different because UC policy did not directly affect the income generation of medical doctors and the implementation in 2001-2002 was prior to the build-up of resistance; therefore, there was no obvious strong opposition to UC policy. Moreover, the Thai medical professionals were represented by the Medical Council of Thailand, and at that time (2001-2) the Council board members were balanced by MoPH doctors, university doctors, and private doctors. Increasing public demand for the greater responsibility (duties) of medical doctors, such as in autopsies, and together with the rise of the law attempting to separate drug prescribing and dispensing, created an alliance amongst medical doctors led by a group of private medical doctors and this group won to have more seats on the board of the Medical Council (an ex member of the Medical Council - personal communication). It is likely that the Medical Council will increase its role in protecting the benefits of medical professionals, especially in the private sector, and will have strong power in resisting regulations which affect its members.

8.3 Contextual factors facilitating or delaying UC policy

How far did contextual factors – situational, structural, cultural, and environmental – influence the perceptions of the policy makers? Situational factors – such as the economic crisis and political regime change – facilitated policy change (Chapter 3). Structural factors affected policy formulation and the capacity for implementation (Chapters 4–7). Cultural and environmental factors were important in the shaping of the ideology (section 8.2.1).

8.3.1 Situational factors

Situational factors – transient, impermanent conditions – played a part in facilitating the UC policy, providing new opportunities for reform. The findings of this study showed that the new political setting was an important factor in policy change and situational factors are important in at least three aspects. Firstly, an event, the general election, provided the opportunity for policy entrepreneurs to push their ideas (Kingdon 1995). Secondly, a crisis – the economic crisis – was ‘a focusing event’ forcing the change of government. And thirdly, political change created demands to speed the implementation of new policies at the beginning of the regime.

Political transition: political windows opened for ideas

Several approaches looking at agenda setting and policy formulation suggest the importance of timing. Hall (1994) suggests legitimacy, feasibility and support all play a part in agenda setting. This research showed that UC was perceived as a legitimate policy for government to consider, and that it was congruent with the Thai Constitution and the Thai Rak Thai Party. Researchers had offered evidence to suggest UC was feasible and there was lots of support from civil society. Kingdon's three stream model is also useful in explaining what happen in Thailand. The problem stream deepened the perception of difficulties for the public in health care access, especially severe after the economic crisis. The policy stream had developed alternative solutions which had been studied by researchers over years, and several financial protection programmes had been scaled up. The political stream pushed for political change and opened the opportunity for UC to reach the political agenda. If the Thai Rak Thai Party had not picked the UC issue in its electoral campaign, UC policy might not have become a government priority. Importantly, it was a 'hidden' policy entrepreneur, who was also a high-level MoPH civil servant and had built his knowledge as a researcher, who advocated UC policy, and tried to sell it to many political parties, but only the Thai Rak Thai Party adopted it. This policy entrepreneur convinced the Party of the feasibility of the policy, of its ideological benefits, pursuing equity and efficiency, and challenged the Party to take it up. As the policy distributed benefits to all social classes, the Party recognized it would gain wide public support. Experience from other countries also suggests that political transition can provide opportunities for reforms (Cheng 2003; Gilson et al. 2003; Reich 1995).

Time of crisis: economic crisis activated demands for government change

Thailand is an emerging democratic polity. The 2001 election reflected the strong demand of people for change because people were suffering from the recession. The Thai Rak Thai Party won the election because of its many popular policies tackling the economic crisis. From media analysis undertaken as part of this study (Chapter 3), many opinion polls confirmed the popularity of poverty remedying programmes such as the suspension of debt for farmers, the village revolving fund, and the 30 Baht health programme. The impact of the crisis was both positive and negative because it created policy debate (Horowitz 1989 in Reich 1995). On the one hand, the economic crisis activated people's demand for a change in government and health reformists saw the situation as an opportunity to strengthen hospital efficiency among other things. On the other hand, medical professionals saw this change instigating resource constraints to the health services.

Timing: political change created a demand for rapid implementation

The UC policy was implemented rapidly in the first year, when the general public mood was optimistic and when coalitions were strong and supportive of good policy. The government had a reasonable majority in parliament. But the Prime Minister wanted to demonstrate results, and so did not delay pushing the Party's intended policy onto the government agenda, to demonstrate that the party would accomplish what it intended to do and so gain support. The implementation of the UC policy was seen as politically symbolic, similar to other health policies in many countries, for example in South Africa (Gilson et al. 2003). However, rapid implementation had its weaknesses. Experience from many countries indicated negative unanticipated impacts from too rapid implementation. For example, the implementation of the resource re-allocation formula and of free health care for mother and child under 6 years in South Africa, and the implementation of the resource allocation formula in Zambia, were not preceded by relevant preparation; therefore, many administrative problems occurred (Gilson et al. 2003). The rapid implementation of national health insurance in Taiwan led to chaos and confusion (Cheng 2003). This study shows that this also occurred to some extent in Thailand. One economist described UC implementation as 'do and correct' without a proper plan (Siamwalla 2002). In fact, interviews and document review suggests that the plan was seriously discussed among high-level civil servants within the MoPH, and it was this discussion that convinced the Permanent Secretary of the MoPH to support and indeed implement the policy, ahead of the expectations of the Health Minister. To avoid unwanted effects, the MoPH tried to anticipate problems, and introduced many strategies to ease obstacles such as phasing the implementation, increasing participation, and prompt feedback. It was for this reason that the 'War Room' was established. Rapid implementation had its merits because it mobilised public support before resistance built up. Other countries, for example, the Bangladesh national drug policy introduced in 1982 (Reich 1995), also went for rapid execution to avoid contestation.

8.3.2 Structural factors

Structural factors played a part in policy formulation and facilitated implementation. The political context, especially the relationship between the state and society, explains the success of reform policy in many studies (Walt and Gilson, 1994). In Thailand, Ford et al (2004) suggest that civil society groups are strong and have an important role in establishing human rights to health by challenging the practices of the multinational pharmaceutical industry (Ford et al. 2004). This thesis also found an increasing role of civil society in establishing human rights to health. This was a result of the political transition after 1992. The study suggests that UC policy was introduced into a relatively open political context, in which state–society relationships were shifting towards greater

democracy and participation. Health policies became a “high politics issue” with direct public support and pressure on the UC policy (Chapter 3).

The study found that the rapid implementation of the UC policy was supported by the previous investment in health care and the capacity of the MoPH bureaucrats, including strong researchers who were capable of providing evidence and analysis to support decision-making. However, the inequitable previous investments in terms of health facilities and human resources allocation were constraints to the establishment of the per-capita allocations, resulting in hospital deficits in some provinces.

8.3.3 Cultural and environmental factors

Cultural factors not only shaped ideologies, but also influenced the rapid action and conflict management in implementation. The political commitment hastened the UC policy introduction and bureaucrats within the hierarchy also responded promptly, not only because the policy was a political directive but also because they perceived the positive notions of UC. Most conflicts could be easily solved through compromise and opposition was not explicitly against the policy itself. However, bureaucrats used delaying tactics to impede the policy while waiting for a change of government and therefore policy. The ‘culture clash’ between groups of MoPH medical doctors was reflected by the conflict between reform supporters and reform resisters.

This study indicated that environmental factors – external pressures – did not directly influence the UC policy.

Leichter’s framework of contextual factors is useful to explain the UC policy and to help understand how contextual factors influenced it. While situational factors activated policy change, structural and cultural factors both facilitated and limited the policy formulation and the implementation.

8.4 Actors: positions and capacities to influence the policy

This study explored the UC at three levels: macro level – the relationship of the actors within political systems; meso level – the relationship between different actors through the lens of policy networks; and micro level – the positions, perceptions, and capacity of individuals in influencing the policy.

The study suggests that decision-making in Thailand was dominated by the state. However, the decision-making was not limited to policy elites; it was more open and participative (as described in section 8.3.2). Looking at the actors through the lens of policy networks, this study showed that

there were several policy networks supporting UC. However, these networks were dynamic and changed at different stages of the policy process (Table 8.1 summarizes dominant actors in the policy process). One network was the policy community – with close relationships – made up of bureaucrats, researchers, academics, and politicians, who all supported UC at the beginning. This policy community continued taking part in policy formulation and some of them were involved in policy implementation. Within this policy community was a core group of researchers, some of whom were of very high status, had significant power and position, formed part of an elite and could influence decisions. The relationships of policy-makers and research communities were dynamic; consensus building sometimes occurred but was inconsistent.

Table 8.1 Dominant actors in policy networks in different stages of policy processes: UC policy, Thailand

Policy processes	Actors involved in policy network	Dominant actors
Agenda setting process	PM (political party leader) and his staff, researchers, NGOs	PM and his staff
Formulation of policy design before election	Political party, politicians, reformists, researchers	Political party and reformists
Formulation of policy design after the issue adopted and during implementation	Researchers, MOPH top civil servants, elected officials	MOPH top civil servants and researchers
Law enactment	Legislature authorities: members of House of Representatives from government's political parties and oppositions, Senators, and Health Commissions; Other interest groups; MOPH bureaucrats, other government departments, NGOs, and medical professionals	Government's politicians and Health commissions
Implementation	Minister of the MoPH, Health Minister, Deputy Minister of Health, top level MOPH bureaucrats, departments in MOPH, provincial and district health authorities, health providers from both public and private sectors	MOPH top civil servants, MOPH bureaucrats at central, provincial and district level and MoPH providers

An early visible catalyst was the new Prime Minister, who was a powerful agenda setter. The PM pronounced that the UC policy was one of the important policies (part of the campaign promise) of the new government, both before and after he won the election. The hidden allies of the TRT Party were the researchers (reformists) and academics who supported the idea of UC. The researchers not only proposed alternative options for solving problems but also played an active part in getting attention for problems, keeping closely in touch with NGOs as well as with politicians. In this event, a politician who is a medical doctor played an important role in linking the researchers and the PM.

Medical professionals, including medical associations and executives in the MoPH, were still in dominant, exclusive, monopolistic positions within the health sector, with considerable control over the training and regulation of their own members and with the ability to subordinate other health professionals to their influence. Some of them opposed some articles of the National Health Security Act, as the law moved the central position of medical professions to a more marginalized position by appointing a commission, composed of consumers, bureaucrats and medical professionals, to regulate health care providers under the contract model. However, in spite of the substantial power of medical professionals, they did not resist UC implementation in 2001, but later tried to influence the law enactment in 2002 through lobbying senators and negotiating with the Health Minister to change the articles that would affect their profession – for example, the issues related to the liability for malpractice.

Bureaucrats in the MoPH included managers and service providers, and could be divided into reform supporters and reform resisters. The core reformers had had experience of community hospitals and many had trained abroad. Their concepts and perceptions were influenced by globalising reform trends. Other reform supporters were the rural doctors in hospitals and many in the provinces, as they gained from the resource reallocation under capitation. The reform resisters were doctors from some general hospitals and regional hospitals, some of whom lost benefits from the resource reallocation. However, most MoPH bureaucrats followed the commands of the Health Minister and the Permanent Secretary of the MoPH. Although some medical doctors and hospital directors resisted the reform, there was little impact on consumers because they disagreed on the way the program was executed, but not on the services provided to the people. Some health administrators, who were used to enjoying hospital income from well-off patients, opposed the inclusion of the well-off because the hospitals would lose this income.

Many academics and researchers agreed with the reform in terms of its general trend, although some expressed concerns about timing because the ‘Health System Reform Bill’, which would set financing priorities, was not finalised. Others were concerned about the tax-finance which would impose a burden on public expenditure.

Consumers also supported the policy, as it extended health protection. The NGOs who pursued consumers’ rights supported the policy, as they hoped the health care system would become more equitable. The private sector, including private hospitals, private clinics and private practitioners, pharmaceutical industries, private insurance companies, might have been expected to be negative about UC policy as it did not promote full competition and capitation sent strong signals for rational use of resources. However, many small private hospitals welcomed the policy, because it helped

them survive during the economic recession. Most of the established larger private hospitals perceived that UC members were not their clients and still believed that UC would not affect their business. Some proposed regulations would control private practitioners, and these were contested, as in other countries such as Korea (Kwon 2003). In the end, the Health Minister negotiated for a compromise, so there was no strong private sector reaction to the UC reforms.

The media played more of an information role to inform the public, evaluate government performance, and reflect the mood of the public. For example, in 1999, the problems of access to health care studied by a group of researchers, including members of NGOs (Ong-somwang, Rojanapaiwong, and Tantawee 1999), were disseminated by the mass media, giving the issue a high degree of visibility. Severe cases were occasionally reported in newspapers. In the UC policy, the media were a source of information on the problems of the system and reflected people's values. The media coverage of citizens' polls and problem cases made the Health Minister look closely at the quality of services. This suggests that the media basically mirrored the views and values of the state and the major interests in it (Herman and Chomsky 1988 in Walt 1994).

In sum, different groups had reservations about different aspects of UC, but overall the vast majority were sympathetic to reform.

8.5 Policy as process

This study analysed and described how UC got onto the political agenda (Chapter 3), how UC policy was formulated (Chapter 4), and how UC policy was implemented (Chapters 5–7). It showed that there was no clear boundary at each stage of policy process. Agenda setting overlapped with policy formulation and policy formulation largely overlapped with implementation. These processes were iterative and shaped by actors who were influenced by their contextual environment.

The agenda-setting process of UC policy was well explained by Kingdon's three-stream model (Chapter 3 and section 8.3.1 in this chapter). Decision-making was the result of interactions of several actors, although dominated by policy elites. Walt (1994) suggests that where reforms are high politics, policies may well be formulated and imposed by narrow elites or a ruling class. This study confirmed that the high politics part of the UC policy – the economic changes, for example the financing sources and payment methods of the health scheme – was imposed by a small group of elites. However, other parts of UC policy fell into the 'low politics' category; for example, the resource allocation formula, provider payment methods, primary health care services and the timing of private providers entering the UC scheme. These aspects of the policy were influenced by many

groups, and the MoPH allowed flexibility in local decisions. Interest groups influenced the policy from outside; however, the changes in the political system permitted them to become part of the institutional process of government decision-making. For example, many medical doctors from both public and private sectors became senators, as did NGO representatives. The Health Security Act was influenced by NGOs and medical professional representations on consumer protection and provider regulation committees.

In spite of considerable interaction between groups at various levels of the policy process, this study suggests UC policy was largely top-down, although implementers had a level of discretion. The government generated the UC policy, formulated its details at central level, and implemented it countrywide. As not all details could be identified before the implementation, the MoPH executed the do-and-correct approach, in spite of criticisms for having no ‘proper’ plan. In fact, the ‘do and correct’ strategy was deliberate, leaving considerable flexibility for provincial authorities, at least for the ‘low politics’ issues. On the other hand, it would be said that the MoPH left some difficult issues to the provinces, rather than taking responsibility for them. For example, provinces had to choose between inclusive and exclusive capitation payment methods, which created some conflicts in the provinces.

Policy styles varied at different stages of the policy process, policy elites, e.g. the Prime Minister, the Health Minister and the Permanent Secretary of the MoPH, had a dominant role in decision-making, but were not able to impose their decisions all the time. For example, the policy makers decided on the timing to start the program but consultations on how to implement followed. The source of finance was decided by the top policy politicians; however, considerable consultation with the research community was allowed in decisions on budget amounts and payment methods.

8.6 Important factors for reform implementation

8.6.1 Policy characteristics

Policy implementation is not always perfect and whether it can be implemented with ease or with difficulty depends on its characteristics (Cleaves 1980). This study suggests UC implementation was not easy (see Table 8.2).

For example, the budget allocation formula was highly complex, the research and evidence was mixed, so policy choice was uncertain. There was insufficient time for analysts to provide viable alternatives. So, the formula was not completed and was unused. The flat rate capitation

introduced in the first year was also not widely accepted, and consequently, the budget allocation in the fiscal year 2003 returned to separating salary budget from the per capita budget.

Table 8.2 UC policy characteristics

Characteristics which make implementation easier (Cleaves 1980)	UC policy (2001)
Simple technical features	High technical features
Marginal change	Radical change
Implemented by one actor	Implementation by one actor at the beginning
Clearly policy goals	Clearly policy goals
One major objective	Many objectives
Short duration	Short duration

The rapid and radical nature of the change meant there was no time to build consensus among the different interests, and led to many facets of resisters. General hospitals and regional hospitals opposed the reallocation of resources. The MoPH civil servants were reluctant to transfer the purchaser role to a new institution. Medical professionals opposed some articles in the National Health Security Act which increased their liabilities in practice. However, the strong political support and the flexibility in the implementation made change possible. This contrasts to the experience from Greece where interest groups prevented radical change and only incremental change was possible (Tragakes and Polyzos 1998).

Lastly, the UC policy had more than one objective. The two main objectives, extension of health insurance and control of costs, were in conflict, because as more patients had access to health services, then expenditure increased.

Looking at policy characteristics helps to explain difficulties in implementation; however, some constraints were unavoidable, although they could be relieved by implementation strategies.

8.6.2 Strategies in the policy implementation

This study found that at least six strategies were utilized to execute the UC policy (Chapter 5-7):

- ‘Learning by testing’ – to fit the policy to the local context,
- Creating space for bargaining and negotiation,
- Prompt problem solving and inviting participation,
- Maintaining leadership,
- Legitimising a stable policy by law, and
- Introducing a grievance process.

‘Learning by testing’

UC policy focused on insurance coverage and financing reform. Some partial designs had been tested in pilot provinces before the policy was launched. However, the experience of those designs led policy-makers to expect different responses in different situations. Therefore, the MoPH decided to implement the policy in several phases to learn how particular designs fitted the provincial context and to adapt the designs in the next phases. The extension of insurance coverage started in six provinces in April 2001, was extended to 15 provinces in June 2001 and to the rest in October 2001. The exception was Bangkok, where extension was accomplished in April 2002. Similarly, changes in the financing system went through several stages. The advantage of phasing was to allow the program management to execute easier issues before facing more difficult problems, e.g. strengthening the beneficiary registration and information system in phases I and II before changing to the new financing system in phase III. Program managers learnt from experience in the forerunner provinces, for example, the problems of clearing payments between providers and the errors in beneficiary registration.

However, the benefits of learning from the phasing were not maximized because the knowledge from evaluations was not widely disseminated before the MoPH moved to the new phases. In other words, the researchers worked more slowly than the politicians driving the change. For example, the MoPH’s evaluation in 15 provinces, started in June 2001, suggested (in August 2001) that there were no clear guidelines on how provinces could use financial incentives to promote activities in disease prevention, although these should be available before the nationwide implementation (The evaluation committee of the UC implementation in the transition period in fifteen provinces 2001). But there were no such guidelines in 2001-2003. Other evaluations by researchers outside MoPH took longer and were released in 2002 (Jariyalertsak 2002; Na Ranong and Na Ranong 2002a; Pannarunothai et al. 2002).

Creating a space for bargaining

Changes in some aspects of health care were emphasised but only partially implemented in the first year. These desired changes were equitable resource allocation, primary care units as gatekeepers, empowering patients’ rights, the single administrative insurance system, and the purchaser-provider split. The policy details from the formulation process indicated mainly the desired outcomes and desired system in the transition, but less the means to achieve these desired outcomes. This allowed flexibility, and striking a balance in bargaining with all stakeholders.

To pursue equitable resource allocation is extremely complicated and has both political and technical difficulties. The management of the health care finance for the insurance benefit package was not sufficient to mobilise human resources and health assets. Therefore, reform which strengthened just the role of the purchaser and left the MoPH management behind delayed achievement of the equity goal. In practice, the MoPH suffered from the radical shift of resource allocation, so it tried to protect its hospitals from purchasers' rules. This calls for a long-term collaboration between the MoPH and the NHSO, i.e. the providers and the purchasers, not only for balancing power but also for a good cooperation in mobilising resources, both money and clinical staff. It is likely that MoPH bureaucrats will attempt to influence the Board of the National Health Security Office to protect budgets of MoPH providers and compromise between the per capita allocations and the historically based allocations.

Similarly, primary care development needed greater technical preparation. The MoPH at central level formulated guidelines and a set of standards for primary care services with progressive targets over five years. However, the guidelines did not show clearly how the MoPH could achieve this goal, and so the MoPH transferred the responsibility for the management of primary care to provinces. As a result, there were several trial models in provinces, varying from the extended outpatient care unit to the holistic care approach, depending on the staff availability and the understanding of the concept of primary care. However, there was little support from the MoPH to mobilise physicians to support primary care both between and inside provinces. The central level let the internal forces push and pull resources within each province. In the province in this study, specialists from regional hospitals were forced to provide services at primary care units, an approach which is unlikely to be sustainable.

The attempt to empower patients was opposed by physicians. This issue was seriously debated in the parliament in the debate on the National Health Security Bill. Finally, both lower and upper houses passed the Bill with the approval of the two articles indicating the liability of malpractice²⁹. The medical professionals subsequently pressured the Minister of Public Health to promise to alter the law when possible. This issue involved politics more than technical issues. In this case, the Minister may need to clearly state the desired outcome and seek support from interest groups.

²⁹ Section 4 article 41 of the National Health Security Act indicates that a victim of iatrogenic error or malpractice will receive initial compensation money from the National Health Security Office. Article 42 indicates that if the case in article 41 is a malpractice, the National Health Security Office has a right to claim a liability from the health provider who is responsible for the case.

The intention to merge health insurance funds was postponed until the trade unions and the civil servant commission agree to join it. However, the Act allowed the National Health Security Board to re-visit the situation and hold consultations once a year. It is likely that civil servants and private employees will never join. It may take another crisis to force this change.

The purchaser-provider split was also postponed, although the law was passed in 2002. The Permanent Secretary of the MoPH successfully negotiated for a three-year time lag to allow the Permanent Secretary to continue to be in charge of the budget allocation for MoPH providers. This released pressure from MoPH civil servants. From 2006, the National Health Security Office (NHSO) will be responsible for the purchaser role and will reallocate resources. That should be enough time for the NHSO to have a proper incremental plan to encourage cooperation with MoPH bureaucrats by increasing consultation and participation.

Prompt problem solving and inviting participation

Unexpected problems occurred and needed to be resolved. The MoPH appointed the Operational Committee known as ‘the War Room Committee’ to respond to problems promptly. This committee held meetings every week at the beginning, and later, twice a month, over the period between September 2000 and August 2001, to respond quickly to questions from implementers, and adjusted rules as problems arose. There were several advantages to this strategy. Firstly, if any problem could not be solved easily, it was at least recognized and transferred to other sub-committees to think about it. Secondly, the committee was open to many, and widened participation. Representatives from all public health providers were invited to be members, and they participated actively. They complained, fed information back, suggested solutions, and negotiated for particular solutions. However, the committee had limited information and was pressured to decide quickly. Therefore, its decisions were sometime influenced more by the power of interest groups than evidence from researchers. For example, the committee approved a proposal from a university hospital to include specialized care in the UC high-cost benefit package without a technical consultation. The weak point of these urgent decisions was that it led provinces to perceive that the policy was changeable and uncertain.

Maintain leadership of the effort

To exercise and maintain Ministry of Health leadership of the reform effort would be expected to be essential for successful implementation (Leighton and Wouters, 1995). Thailand has so far sustained the impetus to reform the health care system, though there have been some changes in leadership. Four groups of leaders were important; the first was the government and political party;

the second was political leadership in the Health Ministry; the third was the MoPH civil servants and the fourth was the technical experts. Fortunately, the government was stable. Its first term was four years and it looked as if it would retain sufficient popularity for the next election, with Thaksin Shinawatra as Prime Minister. The Health Minister, Sudarat Gayuraphan, has been in the position from the beginning (2001-2003), while the deputy minister, Suraphong Seubwonglee, a medical doctor, was replaced in October 2002 by a TRTP member who was a police general. However, while the politicians maintained their leadership, the bureaucrats changed every year. Most of the MoPH Permanent Secretaries (PS) came to the position in their last working years, as this position is perceived as the highest honour for civil servant careers and the Thai culture values seniority. However, changing PS, meant changing the priorities and focus of the health care reform. For example, the 2000/2001 PS focused on insurance coverage and budget reallocation. The 2001/2002 PS devalued the financial reform and concentrated on health promotion and ethics. The 2002/2003 PS turned the method of the budget reallocation back to the supply side adjustment. These changes discouraged reform efforts; however, they decreased stress among bureaucrats by recovering their salary security. However, the Minister of Health maintained a technical expert, who pursued the UC and the reform ideas, at a high level position – the Deputy Permanent Secretary from October 2001 to 2003, who was appointed as the Secretary General of the National Health Security Office in 2003. Therefore, the reform direction was kept under political control.

Toward a stable policy: legitimising organisation development by law

The implementation of the 30 Baht Program in 2001-2003 was under the regulation of the Ministry of Public Health and was in transition. Organisational and structural change was needed, and had to be legislated through law. The legislation of the 2002 National Health Security Act shows clearly the political support, the reform direction, and the foreseen organisation that will be active as health purchaser in the three coming years. This may facilitate the process of long-term planning, technocratic problem solving and management of change (Tragakes and Polyzos 1998).

Grievance process

UC policy established a hot-line telephone number to receive grievances and answer questions from consumers and operational officers. This two-way communication increased understanding about the program, ratcheted down people's expectations, and provided information to improve weaknesses at service points. However, it increased the anxieties of the provincial managers as the problems from their provinces might be reported. The MoPH ordered provinces to keep conflicts with patients to a minimum. All hospitals set up grievance reception counters and tried to adjudicate all arguments within the hospital. According to interviewees, most solutions involved

breaking some rules to satisfy patients. For example, the hospital payment system aimed to strengthen patient referral rules. Patients who registered at a community hospital needed a referral card from the registered hospital before going to a general hospital; otherwise they had to pay for the services. In several cases reported to the researchers, patients argued that they should pay nothing and threatened to report cases to the minister. Finally, the hospital gave the services without charge but at the expense of the hospital.

Summary

The UC policy has several characteristics which make its implementation complex. These characteristics involve highly technical features with professional involvement, and service orientation with customer involvement. Several strategies were implemented to ease both the technical and political difficulties, but there was sometimes trade-off between efficiency and political pressure, as in the examples above, and sometimes the MoPH avoided conflict by making the provinces take difficult decisions.

8.6.3 Staff capacity and ability to shape the outcomes

This research suggests that the initial capacity to implement the UC policy was based on existing resources and infrastructure. Towse et al (2004) also support the findings from this thesis (Towse, Mills, and Tangcharoensathien 2004). This thesis found that three important aspects of the Thai health system facilitated the rapid implementation to achieve universal coverage within a short period. Firstly, the grooming of public health researchers within the MoPH and institutions over a couple of decades yielded “accumulative expertise” in policy analysis in Thailand. Problems were identified, the public was informed, and alternative solutions were sought, though final consensus was not always made. The strength of the researchers within the MoPH was that they proposed pragmatic solutions rather than simply being committed to ideal designs (Chapter 4).

Secondly, the development of the public infrastructure and insurance coverage guaranteed policy feasibility, leading the system to adopt challenges. The strength of public investment is its sustainability, while private investment is much more unstable, and affected by economic change. The public infrastructure, therefore, was a fundamental enabling feature to reform of the Thai health system (Chapter 1). Thirdly, while the MoPH is hierarchical, the provincial health offices and district health offices nevertheless had considerable autonomy over micro-level decisions. Moreover, hospitals and health centres had authority to manage their revenue. This was an incentive for them to register population, improve their performance, satisfy patients, and solve their local problems (Chapter 7).

The MoPH responded to UC policy by developing its staff capacity in three ways. The first was by changing the organisational structure; i.e. the Health Insurance Office was empowered by separation from the MoPH and transformed into an autonomous body, the National Health Security Board, from November 2002. The new Health Security Office has the power to employ staff, buy high technology equipment, and to contract out services. The second way was to create closer linkages between hospitals and health centres, anticipating greater technical support from hospitals to health centres. The third way was by training and exchanging experiences. There were many training courses in 2001-2002, with provinces learning from other provinces, and providers from other providers. The improvement of staff capacity eased implementation.

However, the Thai system still suffered from inequitable staff distribution and there was no evidence that the government had clear plans to cure this problem, constraining one of the UC goals – a more equitable system.

Data in the study province suggest that many factors influenced the successful implementation, the main factors being leadership by the Provincial Chief Medical Officers, the capacity of the officers at the Provincial Health Offices, the relationship among providers within the provinces, and the operational officers' responsiveness at the service points.

8.7 Conclusion

By meeting the aims set out in Chapter 1, this thesis has added to general understanding of policy analysis in developing countries and increases knowledge of health services and financing reform policy in the setting of a developing country. The review in Chapter 1 of the contextual environment of the international health care reform, and specifically the issue of universal coverage, provides understanding of the notion of ideology in the international arena, and how such ideology may influence others. The review in Chapter 2 of the conceptual literature on policy analysis identifies actors, context, and policy processes, e.g. agenda setting, formulation and implementation, as key elements in a deliberately simplified framework. Using this framework, the results in Chapters 3–7 provide thick description of the policy process in relation to UC policy in Thailand.

The main contribution this thesis made was to focus not only on content, context, actors, and process, but to look carefully at the design of the policy and to show how design affected policy implementation. The process was affected because the design of UC policy was technically complicated. This thesis also showed that process was fluid, changeable, and adaptive.

The overall conclusion of this major policy change in Thailand is that within a democratizing context, health policy became a 'high politics' issue, with strong political commitment supporting

implementation. The extent of research and analysis, and the well-developed infrastructure of the health system, facilitated the ease of the implementation, but these were effective only when there was strong leadership. However, there are a lot of areas which need to be considered if the policy is to survive. Major missing strategies requiring government attention include planning for human resource development and distribution, especially providing adequate staff for primary care; design of the role of the tertiary hospitals in supporting primary care; strategic plans to decentralise purchaser functions to provinces; planning for a greater patient choice; expanding the sources of finance beyond general taxation; understanding of the politics in the National Health Security Board; and understanding of the governance and accountability of the National Health Security Office.

Other findings from this case study are useful for research communities and policy-makers. For research communities, recognizing the window of opportunity to advocate a particular policy solution is crucial. But in order to take advantage of coming or rare opportunities, the research solutions and evidence need to be available to get policy-makers' attention – this requires an institutional umbrella for researchers in health systems and policy to work on a full-time basis to ensure relevance and continuity. Secondly, values, position, and the impact of the policy on particular actors is important. Public health advocates up to senior levels of bureaucracy were able to take the political initiative and push UC into action. Other senior levels of bureaucracy were active in translating policy into effective action. This means that an issue could have stronger support when research communities allied with top level bureaucrats or highly placed policy elites. The policy was also supported by the general public. This suggests that coalitions between research communities and NGOs are also important. Thirdly, a body of work, which had built up over a decade by several independent research institutions, supported by government, provided considerable authority in problem identifying and resolution. There was also a lively discourse among researchers over what solutions were best. Many contributed in providing evidence for policy decisions and formulation, some contributed in evaluating the processes and outcomes for tuning the reform. However, these groups were small. Building research capacity and linkages still needs considerable support from the Government.

For policy makers, this study showed that it is extremely difficult to implement policies even when the will and leadership is there. For one thing, getting the technical aspects right is problematic, and may be contested. A great deal of negotiation has to go on, and even where a 'big bang' approach is taken, change may be quite incremental. Also the study suggests it is not possible to implement everything at once – even where the infrastructure and capacity is good – because of lack of time, energy and resources. The success of implementation was partly due to the technical and political

feasibility but it required participation from implementers to constantly adjust aspects of the policy. The level of discretion and authority given to provincial and operational implementers encouraged a highly adaptable system, and left implementers to solve unpredictable problems. Incentives and motivations were important to encourage the willingness of implementers and were able to shape operational behaviour in service provision. The impact on the income security and positions of bureaucrats, which was a point of resistance, was managed through strategic and careful negotiation, and helped to sustain the policy. An important lesson is that actors influenced the policy according to the impact of the policy on them; hence, through being able to evaluate their positions and to negotiate and bargain, they were able to compromise and sustain the policy.

UC policy has attracted a great deal of interest worldwide – not only in Thailand. There is a growing analysis of different aspects of the UC policy. For example, Pannarunothai et al (2002) focus on the equity impact of UC; Na Ranong and Na Ranong (2002) focus on implementation at the initial stage; Srithamrongsawat, Prakongsai, and Pokpermdee are focusing on specific technical issues; and Tantives is focusing on the policy process of a specific benefit, anti-retro viral drugs. This study reviewed the whole policy process, from the very first thoughts about UC, and the implementation in one province. It explored the inter-relationship between actors, process and context, and showed how the design of the policy affected implementation. No other study has yet provided such a comprehensive policy analysis. Nevertheless, much yet needs to be done. There are a number of areas that still need research, including policy analysis to understand reform implementation such as: what kinds of effective incentives and motivations are used in change execution; planning for human resource development and distribution, especially providing adequate staff for primary care; design of the role of the tertiary hospitals in supporting primary care; expanding the sources of finance beyond general taxation; strategic plans to decentralise purchaser functions to provinces; how decentralisation improves the performance; and exploring deeply the decisions and implementation at provincial level, which should be strengthened shortly.

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Appendix 1

Appendix 1 Questions for interviews

Appendix 1.1: Questions and data collection methods: agenda setting and policy formulation

	Objectives	Research questions according to hypothesis/assumptions	Approach or methods
Obj.1	<p>1. Content</p> <ul style="list-style-type: none"> objectives of UC policy institutional arrangement and resource allocation health system support function benefit packages 	<ul style="list-style-type: none"> What are the policy goals? Was it stated clearly? What are the elements of the health system that the UC policy aims to change? What are the actual changes in terms of the institutional arrangements, resource allocation mechanism, health system support functions, and the benefit package? Did the MoPH change any regulation and standard setting to support UC? What? Are they different from the general rules? How? Was the Essential Drug List changed? How? How were providers eligible to join the scheme? Did the MoPH strengthen licensing and accreditation of providers? How? 	<p>1. Document analysis</p> <ul style="list-style-type: none"> MoPH documents <p>2. Key informant interview</p> <ul style="list-style-type: none"> Central level Provincial level
Obj.2	<p>2. Context</p> <ul style="list-style-type: none"> situational factors: transient conditions structural factors: the relatively unchanging elements of the society and polity cultural factors: the value commitments of groups within communities or the society environmental factors: factors outside the boundaries of a political system 	<ul style="list-style-type: none"> Did the change of political regime in 2001 affect UC policy? How? How far did the economic recession influence UC in the agenda setting, the policy formulation and the implementation? How far did other reforms such as the Devolution Act influence the UC implementation? Did health care needs of people influence UC at the agenda setting process? How? Did the uninsured need health insurance? Were their demands taken into account at the agenda setting, the policy formulation process and the implementation? Did international institutions influence the UC policy? 	<p>1. Key informant interview</p> <ul style="list-style-type: none"> Agenda setters Alternative formulation participants Central level implementers provincial level implementers <p>2. Document analysis</p>
Obj.3	<p>3. Influence and roles of actors</p>	<ul style="list-style-type: none"> Who were the visible and hidden actors and what were their roles, interests, power? Who were involved in the UC proposal in the political party's campaign? What were their roles and influence? What was the negotiation style between reformer and politician? Who are likely losers and winners from the policy? What are their interests? What are the positions of interest groups – SSO, Ministry of Finance, Ministry of Commerce, Bureau of Budget, provincial health offices, provincial hospitals, community hospitals, media? What was the policy style of UC in Thailand? Planning or problem solving? Consultation or imposed? How many consultations were there during January 2001 to September 2001? Who were consulted? 	<p>1. Key informant interview</p> <p>2. Meetings (observations)</p> <p>3. Media analysis</p> <p>4. Document analysis: MoPH documents</p>

	Objectives	Research questions according to hypothesis/assumptions	Approach or methods
		<ul style="list-style-type: none"> • Did others try to influence the process? • What was the role of private sector actors, NGOs and civil society in the UC policy? 	
Obj.4	4. Agenda setting and policy formulation	<ul style="list-style-type: none"> • How did universal coverage policy get onto the policy agenda? • How was the policy formulated? • What was the policy style of UC? • How far was decision-making in the hands of policy elites? How many times were consultations made during January 2001 to September 2001? When? • Planning or problem solving? Consultation or imposed? • What were the negotiation styles amongst the policy elites? • How much evidence was used for decision-making? Was it consensual? • Was there any consultation with providers? Was there any negotiation between providers? How was it undertaken? 	See 4.1-4.3
	4.1 Problem stream: indicators	<ul style="list-style-type: none"> • Was there any measurement of health problems regarding UC policy in the system? • Is the information available in annual reports? • Who conducted the measurement of indicators? • How did the mechanisms serve to bring problems to the attention of policy makers? 	<ol style="list-style-type: none"> 1. Key informant interview 2. Document analysis
	Events <ul style="list-style-type: none"> • election • economic crisis 	<ul style="list-style-type: none"> • Did the election serve to focus attention on problems; induce public interest? • Did the economic crisis affect the policy? • Was there any event which served to focus attention on problems? 	<ol style="list-style-type: none"> 1. Media analysis
	Feedback	<ul style="list-style-type: none"> • Was there any mechanism in the system to feedback the failure of the government performance such of the Health Welfare Scheme? 	<ol style="list-style-type: none"> 1. Key informant interview 2. Document analysis
	4.2 Policy stream: technical feasibility	<ul style="list-style-type: none"> • What changes in budget have resulted from UC policy? • Is the government budget enough to implement this policy? Where did the incremental budget come from? How did the Bureau of Budget prepare money for UC? • Do the health officers have new tasks (such as registration, contracting, incentive and penalty procedures to regulate providers, quality assurance process)? What? • Have they trained for the new tasks? Are they capable of implementing them? Do they feel they are difficult? • Are there enough health providers to support UC? 	<ol style="list-style-type: none"> 1. Document analysis 2. Key informant interview <ul style="list-style-type: none"> • Technocrats • Implementers at central level • Implementers at provincial level
	<ul style="list-style-type: none"> • congruence with existing values 	<ul style="list-style-type: none"> • Do people think this policy is a right direction of reform? Why? 	<ol style="list-style-type: none"> 1. Interview representative actors from all groups

	Objectives	Research questions according to hypothesis/assumptions	Approach or methods
	<ul style="list-style-type: none"> • anticipation of future constraints 	<ul style="list-style-type: none"> • Will this policy cause health care cost escalation? • What constraints might occur in the future? • Will there be new technologies that cause difficulties? 	1. Key informant interview
	<ul style="list-style-type: none"> • public acceptability and politicians' receptivity 	<ul style="list-style-type: none"> • Do the public support this policy? • Do politicians support this policy? How? • Which factors made UC acceptable to the political party? • Technical feasibility? • Legitimacy? • Reformer commitment? • Empirical research on problems and solutions? • Economic crisis? Public interest? 	1. Media analysis
	4.3 Political stream <ul style="list-style-type: none"> • National mood: public opinion, climate of opinion, • Organised political forces: parties, legislative politics, pressure groups 	<ul style="list-style-type: none"> • What was public opinion on this policy? • What factors made UC acceptable to the public? • Family financial constraints? • Legitimacy? • Health care needs? • Health insurance needs? • Problem evidence in media? • What were the interest groups' opinions on this policy? • What were the roles of civil society organizations? • What were the roles of private sector actors? 	1. Media analysis 2. Interview representative actors from all groups
	<ul style="list-style-type: none"> • Government: election results • Consensus building: bargaining, bandwagons and tipping 	<ul style="list-style-type: none"> • What were the negotiation styles amongst policy elites, and between reformers and politicians? Was there any negotiation between providers? • How was it undertaken? • Was it consensual? 	1. Key informant interview

Appendix 1.2: Implementation process

Obj.5	Policy characteristics	Research questions according to hypothesis/assumptions	Approach or methods
	1. Complex / simple technical features	<ul style="list-style-type: none"> • How easy is the new health registration system? Primary cares gatekeepers and referral system? Administration of the Area Health Boards and fund holders? • What were the problems in relation to the registration procedure, primary care gatekeeper set up, referral system strengthening, fund holders' roles and AHBs' roles? • Were these activities complex to implement? How did they solve the problems with these issues? 	1. Key informant interview at central level, and provincial level
	2. Big / marginal change	<ul style="list-style-type: none"> • Did the MoPH see UC as a major or incremental change? • How did the implementers at each level perceive the size of changes? • Did the public see UC as a major or incremental change? • What changes affected them, in which aspect? 	<ol style="list-style-type: none"> 1. Key informant interview 2. Media analysis
	3. Extensive / limit participation (implemented by one actor)	<ul style="list-style-type: none"> • Who is involved in the implementation process? • Is there extensive participation? • Is implementation by the MoPH only? 	1. Key informant interview
	4. Conflicting / clearly policy goals	<ul style="list-style-type: none"> • Is there a clearly stated policy goal by the Minister? • What did the implementers at peripheral level perceive as the policy goals? • Was UC clearly stated? 	1. Key informant interview at central level, and provincial level
	5. Many / one major objective	<ul style="list-style-type: none"> • What did the implementers at peripheral level perceive in terms of objective of UC? • What are the objectives of this policy? • Did it have one major direction? • What were the articulated objectives include cost containment, equity in resource allocation, promoting primary care gatekeeper, strengthening referral system etc. 	1. Key informant interview at central level, and provincial level
	6. Long / short duration	<ul style="list-style-type: none"> • Was the policy planned to be introduced in a short time? • Did implementation take place quickly? Why? • Was there any resistance? 	1. Key informant interview
	7. Legitimacy enhancing the compliance of both implementers and targets	<ul style="list-style-type: none"> • Did the implementers perceive this policy to be legitimate? 	1. Key informant interview

Obj.5	Policy characteristics	Research questions according to hypothesis/assumptions	Approach or methods
	8. Weak institutional capacity / skilful implementers	<ul style="list-style-type: none"> • What tasks did the Health Insurance Office staff have? Do they have enough skilled personnel? What are the resources they need? • What are the tasks that the Provincial Health Office staff had to do but couldn't do? Do they have enough skilled personnel? What are the resources they need? (For example, number of computers, number of economists, Information Technology people, and analysts) 	<p>1. Interview - the Health Insurance Office staff - PHO staff</p>
	9. Resist / support of interest groups (public and bureaucrats)	<ul style="list-style-type: none"> • Do the public and MoPH support this policy? • What are the positions of interest groups – SSO, Ministry of Finance, Ministry of Commerce, Bureau of Budget, provincial health offices, provincial hospitals, community hospitals, media? 	<ol style="list-style-type: none"> 1. Interviews of other interest groups, eg. SSO, MOF, MOC, BOB, PHO, Provincial hospitals, Community hospitals 2. Newspaper review
	10. Communication and coordination	<ul style="list-style-type: none"> • How did the central level communicate to the peripheral level? Was there any mis-communication? • How did the private providers negotiate with the public providers? • How did the province negotiate with the central MoPH? • How did the implementers request or suggest their demand for support? What did they request? • How did the implementers interpret the system design in relation to primary care gatekeepers, payment system, etc.? 	<ol style="list-style-type: none"> 1. Interview central and provincial level implementers.
	Context		
	1. Political instability	<ul style="list-style-type: none"> • How stable is the political system? • What changes have there been in political party / government / MoPH? 	<ol style="list-style-type: none"> 1. Media analysis
	2. Poor economic conditions	<ul style="list-style-type: none"> • Was economic recession a constraining factor on this policy introduction? How did it affect the policy? 	<ol style="list-style-type: none"> 1. Key informant interview 2. Media analysis
	3. Incomplete health sector development	<ul style="list-style-type: none"> • How much was the health system developed? Were there sufficient health facilities available to support UC? 	<ol style="list-style-type: none"> 1. Document analysis
	4. Other institutional or managerial reform	<ul style="list-style-type: none"> • What are other sector or institutional reforms currently in Thailand? Do these interventions support or obstruct the UC implementation? 	<ol style="list-style-type: none"> 1. Document analysis 2. Key informant interview
	5. Information constraints	<ul style="list-style-type: none"> • How much information is available to support the decision-making? Does the UC system need new information system? Did the MoPH prepare for the new information system? 	<ol style="list-style-type: none"> 1. Document analysis 2. Key informant interview

Obj.5	Policy characteristics	Research questions according to hypothesis/assumptions	Approach or methods
	Strategies		
	1. Build consensus among policy elites	<ul style="list-style-type: none"> • Who participated in the policy formulation? Did they have different views? Was it consensual? • What is the process of decision making - imposed or by consensus? How? 	<ol style="list-style-type: none"> 1. Key informant interview 2. Document analysis - minutes
	2. Exercise and maintain Ministry of Health leadership of the effort	<ul style="list-style-type: none"> • Which Ministry will be in charge the National Health Insurance Office? And what will be the role of the MoPH? • Will the MoPH still continue the leadership role of this effort? 	<ol style="list-style-type: none"> 1. Key informant interview 2. Document analysis - minutes, Act
	3. Strengthen institutional capacity and personnel skills	<ul style="list-style-type: none"> • Did the MoPH train the provincial health personnel to do purchasing functions? Is there any training course for capacity strengthening in relation to UC? 	<ol style="list-style-type: none"> 1. Key informant interview <ul style="list-style-type: none"> • Central level • Provincial level
	4. Adapt and update reforms to economic conditions	<ul style="list-style-type: none"> • What activities have been adjusted due to economic conditions? 	<ol style="list-style-type: none"> 1. Key informant interview <ul style="list-style-type: none"> • Central level, technocrats
	5. Develop health organisational and financing infrastructure	<ul style="list-style-type: none"> • What are MoPH plans about health organization development and financing structure? 	<ol style="list-style-type: none"> 1. Key informant interview <ul style="list-style-type: none"> • Central level, technocrats
	6. Collect, analyse, disseminate data and information	<ul style="list-style-type: none"> • What arrangements did the MoPH make regarding information systems? And what does it plan to do? 	<ol style="list-style-type: none"> 1. Key informant interview <ul style="list-style-type: none"> • Central level, technocrats
	Resources		
	1. Manpower	<ul style="list-style-type: none"> • What was the doctor-population ratio in the study provinces? • How did the provinces manage the number of health registration in relation to the number of doctor? • Did the doctors have difficulties or higher/lower workload? How did they solve these problems? 	<ol style="list-style-type: none"> 1. Document analysis 2. Key informant interview
	2. Infrastructure	<ul style="list-style-type: none"> • What was the bed-population ratio in the study provinces? • Did the providers have difficulties or higher/lower workload? How did they solve these problems? 	<ol style="list-style-type: none"> 1. Document analysis 2. Key informant interview

Appendix 2 Interview schedules

Using research questions in Appendix1, interview schedules were constructed separately for 1) key informants involved in policy making or policy elite - senior officers, researchers and reformers, and 2) implementers at national level and provincial level. Below is an example of the interview schedule for policy elites. Other interview schedules were similar but focused on different aspects.

Appendix 2.1 Interview checklist: Policy elites	Categories coding
1. Name / position of respondent	ID
2. Age (approximate), school / batch / level of education	Characteristics
3. Place / Date of interview / length / no. of meetings	No. of interview
4. What were your roles in the policy process regarding UC? / level of involvement <ul style="list-style-type: none"> • Agenda setting • Policy formulation • Implementation 	Stakeholders' involvement
5. What are the goals / objectives of UC? <ul style="list-style-type: none"> • Were they stated clearly? Where and when? • Do you think that other MOPH staff perceived the same goals / objectives as you? Why? • How did they receive the information of the policy intent? 	Content, policy characteristics: single objective, stated clearly, communication
6. Do people think this policy is the right direction of reform? Why? <ul style="list-style-type: none"> • Public • You • MOPH staff • Other health providers 	Policy characteristics: legitimacy
7. Did people see UC as a major / incremental change? <ul style="list-style-type: none"> • Public • You 	Policy characteristics: size of change

Appendix 2.1 Interview checklist: Policy elites	Categories coding
<ul style="list-style-type: none"> • MOPH staff • Other health providers 	
<p>8. Did implementation take place quickly? Why? Was there any resistance?</p>	<p>Policy characteristics: rapid change</p>
<p>9. How far does UC aim to change the institutional arrangements of public health insurance schemes in the following aspects? What has been changed? How has the new political regime affected UC? Which content was different from the MOPH's previous proposals?</p> <ul style="list-style-type: none"> • Sources of funds • Allocation from sources to allocating institutions • Allocating institutions • Allocation from insurers to providers • Service providers 	<p>Content, context: political regime</p>
<p>10. Did the MOPH change any regulation and standard setting to support UC? What? Are they different from the general rules? How?</p> <ul style="list-style-type: none"> • Was the Essential Drug List changed? How? • Were prescribing and other treatment protocol determined? How were the details of these protocols? • How were providers eligible to join the scheme? Did MOPH strengthen licensing and accreditation of providers? How? • Did MOPH perform technology assessment? How? For what purpose? 	<p>Content</p>
<p>11. What are the benefit packages of the UC scheme?</p> <ul style="list-style-type: none"> • How were they financed? • What were the payment systems? • Which services were not included in the benefit packages? 	<p>Content</p>

Appendix 2.1 Interview checklist: Policy elites	Categories coding
<ul style="list-style-type: none"> • How are service lists different from other schemes? 	
<p>12. Who were involved in UC proposal in the political party's campaign? What were their roles and influence? What was the negotiation style between reformer and politician? (Consultation or bargaining etc.)</p>	<p>Agenda setting: political stream, context: political regime</p>
<p>13. Which factors made UC acceptable to the political party?</p> <ul style="list-style-type: none"> • Technical feasibility? • Legitimacy? • Reformer commitment? • Empirical research on problem and solution? • Economic crisis? Public interest? etc. 	<p>Agenda setting: Policy characteristics, problem stream, political stream, policy stream</p>
<p>14. Was the election involved in policy agenda setting?</p> <ul style="list-style-type: none"> • Did it serve to focus attention on problems; induce public interest? 	<p>Agenda setting: problem stream</p>
<p>15. How did the problem of health care access come to attention?</p> <ul style="list-style-type: none"> • Was there any measurement of health problems regarding UC policy in the system? What? Who conducted the measurement of indicators? • Was the information available in annual reports? Were the problems they stated clearly? Which reports did mention these problems? • How did the mechanisms serve to bring problems to the attention of policy makers? Was there any mechanism of the system to feedback the failure of government performance, such as of the Health Welfare Scheme? • Was there any event that served to focus attention on problems? - economic recession? 	<p>Agenda setting: problem stream,, context</p>
<p>16. What was public opinion on this policy? Did the public support UC? What factors made UC acceptable to the public?</p> <ul style="list-style-type: none"> • Family financial constraints? 	<p>Agenda setting: political stream, context, policy characteristics</p>

Appendix 2.1 Interview checklist: Policy elites	Categories coding
<ul style="list-style-type: none"> • Legitimacy? • Health care needs • Health insurance needs • Problem evidence in media? • etc. 	
<p>17. Who are likely to lose? Who are likely to gain? Did they ask to influence the process, how?</p> <ul style="list-style-type: none"> • What were the roles of civil society organisations, private health providers, private health insurers, university hospitals and other NGOs in the agenda setting process? • Were they involved in other stages - policy formulation, implementation? How? 	<p>Agenda setting: Political stream</p>
<p>18. What are the positions of interest groups - SSO, Ministry of Finance, Ministry of Commerce, Bureau of Budget, provincial health offices, provincial hospitals, community hospitals, media?</p>	<p>Political steam</p>
<p>19. Who were involved in the policy formulation? What were their roles and influence?</p> <ul style="list-style-type: none"> • How far was decision-making in the hands of policy elites? How many times were consultations made during January 2001 to September 2001? When? • Planning or problem solving? Consultation or imposed? • What were the negotiation styles amongst policy elites? • How much evidence was used for decision-making? • Was it consensual? • Was there a time that policy was imposed with non-agreement among policy elites? What was that issue about? 	<p>Policy formulation: policy style, political stream</p>
<p>20. Was the policy formulation process widely consultative and participative?</p>	<p>Policy formulation: political stream</p>

Appendix 2.1 Interview checklist: Policy elites	Categories coding
<ul style="list-style-type: none"> • Who were asked to participate? • How did stakeholders suggest their ideas? • Did others ask to participate in the policy formulation process? Who was not accepted to join? • Was there any consultation with providers? Was there any negotiation between providers? How was it undertaken? 	
<p>21. Did MOPH's senior officers support UC? What factors made UC acceptable or unacceptable to the MOPH's high-level staff?</p> <ul style="list-style-type: none"> • Legitimacy • Technical feasibility • Congruence with existing values • Anticipation of future constraints • Public acceptability 	<p>Policy formulation: political stream, policy stream, policy characteristics</p>
<p>22. Which situations made the policy formulation difficult? Did the decision-making take these issues into account? Were remedy strategies set up?</p> <ul style="list-style-type: none"> • Did economic recession lead to health budget constraints? • What changes in budget have resulted from UC policy? How many health budgets increased from 2000 to 2001 and 2002? • Is the government budget enough to implement this policy? Did the provincial hospitals survive? What were the remedy strategies? • Where did the incremental budget come from? How did the Bureau of Budget prepare money for UC? 	<p>Policy formulation: context, policy stream-technical feasibility, Implementation: characteristics and strategies</p>
<p>Were knowledge bases on cost and effectiveness of services sufficient? What were MOPH plans in this regard?</p>	
<p>Were the distributions of health personnel and infrastructure appropriate to support UC? If not, what did the MOPH do to solve these problems?</p>	

Appendix 2.1 Interview checklist: Policy elites	Categories coding
<p>What criteria were used to measure the doctor-population proportion? What were the strategies in the area of personnel insufficient?</p> <ul style="list-style-type: none"> • Which areas did not have enough health providers to support UC? What did the MOPH do in this regard? • Did the MOPH change health personnel employing and logistic procurement regulations? How? • What did the MOPH do to strengthen the patient-referral system? • What did the main contractors do when they didn't have some services in the benefit packages? Were referral networks set up? Was there negotiation within and between referral networks? 	
<p>Was there an information technology constraint?</p> <ul style="list-style-type: none"> • Did the information system exist? • Did the programme need a new information system? Did it set one up? Why? 	
<p>Were there constraints in relation to know-how and manpower capability on managerial skills?</p> <ul style="list-style-type: none"> • Do the provincial health officers have new tasks (such as registration, contracting, incentive and penalty procedure to regulate providers, quality assurance process)? Do the hospital staff have new tasks? • Have they trained for the new tasks? Are they capable to implement in them? Do they feel these are difficult? 	
<p>23. Which selected alternatives will lead to constraints in future?</p> <ul style="list-style-type: none"> • Amount of per capita budget? Will this policy cause health care cost escalation? • Rate of co-payment? • Provider payment system? • People registration system? • Will there be new technologies that cause difficulties? 	Policy characteristics
<p>24. What were other sector or institutional reform support/obstruct UC?</p>	context
<p>25. Will UC be sustainable? Will the government be stable for years? Will the MOPH be in charge of the new health insurance office? How will the MOPH maintain the effort?</p>	Strategies

Appendix 2.1 Interview checklist: Policy elites	Categories coding
26. What is your opinion about UC? (support / neutral / resist) Why?	Stakeholders' position
27. What were the issues or comments that you suggested during the policy process? What were the impacts of your comments? Do you have anything that you want to suggest but don't have the opportunity to share your ideas? What?	Stakeholders' interest
28. Researcher's observation and comments	

Appendix 3 Observation coding form

Observation note: MOPH Contingency Fund Committee meeting

1. Name of organizer
The Contingency Fund Committee, Permanent Secretary Office, MOPH
2. Place and date / length
U-thai Sudsuk Room, 5th Floor, 5th PSO Building, MOPH, 2 Nov. 2001: 9.00-12.30
3. Types and number of participants
 - Chair by Deputy Permanent Secretary
 - Hospital Financing Expert, Chief Financing Officer of a company, United State of America
 - Deputy Chief Medical Officers, Ratchaburi Provincial Health Office
 - Hospital officers (Directors and staff), 7 hospitals from Ratchaburi province including Mathernal and Child Hospital 20-30 persons
 - Senior officers, MOPH 5 persons
 - Technical officers, PSO 10-20 persons
 - Technical officers/researchers, HSRI 5 persons
 - Technical officers, Budget Bureau, Finance Ministry 10 persons
 - Other observers
4. Topic and objectives of the meeting
Stakeholders in Ratchaburi provinces including PHO, Regional Hospital, General Hospitals, Community Hospitals present their financing information for declaration of financial status and 2002 estimation. Hospitals in Ratchaburi province requested money from contingency fund.
5. Activities (who does what?)
Hospitals present financial status and reform strategy for hospital survival. Senior officers and technical officers asked questions and suggested some strategies to reduced hospital cost. Senior officer proposed criteria for budget releasing and plan of the next step.
6. Influence and position of participants
The PHO has dominant role in coordination between hospitals and introducing overall provincial strategies but in this meeting the PHO didn't show its plan of reform strategies, just the hospitals' plan, the Deputy Chief Medical Officer will show his plan next time. Provincial (Regional) hospital was very compromised and kind to community hospitals and PHO. Some community hospitals have potential of bankruptcy. The Mathernal and Child Hospital has several roles and has felt reluctant to participate in the UC program. The Chair intervened in the meeting by suggesting the criteria of budget releasing.
7. Who dominate the discussion?- Counting statements by particular participants
Senior officers and PHO.
8. Outcome of the meeting
 - Discussion on data validity of the province
 - Consensus in criteria of budget releasing (suggested by the Deputy Permanent Secretary)
 - Discussion on the reform strategy and let the province to rethink and replan.
9. The meeting will be follow up by an advisory group to supervise the province for data validation and strategy plan. Next meeting will be the issue of another province which need contingency fund.

Appendix 4 List of interviewees

No.	Id	Job title	Roles in the UC policy	Date of interview	Professions
1	K02	Director of the Bureau of Health Policy and Planning (BHPP) (October 2000-January 2002)	Policy formulation and implementation: strategic planning	11 January 2002	MD
2	K01	Officer at a provincial health insurance office	Implementer at provincial level	15 January 2001	Nurse
3	K03	MoPH Researcher	Policy formulation: technical support	17 January 2002	MD
4	K04	MoPH Researcher	Policy formulation: technical support	25 January 2002	MD
5	K05	Deputy Permanent Secretary	Policy formulation and implementation: secretary of the UC Operational Committee	21 January 2002	MD
6	K06	Deputy Director of the Health Care Reform Office	Policy formulation and implementation: assistant of the Secretary of the UC Operational Committee	22 January 2002	MD
7	K07	Deputy Permanent Secretary	Policy formulation and implementation: chair of several sub-committees regarding to financing	26 January 2002	MD
8	K08	Head of the Political Policy Division of BHPP	Policy formulation: coordination and being responsible for publishing policy statement	15 January 2002	Others
9	K10	Senior officer of the Health Insurance Office, MoPH	Implementer at national level regarding health registration and budget allocation	5 February 2002	MD
10	K11	Director of HCRO	Policy formulation regarding Primary Health Care and Primary Care Units	8 February 2002	MD
11	K12	Deputy Director of the Department of Mental Health	Policy formulation	12 February 2002	MD
12	K13	Director of the Mental Health Development Division, Department of Mental Health, subsequently being the director of BHPP from Oct 2001-2002	Policy formulation and implementation: strategic planning	13 February 2002	MD
13	K14	Academic from the Naresuan University	Policy formulation: technical support	14 February 2002	MD
14	K15	Consultant of the Department of Health	Policy formulation: technical support and strategic planning	19 February 2002	MD
15	K16	Deputy Director of the Office of Health Provider Network Development (2001)	Implementer at national level regarding coordination between central MoPH and community hospitals.	19 February 2002	MD

No.	Id	Job title	Roles in the UC policy	Date of interview	Professions
16	K17	Director of Health Systems Research Institute	Policy formulation: technical support	4 March 2002	MD
17	K20	Deputy Health Minister	Policy formulation and implementation: agenda setter and executive manager	10 June 2002	MD
18	K21	Advisor of Health Minister	Policy formulation and implementation: technical support	3 September 2002	MD
19	K22	Secretary General of the Food and Drug Administration	Policy formulation and implementation	12 September 2002	MD
20	K23	Officer at the Consumer Protection Foundation	Civil society movements	4 October 2002	Others
21	K24	Coordinator of the Universal Coverage of Health Care Campaign (NGOs)	Civil society movements	4 October 2002	Others
22	K25	Medical doctor	Secretary of the Bangkok War Room	11 November 2002	MD
23	S1	Head of Planning section, Saraburi Provincial Health Office (SPHO)	Implementer at provincial level	6 February 2002	Nurse
24	S2	Officer, Health Insurance Section, SPHO	Implementer at provincial level	6 February 2002	Nurse
25	S3	Director, Saraburi Hospital	Provider	20 February 2002	MD
26	S4.2	Director, Adisorn Military Camp Hospital	Provider	22 February 2002	MD
27	S4.1	Head of the Human Resource Development and Primary Health Care Development Section, SPHO	Implementer at provincial level	22 February 2002	Nurse
28	S4.3	Head of Dental Health Section, SPHO	Implementer at provincial level	22 February 2002	DDS
29	S5	Deputy Provincial Chief Medical Officer, SPHO	Implementer at provincial level	18 February 2002	MD
30	S6	Nong Don District Health Officer, Saraburi Province	Implementer at district level	25 March 2002	Community Health Officer
31	S7	Health Centre Officer, Tambon Ban Krab, Nong Don District, Saraburi Province	Provider and front line service officer	25 March 2002	Community Health Officer
32	S8	Ban Mor District Health Officer, Saraburi Province	Implementer at district level	25 March 2002	Community Health Officer
33	S9	Director, Buddhabath Hospital	Provider	26 March 2002	MD
34	S10	Director, Nong Don Hospital	Provider	26 March 2002	MD
35	S11	Director, Vihandaeng Hospital	Provider	28 March 2002	MD

No.	Id	Job title	Roles in the UC policy	Date of interview	Professions
36	S12	Director, Mitraphap Memorial Hospital (private hospital)	Provider	7 March 2002	MD
37	S13.1	Director, Kasemratch Hospital	Provider	8 March 2002	MD
38	S13.2	Deputy Director, Kasemratch Hospital	Provider	8 March 2002	DDS
39	S14	Vihandaeng District Health Officer	Implementer at district level	4 April 2002	Community Health Officer
40	S15	Gangkhoy District Health Officer	Implementer at district level	4 April 2002	Community Health Officer
41	S16	Director, Gangkhoy Hospital	Provider	4 April 2002	MD
42	S17	Provincial Chief Medical Officer, Saraburi Province	Implementer at provincial level	10 April 2002	MD
43	S18	Charoentham Health Centre Officer, Vihandaeng District	Provider and front-line service officer	4 April 2002	Health worker
44	S19	Nong Mu Health Centre Officer, Vihandaeng District	Provider and front-line service officer	4 April 2002	Health worker
45	S20	Tab Guang Health Centre Officer, Gangkhoy District	Provider and front-line service officer	4 April 2002	Health worker
46	S21	Cha-om Health Centre Officer, Gaengkhoy District	Provider and front-line service officer	4 April 2002	Health worker
47	C1	Ammar Siamwala, Senior economist	External thinker and chair of a sub-committee regarding the capitation rate	15 July 2002	Economist

Appendix 5 Analysis of policy community regarding UC in Thailand

This section analyses the policy communities in Thailand by investigating participants in four workshop relating to UC and in HSRI's Taskforce on UC. The Table A5 shows names, positions and organisations, sectors, and frequency in participation.

Table A5 List of participants in four workshops, in 1986¹, 1993², 1996³, and 1998⁴ and Committee members in the HSRI's taskforce on Universal Coverage (2000-1)⁵

No	Sectors	Name of participants	Positions / Organisations	1	2	3	4	5
1	MoPH	Dr.Sanguan Nitayarumphong	Primary Health Care Committee Office, MoPH (1986), Director of Health Policy and Planning Office, MoPH (1993), Assistant of PS of MoPH (1996), Office of Health Care reform Project, MoPH (1998-2000)	1	2	3	4	5
2	MoPH	Dr.Viroj Tangcharoensathien	Director of the Puchtrakarn Hospital, MoPH (1986), Policy and Planning Analyst 8, MoPH (1993), Health Systems Research Institute (1998-)	1	2		4	5
3	MoPH	Dr.Paichit Pawabut	Permanent Secretary , MoPH (1993), Office of Health Care reform Project, MoPH (1998)	1	2		4	
4	University	Assoc.Prof.Supasit Pannarunothai	Policy and Planning Analyst 8, MoPH(1993), Pisanulok Hospital (1996), Faculty of Medicine, Narasuan University (1998-)		2	3	4	5
5	MoPH	Dr.Somsak Chunharas	Director, Health System Research Institute (1993-1998), PS's advisor Class10 (2000-1)		2	3	4	5
6	MoPH	Dr.Anuwatra Supachutikul	HSRI		2	3	4	
7	SSS	Dr.Somkiat Chayasriwong	Director of Medical coordination Division, Social Security Office, Ministry of Labour and Welfare (1993), Deputy Director General of Social Security Office (1996-)		2		4	5
8	SSO	Dr.Suradej Walee-itthikul	Head of Medical Audit Section, Medical coordination Division, SSO (1993), Director of Medical coordination Division (2000-),		2			5
9	MoPH	Dr.Amorn Nonthasut	Permanent Secretary of the MoPH	1				
10	MoPH	Dr.Amnuoy Utthangkorn	Second Regional Health Office, Chonburi	1				
11	MoPH	Dr.Damrong Bunyeun	Director of the Health Planning Division, MoPH	1				
12	MoPH	Dr.Dilok Teewthong	Health Card Project Coordination Center, MoPH	1				
13	MoPH	Dr.Komart Jurng-sathiensup	Chumphuang Hospital	1				

1 Workshop 'Health Insurance System for Thailand', Grand Palace Hotel, Pattaya, Chonburi Province, on 10-12 June 1986. Source: I. Boonyuen, D. and Singhaew, S. (1986)

2 Workshop 'Health Financing in Thailand', 11-13 November 1993 at Dusit resort and Polo Club, Petchaburi province, Thailand. Source: Nitayarumphong et al (1993)

3 Workshop 'Health Care Reform: At the Frontier of research and Policy Decisions on 22-24 January 1996 in Nakornrajima Province, Thailand. Source: Nitayarumphong (1997)

4 Workshop 'Achieving Universal Coverage of Health Care: Experiences from Middle and Upper Income Countries' on 15-17 March 1998 in Bangkok, Thailand. Source: Nitayarumphong and Mills ed. (1998)

5 HSRI taskforce members on the Universal Coverage, October 2000-March 2001. Source: Siamwala et al (2001)

No	Sectors	Name of participants	Positions / Organisations	1	2	3	4	5
14	MoPH	Dr.Niwat Thepmanee	Director of the Office of Community Financing Fund Project, MoPH	1				
15	MoPH	Dr.Pairoj Ningsanond	Director General of the Health Department, MoPH	1				
16	MoPH	Dr.Panya Keeratikatathayakorn	Director of the Panusnikhom Hospital	1				
17	MoPH	Dr.Panya Sonkom	Director of the Chonburi Hospital	1				
18	MoPH	Dr.Prasert Jittiwatanapong	Director of the Banglamung Hospital	1				
19	MoPH	Dr.Samroeng Yaeng-kratok	Coordination Office of the Quality of Live Year Campaign	1				
20	MoPH	Dr.Sermsak Siriwechsunthorn	Director of the Rural Health Division, MoPH	1				
21	MoPH	Dr.Shin-o-sod Hasbamrur	Director of the Occupational Health Division, Health Department, MoPH	1				
22	MoPH	Dr.Srinond Ha-wanond	Medical Department, MoPH	1				
23	MoPH	Dr.Surasak Boonyaprapasorn	Director of the Rural Hospital Division, MoPH	1				
24	MoPH	Mr.Chatchai triratanapirom	Health Policy and Planning Division, MoPH	1				
25	MoPH	Ms. Orasa Kowinta	Health Policy and Planning Division, MoPH	1				
26	MoPH	Ms.Atchara Netchsiri	Health Policy and Planning Division, MoPH	1				
27	MoPH	Ms.Molrudee Sawatdecha	Office of Technical and Health Man Power Coordination	1				
28	MoPH	Ms.Pattamawadee Kasigam	Primary Health Care Committee Office, MoPH	1				
29	MoPH	Ms.Sukanya Patarawimol	Health Policy and Planning Division, MoPH	1				
30	MoPH	Ms.Uthai Siriwattthanand	Health Card Project Coordination Center, MoPH	1				
31	MoPH	Dr.Songpan Singh-kaew	Policy and Planning Analyst, Health Policy and Planning Division, MoPH	1	2			
32	MoPH	Dr.Banpot Tontheerawong	Director of Health Policy and Planning Bureau		2			
33	MoPH	Dr.Amom Rodklai	Hadyai Hospital			3		
34	MoPH	Dr.Boosaba Sanguanprasit	Institute of Health Manpower Development, MoPH			3		
35	MoPH	Dr.Daorirk Sinthuvanich	Director of Samutprakarn Hospital			3		
36	MoPH	Dr.Jessada Chungpaibulpata	Hadyai Hospital			3		
37	MoPH	Dr.Khwanchai Visthanon	Institute of Health Manpower Development, MoPH			3		
38	MoPH	Dr.Mingkwan Suphannaphong	Institute of Dermatology, Department of Medical Services, MoPH			3		
39	MoPH	Dr.Payom Buranasis	Nakornratchasima Provincial Health Office, MoPH			3		
40	MoPH	Dr.Petchsri Sirinirund	Phayao Provincial Health Office, MoPH			3		
41	MoPH	Dr.Pathom Sawanpunyalert	Department of Medical Services, MoPH			3	4	

No	Sectors	Name of participants	Positions / Organisations	1	2	3	4	5
42	MoPH	Dr.Pongpisuthi Chongudomsuk	Ubonratchatani Provincial Health Office, MoPH (1993), Office of Health Care Reform (1998)			3		5
43	MoPH	Dr.Samrit Srithamrongsawat	Phuket Provincial Health Office, MoPH (1993), Office of Health Insurance, MoPH (1996-)			3	4	5
44	MoPH	Dr.Somchai Leetongin	Office of Health Insurance, MoPH			3	4	
45	MoPH	Dr.Tawekiat Boonyapisarncha	Ayuttaya Provincial Health Office, MoPH			3		
46	MoPH	Dr.Vichai Kuttiyawithaykoon	Nakhon Ratchasima Provincial Health Office, MoPH			3		
47	MoPH	Dr.Weerawat Phankrut	Kalasin Provincial Health Office, MoPH			3		
48	MoPH	Dr.Wicharn Girdwichai	Director of Sena Hospital, Ayuttaya			3		
49	MoPH	Ms.Sopee Chusaeng	Health Policy and Plan Bureau, Thailand			3		
50	MoPH	Dr.Narumol Silarug	Department of Medical Services, MoPH				4	
51	MoPH	Dr.Preeda Tae-arak	Pitsanulok Provincial Health Office				4	
52	MoPH	Dr.Suwit Wibulpolprasert	Office of Permanent Secretary, MoPH				4	
53	MoPH	Dr.Yaowarat Porapakham	Office of Health Care Reform Project, MoPH				4	
54	MoPH	Dr.Yongyuth Pongsupap	Health Care Reform Project Office				4	
55	MoPH	Dr.Chadej Thammatat-aree	Bangkruay Hospital					5
56	MoPH	Dr.Supakorn Buasai	Health Systems Research Institute (HSRI)					5
57	MoPH	Dr.Thaworn Sakulpanich	Office of Health Insurance, MoPH					5
58	MoPH	Dr.Wiput Pulcharoen	Health Systems Research Institute					5
59	SSO	Prof.Nikom Chantarawitton	The President of the National Council of Labour Development (1986), Senior Advisor of the Social Security Board (1993)	1	2			
60	SSO	Tipaporn Weerapat	Workmen Compensation Fund, Ministry of Labour	1				
61	SSO	Ms.Chantana Boon-arch	Foreign Relation Officer, Technical and Planning Division, SSO		2			
62	SSO	Ms.Chongjt Premlumert	Head of Policy and Planning Section, Technical and Planning Division, SSO		2			
63	SSO	Ms.Jitraporn Kestasuwan	Director of Technical and Planning Division, SSO		2			
64	SSO	Mr.Narong Payungphong	Deputy DG of the SSO		2			
65	NESDB	Mr.Komol Chobchunchom	Social Program Division National Economic and Social Development Board (NESDB)	1				
66	NESDB	Mr.Thammarak Karnpisit	Director of the Social Program Division, NESDB	1				
67	NESDB	Mr.Visut Karnchanasuk	Social Program Division, NESDB	1				
68	NESDB	Ms. Orathai Tansakul	Director of Planning Division, NESDB	1				
69	NESDB	Mr.Boonyong Vechmaneesri	Director of the Social Program Division, NESDB (1993)	1	2			
70	NESDB	Dr.Yaowaluck Ratchapattayakom	Director of the Human Resources Planning Division, NESDB		2			

No	Sectors	Name of participants	Positions / Organisations	1	2	3	4	5
71	NESDB	Mr.Araya Ma-inn	Policy and Planning Analyst 6, NESDB		2			
72	NESDB	Mr.Narong Nittayaporn	Assistant of the DG of NESDB		2			
73	NESDB	Mr.Som Phromros	Policy and Planning Analyst 6, NESDB		2			
74	NESDB	Mr.Sukasem Wongsuwan	Planning Specialist, NESDB		2			
75	NESDB	Mr.Thammarak Kampisit	Deputy Director General of NESDB		2			
76	NESDB	Ms.Chumruthai Karnchanachitra	Head of Health Program and Planning Section, NESDB		2			
77	NESDB	Ms.Orthip Archwiboon-yobol	Planning Specialist, NESDB		2			
78	NESDB	Ms.Warranya Teao-kul	Policy and Planning Analyst 6, NESDB		2			
79	NESDB	Ms.Dangkamon Vimonkit	NESDB, Thailand				4	
80	NESDB	Ms.Naiyana Kong sarai	NESDB, Thailand				4	
81	NESDB	Ms.Suwannee Kham-man	NESDB, Thailand				4	
82	Other Ministries	Mr.Poolsub Piyaanand	Budget of the Bureau, Ministry of Finance	1				
83	Other Ministries	Mr.Cha-ood Ngeun-thai	Deputy Director of Financial Office, BMA		2			
84	Other Ministries	Mr.Niwat Wachirawarakarn	Advisor of Bureaucratic system, CSO		2			
85	Other Ministries	Mr.Sanong Teanmanee	Expert in law and financial regulation Comptroller General's Department,		2			
86	Other Ministries	Ms.Kamol Srinives	Director of Health Budget Division, BOB		2			
87	Other Ministries	Ms.Nattaya Losuwachai	Director of Life Insurance Division, Insurance Department, Ministry of Commerce		2			
88	Other Ministries	Mr.Chawalit Ung-phakorn	Budget Analysis Officer 7, BOB		2			
89	Other Ministries	Mr.Cherdchai Meecome	Head of Financial Regulation Section, Law and Financial Regulation Division Comptroller General's Department,		2			
90	Other Ministries	Ms.Nongluck Charernsuk	Budget Analysis Officer 7, BOB		2			
91	Other Ministries	Ms.Dhipavadee Meksawan	Office of Civil Servant Commission, Bangkok				4	
92	Research Institution	Dr.Korp Kittayakeerana	TDRI	1				
93	Research Institution	Mr.Wanna Pataraplapiboon	TDRI	1				
94	Research Institution	Dr.Matthana Pananiramai	TDRI		2			
95	Research Institution	Prof.Aree Valyasevi	National Health Foundation, Bangkok				4	
96	Research Institution	Prof.Ammar Siamwala	Thailand Development Research Institute					5
97	University	Assist.Prof.Chanpen Wiwat	Faculty of Pharmacy, MU	1				

No	Sectors	Name of participants	Positions / Organisations	1	2	3	4	5
98	University	Assist.Prof.Plernpit Satsanguan	Faculty of Economics, TU	1				
99	University	Assist.Prof.Prapatsorn Leawpairoj	Faculty of Economics, TU	1				
100	University	Assoc.Prof.Methee Krongkaew	Thai Study Institution, Thammasart University (TU)	1				
101	University	Assoc.Prof.Narong Petchprasert	Faculty of Economics, CU	1				
102	University	Assoc.Prof.Saksri Boribalbanpotket	Faculty of Social Welfare, TU	1				
103	University	Assoc.Prof.Taweethong Hongwiwat	Public Health Policy Study Center, MU	1				
104	University	Assoc.Prof.Yupa Wongchai	Faculty of Social Welfare, TU	1				
105	University	Dr.Lurchai Sri-nguean-yuang	Public Health Policy Study Center, MU	1				
106	University	Dr.Worwich Charoenlert	Faculty of Economics, CU	1				
107	University	Mr.Kusol Sunthonthada	Population and Social Research Institute, MU	1				
108	University	Mr.Sampan Hunpayon	Faculty of Economics and Management, Kasetsart University	1				
109	University	Ms.Anong Rojwanij	Faculty of Economics, TU	1				
110	University	Ms.Petchsri Bamrungcheep	Assamchan Business and Administrative College	1				
111	University	Prof.Dr.Pravech Wa-see	Medical Coordination Center, Mahidol University (MU)	1				
112	University	Prof.Dr.Teanchy Keeranund	Faculty of Economics, Chulalongkorn University (CU)	1	2			
113	University	Asso.Prof.Anong Rojwanich	Faculty of Economics, TU		2			
114	University	Asso.Prof.Dow Mongkolsamai	Faculty of Economics, Thammasart University (TU)		2			5
115	University	Dr.Khamethong Intarat	Deputy Director of Health Economics Centre, Chulalongkorn University (1993), Faculty of Health Economics, CU (1998)		2		4	
116	University	Dr.Nuntawan Wichitwatakarn	Public Health College, CU		2			
117	University	Prof.Dr.Chitra Sitthi-amorn	Dean of the Public Health College, CU		2			
118	University	Assoc.Prof.Dr.Virasakdi Chongsuvivatwong	Prince of Songkla University, Thailand			3	4	
119	University	Dr.Phisanes Jessadachatr	Faculty of Economics, CU			3		
120	University	Dr.Surakiat Archananuparp	Faculty of Medicine, Ramathibodi Hospital, Mahidol University,			3	4	
121	University	Assist.Prof.Weerasak Chaipah	Faculty of Public Health, Khon Kaen University				4	
122	University	Assoc.Prof.Pornpan Bunyaratapan	Faculty of Public Health, MU				4	
123	University	Dr.Chanuanthong tanasugarn	Faculty of Public Health, MU				4	

No	Sectors	Name of participants	Positions / Organisations	1	2	3	4	5
124	University	Dr.Mathana Phananimamai	Faculty of Economics, TU				4	
125	University	Dr.Paibul Suruyawongpaisal	National Health Foundation, Bangkok				4	
126	University	Dr.Sirilaksana Khoman	Faculty of Economics, MU				4	
127	University	Dr.Somchai Suksiriserekul	Faculty of Economics, TU				4	
128	University	Dr.Suwat Chariyalertsak	Faculty of Medical Sciences, Chiang Mai University				4	
129	University	Assist.Prof.Jirut Sriratanabun	Faculty of Medicine, Chulalongkorn University					5
130	University	Assist.Prof.Saowakhon Ratanavijitrasil	Faculty of Pharmacy, Chulalongkorn University					5
131	University	Assist.Prof.Wutthisarn Tanchai	Faculty of Social Welfare, Thammasart University					5
132	University	Assoc.Prof.Direk Pattamasiriwat	Faculty of Humanity and Social Sciences, Narasuan University					5
133	University	Assoc.Prof.Khattiya Gannasut	Postgraduate College, Huachiew Chalermprakiat University					5
134	University	Dr.Suchart Soranasataporn	Faculty of Medicine, Ramathibodi Hospital, Mahidol University					5
135	University	Dr.Tipaporn Potavil	Faculty of Social Welfare, Huachiew Chalermprakiat University					5
136	Private	Dr.Prapa Wongpatch	Secretary General of the Private Hospital Association	1				
137	Private	Ms.Praneet Weerakul	Thai Health Insurance Company	1				
138	Private	Dr.Anun Prasarnsuk	President of Private Hospital Association		2			
139	Political Party	Dr.Buranach Samutharak	Democrat party					5
140	NGOs	Ms.Karawin Leechanawanichapan	Center for Study and Development of Working at Home					5
141	NGOs	Ms.Sureerat Treemakka	Universal Coverage Campaign Project (NGO)					5
142	NGOs	Ms.Yuppadee Sirisinsuk	Universal Coverage Campaign Project (NGO)					5
143	Media	Mr.Wisut Charoenwuttiwongsa	The Ban-rao newspaper	1				
144	Media	Mr.Manoch Phothaporn	Editorial Department, The Nation newspaper		2			
145	International agency	Dr.Godfrey Walker	WHO, Thailand		2	3		
146	Int. agency	Dr.Jo Martins	Senior Public Health Specialist, Population and Human Resources Operation Division, WB		2			
147	Int. agency	Dr.Tanaporn Posayananda	Economist, The World Bank Regional Mission in Bangkok		2			
148	Int. agency	Prof.William C.Hsiao	Harvard University		2			
149	Int. agency	Dr.Abdelhay Mechbal	WHO Office Eastern Mediterranean Region, Beirut, Lebanon			3	4	
150	Int. agency	Dr.Aviva Ron	ILO			3		

No	Sectors	Name of participants	Positions / Organisations	1	2	3	4	5
151	Int. agency	Dr.Benjamin Ariel marte	Ministry of Health, Manila, Philippines			3		
152	Int. agency	Dr.Dick Stockford	Director of Commissioning, Sheffield			3		
153	Int. agency	Dr.EL Abassi Abdelwahed	UNICEF			3	4	
154	Int. agency	Dr.Goran Tomson	Karolinska Institute, Sweden			3	4	
155	Int. agency	Dr.Guy Kegels	Prince Leopold Institute of Tropical Medicine, Antwerp, Belgium			3	4	
156	Int. agency	Dr.Jaime Galvez Tan	UNICEF, Bangkok (1996)			3	4	
157	Int. agency	Dr.Jean Louis Lamboray	UNAIDS Coordinator, SEA HIV/AIDS Project in Bangkok			3	4	
158	Int. agency	Dr.Katsuhiko Yoshitake	JICA			3		
159	Int. agency	Dr.Marc De Bruycker	EUROPEAN COMMISSION			3	4	
160	Int. agency	Dr.OK-Kyun Bang	Deputy Director, Division of Health Insurance Policy, Ministry of Health and Welfare, Korea			3		
161	Int. agency	Dr.Paulo Ferrinho	Institute de Higiene e Meficina Tropical, Portugal			3		
162	Int. agency	Dr.Pierre Daveloose	Antwerp / Health Care Reform Office, MoPH			3	4	
163	Int. agency	Dr.Shahidah BT.Addul Manaff	Ministry of health, Malaysia			3		
164	Int. agency	Dr.Toshihiko Hasegawa	National Institute of Health Services Management, Japan			3	4	
165	Int. agency	Miss Oatricia Moser	ADB, Philippines			3		
166	Int. agency	Mr.Tsutomu Kitajima	JICA			3		
167	Int. agency	Prof.Anne Mills	LSHTM			3	4	
168	Int. agency	Prof.David J Hunter	Nuffield Institute of Health, UK			3		
169	Int. agency	Prof.Dr.Bruno Gryseels	Prince Leopold Institute of tropical Medicine (Antwerp)			3		
170	Int. agency	Prof.Dr.Detlef Schwefel	Philippines-German Cooperations in Health Systems Management, Department of Health, Philippines			3		
171	Int. agency	Prof.Dr.Goran Sterky	Karolinska Institute, Sweden			3	4	
172	Int. agency	Prof.Dr.Rainer Sauerborn	Harvard Institute for International Development (1996) Tropical Hygiene Institute, Ruprecht Karls University, Germany (1998)			3	4	
173	Int. agency	Prof.Marui Eiji	School of International Health, Faculty of Medicine, Japan			3		
174	Int. agency	Prof.Wim Van Lerberghe	Antwerp			3	4	
175	Int. agency	Dr.Agnes Soucat	UNAIDS Health Care Reform and HIV project, Bangkok				4	
176	Int. agency	Dr.Ahmet Muderrisoglu	Ministry of Health, Turkey				4	
177	Int. agency	Dr.Alex Preker	The World Bank				4	
178	Int. agency	Dr.Andrew Creese	WHO, Geneva				4	
179	Int. agency	Dr.Charlotte Leighton	Partnership for Health Sector Reform, U.S.A.				4	

No	Sectors	Name of participants	Positions / Organisations	1	2	3	4	5
180	Int. agency	Dr.Daneil Lopez Acuna	WHO-AMRO/PAHO, U.S.A.				4	
181	Int. agency	Dr.E.B. Doberstyn	WHO-Office, Thailand				4	
182	Int. agency	Dr.Fidencio G.Aurelia	William Villegas Memorial Hospital, Philippines				4	
183	Int. agency	Dr.Joseph Kutzin	WHO, Geneva				4	
184	Int. agency	Dr.Maria Dugolecka	Lothian Health Board, UK				4	
185	Int. agency	Dr.Ok Ryun Moon	School of Public Health, Seoul National University, Korea				4	
186	Int. agency	Dr.Peter Lloyd-Sherlock	Health Policy Unit, LSHTM, UK				4	
187	Int. agency	Dr.Phua Kai Hong	Institute of Policy studies, Singapore				4	
188	Int. agency	Dr.Schulti-Sasse Hiemann	AOK, Germany				4	
189	Int. agency	Dr.Shambhu Acharya	WHO-SEARO				4	
190	Int. agency	Dr.Somchai Peerapakorn	WHO-Thailand				4	
191	Int. agency	Dr.Than Sein	WHO-SEARO, India				4	
192	Int. agency	Mr.David Dror	ILO, Geneva				4	
193	Int. agency	Mr.Franz Knieps	AOK, Germany				4	
194	Int. agency	Mr.Jergen Hohman	AOK, Germany				4	
195	Int. agency	Prof.Yoshinori Hiroi	Faculty of Law and Economics, University of Chiba, Japan				4	

Note:

1. Workshop 'Health Insurance System for Thailand', Grand Palace Hotel, Pattaya, Chonburi Province, on 10-12 June 1986. Source: 1. Boonyuen, D. and Singhkaew, S. (1986)
2. Workshop 'Health Financing in Thailand', 11-13 November 1993 at Dusit resort and Polo Club, Petchaburi province, Thailand. Source: Nitayarumphong et al (1993)
3. Workshop 'Health Care Reform: At the Frontier of research and Policy Decisions on 22-24 January 1996 in Nakornrajsima Province, Thailand. Source: Nitayarumphong (1997)
4. Workshop 'Achieving Universal Coverage of Health Care: Experiences from Middle and Upper Income Countries' on 15-17 March 1998 in Bangkok, Thailand. Source: Nitayarumphong and Mills ed. (1998)
5. HSRI taskforce members on the Universal Coverage, October 2000-March 2001. Source: Siamwala et al (2001)

The results indicate that UC was widely discussed. However, key people (number 1 to 8) were involved participated in several workshops. Five of them were in the MoPH. They have published many papers regarding Thai health system. They had long time relationship and sometimes they had conflicts. This core group had their networks and all networks were linked. This relationship supported the knowledge for UC policy decision. Authors of twenty eight papers related to UC are listed below.

Charoenparij, S., Chunharas, S., Donaldson, D., et al. 1999. *Health Financing in Thailand: Final Integrated Report*. Boston: Management Sciences for Health.

Kachondham, Y., and Chunharas, S. 1993. At the crossroads: challenges for Thailand's health development. *Health Policy and Planning* 8 (3):208-216.

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Appendix 6 Quantitative data of Saraburi

Table A6.1 Saraburi proposal for additional budget from the Contingency Fund, December 2001

ID	Network	Beds	Health centres	PCUs	UC beneficiaries	Total Insured	UC capitation budget	Total revenues	Salaries of permanent staff	Total Labour cost	Total expenses	Proportion of revenues divided by labour cost	Requested budget	Approved budget from CF
													Mil Baht	Mil Baht
1	Ban Mo	30	7	2	27,850	37,080	29.3	33.7	15.9	21.3	50.3	1.6	0.0	0.0
2	Gaeng Khoy	60	16	3	53,178	70,932	55.9	67.2	19.9	25.6	57.3	2.6	0.0	0.0
3	Don Phud	30	6	2	7,568	8,634	8.0	9.6	9.1	11.1	21.5	0.9	10.0	5.3
4	Muag Leck	30	10	3	32,320	36,583	34.0	37.6	14.5	19.0	39.9	2.0	0.0	0.0
5	Wong Muang	30	10	2	22,703	24,743	23.9	27.3	10.7	14.2	37.7	1.9	0.0	0.0
6	Wihandaeng	30	7	2	28,003	33,087	29.5	32.9	11.9	16.3	37.1	2.0	0.0	0.0
7	Nong Saeng	10	7	2	13,688	17,187	14.4	17.4	13.1	15.7	31.0	1.1	6.2	3.6
8	Nong Don	10	3	1	10,378	13,384	10.9	14.5	7.6	10.6	23.0	1.4	2.0	0.0
9	Nong Khae	90	10	3	32,324	49,155	34.0	44.7	17.4	23.9	51.5	1.9	0.0	0.0
10	Sao Hai	30	13	2	16,305	23,523	17.2	22.4	16.0	20.0	39.4	1.1	6.0	4.3
11	Pha Budhabaht	400	12	4	62,745	85,329	66.0	189.1	121.2	160.7	262.6	1.0	73.5	15.9
12	Saraburi Hospital	680	26	6	95,949	132,661	100.9	403.3	206.2	292.5	578.8	1.4	117.6	56.4
	All MOPH providers	1,430	127	32	403,011	532,298	424.0	903.6	463.4	631.0	1,230.0	1.4	215.3	85.5
13	Adisorn Hospital	60	0	1	2,484	2,484	2.6	Not applicable						
14	Kasemratch Hospital	200	0	1	19,391	19,391	20.4							
	Total Saraburi	1,690	127	34	424,886	554,173	447.0							

Source: Adapted from Saraburi PHO (2001) ten tables proposed for additional budget from the Contingency Fund (First Round in December 2001)

Table A6.2 Health insurance coverage in Saraburi: before and after the UC Scheme implementation

Insurance schemes	Jul 00*		Jul 01**		Feb 02***	
Uninsured and private insured	188,555	31%	48,961	8%	39,694	6%
UC Scheme (copay 30 Baht)	0	0%	210,987	35%	217,732	35%
UC Scheme (exempt 30 Baht)	0	0%	41,238	7%	224,415	37%
Medical Welfare Scheme	220,103	37%	173,599	28%	0	0%
Voluntary Health Card	78,385	13%	13,176	2%	0	0%
Social Security Scheme	81,282	14%	87,244	14%	100,870	16%
Civil Servant Medical Benefit Scheme and private enterprises	33,362	6%	34,042	6%	31,556	5%
Population number ****	601,687	100%	609,247	100%	614,267	100%

Note: The Universal Coverage Scheme launched in Saraburi from June 2001.

Source: * Saraburi Provincial Health Office. Public Health Performance Report in Saraburi: 9 Months of Fiscal Year 2000

**Saraburi Provincial Health Office. The Universal Coverage of Health Care Program in Saraburi: Performance Report June to July 2001

*** Saraburi Provincial Health Office. Public Health Performance Report in the First Half Year 2002 in Saraburi. A paper presented to the supervision team from the Second Regional Health Office on 13-15 March 2002 at Saraburi Provincial Health Office.

**** The Bureau of Registration Administration Mid Year 2000 and 2001, and December 2001

Table A6.3 Estimations of the required budget for public providers based on 6 months expected revenues and expenses in fiscal year 2002 (October 2001 to March 2002).....

Provider networks	UC beneficiaries (Thousand persons) (1)	Expenses		Revenues from several sources				Required budget	
		In-house expenses (Million Baht) (2)	Export-case expenses (Million Baht) (3)	Import-case revenues (Million Baht) (4)	Out-of-pocket (Million Baht) (5)	Other public insurance schemes (Million Baht) (6)	Other incomes (Million Baht) (7)	Six months (Million Baht) (8)	Per person per year (Baht/capita/year) (9)
1. Don Phud	7.57	7.67	0.79	0.09	0.74	0.31	0.16	7.17	1,894
2. Nong Don	10.38	8.61	2.33	0.00	0.45	1.52	0.38	8.59	1,655
3. Nong Saeng	13.69	11.24	4.13	0.00	0.49	1.51	0.20	13.17	1,925
4. Sao Hai	16.31	13.45	1.20	0.07	0.30	3.81	0.25	10.22	1,254
5. Wang Muang	22.70	12.32	3.32	0.57	1.50	1.91	0.33	11.32	998
6. Ban Mo	27.85	14.63	4.25	0.58	0.20	1.39	0.38	16.33	1,173
7. Wihandaeng	28.00	13.90	7.67	0.26	1.88	0.64	0.30	18.48	1,320
8. Muag Leck	32.32	9.41	1.29	0.55	1.76	0.40	1.89	6.09	377
9. Nong Khae	32.32	22.33	7.19	0.27	2.99	3.22	0.61	22.43	1,388
10. Gaeng Khoy	53.18	27.34	8.27	0.00	2.46	4.32	0.37	28.46	1,070
11. PraBudhabaht	62.75	146.22	0.64	9.71	16.84	28.16	3.46	88.69	2,827
12. Muang Saraburi	95.95	265.74	0.18	39.81	54.58	74.10	17.50	79.94	1,666
Total	403.01	552.86	41.24	117.55	81.91	121.29	25.82	247.54	1,228

Source: Saraburi Provincial Health Office (2002). Financial Status of Health Provider Networks: Data for Evaluation of the Universal Coverage of Health Care Program

Note:

Actual numbers of beneficiaries registered at network of providers under the 30 Baht Scheme in September 2002.

In-house expenses included labour costs and material costs incurred by providers in each network.

Export-case expenses were the expected expenses incurred from the refer-out patients (charges from other providers)

Import-case revenues were expected revenues from refer-in patients (reimbursable from other providers but might not be paid).

Out-of-pocket revenues were incomes from patients at the counter of services.

Other public insurance schemes were the CSMBS, the SSS, and the Traffic Accident Protection Fund (TAP).

Other incomes included 1) budget from other health programs, the High-Cost & Accident & Emergency Fund, and local authorities, 2) income from private health insurers and contracted companies, and 3) donors, fees, and bank interests.

Required budget was an amount of incurred expenses plus export-case expenses and minus import-case revenues, out-of-pocket revenues, revenues from other public insurance scheme, and other incomes.

Required budget per capita was calculated from the amount of required budget divided by the number of beneficiaries and multiplied by 2 to enlarge from 6 months to 12 months. Please note that the per capita budget rate allocated to provinces in fiscal year 2002 was 1,052 Baht per capita per year.

Table A6.4 Unit costs of provider networks in Saraburi during October 2001 to March 2002

	Health Centre care (Visits)	Outpatient care (Visits)	Inpatient care (Cases)	Length of Stay (Days)	Weight units (Equivalent to OP visits)	In-house expenses (Baht)	Unit cost (Baht per OP visit)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Ban Mo	14,045	32,478	1,431	2.83	56,726	13,780,733	243
Gaeng Khoy	30,471	63,087	2,977	4.35	113,906	27,292,395	240
Don Phud	9,485	10,860	579	3.32	21,812	8,055,284	369
Muang Leck	24,729	21,750	1,264	2.23	46,865	9,419,763	201
Wong Muang	26,668	25,797	1,609	1.85	56,323	11,199,849	199
Wihandaeng	27,151	21,822	1,494	2.69	50,883	14,154,315	278
Nong Saeng	11,229	22,221	689	3.58	35,236	10,603,477	301
Nong Don	6,074	19,961	756	3.41	32,367	8,483,766	262
Nong Khae	22,063	28,964	2,311	3.58	67,937	20,842,648	307
Sao Hai	34,974	29,033	841	4.57	51,299	12,495,950	244
Total community hospitals	206,889	275,973	13,951	3.29	533,354	136,328,180	256
PraBudhabaht	31,958	137,473	8,875	6.92	303,615	146,247,341	482
Muang Saraburi	79,467	239,014	17,222	7.44	560,930	264,944,748	472

Source: Saraburi Provincial Health Office (2002). Financial Status of Health Provider Networks: Data for Evaluation of the Universal Coverage of Health Care Program

Note: Weight units are the sum of visits of health centre care, visits of OP care, and visits of IP care of which are multiplied by times equivalent to OP visits

-Assumption 1 for community hospital networks: the average unit cost of health centre care was 0.3 times outpatient care cost and the cost of Inpatient care was 14 times outpatient care cost.

-Assumption 2 for Phabudhabaht hospital network: the average unit cost of health centre care was 0.2 times outpatient care cost and the cost of Inpatient care was 18 times outpatient care cost.

-Assumption 3 for Saraburi hospital networks: the average unit cost of health centre care was 0.15 times outpatient care cost and the cost of Inpatient care was 18 times outpatient care cost.

Table A6.5 The Hospital networks' revenues (or loss) from the referral system and the nurse-doctor ratio

Provider networks	In-house expenses	Export-case expenses	Import-case revenues	Revenues gain/loss from the referral system	Referral revenue or expenses	Medical doctors	Registered nurses	RN/MD
	(Baht)	(Baht)	(Baht)	(Baht)	(percentage of in-house expenses)	(Persons)	(persons)	Nurses per doctor
	(1)	(2)	(3)	(4)=(3)-(2)	(5)=(4)/(1)	(6)	(7)	(8)=(7)/(6)
1 Ban Mo	14.63	4.25	0.58	-3.67	-25%	3	20	6.7
2 Gaeng Khoy	27.34	8.27	0.00	-8.27	-30%	4	34	8.5
3 Don Phud	7.67	0.79	0.09	-0.70	-9%	2	13	6.5
4 Muang Leck	9.41	1.29	0.55	-0.73	-8%	3	15	5.0
5 Wong Muang	12.32	3.32	0.57	-2.75	-22%	2	15	7.5
6 Wihandaeng	13.90	7.67	0.26	-7.41	-53%	2	19	9.5
7 Nong Saeng	11.24	4.13	0.00	-4.12	-37%	2	16	8.0
8 Nong Don	8.61	2.33	0.00	-2.33	-27%	2	12	6.0
9 Nong Khae	22.33	7.19	0.27	-6.91	-31%	3	28	9.3
10 Sao Hai	13.45	1.20	0.07	-1.13	-8%	2	15	7.5
11 PraBudhabaht	146.22	0.64	9.71	9.07	6%	28	197	7.0
12 Muang Saraburi	265.74	0.18	39.81	39.63	15%	75	346	4.6
Total	552.86	41.24	51.93	10.68	2%	128	730	5.7

Source: Saraburi Provincial Health Office (2002). Financial Status of Health Provider Networks: Data for Evaluation of the Universal Coverage of Health Care Program