Reevaluating Pro-Poor Health Care: A Model for Monitoring of the Universal Coverage Scheme in Thailand

Ben Harkins, Chulalongkorn University (Bangkok, Thailand)

Abstract: The Nation of Thailand, which had a GDP per capita of approximately $6,600 (PPP) at the time and was still struggling to recover from the crippling effects of the Asian Financial Crisis, was able to implement a universal coverage program for its citizens with a fairly comprehensive benefits package in 2001. However, the current system for universal health coverage in Thailand is a patchwork of 3 separate and unequal public health insurance schemes. Given the inequity in the Thai health system that preceded the Universal Coverage Scheme, monitoring of the program for pro-poor qualities is a critical aspect of ensuring that the Scheme meets its goal of providing universal access to high-quality healthcare for all. The results of the research lead to the conclusion that universal coverage in Thailand can best be characterized as a “great policy” but perhaps only a “good program” at this time. While the principles and beliefs that went into formulating the objectives of the policy are beyond question, the realities of its translation into an implemented program have sometimes fallen short of the ideals. Universal coverage in Thailand has been achieved partly at the expense of public hospitals, public health staff, and quality of care. While the health economic evaluations of the Scheme have accentuated the successful shift of the financial burden of care from the poor, they have failed to demonstrate the fact that much of that burden has fallen on public health facilities and their staff rather than the general tax revenues of the Royal Thai Government. In addition, there are no econometric indicators appropriate for determining the value of receiving high quality care when medically necessary. The results indicated that further metrics should be included in the monitoring system to help address these concerns.

Keywords: Universal Coverage, Thailand, Pro-Poor, Monitoring, Health Equity

1.0 Introduction

"Ministries of health in many developing countries operate essentially as national health services, with
nationally owned health sector inputs and funding from
general tax revenues. The systems they manage are 
often inefficient and inequitable, reflecting severe 
resource and institutional capacity constraints but also 
a bias in favor of the wealthy and influential. Services 
are meant to cover everyone, but high out of pocket 
payments keep many poor people from participating.”
(The World Bank, 2005, p. 146)

After several decades of policy formulations designed 
to provide insurance coverage, expand access and improve 
quality of health care services for the poor, children, the 
elderly, the formal sector, civil servants and others, the Royal 
Thai Government (RTG) still confronted a gap in services that 
left approximately 20% of the population uncovered by any 
type of insurance in the year 2000. (Tangcharoensathien & 
Jongudomsuk, 2004, p. iv)

The system of coverage was a patchwork of public 
health insurance programs which led to fragmentation of 
funding and service provision, inequitable levels of access 
and quality, and an inefficient public health system. (Bureau 
of Policy and Strategy, 2008, p. 32) There were “Huge 
differences in terms of contribution, public subsidy, benefits 
and quality of services” among the programs offered. 
(Sakunphanit, 2008, p. 11) The Thai health system had 
become notoriously inequitable and privileged the middle 
class over the poor due to higher utilization rates, program 
reliance on user fees for financing, and unequal patterns of 
public subsidy for the programs. (Towse, Mills, & 
Tangcharoensathien, 2004, p. 105)

This paper is based upon research conducted on the 
Universal Coverage Scheme (UC Scheme), which was the 
policy designed by the RTG to address these problems. The 
Nation of Thailand, which had a GDP per capita of 
approximately $6,600 (PPP) (CIA, 2002) at the time and was 
still struggling to recover from the crippling effects of the 
Asian Financial Crisis, was able to implement a universal
coverage program for its citizens with a fairly comprehensive benefits package in 2001.

However, the current system for universal health coverage in Thailand remains a patchwork of 3 separate and unequal public health insurance schemes, the Social Security Scheme (SSS), the Civil Servant Medical Benefit Scheme (CSMBS) and the UC Scheme. Despite the fact that the UC Scheme has been framed as variously an entitlement program for all or a welfare program to serve the needs of the poor depending upon the economic and political climate at the time, (NaRanong & NaRanong, 2006, pp. 3-4) in practical terms it is the public healthcare program used by the poorest Thai citizens.

Given the inequity in the Thai health system that preceded the UC Scheme, monitoring of the program for pro-poor qualities is a critical aspect of ensuring that the program meets its goal of providing universal access to high-quality healthcare for all. The primary objective of this research was to construct a conceptual model for pro-poor monitoring of the scheme based upon survey of frontline stakeholders, key informant interview, participant observation, review of health system data, and a theoretical framework that privileges development and sociological concepts over quantitative economic analysis.

2.0 Objectives and Implementation of the Universal Coverage Policy

In his first address to the parliament on February 26, 2001, Prime Minister Thaksin Shinawatra stated that the goal of the UC policy would be to reduce both national and household expenditures on healthcare by providing accessible, equitable, and high quality healthcare to all Thai citizens with only a 30 baht ($1 USD) out of pocket payment per visit. This would be facilitated by establishment of a general tax financing system which would reimburse providers based upon the population registered for the program in their local districts. In addition, Scheme members would have the choice of registering with either a
public or private sector health care provider and that the Scheme would guarantee the quality of the services as well as the close proximity to a provider. He also said that a legislative framework for the reform would be established under the National Health Security Act which would create a new fund for the program called the National Health Security Fund. The intent of the new fund would be to join the existing insurance schemes under a single fund to create an equitable system through harmonizing the benefits, costs, and management of the 3 Schemes. (Tangcharoensathien & Jongudomsuk, 2004, p. 2)

While this was certainly a well thought out and convincing statement of policy, it’s clear that much of it was overly optimistic operationally. Some commentators have also pointed out that the Thaksin administration developed a habit of altering what the stated objectives of the UC Scheme were depending upon the political and economic situation. While most of the policy literature and statements heavily utilize the language of “universal coverage” and the “entitlement and rights to healthcare of all citizens” rather than framing the UC Scheme as a welfare program for the poor and indigent, the government often sent mixed messages to the public and to health professionals about the purpose of the Scheme. When the Scheme seemed to be at risk due to budget shortfalls and high utilization rates, the government described the program as being intentionally pro-poor, and encouraged higher income groups to seek medical services elsewhere so that they would not be an additional burden on the tight budget of the Scheme. However, when a large coalition in the senate attempted to amend the National Health Insurance Act (The legislative basis for the Scheme) to define the UC Scheme as intended for the poor and uninsured exclusively, the government made use of the opportunity to gain some political capital by affirming that the UC Scheme was intended for all Thai citizens. Later on in the Scheme’s development when on the defensive about some of the weaknesses of the program, the Prime Minister asked the citizenry to be patient with the Scheme, stating that while it still may be somewhat
unsatisfactory to the middle class, the Scheme had been successful in providing services to the poor. (2006, pp. 3-4)

A workshop was held in March of 2001 to reach a consensus about the main objectives of the policy among key stakeholders. The group developed three main policy goals to provide direction for the implementation and development of the Scheme. These were:

1. Universal Coverage: That all Thai citizens are entitled to health care and should be provided with access to high quality medical care based upon need rather than socioeconomic status
2. Single Standard: That the quality of care provided by the Scheme should be of the same standard for all Thai citizens
3. Sustainable System: That the UC Scheme should be developed as a sustainable policy financially, institutionally, and politically. (Nitayarumphong, 2005, p. 196)

However, 9 years into the program, many of the most radical reforms that were planned are essentially still pending. These delays reveal the difficulties faced in translating the strong principles and ideals that were developed in the policy formation stage into a practical model of financing and service delivery during implementation.

The UC Scheme was first implemented as a pilot project in 6 provinces in April of 2001, expanded to cover 15 provinces by June of 2001, and finally to all provinces of Thailand by January of 2002. By 2003, approximately 75% of the Thai population was covered by the Scheme, representing 47.7 million citizens. In combination with the other public insurance schemes, this left only 5% of the population uncovered. (Bureau of Policy and Strategy, 2005, p. 391)

This is what some public health experts have referred to as “the big bang approach” to introducing universal coverage: “After years of debate and slow progress, Thailand extended coverage to 18.5 million people who were previously uninsured”. (Towse, et al., 2004, p. 103) The foundation for this rapid implementation was built through years of investment in the basic infrastructure for health
care in rural areas of Thailand that made service delivery possible. The scale and capabilities of the Ministry of Public Health, who as an institution already had a long history of managing health insurance schemes, made it possible to register 45 million for the Scheme in a 4 month time period. (Towse, et al., 2004, pp. 103-104)

However, a number of major problems occurred during the implementation phase. The Scheme’s emphasis on primary care through financing of district level health service providers was a major redirection of funding for the previously hospital dominated Thai health system. There were major deficits in human resources for health created at the district level which were supposed to be redistributed by the capitation financing mechanism of the policy but which ministry officials were unable to implement due to resistance from health professionals. (Towse, et al., 2004, p. 105)

The rapid pace of implementation also led to problems with management of the system during the first year of implementation. At the provincial level, decision making was largely conducted in an adhoc and reactive manner rather than based upon thorough planning and deliberation. The lack of clear and effective policy direction during the initial phase led to operational difficulties through the end of the first year of the Scheme. Implementation of the policy faced the obstacle of limited staff capabilities in some districts, leadership problems at the provincial level due to chief medical officers and hospital directors being forced to adjust to a radically altered financing environment, and quality concerns in provinces that applied an inclusive outpatient/inpatient capitation budget which created the risk of substandard care provided to beneficiaries due to under referral for secondary and tertiary care. (Pannarunothai, et al., 2002, pp. 15-31)

Another issue that arose during implementation was that UC Scheme participants were assigned to a primary care unit without any opportunity for choice of provider, a major departure from previous schemes which led to low compliance rates for UC Scheme beneficiaries and unnecessary out of pocket payments. It was also found that the financial protections for the poor that were envisioned as
one of the key principles of the Scheme were not immediately apparent. A survey conducted shortly after implementation of the UC Scheme determined that the lowest income quintile were spending 7.5% of their income on health care compared to 1.6% for those covered by the Social Security Scheme and .1% for those covered by the Civil Servant Medical Benefit Scheme. (Towse, et al., 2004, p. 105)

There was also very little private sector participation in the Scheme even in urban areas such as Bangkok that have a high density of private hospitals and clinics. (Towse, et al., 2004, p. 105)

In practical terms, much of what was envisioned during policy formation proved to be quite problematic or impossible to accomplish during the implementation phase. For example, the distinct purchaser provider split that was supposed to include the National Health Security Office (NHSO) as an autonomous purchasing agency to manage the capitation financing of the Scheme met with great resistance from within the Ministry of Public Health (MOPH). The intention was that the funding used by the MOPH for financing of public health facilities and paying for the various insurance schemes would be managed by the NHSO as a single fund. These funds would then be dispersed to provincial purchasing boards based upon registered populations and then contracted out to designated local service providers (called contracting units for primary care (CUPs)). The goal was to redirect funding from secondary care to primary care which was seen as one of the significant problems with the social security scheme caused by using large hospitals as the main contractors. The CUPs would use their funds to provide local services and to pay for necessary referrals. (Hughes & Leethongdee, 2007, p. 1001)

This was a dramatic change in the funding and management model which led to multiple stakeholders resisting the reform. Representatives of the membership of the Social security scheme and the Civil Servant Medical Benefits Scheme fought against what they felt would be a decline in the quality of their coverage if the funding for the schemes was combined and ministry bureaucrats struggled against their own loss of financial control under the plans for the new system. Ultimately, it was decided that the transition from MOPH to NHSO as purchasing authority
would be delayed until May of 2006 (Hughes & Leethongdee, 2007, p. 1001), and that the various Schemes would not be combined until there was mutual agreement from all stakeholders. (Sakunphanit, 2008, p. 11)

The capitation model also led to macro and micro level problems with resource allocation: “At the macro level, capitation funding left many of the larger hospitals, particularly teaching and supertertiary hospitals in the Bangkok Metropolitan Authority area, in deficit. Many could not cover salary costs yet were unwilling to allow the workforce movements that architects of the reforms had envisaged. By November 2001, twenty-nine provinces had made requests for help from the MOPH Contingency Fund and received support totaling 3.2 billion baht.” (Hughes & Leethongdee, 2007, p. 1001) At the micro level, the control of the CUPs in rural areas quickly fell into the hands of community hospital directors who allocated resources based upon their own priorities rather than those of the UC Scheme. This meant that both the secondary and tertiary care hospitals that depended upon the CUPs for referrals as well as the health centers, primary care units, and district health offices which were meant to be strengthened to better serve the rural poor received less funding than expected. (Hughes & Leethongdee, 2007, p. 1001)

During this transitional period, with the MOPH still in charge of purchasing, larger hospitals that were meant to face the brunt of the redistributive effects of capitation funding were still somewhat protected from the full impact through the MOPH maintaining centralized control of budgeting for salaries and the separation of funding for inpatient services from the rest of the UC Scheme financing channeled through the CUPs. Nevertheless, larger hospitals still faced budgetary problems due to the general underfunding of the UC Scheme. Every year between 2001 and 2006, the funding provided by the Royal Thai Government fell short of the capitation rate determined by MOPH and NHSO staff. (Hughes & Leethongdee, 2007, p. 1005)

Some of the early problems with the UC Scheme attracted media coverage including the lack of policies and
procedures for treating Scheme members while away from their homes and criticisms by some that the UC Scheme provided a lower quality of care than previously existing Schemes. (Hughes & Leethongdee, 2007, p. 1001) Many citizens also voiced their displeasure with the service standards and the quality of drugs provided by the UC Scheme. (Sakunphanit, 2008, p. 11)

However overall, the rapid expansion of health insurance coverage during the initial implementation phase of the UC Scheme was generally viewed as a major success. (Hughes & Leethongdee, 2007, p. 1001)

3.0 Conceptual Framework for Monitoring of Pro-Poor Health Care

While it is important to understand the vicious cycle of the poverty trap whereby poverty leads to increasingly ill health and ill health leads to increased poverty, it is also critical to recognize that the goal of healthcare ultimately is not to raise economic status but to attain wellbeing.

Although it is in an essential consideration, achieving good health should not be defined only as a requirement and capability for reducing inequity of economic development. It is more than simply a resource that can be exploited to reach a higher income quintile. It is also a prerequisite for participating in community life, and is critical to attaining a sense of social as well as physical and mental wellbeing. In other words, good health has intrinsic value beyond economic benefit.

According to Amartya Sen, there are 3 main arguments that support a definition of poverty broader than the traditional income based conceptualization:

1. “Poverty can be sensibly identified in terms of capability deprivation: the approach concentrates on deprivations that are intrinsically important (Unlike low income, which is only instrumentally significant)

2. There are influences on capability deprivation and thus on real poverty-other than lowness of income (Income is not the only instrument in generating capabilities)

3. The instrumental relation between low-income and low capability is variable between different communities and even between different families and different
individuals (The impact of income on capabilities is contingent and conditional)” (1999, pp. 87-88)

Applying this broader definition of poverty, public health policies designed to provide pro-poor healthcare need to do more than simply equip the poor for work. Instead, they should empower the poor to be fully participatory members of society with hope for a long life expectancy and freedom from the fear of preventable and treatable diseases. With this in mind, this paper will examine whether pro-poor monitoring of the UC Scheme should be expanded beyond quantitative economic measurements to address poverty and the needs of the poor with a broader, more flexible, and fully inclusive approach.

In order to provide a common understanding of the core concepts being used to evaluate the UC Scheme in this article, the term “Pro-poor” is utilized detached from its more typical definition as a strategy for economic growth. In their well-known article, Kakwani and Pernia define pro-poor growth as “A strategy that is deliberately biased in favor of the poor so that the poor benefit proportionally more than the rich.” (2000, p. 3) For the purposes of this article, the term is applied in a broader sense to mean any strategy or outcome that disproportionately benefits the poor.

This article also utilizes the concept of “Monitoring”, best defined by the International Fund for Agricultural Development as “The regular collection and analysis of information to assist timely decision-making, ensure accountability, and provide the basis for evaluation and learning. It is a continuing function that uses methodical collection of data to provide management and main stakeholders of an ongoing project or program with early indications of progress and achievement of objectives.” (Guijt & Woodhill, 2002, p. A7)

4.0 Research Methods

The principal research methods used to gather the data for this article were:
1. Primary research through survey, key informant interview and participant observation

2. Secondary research through review of literature on the UC Scheme, theory relevant to pro-poor monitoring, and Thai health system data

The primary research was conducted during 9 days in the middle of July of 2009 through visits to public hospitals providing services for the UC Scheme in Saraburi Province as well as the Provincial Health Insurance Office. The hospital sites were selected to provide a good cross-section of hospital facilities providing UC Scheme services. The sites ranged from small rural district hospitals to large urban provincial hospitals as well as within the range of care provided from essentially primary care to better equipped tertiary care facilities.

Survey subjects in each hospital were medical professionals who directly provide the services of the UC Scheme and UC Scheme beneficiaries who met the sample qualification criteria for poverty and/or vulnerability. A total of 56 beneficiaries and 26 professionals were surveyed.

Figure 1: Map of Field Research Sites
The secondary research was used to provide additional quantitative and qualitative data to mitigate the small scale of the data gathered during primary research. This allowed synthesis between grassroots stakeholder opinion about critical pro-poor monitoring concerns with a broad variety of experts on pro-poor relevant theory and macro-level health system data. The additional data sources also helped to differentiate and associate between local and global concerns within the research results.

5.0 Results and Analysis
The results of the qualitative and quantitative research were analyzed to form the empirical basis of the model for monitoring:

Figure 2: Model of Analysis

The analysis of qualitative data from key informant interview and participant observation is ordered by field research site. The analysis of quantitative data from the medical professional and beneficiary survey is ordered by the thematic areas of the research questions and are presented as key bullet points.

Crosstabs were run for all survey variables against all demographic variables and were chosen for inclusion based on the significance and relevance of the subgroup comparison revealed.

An abridged version of the synthesis of monitoring indicators produced by the analysis concludes this paper.

5.1 Saraburi Provincial Health Office

The UC Scheme appears to have had a number of both positive and negative impacts on Saraburi Province, many of which are consistent with the successes and challenges associated with the program on a national level. Without question, the UC Scheme has expanded access to care in Saraburi. Almost all poor residents of the province are now able to access services at their district hospital without fear of incurring significant out of pocket costs. In addition, the overall insurance coverage rate of 98% is above the national average of 96% (The National Statistical Office, 2008, p. 78) and represents near universal coverage. However, this increased access has had a number of detrimental effects on health care provision in the province. The health system infrastructure in Saraburi shows the strains of providing
services to the 426,322 registered members of the UC Scheme in the Province. Underfunding of hospitals has led to heavy workloads on public health staff and an inability to pay doctor salaries competitive with those available at private sector facilities. In addition, the epidemiological transition in Saraburi (as well as in Thailand as a whole (UNESCAP, 2009, p. 59)) to a higher burden of non-communicable diseases has forced hospitals to shoulder the cost of providing expensive treatments for chronic illnesses. The overall shortage of funding caused by an annual capitation rate of only 2,202 baht per person for the UC Scheme, combined with a high demand for services has led to problems with the quality of inputs and outcomes of UC services.

5.2 Saraburi Hospital

It was clear based on the interviews with key informants that Saraburi hospital is largely able to provide UC Scheme services without going deeply into debt because it can rely upon reimbursement for tertiary care services from the Royal Thai Government. Unfortunately, this is an answer to the fiscal difficulties created by providing UC Scheme services that most hospitals in Thailand cannot rely upon.

5.3 Don Phut Hospital

Don Phut is exactly the type of small rural hospital and health center network that was intended to be strengthened under the UC Scheme and that does appear to be the case. The hospital has been fluid enough post-UC Scheme to reopen a separate building for inpatient services and has added an additional 5 beds as well as a Thai massage clinic. However, the recent financial troubles at Don Phut could also be identified as systemic problems within the UC Scheme as underfunding has lead to difficulties offering competitive compensation and retaining staff at many public hospitals in Thailand.
5.4 Kaeng Khoi Hospital

The volume of concern voiced about overuse of the UC Scheme was certainly louder at Kaeng Khoi hospital as both leadership staff and service staff stated the worry that “People are not taking care of themselves because they can go to the hospital for free”. However, nothing to substantiate this belief was offered and it appears to be based mostly on anecdotal evidence. The logic of someone indulging themselves in self-destructive behavior because of free medical care is a bit hard to follow. After all, going to a hospital, waiting several hours for service, being examined by a nurse and doctor, and then receiving treatment is still an expensive (in terms of transportation and lost wages), time consuming, and invasive process. It seems more likely that what has begun to occur with the implementation of universal coverage is that patients are not forced out of financial hardship to wait for their health problems to become intolerable before choosing to seek treatment. Simply adding a co-payment to the UC Scheme would most likely reduce the amount of patients seeking care but would also disproportionately hurt the poor, for whom even a small co-payment can be a significant barrier to care.

5.5 Nong Khae Hospital

The small number of doctors at Nong Khae appeared to be a major problem for meeting the service needs of the community. To address the situation, nurses were being asked to play a larger role in providing primary care. This seems to be a widely used stop-gap strategy for addressing the shortage of doctors in Thailand outside of Bangkok, where nearly 40% of the nation’s MDs are concentrated. (Hiroshi Nishiura, et al., 2004) While the nurse to doctor ratio at many of the hospitals we visited was around 10:1, at Nong Khae it was closer to 15:1. The statistics show that Saraburi province as a whole actually has an above average population to doctor ratio for Thailand at 2319:1. (Alpha Research, 2009, p. 279) However, there are certainly
individual districts in the province where the ratio is significantly lower and Nong Khae appears to be one of these. The effect on quality of care is an issue for further study.

5.6 Sao Hai Hospital

It was quite noticeable that Sao Hai hospital was staffed almost entirely by very young doctors straight out of medical school, a phenomenon also observed at other hospitals in Saraburi Province. While this is largely attributable to the 3 years of mandatory rural service required of new medical school graduates, it does make one wonder if the UC Scheme is essentially becoming a training program for doctors in Thailand. After completing their service in rural hospitals, a large proportion of young doctors seem to want to move to Bangkok, taking their improved skills and knowledge of the community with them. This braindrain from district hospitals certainly appears detrimental to the quality of services provided under the UC Scheme, particularly at small rural hospitals who can ill afford to lose any physicians.

5.7 Wihan Daeng Hospital

As with the other smaller rural hospitals visited in Saraburi Province, Wihan Daeng seems to be faring better in terms of finances and service capacity under the UC policy, appearing less overwhelmed with patients and with more than half of its budget provided by capitation payments. While it is a positive that many smaller hospitals appear to be able to maintain a large degree of financial stability under the UC Scheme funding model, it also encourages a limitation of services offered due to the heavy demand for outpatient care and the reliance on general and provincial hospitals for secondary and tertiary care. In effect, many smaller hospitals are forced into becoming little more than outpatient clinics rather than the primary and secondary care facilities that they are intended to be.
5.8 Individual Health

- 86% of respondents agreed that their health had improved from using the UC Scheme, an impressive achievement which would seem to be highly attributable to increased access to services. Crosstab comparison of subgroups revealed that 89% of rural inhabitants agreed that their health had improved compared with 73% of urban inhabitants. This may indicate that while health status is still affected by place of residence in Thailand, the playing field is beginning to be leveled slightly.

- When beneficiaries were asked what they would do for healthcare if the UC Scheme did not exist, one particularly arresting response was: “Use the public hospital but I would have to pay out of pocket which I cannot afford. My daughter would likely have to sell our farmland which has belonged to the family for many generations. Even then I might not be able to afford the treatments.” This reflects a common reality for many of the rural poor in Thailand which is that the family members of the chronically ill would suffer just as much financially as the patients themselves in the absence of a subsidized healthcare system.

5.9 Challenges and Accomplishments

- The most frequent responses were the financial concerns of insufficient budget and ineffective budget allocations as the biggest challenges for the UC Scheme services. The challenges that scored lowest were low quality of medicines and equipment and too much bureaucracy. Common threads running throughout the research for the professional staff were concerns that the UC Scheme is underfunded and that the money is not being allocated properly to address basic service concerns such as appropriate staffing levels.

- The results for the biggest accomplishment of the UC Scheme for the poor showed that access to care was the most commonly selected choice with 34% of responses. This was followed by guarantee of medical care at 26% of the total. One perspective on these results is that the most frequent responses can be viewed as what the
professional staff believes that the UC Scheme does best. Therefore, the other side of the analysis demonstrates that what they believe the UC Scheme does worst, which has been to improve quality of care at only 6% of the total.

5.10 Quality

➢ A subgroup comparison of quality of medical facility by hospital location showed that the highest score was received by Saraburi Hospital with 93% rating the facility good or better. It appears that although the UC Scheme was meant to strengthen district hospitals, provincial hospitals are still recognized as much higher quality facilities by many beneficiaries. Further crosstab results revealed that there was a significant division between urban and rural inhabitant ratings, with 91% of urban residents rating their facilities good or better and 69% of rural residents rating their facilities good or better. This implies that the quality divide in urban and rural facilities likely still exists.

5.11 Equity

➢ For those who felt that unequal quality care is provided between public health insurance schemes, the responses of professionals about how to make them equal included comments about including private rooms, higher quality of medicines and choice of hospitals for UC Scheme members. The beneficiary responses addressed similar concerns as well as the need for faster service.
➢ When asked about the equity of medical care provided under the UC Scheme between the rich and the poor, the overwhelming majority of both professionals and beneficiaries stated that the care provided was equal. For those who responded that the care provided is not equal, professionals stated that the rich still have more options, receive better treatment and that sometimes the poor are not confident about using UC Scheme services.
5.12 Targeted and Appropriate

- More women than men rely on the UC Scheme for healthcare partly due to higher levels of employment in the informal sector as well as unrecognized and unremunerated work as caregivers and homemakers. When asked whether the UC Scheme does as good a job of providing the services needed by women as for men, 96% of professionals and 79% of beneficiaries agreed that it does. When the beneficiary responses were disaggregated by gender, 83% of women and 72% of men agreed that UC does as good a job for women.

- Rural areas throughout the world, as well as in Thailand, are often where poverty is most concentrated. As of 2004, 86% of the poor in Thailand were residing in rural areas. (Office of the National Economic and Social Development Board, 2006, p. 3) When asked whether the UC Scheme does as good a job of providing the services needed by rural inhabitants as by urban inhabitants, 85% of professionals and 80% of beneficiaries agreed. When the beneficiary results were divided by residence type, 86% of rural inhabitants and a full 100% of urban inhabitants agreed that the services are as good. This was a surprisingly positive result from a consumer satisfaction standpoint, particularly given the clear differences in investment for health sector inputs between rural and urban areas in Thailand.

5.13 Barriers to Care

- When beneficiaries were asked what the biggest obstacle for them to use UC Scheme services is, there were 3 responses that came out as clearly the most critical obstacles. 30% chose time away from their family, 26% chose time away from work, and 21% chose transportation.

- When beneficiaries were asked how long it takes them to access services including transportation time, waiting time, and treatment time, the most frequent response for both urban and rural inhabitants was 1-3 hours. Surprisingly, the results strongly favored rural inhabitants overall which appears to be due to long waiting times at many busy urban hospitals.
When beneficiaries were asked if they found the information given to them about the UC Scheme easy to understand, 84% responded yes. However, when the results were divided by educational level, there was a very steady decline in understanding from 100% of those with a post-secondary education, to 67% of those with no formal education.

5.14 Participation and Accountability

When asked whether they thought beneficiaries should have more voice in how the UC Scheme services are provided in their community, 81% of professionals but only 41% of beneficiaries agreed. This divide in responses shows that while community participation always sounds like it will be a great benefit to the community as a whole, getting individual members interested enough to participate in decisionmaking is still a significant challenge.

When professionals were asked if they felt that the resource allocations of the UC Scheme effectively address the health needs of the poor, 54% of respondent disagreed with the statement, a dramatically strong indictment of the management of the UC Scheme when taken in light of the general positivity expressed about universal coverage throughout most of the research. When asked an open-ended question about what the resources should be invested in to improve services for the poor, the emphasis areas were more staff and higher quality medicines and facilities.

5.15 Economics

When professionals were asked whether the UC Scheme does a good job of protecting the poor from out of pocket payments for healthcare, 96% agreed that it does. When beneficiaries were asked the same question about themselves, 98% agreed with the statement. This result supports the findings of the majority of the published health economic research available, which show that the
UC Scheme has been effective at reducing out of pocket payments for the poor.

- When research subjects were asked if they feel that the economy of the community has improved as a result of the UC Scheme, 54% of professionals and 91% of beneficiaries agreed that it has. It is difficult to account for the difference in response on this question, although it is likely that professionals answered from a broader community-wide perspective and that beneficiaries gave more consideration to the economic status of themselves and those close to them. However, the real level of attribution for economic development resulting from the UC Scheme is quite difficult to quantify reliably.

5.16 Right to Health Care

- When professionals were asked if patients are generally aware that they are guaranteed the right to healthcare in Thailand, 81% responded that they were. When beneficiaries were asked the question of themselves, 96% stated that they were aware of their right. The slightly lower positive response from professionals may be due to the fact that many professionals that were interviewed believe that beneficiaries don’t really understand what their right to healthcare actually means in practical terms.

- When beneficiaries were asked if they have ever had an experience where they felt that their rights were not respected when using the UC Scheme, 13% responded that they had. When asked to describe these experiences, the majority of responses were related to staff acting impolitely. A more troubling response was provided by one beneficiary who stated that “I was told that I could not get the medicines I needed for diabetes because they are not covered by the UC Scheme benefits package”. While the details of the situation were not available, it is true that many imported medications are not covered under UC Scheme benefits.

5.17 Medical Staff and Concerns

- When asked if they felt that the staff at their facility is overworked as a result of providing services for the UC
When asked if they had ever made a formal complaint about the heavy workload, 15% of professionals stated that they had. When asked what the result of the complaint was, all responses were that nothing had changed or that there was no response. A professional who sounded like he was speaking from experience stated: “No response. The Ministry of Public Health seems to be more interested in patient concerns than staff concerns.”

When asked if they have any medical concerns with the services provided under the UC Scheme, the majority of professionals answered no at 54% of the total. However, when divided by occupation, it was clear that it was overwhelmingly administrators and nurses who had no concerns about the medical care provided. In fact, 100% of the doctors, dentists, and pharmacists interviewed expressed that they had medical concerns about UC Scheme services.

5.18 Priority Setting

For professionals, the top priority was more funding for services and that message was repeated throughout the research. The staff at public hospitals in Saraburi Province overwhelmingly expressed that the UC Scheme is underfunded and critically needs additional financing to provide the necessary services. It is notable that although the capitation rate for the UC Scheme has been raised significantly since the beginning of the UC Scheme, the rate still fell short of completely funding outpatient services provided under the UC Scheme at every hospital visited during the research.

For beneficiaries, the top priority was services designed for the needs of the poor and vulnerable, which was a surprisingly intangible issue to be the number one concern but shows that a passion for public health has certainly been instilled in many Thai citizens. The next two priorities were more expected as both the quality of
medical facilities and medicines are well established as ongoing concerns with the services of the UC Scheme.

5.19 General Concerns

- When asked what the most important things that could be done to improve the UC Scheme for the poor are, a critical case response to the question that summed up many of the answers was “If the government wants to continue UC, they need to focus on reducing staff workloads and increasing financial incentives for both hospitals and medical staff.” When beneficiaries were asked the same question, the most frequent responses were “additional medical staff”, followed by “better quality medicines”.

- When beneficiaries were asked for personal stories about using the UC Scheme, some of the most compelling included: “I have HIV and before UC I was not receiving any treatment because I am very poor. However, after UC was started I receive proper treatment and have learned how to care for myself. I am healthy enough now to volunteer for the HIV support group and at the hospital.” A male patient stated that “I have cirrhosis of the liver and I was referred several times for more specialized care. The cost of the treatment was actually around 70,000 baht but I only had to pay 51 baht out of pocket. I feel that the UC Scheme saved my life.”

6.0 Conclusion

The UC Scheme in Thailand has enjoyed both a very high level of national support from the Thai population and a large amount of international attention for its innovation and achievements. There is good reason for much of this support and praise as anyone with practical involvement with the UC Scheme can attest. The expansion of coverage accomplished has improved access to healthcare for millions of poor Thai citizens and freed them from the fear of not being able to afford essential medical care. The majority of those interviewed during this research responded with praise and civic pride when asked about the UC Scheme.
However, despite these achievements, there is still a significant discrepancy between the policy goals of the Universal Coverage Scheme and its execution in practical terms for many Thai citizens. After a considerable amount of primary and secondary research to develop a conceptual model for program monitoring of the Scheme, the overall impression left is that universal coverage in Thailand can best be characterized as a “Great policy” but perhaps only a “Good program” at this time. While the principles and beliefs that went into formulating the objectives of the policy are beyond question, the realities of its translation into an implemented program have sometimes fallen short of the ideals. It should be admitted that universal coverage has been achieved partly at the expense of public hospitals, public health staff, and quality of care.

The hypothesis tested in this research was to determine if there are additional pro-poor characteristics of the UC Scheme that should be monitored beyond quantitative economic measures. While the results did indicate the importance of economic monitoring to address some stakeholder concerns, they also appear to show that further metrics should be included in pro-poor monitoring for the UC Scheme.

This research appears to expose that there is a certain danger in relying too heavily upon economic metrics for monitoring of the UC Scheme because they place a heavy emphasis on its already known achievements and do not reveal many of the ongoing problems. Critically, while the health economic measures of the UC Scheme have accentuated the successful shift of the financial burden of care from the poor, they have been less revealing about the fact that much of that burden has fallen on public health facilities and their staff. In addition, there are no econometric indicators appropriate for determining the value of receiving high quality care when medically necessary.
7.0 Recommendation

The results of this research appear to show that the UC Scheme could be improved to better meet the needs of the poor and vulnerable in Thailand through monitoring of additional indicators. Further study of stakeholder concerns on a broader scale would be beneficial.

Abridged Model of Recommended Monitoring Indicators

- Monitoring of the impact of services on disease management and health outcomes among poor and vulnerable demographic groups
- Patient and medical staff based metrics for quality of inputs, outputs, and outcomes of the UC Scheme
- Monitoring for the equity of service quality, patient satisfaction, utilization, health status and outcomes between public health insurance schemes
- Monitoring of health services utilized by poor and vulnerable demographic groups to guide investment
- Monitoring of the comprehensiveness of UC enrollment coverage among poor and vulnerable groups
- Monitoring of upper level management accountability and transparency through regular reporting, auditing, and forums for community feedback on policy decisions
- Monitoring of the number and type of reported rights violations and their resolutions. Establishment of standards for service utilization to medical staff ratio and monitoring of progress towards reaching those standards

References


Ben Harkins, Chulalongkorn University (Bangkok, Thailand)


Unrest Magazine
New Issue - February 2011

Unrest Magazine is a web-based publication dedicated to advancing critical conflict theory and engagement. Unrest aims to explore the structures responsible for human discontent and cultures of violence, while promoting alternatives to militarism and exploitation.

Previous issues featured work from:
Richard E. Rubenstein, Johan Galtung, Roberto Luna Salvador,
Otto F. von Feigenblatt, Michael D. English, Sarah Rose Jensen,
Jay Filipi and Derek Sweetman.

Those interested in collaborating with Unrest Magazine should go to www.unrestmag.com
or contact The Editorial Cell at unrestmag (at) gmail.com for more details.