

# An Evaluation of Universal health Care Coverage among low Income Groups in Thailand by Using four Selected Characteristics of Good Governance

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## *Abstract*

**Background:** This study focuses on an evaluation of the universal health care coverage among low income groups by using four selected characteristics of good governance: equity, efficiency and effectiveness, participation and transparency.

**Methods:** The interviews with policy makers and patient representatives were conducted. The purposive sampling was used to select interviewees. The data was analyzed by a template analysis style, as the templates are the four selected characteristics of good governance.

**Results:** After the introduction of universal health care coverage in Thailand, the Thai health care system has improved. First, equity in Thai health care system is largely improved, which can be seen by improvement of the accessibility to health services among low income groups. Second, the efficiency of health care systems has enhanced. Third, people have better opportunity to participate in decision making process of the health care systems. Fourth, the transparency of health care systems is improved due to the shift of power to allocate health fund from the Ministry of Public Health to the National Health Security Office.

**Discussion:** Despite the improvements in the health care systems, there are still several challenges that the Thai health care system is facing. For example, the geographical barriers prevent low income groups from accessing care for chronic conditions, this result showed insufficient allocation of resources in health care systems. Another challenge for the Thai health care system is a shortage of medical professionals.

**Conclusion:** the universal health care coverage has improved the accessibility of health care services among low income groups, efficiency of health care systems and participation of people in decision making. However, the challenges are still occurring, for example, insufficient of human resources and geographical barriers.

*Key words:* universal health care coverage, equity, efficiency and effectiveness, transparency, participation

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**บทคัดย่อ** การประเมินผลกระทบของหลักประกันสุขภาพถ้วนหน้าในกลุ่มผู้มีรายได้น้อยในประเทศไทย โดยใช้หลัก  
ธรรมาภิบาล

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การศึกษานี้มุ่งเน้นการประเมินผลกระทบของหลักประกันสุขภาพถ้วนหน้าในกลุ่มผู้มีรายได้น้อยโดยใช้หลักสี่ประการของหลักธรรมาภิบาลเป็นตัวชี้วัด ผู้ศึกษาได้สัมภาษณ์ผู้วางแผนและนโยบายระบบสาธารณสุขและตัวแทนผู้ป่วยที่ใช้สิทธิในหลักประกันสุขภาพถ้วนหน้า การศึกษาในครั้งนี้พบความสำเร็จที่สำคัญสี่ประการหลังจากมีหลักประกันสุขภาพถ้วนหน้า อันประกอบด้วย ประการที่หนึ่งกลุ่มผู้มีรายได้น้อยมีโอกาสในการเข้าถึงบริการทางด้านสาธารณสุขมากขึ้นซึ่งแสดงถึงระบบหลักประกันมีความเป็นธรรมมากขึ้น ประการที่สองคือประสิทธิภาพของระบบการดูแลสุขภาพดีขึ้นเนื่องจากการจ่ายเงินให้กับผู้ให้บริการสุขภาพแบบเหมาจ่ายรายหัว ประการที่สามคือประชาชนมีโอกาสในการเข้าร่วมในกระบวนการตัดสินใจของระบบการดูแลสุขภาพ ประการสุดท้ายคือความโปร่งใสของระบบสาธารณสุขไทยดีขึ้นเนื่องจากการเปลี่ยนแปลงอำนาจในการจัดสรรเงินกองทุนสุขภาพจากกระทรวงสาธารณสุขไปสู่สำนักงานหลักประกันสุขภาพแห่งชาติ อย่างไรก็ตาม ยังมีปัญหาอีกหลายประการที่ระบบสาธารณสุขของไทยจะต้องดำเนินการแก้ไข ตัวอย่างเช่นอุปสรรคทางภูมิศาสตร์ที่เป็นปัญหาต่อการเข้าถึงบริการในกลุ่มผู้มีรายได้น้อยโดยเฉพาะการรักษาในกลุ่มผู้ป่วยโรคเรื้อรังอีกหนึ่งปัญหาของระบบสุขภาพไทยก็คือการขาดแคลนบุคลากรทางการแพทย์ซึ่งส่วนใหญ่เกิดจากสมองไหลของบุคลากรทางการแพทย์จากชนบทไปยังเขตเมืองและจากโรงพยาบาลของรัฐไปยังโรงพยาบาลเอกชน

**คำสำคัญ:** หลักประกันสุขภาพถ้วนหน้า ความเสมอภาค ประสิทธิภาพ ประสิทธิผล การมีส่วนร่วม ความโปร่งใส

**Introduction**

Thailand was one of the first countries in Asia to introduce universal health care coverage (UC).<sup>(1)</sup> In 2001, Thailand introduced the UC after the Thai Rak Thai party, which is the political party that won the election as it promised in the campaign to introduce 30 Bath Rak Sa Took Rok (30 Baht co-payment scheme or universal health care coverage). Before implementing universal health care coverage, four health insurance schemes were developed for different population groups. The Civil Servants Medical Benefits Scheme (CSMBS) covers all civil servants and some of their family members. The Social Security Scheme (SSS) covers employees who have worked in the formal employment sector. The Medical Welfare Scheme covered poor, senior citizens, children under 12 and the disabled. The Voluntary Health

Card Scheme covered general population, especially in rural areas. The last two schemes were replaced by the UC in 2001.<sup>(2)</sup> Although there were four schemes of health insurance, only three quarters of the Thai population were covered<sup>(3)</sup> which left 18.5 million people paying “out of pocket” for health services.<sup>(4)</sup> After introducing the universal health care coverage, it extended to cover also these 18.5 million people who were not insured before.<sup>(4)</sup>

The inequality in health status and access to health care among different socioeconomic groups were the main reasons for implementing universal health care coverage.<sup>(3)</sup> In 2001, the implementation of the universal health care coverage was reached, which aimed at improving access to health care services especially among low income groups.<sup>(5)</sup> There are two explanations for why the low income groups

were focused on when implementing universal health care coverage. First, the usage of health services among low income households was lower than high income households. Second, health discrepancies between different income groups are also large, for instance, low income groups perceived their health more negatively than higher income groups.<sup>(3)</sup>

After implementation of universal health care coverage, an evaluation needs to be performed in order to improve health care systems. Therefore, this article focuses on evaluation of the universal health care coverage by using the four selected characteristics of good governance. The research question states below:

*What are the successes and failures of universal health care coverage regarding low income groups, based on selected characteristics of good governance?*

### **Good governance**

The concept of Good Governance was applied in this research as this is a pivotal concept when assessing political and social developments. Following the UNESCAP, UNDP & ADB, good governance can be defined as high quality of processes and decision making, by which decisions affecting public affairs are reached and implemented. Furthermore, good governance assures that all, including the poor and other disadvantaged groups, are included in the process of decision making and have the ability to influence the direction of development in particular as far as it affects their lives. Moreover, good governance ensures the adequacy of all stakeholders to have access to services and resources.<sup>(6)</sup>

There are eight characteristics of good gover-

nance: rules of law, participation, transparency, consensus oriented, accountability, responsiveness, inclusiveness and equity, and effectiveness and efficiency. However, this research applied only four characteristics of good governance: equity and inclusiveness, efficiency and effectiveness, transparency, and participation, due to applying four instead of eight characteristics allowed the researcher to analyze a specific problem in a greater detail within the limited time frame.

*Inclusiveness and equity* is meant to include everybody in the process of development, including poor and disadvantaged groups. Furthermore, everyone should have the same opportunity to access services and resources according to their needs. *Participation* refers to the possibilities for people to influence the process of decision-making in direct or indirect ways. In addition, the participation can also refer to the freedom of association, speech and capacities to participate in the process of development that affects lives. *Transparency* is defined as the degree to which the rules, standards and procedures for decision-making are open, clear, verifiable and predictable. Moreover, the transparency can be identified as the degree to which people have accesses to information, which provides them with full understanding and enables them to monitor the process.<sup>(6)</sup> *Efficiency and effectiveness* is defined as achieving an optimal use of resources to produce the results that meet with all needs of stakeholders.<sup>(7)</sup>

### **Objectives of this study**

Regarding the research question, the objective of this study is to evaluate the failures and successes



of the universal health care coverage scheme among low income groups. Within this objective, the characteristics of good governance were used to assess the universal health care coverage scheme. Moreover, the research outcomes were expected to provide evidence for policy makers to improve the universal health care coverage among low income groups in Thailand.

## Methods

In this section, research design will be presented, and will be followed by how to collect data. Moreover, methodology for analyzing data will be described.

### **Research design**

The research had a qualitative approach as it focused on the perspectives of experts who were representatives for patients. The research was an evaluative research as it evaluated the health policy that has been implemented in Thailand.

### **Sampling procedure**

In order to answer the research question, purposive sampling was used to select the population. Those selected populations were the expert groups, who represented patients and had knowledge about and experiences with UC, as is shown in table 1. Moreover, those selected groups were involved in decision making process of health care systems. The reason why interviews with patients were not carried out was time limitation.

### **Data collection**

The researcher formulated the questions that were used in the semi-structured interview and pre-tested them. The semi-structure interview was de-

finied as the researcher followed a list of questions.<sup>(8)</sup> Twenty-one participants were contacted and 19 participants agreed to participate in the interviews. Two experts from the Research Health Institute and the Cancer Health Institute were not able to participate due to a busy schedule. All the interviews were recorded with the consent of the participants. The interview was performed in Thai to avoid a language barrier as Thai was the mother tongue of the researcher and the respondents. Moreover, in order to ensure confidential of participants, the names of participants are kept anonymous.

### **Data analysis**

The transcription of the data was translated into English and the translation was checked by an expert in Thai-English-translations. Moreover, a template analysis was selected to analyze data<sup>(9)</sup>. The data was classified into four categories, including equity and inclusiveness, efficiency and effectiveness, participation, and transparency. Within different categories, successes and failures of the universal health care coverage were analyzed.

## Results

The results will be presented according to the four selected characteristics of good governance: equity, efficiency and effectiveness, participation and transparency.

### **Equity**

In the principle of equity, this study focused on three areas of the Thai health care system, including accessibility of health care services in general care, accessibility of health care services more specifi-

cally on chronic care, and equality of quality of care.

Both general care and chronic care, the Thai health care system provided more opportunity for Thai population to access health care services after introducing UC.<sup>(p2, p3, p4 & r2 see clusters in table 1)</sup> Considerably, low income groups largely benefits from the universal health care coverage. As shown, accessibility of health care services among low income groups has been increased<sup>(p1, p4, r1 & r6)</sup>. However, there is a geographical barrier that prevents low income groups from accessing health care services in rural areas.<sup>(p1 & p3)</sup>, especially for chronic care due to the treatments of chronic diseases are mostly available in urban areas.<sup>(p1)</sup> As UC covers low income groups and Civil Servant Medical Benefits Scheme (CSMBS) and Social Security Scheme (SSS) cover middle and high income groups, when compared UC with other two schemes, the chronic conditions that have been treated by using UC are less than other two schemes.<sup>(p4)</sup>

People should have access to good quality of care, regardless of their income, social status and residency. Therefore, quality of care is one indicator that should be considered in the principle of equity. The quality of care in public hospitals that provides health care for the rich and the poor is similar if they access the same health care units.<sup>(p3 & r2)</sup> However, the rich groups can have access to hospitals that have a higher quality of care, especially in private hospitals.<sup>(r4)</sup> Moreover, if comparing urban and rural areas, the quality of care is different. In urban areas, there is better medical equipment, treatment and sufficient human resources.<sup>(p3)</sup> Furthermore, when different coverage

schemes are compared, patients who are covered by the Civil Servant Scheme and the Social Security Scheme receive better quality of care than those under UC. This can be underpinned a difference in medicine lists provided to people covered by three different schemes.<sup>(r1 & r5)</sup>

### **Effectiveness and efficiency**

After introducing UC, health care demand has dramatically increased. However, the number of medical professionals remains the same. This leads to an increased productivity of health care providers.<sup>(p4)</sup> Moreover, the brain drain problem of medical professionals from public hospitals to private hospitals and from rural to urban areas has also increased.<sup>(p4)</sup> Increasing accessibility and brain drain can cause an increase in workload of medical professionals in public hospitals.<sup>(p4)</sup>

In addition, provider payment mechanisms of health care budget can influence the efficiency of health care systems. The capitation payment is used, which can influence the efficiency of health care budget. This payment mechanism sets the ceiling for health care providers to use their budget; therefore, they spend according to the budget that they receive. This causes the improvement of efficiency in the health care systems.<sup>(p1 & p3)</sup>

Health care systems in Thailand focus on secondary care, which could influence the efficiency of health care systems, as the problem of moral hazard tends to be increased. By that it means people intend to make use of health care services more than necessary. Moral hazard is caused by the free provision of health care services.<sup>(p1)</sup>



## Participation

At the policy level, there are nine groups according to the national health law. These nine groups consist of children and adolescents, women, elderly, disabled or mental health patients, HIV or other chronic disease patients, labor, populous communities, agriculturists and minorities. They participate in decision making process, controlling quality of care. Moreover, they also have power and duties in managing health care.<sup>(r1)</sup>

At community level, people have more opportunities to participate in decision making process, for example, the project of the NHSO is trying to promote the participation of people in communities, which is called the Local Tambon (sub-district) Administrative Organization Health Fund. This project aims at providing a health fund for leaders of communities to promote participation of people in communities in order to improve their health. Moreover, this fund is also spent on health promotion and health prevention, which should involve people in communities.<sup>(p1 & p4)</sup>

## Transparency

Before introducing UC, the health care budget, health care services, quality of care control, and health care evaluation were done by the Ministry of Public Health. Therefore, it was very difficult for external organizations to check and evaluate health care services. After introducing UC, more parties check for quality of care as well as allocation of budgets. This leads to the enhancement of accountability and transparency in the health care systems because most

activities, particularly allocating of health funds, of the Ministry of Public Health have been transferred to the NHSO. The NHSO's organization and its performance are evaluated by both internal and external parties.<sup>(p4)</sup> Moreover, more parties are involved in policy development. Therefore, decision makers in health care sector need to become more accountable for their own actions and decision making process. However, one policy maker stated that *"the openness of information in health care systems is still in a grey area, which is indicated by some parties in health care systems do not want to open and discuss about some information"* If there is hidden information, some processes and actions in health care systems are not fully transparent.<sup>(p4)</sup>

In addition, there is some information on health care systems that citizens should know but few population groups received information. For example, one patient representative stated *"capitation payment mechanism that is presently used in health care systems, the government did not disseminate information about the sources, advantages, disadvantages of this capitation payment mechanisms to citizens. How many of Thai citizens know about this information? However, this information has a huge influence on health care expenditure and health care management."*<sup>(r7)</sup>

Unexpected result is showed when asking representatives of patient about transparency in health care systems. They pointed out the right to access information of diseases and symptoms of patients and relationships between patients and doctors. This result is not considered in the transparency of good governance concept.

## Discussion

According to the concept of equity, everyone should have the same opportunity to access health care services according to his/her needs. As the results confirm, the accessibility to health care services of low income groups has dramatically increased. This results show that the equity has been improved after introducing the universal health care coverage as people have more access both general care and chronic care. However, the problem that still occurs among the low income group is geographical barriers. As the results revealed, chronic care is mostly available in urban areas, which can cause low income groups unable to access to the chronic care. It is critical to note that the accessibility of health care services might be related to the allocation of resources to all stakeholders in the concept of efficiency. By that it means, if the resources are well allocated, for example, physicians and high technological equipments are sufficient allocation to rural areas, low income groups might be able to access health care services without any barrier.

The quality of care is one of the indicators that is considered in the concept of equity. People should have access to equal quality of care regardless of their income and social status. As the results reveal other two schemes (Civil Servants Medical Benefits Scheme and Social Security Scheme) receive better quality of care when compared with the UC. To analyze these results, it can be concluded that the opportunity to access health care services is quite similar between high income and low income groups; however, quality of care that both groups receive differs.

After considering concept of equity, one might see that equity is related to efficiency and effectiveness. As the accessibility of health services is improved but the number of medical professionals remains the same, which means that the medical professionals work more efficient. However, if one looks more closely the medical professional side, one could criticize that the systems induced unmet challenges for the medical professionals, as the result reveals workload of medical professionals. Increasing the workload plus high incentives from private hospitals may result in the outflow of physicians from rural areas to urban areas and from public hospitals to private hospitals. Furthermore, the workload of medical professionals might explain the unequal quality of care services in public hospitals compared to private hospitals as mentioned earlier. Increasing the workload could affect the quality of care and the performance of medical professionals. On the one hand, medical professionals work efficiently. On the other hand, the quality of care and the effectiveness of treatment are still questionable for the patients.

Considering the implications from the health care receiver side, patients have higher incentives to go to hospitals because they do not have to pay for health care services. It can induce the problem of moral hazards as mentioned in the result earlier. This can affect the efficiency of the Thai health care system. Another aspect that can enhance efficiency is payment mechanisms of health care providers. Capitation payment as presently used can influence on the efficiency of health care expenditure. It is indicated in the results that capitation payment sets the ceiling for health care providers to use their budget; there-



fore, health care providers need to spend according to their received budget.

After analyzing the results in the concept of efficiency and effectiveness, participation of people in decision making process needs to be considered. The movement of patients at policy levels helps to improve the health care systems. The national health law prescribes the nine groups that should be involved in decision making process. These nine groups have an active role in influencing decision making in health care systems.

The trends of participation of local people are largely improved as shown in the result on the project of the Local Tambon Administration Organization Health Fund. This can support leaders of communities and people in communities to participate and have an active role in responsibilities for their health, involvement in health promotion and management of health funds. This shows that health care systems increased the degree of participation by allowing leaders of communities to manage the health funds.

Considering the principle of transparency, distribution of the power from one party to another party helps to increase transparency. As the power is distributed from the Ministry of Public Health (MoPH) to the National Health Security Office (NHSO), the transparency has been improved. The evaluation of decision making process of both parties became explicitly clear. Therefore, the decision-making of MoPH and the NHSO needs to be clear, open and predictable in order to allow people to check and evaluate their decision making process. However, as the result indicates some hidden information is still occurred in the Thai health care system, one can criticize that

transparency of the Thai health care system is not really strength.

Moreover, transparency can be identified as the degree to which people have access to information which provides them with full understanding and enable them to monitor the process. As the result reveals, a few people can access to the information about sources, advantages and disadvantages of capitation payment mechanisms. From this result, one might assert that the health care system is not fully opening opportunities for all people to check and monitor the decision making process.

Regarding the results, the concept of good governance might be understood differently in different context. For example, as results show the patient representatives mentioned the transparency and related to the transparency of the doctors. Therefore, in order to discuss the concept of good governance, the further researcher needed to take cultural differences into account.

### **Limitation of study**

The results of this study are mainly coded from the interviews, which might not be sufficient to evaluate health care systems after introduction of the universal health care coverage. However, the selected policy makers and patient representatives are quite relevant groups due to most of selected the policy makers and patients representatives involved in decision making process.

### **Conclusion and recommendations**

After the introduction of universal health care coverage the Thai health care system has improved,



**Table 1** participant data

Interviewees	Number of respondents	cluster	Reason to choose
Ministry of Public Health	2	Policy maker1 (p1)	Having experience and knowledge about UC due to interviewees have involved in health care systems before health care reform in 2001
Moh Choa Ban; Thai Public Health Journal and professor in Mahidol University	1	Policy maker2 (p2)	
ASEAN Institute for Health Development (AIHD)	1	Policy maker3 (p3)	
Health Insurance System Research Office	2	Policy maker4 (p4)	
Thai Consumer Foundation (NGO)	1	Patient representative1 (r1)	Patient Representative
HIV/AIDS patient association	3	Patient representatives2 (r2)	Patient Representatives
Kidney patient association	1	Patient representative3 (r3)	Patient Representative
Cancer patient association	3	Patient representatives4 (r4)	Patient Representatives
Disable patient association	3	Patient representatives5 (r5)	Patient Representatives
Diabetic patient association	1	Patient representative6 (r6)	Patient Representative
Psychotic patient association	1	Patient representative7 (r7)	Patient Representatives

as confirmed by the results of this study. There are four successes of UC that were identified. First, the accessibilities of health care services are improved; low income groups have better access to health care services. Second, the payment mechanism of health care providers helps to improve the efficiency of health care systems, as the capitation payment sets the ceiling for the health care budgets of health care providers. Third, people have more opportunities to participate in decision making, particularly the participation of patient representatives in the decision making process of health care systems at the policy level. Finally, the transparency has improved after distributing the power from the MoPH to the NHSO, which

leads to better evaluation and monitoring of both parties. However, there are still several challenges that the Thai health care system is facing. First, the geographical barriers prevent low income groups from accessing care for chronic conditions. Second, the differences in quality of care between three different schemes (the Civil Servants Medical Benefits Scheme, the Social Security Scheme and universal health care coverage) are still occurring. Third, shortage of medical professionals is mainly caused by brain drain from rural to urban areas and from public hospitals to private hospitals. Finally, the passive role of low income groups in health care systems is another challenge that policy makers need to take into account.



Regarding the findings of this study related to health care systems in Thailand, we wish to give policy recommendations to the Thai policy makers in four areas. First, the distribution of resources, particularly human resources and medical equipments, to rural areas should be improved as geographical barriers are the hinder factors to access healthcare services among low income groups. Second, the problem of insufficiency of medical professionals in public hospitals should be overcome by providing high incentives, such as higher incomes and higher rewards for medical professionals to work for public hospitals. Third, the Thai health care system should provide better opportunities for low income groups to participate in the decision making process. Finally, information about the action and decision making process of governments in public health sector should be more socially accountable in order to allow people to monitor and check the process.

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